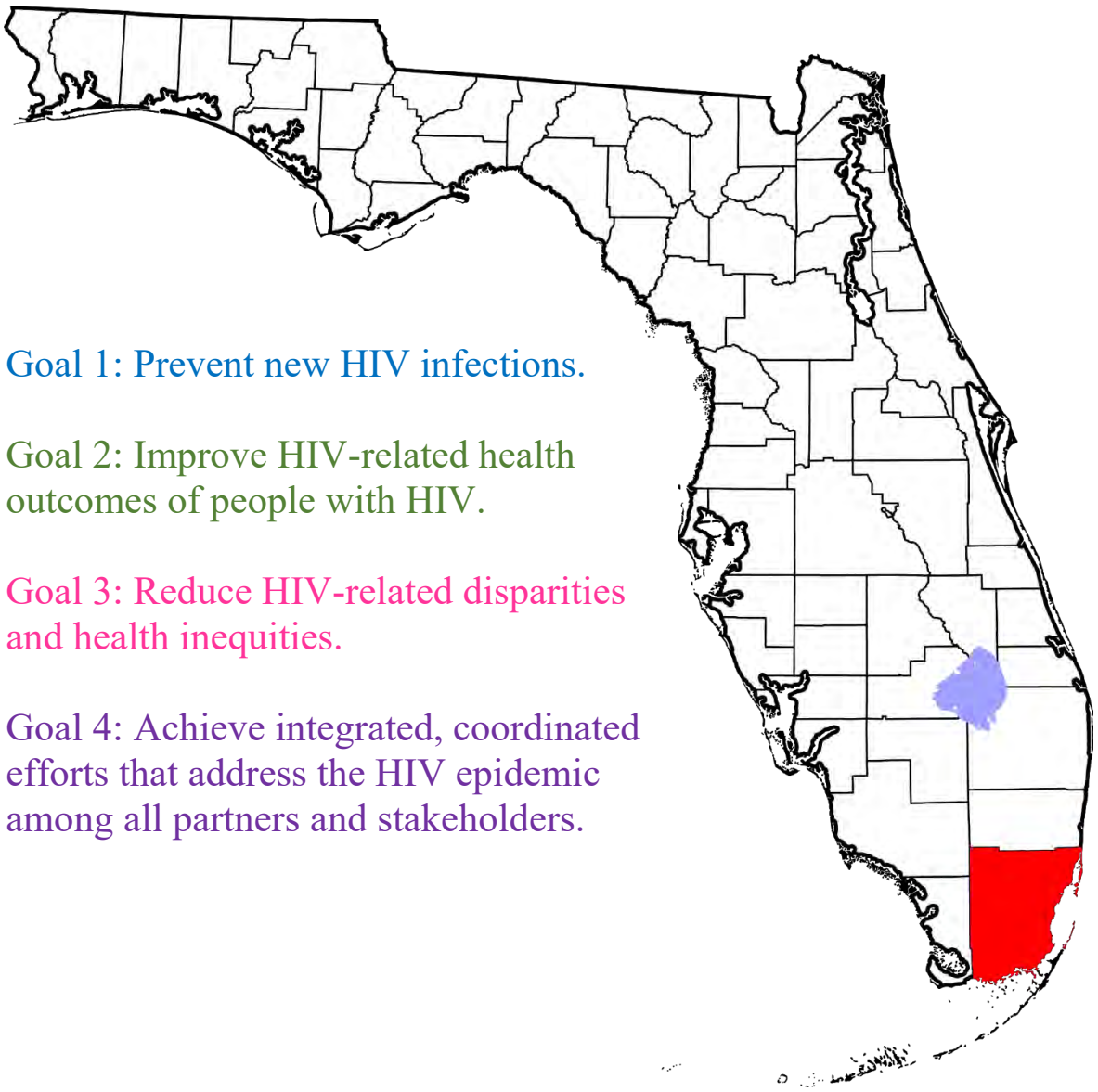
ATTACHMENT #3

MIAMI-DADE COUNTY 2022-2026 INTEGRATED HIV PREVENTION AND CARE PLAN



Goal 1: Prevent new HIV infections.

Goal 2: Improve HIV-related health outcomes of people with HIV.

Goal 3: Reduce HIV-related disparities and health inequities.

Goal 4: Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders.

MIAMI-DADE COUNTY | MIAMI-DADE HIV/AIDS PARTNERSHIP | BEHAVIORAL SCIENCE RESEARCH | Florida HEALTH Miami-Dade County

With participation by people with HIV and other community partners in Miami-Dade County.

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Acronyms and Terminology

These acronyms and terminology are used throughout this Plan. Prevention goals also include activity-specific definitions.

ACRONYMS & TERMS	DEFINITION
ACA	Affordable Care Act
AD	FDOH-MDC Academic Detailer
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
B/AA	Black/African American (may or may not indicate "including Haitians")
BSR	Behavioral Science Research Corporation, (Administrative/CQM Subrecipient)
CHARTS	Florida Community Health Assessment Resource Tool Set
CQM	Clinical Quality Management Program at BSR, including CQM Committee and MAI CQM Team
CY	Calendar Year
DTC	Data To Care
EHE	Ending the HIV Epidemic, A Plan for America
▪ **EHE HealthTec**	EHE telehealth program (EHE HealthTec providers: Care Resource Community Health Center and The Village South)
▪ **EHE Quick Connect**	Program to provide access to medications for those above the RWHAP 400% FPL threshold and those who are not residents of MDC (EHE Quick Connect provider: Borinquen Health Care Center)
▪ **FDOH-EHE**	FDOH EHE PS20-2010: EHE grant under the jurisdiction of FDOH-MDC
▪ **RWHAP-EHE**	EHE grant under the jurisdiction of MDC OMB
EMA	Eligible Metropolitan Area as designated by HRSA under the RWHAP, local, Miami-Dade County
FDOH-MDC	Florida Department of Health in Miami-Dade County
FPL	Federal Poverty Level
G2Z	Getting 2 Zero
HCSF	Health Council of South Florida
HIPC	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals
HRSA	Health Resources and Services Administration
HOPWA	Housing Opportunities for Persons With AIDS
IDEA Exchange	University of Miami Infectious Disease Elimination Act
IDU	Intravenous Drug Use
JIPRT	Joint Integrated Plan Review Team (Partnership Strategic Planning and Prevention Committees)
MAI	Minority AIDS Initiative, part of the RWHAP
MAI CQM Team	Minority AIDS Initiative Clinical Quality Management Team; see CQM
MCM	RWHAP Medical Case Management or Medical Case Managers
MDC	Miami-Dade County
MMSC	Male-to-Male Sexual Contact (Refers to mode of transmission)
MSA	South Florida Metropolitan Statistical Area
MSM	Men Who Have Sex With Men (Refers to people)
NHAS	National HIV/AIDS Strategy
OAHS	Outpatient/Ambulatory Health Services, provided by the RWHAP
OMB	MDC Office of Management and Budget, Grants Coordination
▪ **Recipient**	MDC Office of Management and Budget, Grants Coordination
Part A/MAI	Part A and the Minority AIDS Initiative of the RWHAP
Partnership	Miami-Dade HIV/AIDS Partnership, Ryan White Program Planning Council

ACRONYMS & TERMS	DEFINITION
PE-Miami	Provide® Enterprise Miami (data management system utilized by RWHAP Part A & Part B)
Plan	*Miami-Dade County 2022-2026 Integrated HIV Prevention and Care Plan*
PrEP	Pre-Exposure Prophylaxis
▪ **nPEP**	Non-occupational Post-Exposure Prophylaxis
▪ **PEP**	Pre-exposure Prophylaxis
▪ **PrEP WG**	FDOH-MDC PrEP Work Group
PCN	HRSA Policy Clarification Notice
PWID	Persons Who Inject Drugs
QI	Quality Improvement
RFP	Request for Proposal
Risk Factor	Self-reported mode of initial HIV/AIDS diagnosis
RWHAP	Miami-Dade County Ryan White Program Part A/MAI
SCSN	Statewide Coordinated Statement of Need
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
Subrecipients	Organizations funded under the RWHAP Part A/MAI; (also called providers)
TTRA	Test and Treat / Rapid Access (local "rapid start" project)
U=U	Undetectable = Untransmittable Campaign
UM	University of Miami
VL	Viral Load
VMSG	Vision Mission Services Goals Dashboard (FDOH database)

Section I: Executive Summary of Integrated Plan and SCSN

I.i. Executive Summary of Integrated Plan and SCSN

For over a decade, the Miami-Dade County (MDC) Eligible Metropolitan Area (EMA) has been a national HIV/AIDS hot spot. The EMA leads the State of Florida in the total number of people with HIV. 27,782 people with HIV – more than 23% of the entire state's population of people with HIV – lived in the EMA in Calendar Year (CY) 2020. For nine of the past 10 years, the South Florida Metropolitan Statistical Area (MSA) has led the nation in the annual new-infection rate for HIV. During that time, the MDC Ryan White HIV/AIDS Program (RWHAP) Part A/Minority AIDS Initiative (MAI), through the MDC Office of Management and Budget (OMB or Recipient; the Florida Department of Health in MDC (FDOH-MDC); and the Miami-Dade HIV/AIDS Partnership (Partnership), the official RWHAP Planning Council, have been coordinating responses to the HIV epidemic, linking programs in community education, HIV prevention, HIV testing, linkage to care, and medical and social support for people with HIV. These collaborative activities include the *Getting to Zero* initiative in 2016, the *2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan (2017-21 Integrated Plan)*; the *National HIV/AIDS Strategy 2022-2025*; the *Ending the HIV Epidemic Jurisdictional Plan;* and the ongoing cooperation between the Partnership's Prevention and Strategic Planning Committees.

This document, the *2022-2026 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan* (2022-26 Integrated Plan or Plan), represents the latest collaborative effort. The 2022-26 Integrated Plan incorporates the goals and objectives of local, state, and national initiatives to achieve the national HIV goal, "Reducing the number of new HIV infections in the US by 75% by 2025, and then by at least 90% by 2030." Specifically, this Plan is a comprehensive update of the 2017-21 Integrated Plan and fully incorporates the 2021 Ending the HIV Epidemic Jurisdictional Plan, and the Getting to Zero and other jurisdictional needs assessments and targeted community initiatives. The activities detailed in **Section V,** below, include efforts to reduce duplication of resources across funding streams, address HIV/AIDS stigma and systematic racism (through cultural competency training) as public health threats, adopt the status-neutral approach to care, target services toward the special needs of at-risk populations, and address the particular needs of an aging population of people with HIV.

This Plan was developed entirely as an ongoing collaboration between the FDOH-MDC, the RWHAP, the Partnership, people with HIV, including RWHAP clients and peer educators, and a broad spectrum of community stakeholders, including representatives of RWHAP Parts A, B, C, and D; the AIDS Drug Assistance Program (ADAP); the prevention and planning workgroups within the FDOH-MDC; the Florida Agency for Health Care Administration (Medicaid); and others as detailed in **Section II.**

Both qualitative and quantitative data are used in the 2022-26 Integrated Plan to describe the impact of HIV in the EMA; determine service gaps and barriers to care; identify prevention and treatment areas where cultural biases, stigma, and non-gender-neutral service provision need to be addressed; and develop goals and objectives to ensure access to HIV prevention and care services across the service delivery system, as detailed in **Section III.**

As detailed in **Section VI,** the Recipient, FDOH-MDC, RWHAP, and the Partnership will be responsible for monitoring, evaluating, and reporting on Plan activities. As with the 2017-21 Integrated Plan, regular

process improvement and updates are expected and will be conducted under the purview of the Partnership and publicized widely for continued community engagement and stakeholder collaborations.

I.i. (a) Approach

As noted above, the RWHAP Recipient, FDOH-MDC, and Partnership staff were the key collaborators and made every effort to include a broad range of community input. This included Partnership meetings, outreach to targeted populations, online surveys, and key informant interviews.

Throughout February and March, 2022, under the purview of the RWHAP, Behavioral Science Research Corporation (BSR) - the RWHAP contracted subrecipient for Partnership staff support and clinical quality management - conducted community listening sessions, targeted interviews, key informant interviews, online surveys, and feedback gathering from Partnership committees. Results of those efforts are detailed in **Section II.**

People with HIV who contributed to the development of the 2022-26 Integrated Plan – both RWHAP clients and others – represented a vast array of lived experiences, including those who have experienced homelessness, sex work, substance use and recovery, mental health treatment, incarceration, racial, ethnic, and gender discrimination, and general stigmatization around those experiences.

The broad spectrum of community input served to identify strengths, challenges, and needs, to address the four pillars of Ending the HIV Epidemic-A Plan for America (EHE) and the four key strategies of the Statewide Coordinated Statement of Need (SCSN), as detailed in **Section IV**; and the corresponding activities and expected outcomes, as detailed in **Section V.**

From January through November 2022 the Partnership's Joint Integrated Plan Review Team (JIPRT), a collaboration of the Prevention and Strategic Planning Committees, reviewed draft sections and supporting documents, refined goals and objectives, and finalized the 2022-26 Integrated Plan draft. Members of the Prevention Committee include people with HIV, FDOH-MDC staff and contracted agencies engaged in prevention activities, RWHAP service-provider subrecipients, and other community stakeholders. Members of the Strategic Planning Committee include people with HIV, FDOH-MDC staff engaged in linkage and treatment activities, RWHAP service-provider subrecipients, and other community stakeholders.

The JIPRT collaboration led to the adoption of the Letter of Concurrence which encompasses agreement across all local HIV planning bodies, people with HIV, service providers, and other community stakeholders. The letter was approved by the Partnership and signed by the Partnership Chair on November 21, 2022; attached hereto as **Section VII**.

Throughout the year, Plan drafts were available for review on the Partnership's website (www.aidsnet.org) and distributed at meetings, allowing access to and feedback from Partnership members or any other interested parties. The *2022-2026 Integrated Prevention and Care Plan for Miami-Dade County* was finalized and approved unanimously by the Partnership on November 21, 2022.

I.i. (b) Documents submitted to meet requirements

Data were drawn from the following source documents:

- The 2017-2021 Integrated HIV/AIDS Prevention and Care Plan;
- National HIV/AIDS Strategy (NHAS) 2022-2026 Integrated Plan Guidance;
- The Health Council of South Florida (HCSF) report on community needs, prepared for the FDOH-MDC/EHE;
- The EHE Jurisdictional Plan, prepared by the FDOH-MDC;
- MDC Epidemiological data provided by the FDOH-MDC for CY 2019;
- Data on service gaps, provided by the FDOH-MDC and the RWHAP;
- Testing data provided by the FDOH-MDC, and program utilization data provided by the RWHAP, for 2019, 2020 and 2021;
- Client Satisfaction data provided by the Ryan White Program (RWHAP) for 2019, 2020, and 2021;
- Results from the listening sessions, interviews, community input sessions, and online surveys conducted by BSR.

Section II: Community Engagement and Planning Process

II.i. Jurisdiction Planning Process

Community engagement activities were conducted to reach a broad range of community stakeholders and to gather information from persons both inside and outside the Partnership and RWHAP services system. **See II.i. (e),** below, for a complete list of community engagement activities.

II.i. (a) Entities involved in process

The primary planning team was comprised of staff from OMB, FDOH-MDC, and BSR. This core group determined the timeline for completion of each section, organized community engagement activities, and posted, distributed, and presented data and drafts to the JIPRT and Partnership. As noted in **I.1. (a)**, above, throughout Plan development, all documents were available for review on the Partnership's website which is advertised to and accessible to Partnership members, the Partnership's listserv of more than 2,000 people, and the general public.

Entities involved in the process are further detailed in **II.i. (b)** and **II.i. (c)**, below.

II.i. (b) Role of the RWHAP Part A Planning Council

At monthly meetings from January through November 2022, JIPRT members were instructed on completion deadlines, reviewed draft sections, provided edits and additional feedback, and refined the final draft Plan. The JIPRT also considered feedback from other Partnership committees on current activities and in development of new, forward-thinking activities. All meetings were broadly advertised and open to the public. Meetings were conducted in-person with virtual (Zoom) attendance from January through April, and in-person only after May. **See II.i. (c),** below, for details on the composition of the PC and its committees.

As noted above, the Partnership's JIPRT was the primary group who reviewed and provided feedback and edits to Plan drafts. Revised sections were then brought back to the JIPRT for review until all members agreed upon the final versions to present to the Partnership. On November 10, 2022, the JIPRT voted on the complete Plan and presented their recommendation to the Partnership on November 21, 2022.

The Partnership includes voting members representing the RWHAP Recipient, Part B, and FDOH-MDC. The deliberations of the JIPRT and the Partnership are recorded in the approved minutes of each meeting. People with HIV and community stakeholders participate as members of the Partnership and all committees. The key stakeholders represented as voting members of the JIPRT and Miami-Dade HIV/AIDS Partnership are:

- Persons with HIV, both RWHAP and non-RWHAP clients;
- FDOH-MDC representatives;
- RWHAP Parts A, B, C, D and F (ADAP) representatives;
- State of Florida General Revenue representative;
- Local private and university researchers;
- Prevention providers;
- LGBTQ+ advocates;
- Advocates for victims of abuse;

- Local hospital representatives; and
- RWHAP subrecipients providing:
  - medical case management,
  - outpatient ambulatory health care,
  - oral health care,
  - mental health services,
  - substance use disorder treatment (outpatient and residential), and
  - health insurance premium and cost sharing assistance.

II.i. (c) Role of Planning Bodies and Other Entities

In the EMA, the RWHAP Part B and HIV/STD Prevention programs are under the jurisdiction of the FDOH-MDC. Ending the HIV Epidemic initiatives are funded through FDOH-MDC and the RWHAP Recipient. As noted above, both FDOH-MDC and the Recipient were involved in every part of creating this Plan, including scheduling and coordination of efforts, data collection, goals and activities development, and final draft submission.

Ending the HIV Epidemic goals and activities have been combined with Integrated Plan goals and activities, with the funding source and responsible entities noted. The Plan was designed in this way to build on the strength of existing EHE initiatives and activities, avoid duplication of efforts, and promote a more cohesive and collaborative approach to prevention and care planning and implementation.

In order to gather input from other entities who may not otherwise be involved in integrated planning, a general Survey Monkey survey with open-ended questions on each of the four NHAS goals was open from February through April. The survey was promoted at Partnership meetings and community engagement activities, and through the Partnership's social media, weekly newsletter, website postings, and listserv.

Feedback was gathered from these stakeholders:

- FFDOH-MDC;
- RWHAP Part C or Part D provider;
- Community health care center, including FQHCs;
- Housing and/or homeless services provider;
- Social services provider;
- Persons with HIV;
- Sexually transmitted disease (STD) clinic and/or STD program;
- Local, regional, or school-based clinic or healthcare facility;
- HIV clinical care provider;
- Pharmaceutical company;
- Clinician or other medical provider;
- Behavioral scientist;
- Epidemiologist;
- Intervention specialist;
- Business or labor representative; and
- Community advisory board member.

At the end of the survey, respondents were encouraged to continue contributing to the development of this Plan in meetings of the JIPRT and all Partnership activities.

II.i. (d) Collaboration with RWHAP Parts – SCSN requirement

The Partnership's JIPRT includes member representatives from RWHAP Part B and Part D. The Partnership's Care and Treatment Committee, which conducts the Annual Needs Assessment, and whose members were solicited for feedback on Plan development, includes representatives from RWHAP Part A, Part C, and ADAP. All those members are also members of the Partnership and had a vote on this Plan prior to final submission.

II.i. (e) Engagement of people with HIV – SCSN requirement

People with HIV were included in all stages of planning, primarily through JIPRT involvement, Partnership membership, and the listening sessions, detailed below. As Partnership members and meeting guests, people with HIV contributed at all meetings and listening sessions. It is our expectation that people with HIV and other community stakeholders will continue to be engaged in all ongoing facets of Plan implementation, monitoring, evaluation, and improvement.

The Partnership advertises open meetings through a large listserv (more than 2,000 members), calendars posted on the Partnership and County websites, and through social media outlets. Persons are encouraged to join meetings as voting members or as contributing guests. Reference materials are available to all interested parties at www.aidsnet.org. Printed copies of materials are distributed at meetings and available to be mailed by request.

Community engagement activities were scheduled to reach a broad range of community stakeholders and to gather information from persons both inside and outside the Partnership and RWHAP services system. A complete list of community engagement activities is detailed below. In coordination with FDOH-MDC and the Recipient, Partnership staff facilitated 15 listening sessions covering each of the four NHAS goals and encouraging attendees to think "outside the box" on what is working well, what needs to be improved, as well as what new and innovative solutions should be considered. The following groups were included:

1. **FDOH-MDC Workgroups**

   - Florida Black HIV/AIDS Coalition – Miami Chapter (2 meetings);
   - Hispanic Initiative (Iniciativa Hispana) (2 meetings conducted in Spanish);
   - Pre-Exposure Prophylaxis Workgroup (2 meetings);
   - Transgender Tenacity Power;
   - Youth Health Workgroup; and
   - The Miami Collaborative MSM Workgroup.

2. **RWHAP Client Focus Groups**

   - Clients over 55 years of age;
   - Clients under 55 years of age; and
   - Haitian clients (conducted in Haitian Creole).

3. **Non-RWHAP Focus Groups:**

   - Positive People Network, Inc., an HIV community advocates group; and
   - Gay Men's Hispanic Support Group at Pridelines, a community organization serving Hispanic MSM clients as well as LGBTQ+ youth.

4. Community Coalition Roundtable

□ Partnership committee comprised primarily of persons with HIV both inside and outside the RWHAP care system, including peer educators.

II.i. (f) Priorities

Priorities and concerns for people with HIV that arose from the planning sessions noted above, include:

- **Enhance services for and support people with HIV's lived-experience.** There is a need to enhance the system of care so that planners and service providers clearly understand that a person with HIV's lived-experience may include dealing with a lot more than just HIV. Clients have difficult and competing priorities on top of managing their HIV, including the stresses of living in poverty, housing instability, hiding their HIV status (stigma), managing mental health issues, and navigating substance use issues and recovery.

- **Empower people with HIV.** To counteract feelings of general apathy, people with HIV need to be empowered: Clients expressed frustration with continually voicing their needs without seeing meaningful change. Clients no longer feel empowered to advocate for themselves, rather they feel disenfranchised. Most clients were unaware of many Partnership and RWHAP resources or how to access non-RWHAP resources. Many clients expressed feelings of being disrespected and are cynical about involvement in activities that could truly empower them.

- **Clear messaging about available HIV/STD prevention, linkage and care services** Messaging and resources should clearly convey the full breadth of available services throughout the county, not limited to services available through the RWHAP. Several clients reported never being advised of mental health and support services, such as food bank. Subrecipient service providers may not advise clients of services outside their agency for fear of losing the client.

- **Enhance Pre-Exposure Prophylaxis (PrEP) messaging.** More comprehensible and culturally appropriate messaging about PrEP is needed to mitigate misunderstandings about this prevention option. Some people with HIV who participated in the community engagement sessions still believe PrEP is just for men, others had never even heard of PrEP.

- **Put "People" back into "People with HIV."** Remember that clients are more than a number and may need more time during medical and social service appointments to ensure all concerns are addressed. Clients feel rushed through appointments and feel providers get defensive if needs or feelings of isolation are expressed. Service providers are not always fully present during a client visit or encounter; they seem to be more involved with filling out paperwork than completely listening to the client.

- **Educate providers and clients regarding private insurance benefits, including Affordable Care Act (ACA), and how to effectively use the insurance benefits.** The ACA Marketplace is complex for both providers and clients to navigate. Clients with providers who are not well versed in the ACA Marketplace specific to the complexities of HIV care face additional struggles.

- **Develop relevant and engaging HIV messaging.** Prevention, care, and treatment messaging needs to represent the communities we are trying to engage in care. Community engagement participants repeatedly asked for "messaging with people who look like us!" Clients want to see prevention messaging with people who like them across all races/ethnicities, cultures, gender and sexual

identities, ages, geographic areas and languages. Messaging must also take into account the limitations some people face in access to and understanding of modern technology.

- **Address stigma.** Stigma is a complex issue for the affected community. Myths about HIV are still prevalent among some people with HIV, particularly those in immigrant communities. People with HIV report living with fears of disclosure within their own families and social networks, afraid that if their HIV status is disclosed their identities will be ruined. Transgender people report feeling stigmatized from service providers throughout the service system. Racial/ethnic and sexual orientation microaggressions are reported throughout the service system. Both the prevalence of self-stigmatizing feelings felt internally among the affected community and the incidence of stigmatizing comments from outside are part of these demeaning and demoralizing experiences.

II.i. (g) Updates to Other Strategic Plans Used to Meet Requirements

This Plan incorporates goals and objectives of the 2017-2021 Integrated Plan, the RWHAP Ending the HIV Epidemic plan (RWHAP-EHE); and the FDOH-MDC Ending the HIV Epidemic plan (FDOH-EHE), as noted, below, in **V.i.** Thereby, achievement of our goals will ensure continued collaboration between the RWHAP Recipient - responsible for the RWHAP-EHE plan; the local health department - responsible for the FDOH-EHE plan; and the RWHAP planning council - responsible for complete Plan oversight.

1. The Partnership's Care and Treatment Committee conducts a complete annual Needs Assessment including prioritization of all RWHAP Part A/MAI services. Although the EMA does not fund all service categories through Part A/MAI, the entire roster of services was considered during prioritization. For each service, members considered funding sources outside of RWHAP Part A/MAI. For instance, Home Health Care is funded under Part B and non-Medical Case Management is funded under General Revenue.

There is not a direct correlation between the funding and ranking of Part A/MAI services and Integrated Plan development in the EMA. However, both activities consider epidemiological data, comprehensive review of EMA HIV funding, utilization data, viral load suppression data, and unmet needs in decision making. Furthermore, several members of the JIPRT participate in the Needs Assessment and share information between those two activities.

2. As noted in **II.i. (e),** ongoing feedback of people with HIV and stakeholders is accomplished by broadly advertising public meetings, allowing public access to all draft and completed reference documents through online postings, and encouraging participation by members and guests at all meetings. Further, following completion, this Plan will be presented to the groups who contributed to ensure ongoing community engagement.

3. Based on EHE plans, community input, and JIPRT meetings, this Plan has been updated with new areas of concern and corresponding activities, including:

- □ Transgender health;
- □ Homelessness and housing instability;
- □ PrEP for women;
- □ Special considerations for people over age 50;
- □ Special needs of youth and young adults; and
- □ Focus on improving social media and targeted messaging.

4. As previously noted, this Plan was developed in close coordination between the RWHAP Recipient, the FDOH-MDC, and the Partnership. The 2017-2017 Plan was developed prior to the launch of Ending the HIV Epidemic, therefore a major change in the 2022-2026 Plan is the incorporation of locally-funded EHE activities. The EMA is also a Getting to Zero (G2Z) jurisdiction, however, those initiatives were not funded and therefore the G2Z activities were not accomplished. The FDOH-EHE Plan was able to fold in some of the initiatives proposed in G2Z, therefore this Plan, by proxy, contains both G2Z and EHE initiatives.

Another change in the planning process has been understanding how communication has changed in the past five years, particularly in light of the COVID-19 pandemic. This Plan attempts to identify new ways of communicating with an increasingly on-line world, particularly among youth and young adults, while also taking into account the technological limitations of older adults and those without the understanding of or access to computer- and web-based technology.

Section III: Contributing Data Sets and Assessments

III.i. Data Sharing and Use

Data for development of this Plan were gathered from FDOH-MDC; Provide® Enterprise-Miami (PE-Miami) - the RWHAP Part A/MAI client-level database; Florida Community Health Assessment Resource Tool Set (CHARTS) - www.flhealthcharts.gov/charts/; Annual Needs Assessment data; and community feedback. Note that data for the year 2020 should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV prevention, HIV testing, care-related services, case surveillance, and educational activities.

Though the jurisdiction does not have formal data-sharing agreements, due to the close collaboration between the RWHAP Recipient, the RWHAP Partnership, and FDOH-MDC, necessary data is readily available.

III.ii. Epidemiologic Snapshot

Data used for this snapshot are for the most recent five years: CY 2016 - CY 2020. Partial data for CY 2021 is included for illustration purposes only since CY 2021 data sets were not complete at the time of writing.

III.ii. (a) Summary of people diagnosed with and at-risk for exposure to HIV in the EMA

The EMA has a high concentration of people with HIV and high rates of new HIV infection, with both indicators among the highest in the United States. As of 2021, the FDOH reports 27,782 people with HIV in MDC, approximately 1% of the entire EMA population. Both the composition of the EMA's total population and the population diagnosed with and at-risk for HIV are primarily racial and ethnic minorities.

From CY 2017 through CY 2021, the EMA reported a total of 5,543 new HIV cases and 1,875 new AIDS cases. This indicates a 48% increase from 2020 to 2021, and a 3% increase from 2017 to 2021 in HIV cases. In AIDS cases, these figures indicate a 28% increase from 2020 to 2021, and a 3% decrease from 2017 to 2021. Data from 2020 and 2021 have been impacted by the COVID-19 pandemic, and should be treated cautiously.

Table 1: HIV and AIDS Incidence and HIV Prevalence for 2017-2021

Measurement	Calendar Year				
	2017	2018	2019	2020	2021
New HIV Cases (Incidence)	1,167	1,194	1,164	814	1,204
New AIDS Cases (Incidence)	400	403	381	303	388
Persons Living with HIV (Prevalence)	27,198[1]	27,268[1]	27,245[1]	27,214[1]	27,782

[1]*Sources: FDOH, September 2021; FL CHARTS, September 2022*

III.ii. (b) Number of individuals with HIV who do not know their HIV status

By the latest estimate (2017), there were 4,400 individuals in the EMA who have HIV and are not aware of their status. Great strides have been made to improve access to HIV testing, however 2020 saw a steep decline in testing events due to the COVID-19 pandemic:

- 2019: more than 60,000 testing events;
- 2020: just over 39,000 testing events; and
- 2021: more than 48,000 testing events.

Strategies to increase HIV testing opportunities and partners are addressed in **Goal 1, Objective P1**, below.

III.ii. (c) Demographics, geography, socioeconomic factors, behavioral factors, and clinical characteristics of newly diagnosed, all people diagnosed with HIV, and persons at-risk for exposure to HIV

Demographics

One of the defining characteristics of the EMA's population is the high proportion of racial/ethnic minority groups, accounting for 90% of the 27,214 people identified by FDOH-MDC with HIV in CY 2020.

For the purposes of this Plan, Hispanics include persons who identify as Hispanic, Latina, Latino, and Latinx. Hispanics represent the largest demographic group within the EMA. The high percentage of Hispanics among the newly-diagnosed is easily understood as correlated with the high numbers of Hispanics living in the EMA. Between 2020-2021, Hispanics represented:

- 69% of the total EMA population;
- 48% of people with HIV;
- 64% of new HIV diagnoses; and
- 53% of new AIDS diagnoses.

By contrast, the incidence and prevalence of HIV/AIDS among Black/African Americans (B/AA) is grossly disproportionate. Black/African Americans, who constitute only 15% of the total populations continue to have an infection rate more than twice as high as the rate for Hispanics. In CY 2020, there were 46.8 new HIV infections per 100,000 among B/AA compared to 26.3 per 100,000 among Hispanics; see **Table 2**. Between 2020-2021, B/AA represented:

- 15% of total EMA population;
- 40% of people with HIV;
- 25% of new HIV diagnoses; and
- 39% of the new AIDS diagnoses.

Only 14% of the EMA's population are White/non-Hispanics who accounted for only 9% of new HIV diagnoses in 2020. Overall, there has been a 33% decrease in HIV incidence and a 7% decrease in HIV prevalence among White/non-Hispanics.

Persons at high risk for HIV in MDC mirror the epidemic with B/AA having a higher incidence rate than Hispanics or Whites, as shown in **Table 2**. Additional details for persons who are newly diagnosed and all persons diagnosed are in **Tables 5 and 6**. Also note for Tables 5 and 6:

- Source is FDOH Bureau of Communicable Diseases, HIV/AIDS Section, as of June 30, 2021.
- Percentages in the tables above may sum to more or less than 100% (by +/-1%) due to rounding; however, 100% is noted.
- Rate changes from zero are not substantial to count.

Note, the figures for 2020 are unusually low which is likely due to impacts from the COVID-19 pandemic.

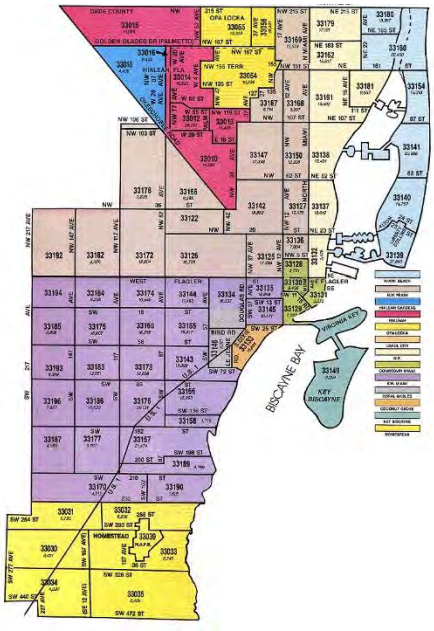
Regarding gender, males are the predominate gender group leading the epidemic. Cisgender men comprise 75% of those living with HIV; and among those, 85% of diagnoses were attributed to male-to-male sexual contact (MMSC). Transgender persons account for the smallest gender group. Less than 1% of those living with HIV and less than 1% of those newly diagnosed with HIV identify as transgender. Although transgender people comprise a small number of persons with HIV, this Plan acknowledges the unique challenges faced by transgender people and has built improving health outcomes for transgender people with HIV into our objectives.

The EMA continues to see a trend of people aging with HIV. Thirty percent of new HIV infections were reported among persons aged 30 to 39 years of age in 2020; representing a decrease of 34% in new HIV infections in this age group since 2016, but living cases over 60 years of age increased 42% from 5,113 to 7,272.

Geography

MDC occupies only 4% of the total area of the State of Florida and supports only 13% of Florida's population, yet it accounts for 23% of the total number of people with HIV in the state (FDOH, September 2021). Areas of the highest concentration of newly diagnosed clients from 2018-2020 (over 90 cases) can be found in five zip codes:

- 33139 - Miami Beach;
- 33147 - West Little River;
- 33161 - Miami Shores;
- 33142 - Brownsville; and
- 33136 - Overtown/Midtown.



While HIV/AIDS cases are dispersed throughout the entire 2,431-square-mile EMA, 19% of the people with HIV (over 1,000 cases in 2020) are concentrated in four zip codes:

- 33139 - Miami Beach;
- 33147 - West Little River;
- 33161 - Miami Shores; and
- 33142 - Brownsville.

Areas of newly diagnosed persons and persons living with HIV also represent high concentrations of racial/ethnic minorities, and high rates of poverty, unemployment, and drug use, all of which are indicators of greater risk for HIV transmission.

Table 2: Persons at Higher Risk for HIV for 2016-2020

Race/Ethnicity	HIV Incidence rate (per 100,000 population)					
	2016	2017	2018	2019	2020	% Change 2016-2020
B/AA	84.2	81.6	77.3	70.1	46.8	-44%
Hispanic	42.2	37.4	36.7	38.7	26.3	-38%
White	29.0	25.0	34.5	25.8	20.0	-31%
All other	14.3	12.4	18.4	10.6	13.6	-5%

Source: FDOH, September 2021

Socioeconomic Factors

People with and at risk of HIV in the EMA deal with language barriers, poverty, unstable housing, and uninsured status, all of which represent barriers to being tested, knowing their status, and accessing care.

Language barriers. With a high minority population, language barriers impact a large percentage of people living with or at risk of HIV in the EMA. In the EMA, 40% of newly-diagnosed person were born outside of the United States, primarily in non-English speaking countries. Having a lack of resources in one's native language can create a barrier to HIV testing and accessing services, as well as to accessing employment opportunities. From 2016 through 2020, the EMA has seen an increases in new cases and overall cases in people from three non-English speaking countries:

- Brazilians: 14% increase in new HIV cases;
- Venezuelans: 21% increase in people living with HIV; and
- Columbians: 6% increase in people living with HIV.

Poverty. According to the 2020 Small Area Income and Poverty Estimates (US Census, October 2022) 15% of persons in the EMA live in poverty.

Unstable housing. Unstable housing and homelessness are indicators for increased likelihood of HIV transmission and falling out of care.

- It is estimated that over 3,500 individuals are unstably housed in MDC (Council on Homes, 2020 Report, June 2021).
- FDOH-MDC estimates 417 of those who were HIV positive in 2020 were homeless.
- The University of Florida (UF) Shimberg Center for Housing Studies' 2022 Rental Market Study indicates of all renters in MDC, 27% are low-income, earning less than 60% of the area median income.
- The same UF study indicates a renter cost burden of over 40% (over 40% of income is needed for rent).

The combination of high rates of poverty, as noted above, and high rental burden creates a situation where groups are more vulnerable to engaging in behaviors (sex work, needle-sharing, etc.) which are vectors for HIV transmission.

Uninsured status. Uninsured rates based on the US Census indicate 17.6% of residents under age 65 years of age have no health insurance.

Behavioral Factors

Numerous behavioral factors influence HIV in the EMA, including sexual risk factors, health related risk factors, mental health needs, and substance abuse. As previously indicated in the demographic section, the epidemic continues to be driven by men who have sex with men (MSM), who comprise approximately 49% of those living with HIV. Note, in recognition of people-first language, this Plan uses the acronym "MSM" (men who have sex with men) when referring to people, and "MMSC" (male-to-male sexual contact) when referring to modes of HIV transmission.

Sexual risk factors. Among new (non-pediatric) HIV cases in cisgender women, 96% were attributed to heterosexual contact, and 4% to injection drug use (IDU). New HIV cases among women decreased 48% between 2016 and 2020, and the number of women living with HIV decreased 4%; see **Table 5**.

Sexually transmitted infections. Sexually transmitted infections (STIs) serve as a vector for HIV acquisition and MDC has a high incidence of STIs. STIs such as gonorrhea and early syphilis are at unprecedented levels with a growth of 3% and 10%, respectively from 2019-2020. Even more concerning are the rates over the five year period 2016 to 2020, in which cases of gonorrhea and early syphilis each increased more than 60%. Of those newly HIV diagnosed clients in 2020, 7% were co-infected with chlamydia, 18% with gonorrhea, and 51% with early syphilis (FDOH, 2021): **Table 3**.

Table 3: Sexually Transmitted Infections, 2016-2020

STI	2016	2017	2018	2019	2020	% Change 2019-2020	% Change 2016-2020
Chlamydia	12,682	12,264	13,395	14,735	12,426	-16%	-2%
Gonorrhea	3,064	3,538	4,307	5,001	5,135	3%	68%
Early Syphilis	1,313	1,439	1,813	1,957	2,152	10%	63%

Source: Florida CHARTS, October 2022

Mental health care. Engaging people in need to mental health care plays an important role in preventing HIV infections and retaining those who are positive in care. FDOH estimates that in 2020, 1,057 persons with HIV in the EMA had a history of mental illness, which is 3.88% of the persons with HIV in the EMA. Mental health diagnoses - including severe depression - are closely associated with HIV diagnoses, HIV/AIDS stigma, and the sense of isolation that comes with hiding your disease status from friends, family, and intimate partners (HIV Stigma Among Substance Abusing Persons With AIDS, AIDS Patient Care Standards, August 2014).

Substance use. Another factor in HIV transmission and inability to remain in care is substance use. 2020 FDOH-MDC estimates indicate that 3,986 persons with HIV had a history of substance abuse, which comprises 14.65% of the persons with HIV in the EMA. However, transmission by injection drug use (IDU) remains low with less than 5% transmission rate among both males and females.

The EMA is seeing a positive trend in IDU transmission; from 2016-2020 for those newly diagnosed with HIV there was a:

- 9% overall decrease in transmission via IDU;
- 54% decrease in transmission via MMSC/IDU; and
- 29% decrease in transmission via female IDU.

Of those living with HIV from 2016-2020, there has been a:

- 13% overall decrease in transmission via IDU;
- 15% decrease in transmission via MSM/IDU; and
- 21% decrease in transmission via female IDU.

See **Tables 5 and 6** for additional data specific to demographics and HIV transmission.

Identified HIV clusters and key characteristics

Six zip codes are possible HIV cluster locations

- 33122 - Doral;
- 33166 - Medley;
- 33187 - Richmond West;
- 33131 - Downtown Miami;
- 33126 - Fontainebleau; and
- 33185 - Kendall West.

Twenty percent or more of newly diagnosed HIV cases reside within those areas which make them areas of interest and to be closely monitored. Most of those zip codes are densely populated and comprised of primarily racial/ethnic minorities.

As shown in **Table 4**, there are ten key populations which are of concern. Hispanic males account for the largest group. Rates among cisgender men and those who identify as MSM have also been steadily increasing.

Table 4: Special Populations By Incidence

#	Special Populations	HIV Incidence Cases Diagnosed (%) in Order By 2020 Percentages					
		2016	2017	2018	2019	2020	% Change 2016-2020
1	Hispanic Cisgender Man	55%	54%	53%	57%	59%	7%
2	Hispanic MSM	51%	49%	48%	50%	53%	4%
3	B/AA Cisgender Man	18%	18%	19%	17%	17%	-6%
4	B/AA Heterosexual Contact	17%	19%	17%	15%	13%	-24%
5	B/AA MSM	12%	12%	11%	11%	12%	0%
6	Hispanic Heterosexual Contact	8%	10%	10%	13%	10%	25%
7	B/AA Cisgender Woman	11%	13%	10%	9%	8%	-27%
8	B/AA Cisgender Woman Heterosexual Contact	11%	13%	10%	9%	8%	-27%
9	White Cisgender Man	7%	7%	10%	7%	8%	14%
10	White MSM	6%	6%	9%	7%	7%	17%

HIV Care Continuum

Figure 1 details the impact of HIV on the care system. Of those diagnosed, 83% are linked to care and 62% are virally suppressed. While these figures represent some improvements, the figures for 2020 are lower than usual. For comparison see **Figure 2**: 2019 epidemiological data compared to 2020 RWHAP data indicated RWHAP clients have higher viral load suppression rates.

Figure 1: FDOH-MDC Diagnosis-based HIV Care Continuum for Miami-Dade County, CY 2020

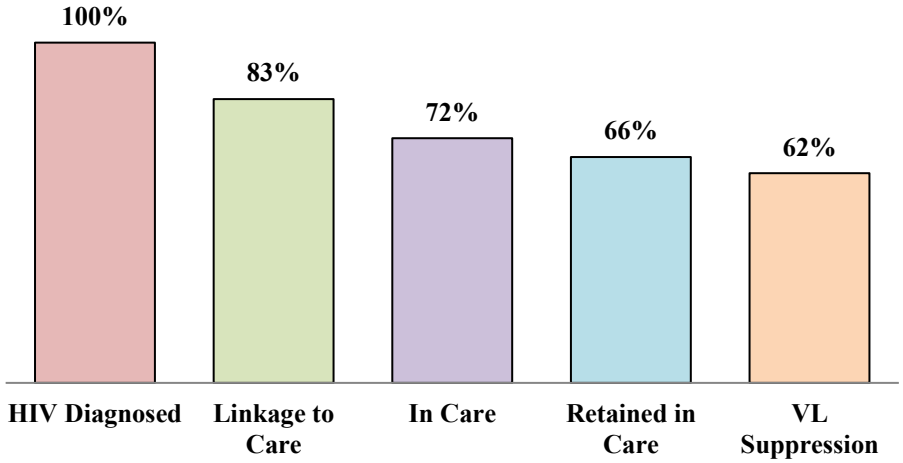


Figure 2: HIV Care Continuum Miami-Dade County and Ryan White Program Comparisons

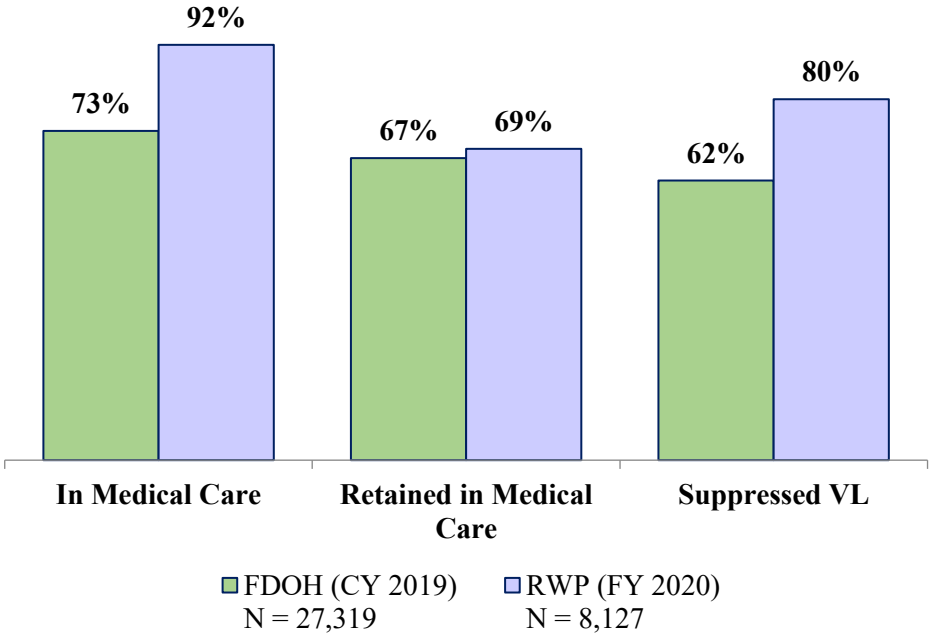


Table 5: HIV Incidence
Demographics and Transmission Categories
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Persons Newly Diagnosed (HIV Incidence) Miami-Dade County – Calendar Years 2016 to 2020											
Demographics/ Transmission	**2016**		**2017**		**2018**		**2019**		**2020**		**% Change 2016 - 2020**
Race/Ethnicity	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**%**
White	111	9%	95	8%	128	11%	95	8%	74	9%	-33%
Black/African-American	375	30%	364	31%	344	29%	309	26%	206	25%	-45%
Hispanic	769	61%	697	60%	706	59%	756	65%	524	64%	-32%
Asian/Native Hawaiian/Pacific Islander	6	<1%	4	<1%	6	<1%	2	<1%	5	1%	-17%
American Indian/Alaska Native	0	0%	2	<1%	0	0%	0	0%	1	<1%	100%
Multi-race	3	<1%	2	<1%	6	<1%	5	<1%	3	<1%	0%
Total	**1,264**	**100%**	**1,164**	**100%**	**1,190**	**100%**	**1,167**	**100%**	**813**	**100%**	**-36%**
Current Gender Identity											
Cisgender Man	1,026	81%	933	80%	984	83%	953	82%	688	85%	-33%
Cisgender Woman	232	18%	231	20%	199	17%	208	18%	121	15%	-48%
Transgender Man	0	0%	0	0%	1	<1%	0	0%	0	0%	0%
Transgender Woman	6	<1%	0	0%	6	<1%	6	<1%	4	<1%	-33%
Total	**1,264**	**100%**	**1,164**	**100%**	**1,190**	**100%**	**1,167**	**100%**	**813**	**100%**	**-36%**
Age											
0-12 years old	4	<1%	2	<1%	0	0%	1	<1%	0	0%	-100%
13-19 years old	44	3%	42	4%	40	3%	35	3%	25	3%	-43%
20-29 years old	365	29%	308	26%	339	28%	306	26%	213	26%	-42%
30-39 years old	370	29%	363	31%	330	28%	331	28%	244	30%	-34%
40-49 years old	256	20%	198	17%	217	18%	216	18%	142	17%	-44%
50-59 years old	151	12%	151	13%	182	15%	170	15%	123	15%	-18%
60+ years old	74	6%	100	9%	82	7%	108	9%	66	8%	-11%
Total	**1,264**	**100%**	**1,164**	**100%**	**1,190**	**100%**	**1,167**	**100%**	**813**	**100%**	**-36%**

Table 5: HIV Incidence
Demographics and Transmission Categories
Continued from previous page

Persons Newly Diagnosed (HIV Incidence) Miami-Dade County – Calendar Years 2016 to 2020						
Demographics and Transmission	**2016**	**2017**	**2018**	**2019**	**2020**	**% Change 2016 - 2020**
Cisgender Man Adult/Adolescent Transmission Categories (13 years and older)						
	n=1,025	**n=933**	**n=984**	**n=952**	**n=688**	
Male-to-Male Sexual Contact (MMSC)	85%	84%	82%	84%	85%	-33%
Injection Drug Use (IDU)	1%	1%	2%	1%	2%	-9%
MMSC/IDU	1%	1%	1%	<1%	1%	-54%
Heterosexual Contact	12%	14%	15%	15%	12%	-34%
Other Risk	0%	0%	0%	0%	0%	0%
Cisgender Woman Adult/Adolescent Transmission Categories (13 years and older)						
	n=229	**n=229**	**n=199**	**n=208**	**n=121**	
IDU	3%	2%	4%	3%	4%	-29%
Heterosexual Contact	97%	98%	96%	97%	96%	-48%
Other Risk	0%	0%	0%	0%	0%	0%
Transgender Transmission Categories (13 years and older)						
	n=6	**n=0**	**n=7**	**n=6**	**n=4**	
IDU	0%	0%	0%	0%	0%	0%
Sexual Contact	100%	0%	100%	100%	100%	-33%
Other Risk	0%	0%	0%	0%	0%	0%
Pediatric Transmission Categories (ages 0-12 years old)						
	n=4	**n=2**	**n=0**	**n=1**	**n=0**	
Perinatal Exposure	100%	100%	100%	0%	0%	-100%
Non-Perinatal Exposure	0%	0%	0%	100%	0%	NA

Table 6: HIV Prevalence
Demographics and Transmission Categories
Continued on next page

People with HIV (HIV Prevalence) Miami-Dade County – Calendar Years 2016 to 2020											
Demographics and Transmission	**2016**		**2017**		**2018**		**2019**		**2020**		**% Change 2016 - 2020**
Race/Ethnicity	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**%**
White	2,926	11%	2,855	10%	2,822	10%	2,735	10%	2,726	10%	-7%
B/AA	11,634	43%	11,567	43%	11,378	42%	11,165	41%	10,933	40%	-6%
Hispanic	12,101	45%	12,418	46%	12,709	47%	13,000	48%	13,213	49%	9%
Asian/Native HI/PI	74	<1%	83	<1%	89	<1%	86	<1%	86	<1%	16%
American Indian/Alaska Native	10	<1%	7	<1%	8	<1%	8	<1%	9	<1%	-10%
Multi-race	286	1%	268	1%	262	1%	251	1%	247	1%	-14%
Total	**27,031**	**100%**	**27,198**	**100%**	**27,268**	**100%**	**27,245**	**100%**	**27,214**	**100%**	
Current Gender Identity											
Cisgender Man	20,027	74%	20,236	74%	20,383	75%	20,426	75%	20,506	75%	2%
Cisgender Woman	6,928	26%	6,884	25%	6,808	25%	6,737	25%	6,626	24%	-4%
Transgender Man	2	<1%	2	<1%	3	<1%	3	<1%	3	<1%	50%
Transgender Woman	74	<1%	76	<1%	74	<1%	79	<1%	79	<1%	7%
Total	**27,031**	**100%**	**27,198**	**100%**	**27,268**	**100%**	**27,245**	**100%**	**27,214**	**100%**	
Age											
0-12 years old	30	<1%	31	<1%	27	<1%	27	<1%	24	<1%	-20%
13-19 years old	130	<1%	119	<1%	100	<1%	82	<1%	69	<1%	-47%
20-29 years old	2,278	8%	2,175	8%	2,078	8%	1,939	7%	1,781	6%	-22%
30-39 years old	4,316	16%	4,401	16%	4,483	16%	4,410	16%	4,371	16%	1%
40-49 years old	6,498	24%	6,170	23%	5,826	21%	5,623	21%	5,394	20%	-17%
50-59 years old	8,666	32%	8,634	32%	8,582	31%	8,416	31%	8,303	30%	-4%
60+ years old	5,113	19%	5,667	21%	6,172	23%	6,748	25%	7,272	27%	42%
Total	**27,031**	**100%**	**27,198**	**100%**	**27,268**	**100%**	**27,245**	**100%**	**27,214**	**100%**	

Table 6: HIV Prevalence
Demographics and Transmission Categories
Continued from previous page

People with HIV (HIV Prevalence) Miami-Dade County – Calendar Years 2016 to 2020						
Demographics	**2016**	**2017**	**2018**	**2019**	**2020**	**% Change 2016 - 2020**
Cisgender Male Adult/Adolescent Transmission Categories (13 years and older)						
	n=20,012	**n=20,221**	**n=20,371**	**n=20,414**	**n=20,497**	
MMSC	72%	73%	73%	74%	74%	5%
IDU	5%	4%	4%	4%	4%	-13%
MMSC/IDU	4%	4%	4%	3%	3%	-15%
Heterosexual Contact	19%	18%	18%	18%	18%	-1%
Other Risk	<1%	1%	1%	1%	1%	-7%
Cisgender Woman Adult/Adolescent Transmission Categories (13 years and older)						
	n=6,913	**n=6,868**	**n=6793**	**n=6,722**	**n=6,611**	
IDU	10%	9%	9%	9%	8%	-21%
Heterosexual Contact	87%	88%	88%	89%	89%	-2%
Other Risk	3%	3%	3%	3%	3%	-12%
Cisgender Woman Adult/Adolescent Transmission Categories (13 years and older)						
	n=6,913	**n=6,868**	**n=6793**	**n=6,722**	**n=6,611**	
IDU	10%	9%	9%	9%	8%	-21%
Heterosexual Contact	87%	88%	88%	89%	89%	-2%
Other Risk	3%	3%	3%	3%	3%	-12%
Transgender Adult/Adolescent Transmission Categories (13 years and older)						
	n=76	**n=78**	**n=77**	**n=82**	**n=82**	
IDU	5%	6%	6%	7%	6%	0%
Sexual Contact	95%	94%	93%	93%	94%	7%
Other Risk	0%	0%	0%	0%	0%	0%
Pediatric Transmission Categories (under 13 years old)						
	n=30	**n=31**	**n=27**	**n=27**	**n=24**	
Perinatal Exposure	100%	100%	100%	96%	96%	-23%
Non-Perinatal Exposure	0%	0%	0%	4%	4%	100%

III.iii. HIV Prevention, Care and Treatment Resource Inventory

The organizations and agencies noted in this section provide care and treatment and prevention services throughout the EMA under various funding streams.

The Partnership, specifically the Prevention Committee which oversees Prevention activities (Goal 1), and the Strategic Planning Committee which oversees Care and Treatment activities (Goals 2-4), includes members who represent organizations covering all funding streams noted in the tables below. Management within each funding stream is based on the parameters of the funded programs. Additional efforts are ongoing to bring more stakeholders to the table and gain broader buy-in of NHAS goals across HIV and related social services providers.

Regarding substance use prevention, the EMA works in close coordination with the University of Miami Infectious Disease Elimination Act (IDEA Exchange) which is the only syringe exchange program in Florida, and whose Program Director is a member of the Partnership. This Plan includes a Prevention objective to promote and support the IDEA Exchange as well as activities to train providers on trauma-informed care, the status-neutral care model, and patient-centered care.

Further, the EMA receives close to $2 million in SAMHSA funding, some of which is directed to RWHAP subrecipients and stakeholders in substance use/HIV prevention. Creating partnerships with SAMHSA-funded organizations not currently counted among stakeholders in this Plan will be addressed under Goal 4 which includes leveraging substance abuse residential and outpatient care and mental health services outside RWHAP.

To date, for the three years since programs were implemented, RWP-EHE has received $1,704,338, with $642,504 allocated to EHE Quick Connect, and $1,061,834 allocated to EHE HealthTec.

MDC is fortunate to have a broad range of funding sources covering all RWHAP categories of services. It is the aim of this Plan to ensure all persons who have or are at risk of acquiring HIV are aware of and utilize all available services for which they qualify. Persons who enter the service system through the Test and Treat/Rapid Access protocol and those who are enrolled in RWHAP and ADAP care can be monitored to ensure they are maximizing available needed services. However, we acknowledge some limitations for persons who are above 400% Federal Poverty Level (FPL), who have private medical coverage, and whose plans of care are not known to us. See **Tables 7-8** for distribution of Care and Treatment services across funding streams for FY 2021.

HIV prevention efforts are funded through various local, state, and federal funding streams as detailed in **Table 9**, below. Note that **Table 9** is sorted by funding source. Many agencies receive funding from multiple funding sources.

Table 7: Core Medical Services Resource Inventory

2021 Resource Inventory - Core Medical Services													
Funding Source	**AIDS Drug Assistance Program Treatments**	**AIDS Pharmaceutical Assistance**	**Early Intervention Services**	**HIPC-Sharing Assistance for Low-Income Individuals**	**Home and Community-Based**	**Home Health Care**	**Hospice**	**MCM, including Treatment Adherence Services**	**Medical Nutrition Therapy**	**Mental Health**	**Oral Health Care**	**Outpatient/Ambulatory Health Services**	**Substance Abuse Outpatient Care**
Part A		x		x				x		x	x	x	x
Part B	x			x	x	x				x		x	
Part C		x	x					x	x	x	x	x	
Part D								x		x		x	
Part F		x									x	x	
EHE		x				x				x		x	x
State		x		x	x	x	x	x		x	x	x	
Federal		x		x	x	x	x	x		x	x	x	
SAMHSA										x			x
Local										x		x	

Table 8: Support Services Resource Inventory

2021 Resource Inventory – Support Services														
Funding Source	**Emergency Financial Assistance**	**Food Bank/Home Delivered Meals**	**Health Education/ Risk Reduction**	**Housing, Rental, and Utility Assistance**	**Other Professional Services: Legal Services/Permanency Planning**	**Linguistic Services**	**Medical Transportation**	**Non-Medical Case Management Services**	**Outreach Services**	**Psychosocial Support Services**	**Referral for Health Care and Support Services**	**Rehabilitation Services**	**Substance Abuse Services – Residential**	**Treatment Adherence Counseling**
Part A	x	x			x		x		x	x			x	
Part B	x			x			x	x						x
Part C			x				x		x	x	x			x
Part D		x				x		x	x	x	x			x
Part F			x								x			x
EHE				x							x			x
HOPWA				x				x						
State		x		x			x			x	x	x		
Federal		x					x			x	x	x		
CDC											x			
SAMHSA								x	x	x	x		x	x
Local									x	x	x			

HIV care and treatment services funding totaled $518,760,934 in Fiscal Year 2021 (date ranges for Fiscal Years vary). Where multiple funders are noted, RWHAP Part A is the funder of last resort.

Ryan White Program Part A/MAI
2021 Funding: $26,097,982
- AIDS Healthcare Foundation (AHF)
- Better Way of Miami
- Borinquen Health Care Center*
- CAN Community Health
- Care 4 U Community Health Center*
- Care Resource*
- Citrus Health Network
- Community Health of South FL (CHI)
- Empower U Community Health Center*
- Food for Life Network
- Jessie Trice Community Health System
- Latinos Salud
- Legal Services of Greater Miami
- Miami Beach Community Health Center* and St. Luke's Addiction Recovery Center
- New Hope C.O.R.P.S.
- Public Health Trust/Jackson Health System
- University of Miami (UM)*

* Indicates MAI-funded subrecipients

Ryan White Program Part B
2021 Funding: $57,451,505
- Borinquen Health Care Center
- CAN Community Health
- Care 4 U Health Center
- Care Resource
- CHI – Community Health of South Florida
- Citrus Health Network
- Empower U Community Health Center
- Miami Beach Community Health Centers
- University of Miami

Ryan White Program Part C
2021 Funding: $2,742,5
- Empower U Community Health Center
- Miami Beach Community Health Center
- University of Miami

Ryan White Program Part D
2021 Funding: $1,923,552
- UM Department of Pediatrics Division of Infectious Disease & Immunology

Ryan White Program Part F
2021 Funding: $1,522,596
- University of Miami

EHE
2021 Funding: $5,512,323
- Grantee: FDOH-MDC
- Grantee: MDC OMB

HOPWA
2021 Funding: $12,874,914
- Grantee: City of Miami

State
2021 Funding: $146,820,852
- ADAP Grantee: FDOH-MDC
- GR Grantee: South FL Florida AIDS Network

CDC
2021 Funding: $9,181,161
- Borinquen Health Care Center
- Care 4 U
- Care Resource
- Community Rightful Center, Inc.
- Empower U Community Health Center
- Latinos Salud, Inc.
- Prevention 305
- Pridelines
- Project Access Foundation
- Survivor's Pathway
- The Village South
- University of Miami

SAMHSA
2021 Funding: $1,977,504
- Banyan Community Health Center
- Bethel Family Enrichment Center
- Borinquen Health Care Center
- Citrus Health Network
- Florida International University
- Gang Alternatives
- Jackson Memorial Hospital
- Jewish Community Services of South FL
- Miami Dade College
- Miami-Dade County
- Pridelines Youth Services
- South Florida Jail Ministries
- The Village South

Other Local Funding
2021 Funding: $3,753,205

Table 9: Prevention Resource Inventory

Agency	Funding Amount	Target Populations(s)	Funded Services
Funding Source: Centers for Disease Control and Prevention/High Impact Prevention (HIP)			
Borinquen Health Care Center, Inc.	$441,625	HIV(+) Black/African Americans (B/AA)	HIV/STD testing and referrals, partner prevention services, condom distribution, PrEP screening, referrals, and linkage, outreach activities, prevention for negatives, linkage to care, individual/group level sessions, referrals.
Empower U, Inc.	$347,599	HIV early intervention	HIV/STD testing and referrals, partner prevention services, condom distribution, outreach activities, prevention for negatives, linkage to care.
Latinos Salud, Inc.	$147,208	Latino MSM, other minorities	HIV/STD testing and referrals, partner prevention services, condom distribution, outreach activities, prevention for negatives, linkage to care.
Village South	$441,624	Heterosexual females	HIV/STD testing and referrals, partner prevention services, condom distribution, outreach activities, prevention for negatives, linkage to care, individual level sessions, referrals.
Funding Source: Frontlines of Communities in the United States (FOCUS)			
Health Choice Network	$261,140	General population	Routine testing in medical setting.
Homestead Hospital	$148,979	General population	Routine testing in medical setting.
Jackson Memorial Hospital- Main	$279,387	General population	Routine testing in medical setting.
Jackson Memorial Hospital-North	$94,977	General population	Routine testing in medical setting.
Jackson Memorial Hospital-South	$192,228	General population	Routine testing in medical setting and linkage to care.
University of Miami-ED	$167,188	General population	Routine testing in medical setting.
University of Miami–IDEA Exchange Miami	$225,731	PWID (Persons Who Inject Drugs)	HIV testing and referrals, linkage to care.
West Kendall Baptist Hospital and FS ED at Coconut Walk	$148,979	General population	Routine testing in medical setting and linkage to care.
Funding Source: Department of Health & Human Services/EHE			
Banyan Community Health Center, Inc	$343,379	Latino and B/AA MSM	HIV testing and referrals, PrEP, outreach activities, workforce development, linkage to care, PCHP activities.
Borinquen Health Care Center, Inc.	$284,779	HIV (+)	HIV testing and referrals, partner prevention services, PrEP, outreach activities, prevention for negatives, linkage to care, individual/group level sessions.
Care Resource Community Health Centers, Inc.	$269,322	Individuals at risk for HIV	HIV testing and referrals, PrEP, outreach activities, workforce development, linkage to care, PCHP activities.
Community Health of South Florida, Inc.	$300,697	General population	HIV testing and referrals, outreach events

Funding Source: Department of Health & Human Services/EHE (continued)			
Empower U, Inc.	$253,689	B/AA MSM and Transgender	HIV testing and referrals, PrEP, outreach activities, workforce development, linkage to care, PCHP activities.
Jessie Trice Community Health System, Inc.	$284,758	HIV(+) LGTBQ and heterosexuals	HIV testing and referrals, PrEP, outreach activities, workforce development, linkage to care, PCHP activities.
Miami Beach Community Health Center, Inc.	$308,991	At risk individuals	HIV testing and referrals, PrEP, outreach activities, workforce development, linkage to care, PCHP activities.
Funding Source: Department of Health & Human Services/Federal			
Latinos Salud, Inc.	$109,000	Latino MSM, other minorities	HIV testing and referrals, condom distribution, PrEP and nPEP; *Supports Miami SW* for HIV/STI testing, STI screening and linkage, PrEP/nPEP screening and linkage, condom distribution, outreach, media advertising, treatment/support services referrals.
Funding Source: Local/FDOH-MDC			
Health Council of South Florida	$190,000	Targeted population	Contracts service providers.
Funding Source: Local/HIP			
Health Choice Network	$82,131.53	General population	Linkage to care.
Jackson Memorial Hospital (PHT)	$146,077.50	General population	Linkage to care.
University of Miami	$95,000	General population; all youth living with and at increased risk for HIV, ages 14–24	HIV testing and referrals, counseling, linkage to care, and treatment adherence counseling
Funding Source: Local/EHE			
AIDS Healthcare Foundation	$125,000	General population	HIV testing and referrals, partner prevention services, condom distribution, PrEP screening, referrals, and linkage, outreach activities, prevention for negatives, linkage to care, individual/group level sessions, referrals, HIV/STD education/awareness.
CAN Community Health	$125,000	Young MSM of color, transwomen, and high-risk heterosexuals	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, mobile/venue-based outreach events, linkage to care and treatment, social media posts, online conversations with priority populations.
CareFirst Foundation, Inc.	$125,000	Gay, bisexual men of all races/ethnicities; heterosexual B/AA, Haitians, Hispanics, and injection drug users	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, outreach/education events, social media posts, online conversations with priority populations, development of communication plan for social marketing, educational and recruitment purposes.
Community Health of South Florida, Inc.	$125,000	General population	Screening and referrals, condom, distribution, PrEP screening, referrals, and linkage, other essential support services as appropriate, community outreach events, social media posts, connecting 90% of eligible clients with a network navigator for follow-up.

Funding Source: Local/EHE (continued)			
FDOH-MDC	$379,607	Targeted population	HIV/STD testing and referrals, partner prevention services, linkage to care, referrals, academic detailing, retention.
Family and Children Faith Coalition dba Hope for Miami	$84,472	General population, youth, parents of adolescents and young adults, coaches, mentors, family members, faith leaders and health professional that serve youth	HIV testing referrals, PrEP screening, referrals, and linkage, other essential support services, education (youth and adults), community outreach events, social media posts.
Health Education Prevention Promotion	$57,345	B/AA, Haitian and other Caribbean American communities	HIV testing referrals, PrEP screening, referrals, and linkage, essential support services, individual and group-level education, social media posts, media/marketing, follow-up calls with registered participants.
Latinos Salud, Inc.	$125,000	Latino MSM and bisexual, other MSM of color, persons living with HIV, transgender persons and their partners	HIV/STD testing and referrals, partner prevention services, condom distribution, PrEP assistance, DiversiSAFE education sessions, mobile/ venue-based outreach, social media posts, online conversations with priority populations, assist PrEP clients with insurance confirmation or paperwork to qualify for Patient Assistance or Co-Pay Assistance Programs.
Media vendors (i.e., WSFL-TV, iHeart Media, Audacy, Outfront, AllOver Media, Mesmerize, Commando, WSFR)	$451,183.33	General population	Media
Positively U, Inc.	$72,916.67	General population	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, outreach and/or venue outreach, bulk and individual condom distribution, social media posts.
S.O.U.L Sisters Leadership Collective	$50,000	Youth (B/AA and Indigenous)	HIV testing and PrEP referrals, develop a “Design Camp” program curriculum, recruit an “EHE Cohort of Youth Designers” to participate in the “Design Camp” program, conduct the "Design Camp HIV Education and Awareness Campaign", develop a follow-up plan and attempt to follow up with all clients, create social media posts, host virtual engagement with EHE-related messaging and topic.
Survivors’ Pathway Corp.	$108,000	LGBTQ community, the Hispanic community, victims of domestic violence, sex trafficking and sexual assault	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, education and outreach, social media posts, support and referral services for trauma-informed care and mental health services, free access to immigration legal services.

Funding Source: Local/EHE (continued)			
The Community Health and Empowerment Network	$93,000	B/AA, Haitians, Undocumented, Hispanics, people with HIV/AIDS, Low-Income, LGBT, Homeless	HIV testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, mobile/venue-based outreach events, social media posts, designing and implementing a marketing campaign to promote HIV testing, PrEP, and other EHE community engagement activities.
University of Miami–Adolescent Medicine	$110,000	At-risk adolescents and young adults	HIV/STD testing and referrals, partner prevention services, PrEP/nPEP screening, referrals, and linkage, consultations to community members/ partners, linkage to care, individual-level education with health care trainees (e.g., medical residents, medical students, nursing students), group-level education with health care providers, social media posts.
University of Miami–IDEA Exchange Miami	$57,683	PWID	Screen and link PWID who are not in care via mobile wellness clinic telehealth services, ART initiation and opioid use disorder medications, conduct monthly presentations to providers in MDC to expand their ability to initiate and/or reinitiate HIV/STI care via telehealth services in clinic and/or mobile settings, offer technical support as needed to community partners, conduct quarterly presentations on culturally competent care for PWID or drug users, social media posts.
Funding Source: MDC-County Community Action and Human Services			
Latinos Salud, Inc.	$109,000	B/AA population, persons at-risk for HIV, and substance users	Reduction, prevention, and early intervention services.
Thelma Gibson Health Initiative, Inc.	$16,000	B/AA, persons at-risk for HIV, and substance users	Reduction, prevention, and early intervention services.
Urgent, Inc.	$20,000	Youth and families at-risk for HIV	Reduction, prevention, and early intervention services.
Funding Source: Our Fund Foundation			
Latinos Salud, Inc.	$30,000	Latino MSM and other minority MSM	HIV/STD testing and referrals, support for community health programs including HIV/STD testing, referral and treatment.
TransSocial, Inc.	$3,000	Transgender and LGBTQ	Linkage services to affirming health care providers.
Funding Source: Public Health Trust			
FDOH-MDC	$248,318	General HIV-risk population	HIV/STD testing and referrals, outreach activities, and linkage to care, DIS.
Funding Source: RFA-PS21-2102			
Care Resource Community Health Centers, Inc.	$441,625	MSM	HIV/STD testing and referrals, partner prevention services, condom distribution, PrEP screening, referrals, and linkage, outreach activities, prevention for negatives, linkage to care, referrals.
Funding Source: RWHAP-EHE (Quick Connect)			
Borinquen Health Care Center, Inc.	$236,712	General population	HIV testing and referrals, linkage, providers education.

Funding Source: State			
University of Miami, PrEP Mobile Unit	$187,500	Individuals at increased risk for HIV infection or persons requesting PrEP, residing in MDC	HIV/STD testing and referrals, PrEP/PEP screening, referrals, and linkage, behavioral risk screening, targeted outreach, online outreach, rapid ART starts.
Funding Source: State/Office of Mental Health			
Arianna's Center	$46,894	Latino MSM, other minorities; transgender people	HIV testing and referrals, partner prevention services, condom distribution, PrEP screening, referrals, and linkage, outreach activities, prevention for negatives, referrals, media.
Latinos Salud, Inc.	$275,000	Latino MSM, other minorities; transgender people	HIV/STD testing and referrals, partner prevention services, condom distribution, PrEP screening, referrals, and linkage, outreach activities, prevention for negatives, referrals, media.
TransSocial, Inc.	$42,032.27	Latino MSM, other minorities; transgender people	HIV/STD testing and referrals, partner prevention services, condom distribution, PrEP screening, referrals, and linkage, outreach activities, prevention for negatives, referrals, media.
Funding Source: State/HIP			
Borinquen Health Care Center, Inc.	$200,000	High-risk adults Hispanics and B/AA	HIV testing/referrals, condom distribution, F2F outreach, community engagement, social media.
Borinquen Health Care Center, Inc.	$85,000	Pregnant women with HIV or at-risk for HIV	Perinatal HIV prevention activities for pregnant women living with HIV and those at increased risk for HIV acquisition through the Targeted Outreach for Pregnant Women Act (TOPWA) program.
Care 4 U Management, Inc.	$225,000	B/AA and Hispanics	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, PfH-Medication Adherence, referrals, Safe in the City, F2F outreach, community engagement, social media.
Care Resource Community Health Centers, Inc.	$400,000	MSM, B/AA heterosexual men and women	HIV testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, prioritized HIV testing, CLEAR for people with HIV, Cognitive Behavioral Therapy (CBT), risk reduction counseling for HRN, F2F outreach, community engagement, one-on-one online outreach, social media posts.
Community Rightful Center, Inc.	$75,000	B/AA men and their sexual partners	HIV testing/referrals, partner prevention services, PrEP/nPEP screening, referrals, and linkage.
Empower U, Inc.	$375,000	B/AA heterosexual men & women, B/AA MSM and young MSM of color	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, ARTAS, CLEAR, PrEP/nPEP screening, referrals, and provision, Mpowerment, F2F outreach, one-on-one online outreach, social media posts.
Latinos Salud, Inc.	$400,000	Latino and other MSM	HIV/STD testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, CLEAR, risk reduction counseling/DiversiSAFE, F2F outreach, community engagement, social media posts, digital ads.

Funding Source: State/HIP (continued)			
New Hope	$150,000	Individuals >13	HIV testing and referrals, outreach, prevention for HIV positive persons and HIV negative persons at increased risk, community level prevention and linkage to prevention and essential services.
Prevention 305, Inc.	$100,000	MSM, bisexual and transgender Hispanic immigrants younger than age 35	Condom distribution, PrEP screening, referrals, and linkage, face-to-face outreach, one-on-one online outreach, community engagement, social media posts, Latin influencers messaging, digital ads.
Pridelines Youth Services, Inc.	$100,000	Latino, B/AA, and white MSM, transgender people ages 14 to 65	Condom distribution, face-to-face outreach, BRTA, SNS, social media posts, peer program.
Project Access Foundation, Inc., MDC	$250,000	General population, high risk individuals, young adults, LGBTQ	HIV testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, ARTAS, risk reduction counseling for PLWH, risk reduction counseling for HRN, community engagement, social media posts.
Survivors' Pathway Corp.	$200,000	Hispanic LGBTQ and victims of sex trafficking and sexual assault	HIV testing and referrals, condom distribution, PrEP/nPEP screening, referrals, and linkage, prioritized HIV testing, peer program, PrEP/nPEP screening and referrals, support groups HRN, condom distribution, F2F outreach, one-on-one online outreach, community engagement, social media posts.
Funding Source: Vanderbilt			
MJD Wellness	$40,000	General population, homeless, 16+, any gender, Haitian community	HIV testing and referrals, condom distribution, outreach.

III.iii. (a) Strengths and Gaps

The ultimate strength of this jurisdiction is the active involvement and dedication of various stakeholders, including, but not limited to funders who see a challenge and collaborate with other stakeholders to address it, ideally working together to improve the availability, accessibility, and quality of HIV services. Through the Partnership, stakeholders are engaged in needs assessment, client satisfaction survey, prevention, care, and treatment planning, priority setting, and resource allocation activities. Recipients and subrecipients are in ongoing, daily communication to help ensure quality services are provided to people with HIV.

Feedback from and discussions with people with HIV and other stakeholders in preparation for this Integrated Plan update have also focused on social determinants of health and how we must prioritize what is most important to identify, engage, and retain people with HIV in care. Needs assessments have not only identified the importance of continued prioritization of core medical services, but also the need to provide essential supportive services including, but not limited to, affordable and stable housing, transportation to get to medical and social services appointments, childcare, early intervention services, employment services, and mobile non-HIV specific clinic services to meet people with HIV where they live, work, or play.

HIV Prevention Services

Based on the Resource Inventory for HIV Prevention Services in the **Table 9**, above, no significant gaps are seen currently in the community's ability to address demand and need for HIV/STI testing and counseling, partner prevention and notification, condom distribution, and PrEP, Non-occupational Post-Exposure Prophylaxis (nPEP), and Pre-exposure Prophylaxis (PEP) screening, referral, and linkages to services. However, prevention planning teams – including the Partnership's Prevention Committee, FDOH Workgroups, and FDOH-MDC – must ensure that media campaigns and services are designed with designated priority populations in mind. Messaging needs to incorporate cultural humility guidance, as well as look like and appeal to the communities we are trying to educate and inform. HIV prevention resources included in **Table 9** are expected to support the listed prevention services throughout the period of the Integrated Plan, 2022 through 2026, as long as the funding continues at least at current levels.

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Underutilization of new HIV prevention tools such as injectable antiretrovirals (e.g., Cabenuva®), medication therapy for PrEP (e.g., Descovy®), and ways to address medical mistrust are gaps in the prevention process that need to be addressed over the course of this Integrated Plan. Those who are on stable regimens may benefit from a change to Cabenuva®, once a month or every two months, rather than taking pills daily, to help maintain viral suppression and prevent HIV transmission. Further community education is needed regarding the benefits of Cabenuva® with the goal of getting people with HIV to viral suppression and using this HIV treatment as prevention, thus Treatment as Prevention.

This long-acting injectable is available for people with HIV " . . . who may not prefer daily Pill-taking . . . That includes folks who, for example, don't want their intimate partners or family members to find their HIV pills (perhaps out of a fear of shaming stigma or even violence), who are intermittently without shelter, or who – because of drug use, mental illness, or many other reasons – just aren't' able or willing to keep track of a daily pill-pop."

The Body: The HIV/AIDS Resource, Cabenuva, the First Long-Acting Injectable HIV Regimen, Is Here; Now, Who Will Take It?
January 28, 2021

Visit www.thebody.com/article/cabenuva-first-long-acting-injectable-hiv-regimen, for the complete article.

There is also a need to further educate the community on the HIV Undetectable = Untransmittable (U=U) campaign. Appropriately appealing messaging is necessary to inform the public of the overwhelming evidence that this concept works to improve the quality of life for people with HIV and can prevent HIV transmission. Getting people with HIV to undetectable viral loads helps ensure the virus cannot be transmitted. For the complete report, visit NIAID website: www.niaid.nih.gov/diseases-conditions/treatment-prevention.

"U=U means that people with HIV who achieve and maintain an undetectable viral load – the amount of HIV in the blood – by taking antiretroviral therapy (ART) daily as prescribed cannot sexually transmit the virus to others."

National Institute of Allergy and Infectious Disease (NIAID)

When prevention activities are not enough, strong linkages to HIV care and treatment (e.g., core medical and support services) is needed. Related gaps in this area are presented in the section directly below.

HIV Care and Treatment Services

As reflected in the Miami-Dade County Resource Inventory: Care and Treatment Services, **Tables 7 and 8,** above, with nearly $519 million in resources from 12 funding sources (directly or as a pass-through) across 27 core medical and support service categories, it would appear that resources might be sufficient to cover the needs of the 27,782 people with HIV who reside in MDC (CY 2020 epidemiological data). This equates to nearly $19,000 per person per year; including, but not limited to, costly services such as medical care, antiretroviral medications, other medications to treat co-occurring conditions, oral health care, and residential substance abuse treatment. However, some gaps may be interpreted from the EMA's Care and Treatment Resource Inventory where only one funding source is indicated for a service category (e.g., ADAP, Early Intervention Services, Medical Nutrition Therapy, Linguistic Services, and Other Professional Services), even if the number of funded recipients is limited by legislation (e.g., FDOH is the sole pass-through agency overseeing ADAP funding throughout the state).

The RWHAP Part D Program has only one recipient of these resources, the University of Miami (UM). While this may be seen as a resource inventory gap, this organization has unique expertise to serve the needs of women, infants, children, and youth (WICY) throughout the county – so much so that the County's Ryan White Part A Program has historically relied on UM's RWHAP Part D Program as its main resource for the WICY waiver.

Furthermore, where their expertise is demonstrated by the ability to engage and retain clients who struggle with various socio-economic, medical, and/or behavioral health challenges, some organizations do not have sufficient staffing or understanding of the complexities of managing federal, state, or local service contracts. There is a need to build capacity of service providers (including small, women-run, and minority-based organizations) at the grassroots level who over time have developed rapport with and earned the respect of people with HIV in their service area. These grassroot or neighborhood organizations can be recruited and engaged through training and less complex procurement processes to help address issues of stigma, underutilization of services, and medical mistrust, especially if many of their staff come from community and priority populations they serve.

There is a growing need to provide guidance, training, support, and mentorship to these neighborhood service providers to help them understand and work through the many complex legislative stipulations and Uniform Guidance conditions required of funded recipients and subrecipients. By providing this administrative guidance and support, we would expect to see an increase in the number of new or returning organizations applying for funding who are capable and willing to accept federal resources to provide these services. Notably, OMB, where the MDC RWHAP Part A, MAI, and RWHAP-EHE are managed, is in the process of developing a capacity building component for non-profit organizations; this would not be specific to federal grants or HIV services, but rather would have a general and countywide reach, where information on federal grant requirements could be addressed.

With a total area of 2,431 square miles, this jurisdiction must also address geographic disparities, including the issues of cost, distance, and time it takes some people to travel to appointments, especially for those who don't have their own reliable transportation. Utilizing RWHAP Parts A, B, and C funding along with federal and state resources, there are means and well-developed procedures for clients to access public transportation (e.g., Metrobus and Metrorail). Unfortunately, public transportation is not always the most effective or efficient mode of travel; with some clients taking two h ours or more just to get to their appointments. Also, weather in MDC affects the ability and willingness of some people to use public transportation: many bus stops simply have a bench with no shelter and other bus shelters are open on one side. During stormy weather, anyone waiting on public transportation in these areas would be exposed to the rain and possible thunder and lightning. There is a need to enhance funding and procedures for clients to also access non-public transportation alternatives, (i.e., ridesharing services such as Uber, Uber Health, Lyft, etc.), and telehealth services.

Similarly, the Resource Inventory for Care and Treatment services, above, only lists one funding source (the Ryan White Part C Program) for Medical Nutrition Therapy and Early Intervention Services. At this time, Ryan White Part C Program resources appear to be sufficient to provide Early Intervention Services, while the Florida Department of Health has several staff in a related position titled Disease Intervention Specialist, which is funded through the Ryan White Part B Program. While only one funding source specifically covers the Medical Nutrition Therapy service category, the local Ryan White Part A Program reimburses eligible subrecipients for nutrition services through the Outpatient/Ambulatory Health Services program. This is allowable when the nutrition counseling services are provided by appropriate clinical staff (e.g., registered dietitians, physicians, etc.) and the services are billed using applicable American Medical Association Current Procedural Terminology (CPT) coding.

Other Professional Services have only one funding source and one subrecipient. This subrecipient is funded through the local Ryan White Part A Program to provide legal assistance and permanency planning services. Due to legislative and funding source limitations, this service category is underutilized with annual expenditures of less than $160,000. Currently, this service category is limited to the following components:

- **Collections/Finance.** Issues related to unfair or illegal actions by collection agencies related to health care debt (e.g., bankruptcy due to health care debt).

- **Employment Discrimination Services.** Issues related to discrimination while at work, unfair terminations, unfair promotion policies, or hostile work environment as related to HIV diagnosis or status.

- **Health Care Related Services.** Issues related to ensuring that the client is treated in a fair manner, and issues relating to breach of confidentiality by divulging HIV status or other confidential medical/income information without client consent.

- **Health Insurance Services.** Issues related to seeking, maintaining, and purchasing of private health insurance.

- **Government Benefit Services.** Issues related to obtaining or retaining public benefits which the client has been denied and is eligible to receive, including but not limited to Social Security Disability and Supplemental Income Services (SSDI and SSI) benefits, Unemployment Compensation, as well as welfare appeals, and similar public/government services.

- **Rights of the Recently Incarcerated Services.** Issues related to a client's right to access and receive medical treatment upon release from a correctional institution.

- **Adoption/Guardianship Services.** Issues relating to preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

- **Permanency Planning.** This component helps clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: the provision of social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney. This sub-component includes preparation of advance directives, healthcare power of attorney, durable powers of attorney, and living wills.

Recently, legal assistance to aid the transgender community with gender-affirming services and expenses related to legal name and identity changes was added under the Ryan White Part A Program. Based on local needs assessments, other legal services covering housing discrimination, rental evictions, and immigration issues, would be utilized if HRSA Policy Clarification Notice (PCN) #16-02 was updated to explicitly state if those components are program-allowable. For the complete PCN, see https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.

"interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP"

PCN 16-02, page 21

As noted in the Resource Inventory above, Linguistic Services as a distinct service category is only funded under the Ryan White Part D Program. Notably, all RWHAP-funded subrecipients are contractually required to offer services in English, Spanish, and Haitian-Creole. Subrecipients offer access to language translation and interpretation services as needed and requested by their clients. These services are covered through other resources.

As our local HIV population ages beyond 55 years old, an array of age-related illnesses and issues need to be considered. While three funding sources support Home Health Care at this time, as shown in the Resource Inventory for Care and Treatment services, above, this is an area that needs to be closely monitored to address emerging gaps. Similarly, access to durable medical equipment through the Outpatient/Ambulatory Health Services category will need to be considered for this aging population, especially for mobility and auditory issues that affect this aging population but may not be directly related to their HIV condition.

In the Resource Inventory for Care and Treatment services, above, Housing Services only has one distinctly funded program, the Housing Opportunities for Persons With AIDS (HOPWA). While

funding for this service category may seem significantly high at over $12 million, the local HOPWA program has had a waiting list for several years. FDOH-MDC is currently funding a smaller rental assistance program through a contract with the HCSF, a local health planning agency established by Florida Statute, but that contract is scheduled to end in December 2022. The Recipient of EHE Initiative funding is currently exploring ways to operationalize EHE program-funded housing services for clients through a designated sole source procurement method by potentially contracting with the HCSF. This method would move much more quickly than the months long Request for Proposals (RFP) process, and may be used to provide short-term housing assistance to clients until a related RFP process can be completed.

While not specifically noted by service category as a gap in the Resource Inventory for Care and Treatment services, above, there is an emerging opportunity for coordination between the FDOH-MDC EHE Recipient, and other stakeholders to assist with quick responses to HIV clusters or outbreaks. The MDC EHE Recipient will be including a cluster response approach in its next RFP. This component, currently referred to as the Mobile GO TEAM, intends to fund the purchase or enhancement of one or more mobile clinic vans, along with a coordinated team of clinical professionals, which can be quickly dispatched to HIV cluster areas upon request to provide care, treatment, and linkage to provider agencies for ongoing HIV services.

III.iii (b) Approaches and Partnerships

Care and Treatment Resource Inventory

BSR directly contacted each agency and/or a representative of the noted funding stream to gather the data for Care and Treatment Resource Inventory, above. This data collection is an annual activity of the Partnership's Priority Setting and Resource Allocation process.

Prevention Resource Inventory

In February 2022, FDOH-MDC sent an email and survey to all services providers (i.e., EHE funded providers, FQHCs, free clinics, and others in their listserv), requesting information on their funding received for prevention services during the year 2021. Where clarification was needed by FDOH or providers, follow up emails were sent and/or phone meetings were conducted. To emphasize the importance of collecting the data, a letter signed by FDOH STD/HIV Prevention Program Director was sent to providers urging their participation. Partners who responded to the survey are noted throughout **Table 9**, above.

III.iv. Needs Assessment

III.iv. (a) Priorities

Activities to assess community need are detailed in **Section II**. Regarding access to HIV testing, the EMA has a robust and widely promoted HIV testing program which includes on-site rapid testing, after-hours rapid testing, mobile rapid testing, opt-out testing in emergency rooms and clinics, and at-home testing.

These are further detailed in **Table 9**, above. Further, the EMA's TTRA process is proficient in connecting newly diagnosed persons to care, including referrals to mental health, substance use, and medical care appointments. Persons at-risk who test negative are directed to PrEP services, also widely available throughout the EMA.

Activities specific to both testing and linkage to care are detailed within the goals of this Plan and will be evaluated and monitored throughout the life of the Plan to determine strengths, barriers, and areas of needed improvement.

This Plan also includes activities to ensure training on the status-neutral approach to health care; a relatively new concept in the EMA and one which has been largely embraced as a new standard of care across the spectrum of prevention, care, and treatment.

As detailed in **Section II.i. (f)**, services that people with HIV need to stay in care and achieve viral suppression, and concerns which may act as barriers to achieve those ends include:

- Need for enhanced services for and support people with HIV's lived-experience;
- Targeted messaging about available HIV/STD prevention, linkage, and care services;
- Enhanced Pre-Exposure Prophylaxis (PrEP) messaging;
- Putting "People" back into "People with HIV";
- Educating people with HIV regarding private insurance benefits, including ACA, and how to use the insurance benefits effectively; and
- Addressing stigma.

III.iv. (b) Actions Taken

The breadth of goals and activities laid out in this Plan speak to the actions the EMA will take to improve all stages of the continuum of care.

III.iv. (c) Approach

The approach to assessing community needs is detailed in **Section II**, including the data gathering processes, community partners, and resulting actions.

Section IV: Situational Analysis

IV.i. Situational Analysis

Feedback obtained from the Community Engagement and Planning Processes in **Section II** and the Contributing Data Sets and Assessments (epidemiological snapshot and resource inventories) in **Section III** are summarized in the Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis in **Table 10.**

Table 10: Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

 ▪ More than 30 years of service delivery experience. ▪ $519 million in overall, combined funding for FY 2021 HIV services as a whole. ▪ Active involvement and dedication of various stakeholders engaged in needs assessment, client satisfaction survey, prevention, care, and treatment planning, priority setting, and resource allocation activities. ▪ Recipients and subrecipients are in ongoing, daily communication to help ensure quality services are provided to people with HIV. ▪ An array of available ART medications - oral medications and a long-acting injectable.
 ▪ Not enough culturally appropriate messaging about PrEP, nPEP, and PEP. ▪ Clients feel a lack of empowerment to manage their own health care or participate in the planning process to improve service, especially in the priority populations. ▪ Not enough "People" first messaging and service delivery. ▪ Not enough relevant or engaging prevention, care and treatment messaging that looks like the community that we are trying to serve. ▪ Have not been able to adequately measure or address stigma. ▪ Need to provide more education regarding health insurance, navigating the health care system, mitigating feelings of mistrust with medical system, and how to effectively use insurance benefits.
 ▪ Partnering with other entities for training: Cultural humility training – Gilead Sciences; understanding needs of and optimal service delivery approaches for transgender community; partnerships with TransSocial and LGBTQ+ advocacy organizations; and health literacy training for service providers and clients. ▪ Partnering with other entities for model (best practice) media campaigns for PrEP, U=U, available services, etc. ▪ Employ more people with HIV in the system of care that serves them, especially those in the priority populations with unique lived experience. ▪ Identify additional funding partners.
 ▪ Funding may not be sufficient to address all needs identified in the Plan. ▪ Aging workforce – succession planning must be prioritized. ▪ Clients lost to care if we can't address stigma issues or the socio-economic factors people with HIV, especially in priority populations, face at same time they are trying to focus on their healthcare. ▪ Legislation is not keeping up with changes in current needs of clients, changing healthcare landscape, and more. ▪ Treatment fatigue for clients. ▪ Service delivery fatigue for service providers, subrecipients, and recipients

Each of the four EHE pillars are addressed below, including a brief analysis, further outlined throughout this Plan, and related strategies which are detailed in **Section V**. Some strategies overlap pillars.

Regarding structural and systemic issues impacting populations disproportionately impacted by the HIV epidemic in the EMA, see **Section III.ii.**, which details racial and ethnic disparities, high rates of poverty, the difficulties of being homeless or unstably housed, challenges of navigating a complex service system as a non-native speaker of English, stigma and fear of disclosure of HIV status, and dealing with biases around sexual- and gender-identification.

Because development of this Plan was an integrated process, key partners are consistent and redundant across all pillars, including:

- FDOH-MDC and partners (**Table 9**);
- RWHAP recipients, subrecipients, front line service providers, and other partners (**Table 8**);
- Partnership and Clinical Quality Management (CQM) members and staff; and
- Other community stakeholders.

It is the intent of the JIPRT to expand community stakeholders and continue to engage the broadest scope of partners throughout the implementation of this Plan. At the same time, this Plan is intended to integrate efforts without unnecessary duplication of effort.

Diagnose

Testing is the key to making people aware of their HIV status. The goal of HIV counseling and testing is to assist individuals in assessing their risk, getting tested, understanding their test results, helping people with negative results develop a personalized prevention plan, and helping people with positive results link to care. According to Florida CHARTS, MDC ranked as the Florida county with the most HIV diagnoses for each of the five years from 2017 to 2021. As noted in **Section III.ii.**, above, the EMA has a high concentration of people with HIV and high rates of new HIV infection. From CY 2017 through CY 2021, the EMA reported a total of 5,543 new HIV cases and 1,875 new AIDS cases. The EMA has a robust and widely promoted HIV testing program which includes on-site rapid testing, after-hours rapid testing, mobile rapid testing, opt-out testing in emergency rooms and clinics, and at-home testing. Marketing of testing availability is developed in English, Spanish, and Haitian Creole. Prevention activities in this plan related to diagnosing more people who do not know their status will further target the most at-risk populations beyond language differences.

Diagnose - Related Strategies

- P1.1: Implement HIV, HCV, and STI testing as part of routine medical care in all health care settings, including urgent care centers, FQHCs, small clinics, public hospitals, and emergency departments.
- P1.2: Expand HIV/STI testing in traditional and non-traditional settings.
- P1.3: Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative, and immediate linkage to HIV care and treatment for those who test positive.
- P2.1: Increase awareness of healthcare providers of the opt-out HIV and STI screening for pregnant women per Florida Statute 64D-3.04.
- P2.2: Increase awareness among women of childbearing age about HIV testing, prevention, prenatal care, and postpartum/family planning services.

Treat

The EMA's Test and Treat/Rapid Access (TTRA) protocol is the basis for rapid linkage to care. The protocol has a demonstrated success in linking newly diagnosed persons to care, with a linkage rate of 83% in CY 2021, see **Figure 1**. Persons who enter the RWHAP service system through TTRA and those who are enrolled in RWHAP and ADAP care can be monitored to ensure they are connected to and accessing available needed services. However, we acknowledge some limitations in tracking treatment protocols for persons who are above 400% of the Federal Poverty Level (FPL), who have private medical coverage, and whose plans of care are not known to us. Across the EMA, HIV care and treatment services funding totaled $518,760,934 in Fiscal Year 2021 (date ranges for Fiscal Years vary among funders). A major shift in this Plan is the adoption of strategies to train providers on status-neutral care and cultural competency in an effort to address HIV/AIDS stigma, systematic racism, and gender- and sexual-identity disparities as public health threats. Additionally, the Plan includes activities to target services toward the special needs of at-risk populations, see **Section IV.i.**, below; and address the particular needs of an aging population of people with HIV.

Treat - Related Strategies

- P1.3: Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative, and immediate linkage to HIV care and treatment for those who test positive.
- P2.2: Increase awareness among women of childbearing age about HIV testing, prevention, prenatal care, and postpartum/family planning services.
- L1.1: Expand capacity and access to local TTRA.
- L2.1: Improve linkage to HIV health care within 30 days for all persons who test positive for HIV.
- Strategy L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA access.)
- R1.1: Identify and reengage clients in danger of being lost to RWHAP care.
- R1.2: Increase Peer (PESN) involvement in client care to improve retention and viral load suppression.
- R1.3: Ensure a "whole person," holistic treatment approach that recognizes that care for RWHAP clients must go beyond viral load suppression and retention in care.
- R2.1: Evaluate retention in care rates among non-RWHAP clients.
- SP2.1: Improve health outcomes for adults over age 50 with HIV.
- SP1.1, SP3.1-SP6.1: Expand existing programs and collaborations to address specific needs of for women with HIV, transgender people with HIV, people with HIV experiencing homelessness or housing instability, MSM with HIV and co-occurring health conditions, and youth (ages 13-24 years old) who are living with HIV.
- S1.1: Increase awareness of stigmatizing behaviors throughout the system of care.
- DR1.1-DR1.3: Increase Retention in Medical Care (RiMC) rates for Black/African-American (B/AA) male, B/AA female, and Hispanic MSM RWHAP clients.
- DV1.1-DV1.3: Increase annual VL suppression rates for B/AA male, B/AA female, and Haitian male and female RWHAP clients.

Prevent

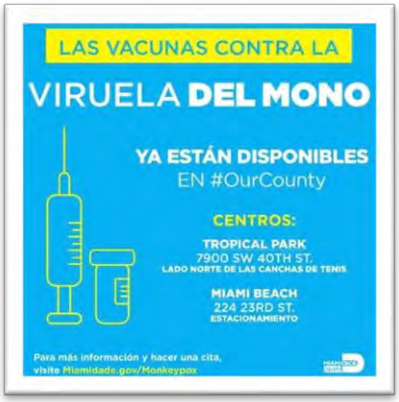
As detailed in **Table 8**, the EMA has considerable funding and a broad range of providers offering prevention services, including HIV/STD testing and referrals, partner prevention services, condom distribution, prevention for negatives, needle exchange, individual- and group-level educational sessions, and PrEP and nPEP screening, referral, and linkage. Prevention initiatives are conducted throughout the EMA via face-to-face and virtual interventions, mobile testing units, social media platforms, and print, radio and television advertising. FDOH has a dedicated website for HIV testing, www.testmiami.org, which promotes PrEP, condom distribution, and testing sites, with links to locate services throughout the EMA. Even with prevention initiatives targeted at the most at-risk populations and a broad general availability of prevention messaging and resources, by the latest estimate (2017), there were 4,400 individuals in the EMA who have HIV and are not aware of their status. That figure underscores the considerable strategies and activities in this Plan to identify those individuals.

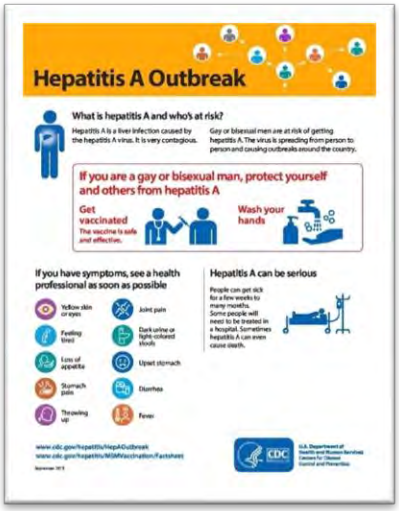
Prevent - Related Strategies

- P1.2: Expand HIV/STI testing in traditional and non-traditional settings.
- P1.3: Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative, and immediate linkage to HIV care and treatment for those who test positive.
- P2.2: Increase awareness among women of childbearing age about HIV testing, prevention, prenatal care, and postpartum/family planning services.
- P3.1-P4.1: Ensure access to and availability of PrEP and nPEP.
- P5.1: Continue free condom distribution.
- P6.1: Inform HIV service providers and the community about IDEA Exchange services.
- P7.1: Expand community engagement efforts for populations most at risk in MDC.
- P1.4: Provide partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.
- SP1.1: Expand existing programs and collaborations for women with HIV.
- SP6.1: Expand existing programs and collaborations to address specific needs of youth (ages 13-24 years old) who are living with HIV.
- S1.1: Increase awa reness of stigmatizing behaviors throughout the system of care.

Respond

In addition to responding to the COVID-19 pandemic, the EMA has had to mobilize a response to outbreaks of Monkeypox, Meningococcal Disease, and Hepatitis A. Several of the flyers regarding those outbreaks are shown on this page. These were distributed by FDOH and promoted via the Partnership's website and listserv. Note, most notices are available in English, Spanish, and Haitian-Creole. As previously noted, HIV prevention and care resources are widely available throughout the EMA, and many of those partners were instrumental in disseminating information about other disease outbreaks. Nonetheless, developing more community partnerships to leverage available services and funding will enhance our ability to respond quickly to HIV outbreaks. Stakeholders who are targeted for future engagement include police departments/first responders, celebrity/social media personalities, domestic violence prevention organizations, and Business Respond to AIDS (BRTA) organizations. Coordination across funding streams is also important to avoid delays in reacting to outbreaks. Currently, the EMA's RWHAP Part A/MAI, RWHAP Part B, General Revenue, and FDOH are engaged in a data sharing agreement using the PE-Miami database to reduce duplication of effort across funding streams and simplify service delivery for clients. Purchase of a mobile van and related staffing to help FDOH-MDC respond to HIV clusters will be part of an upcoming MDC-EHE RFP. Additionally, the CQM quarterly Performance Report Card provides Part A/MAI, Part B, and GR data along with subrecipient level extract files (CQI subrecipient dashboard data) that allows individual subrecipients to monitor detailed data on overall performance and individual clients referenced in the report, allowing them to proactively address where clients may be lost to care or are not meeting VL suppression rates. We also recognize that identifying outbreaks is not always obvious since outbreaks need to be determined by genetic testing to verify if a cluster is all the same strain of the virus.





Respond - Related Strategy

- IPC1.1. Maintain and develop community partnerships.

IV.i. (a) Priority Populations

The designated priority populations for retention in medical care (RiMC) and viral load (VL) suppression represent the largest racial and ethnic subpopulations with the lowest VL suppression rates (see **III.ii. (c) Demographics**). Plan activities will focus on identifying and disseminating best practices for culturally relevant prevention, care and treatment efforts for those populations.

Strategies and activities to increase RWHAP RiMC rates among priority populations are detailed in **Objective DR1**, below. The priority populations for RiMC are:

- Black/African American Males;
- Black/African American Females; and
- Hispanic MSM.

Strategies and activities to increase the annual VL suppression rates among priority populations are detailed in **Objective DV1**, below. The priority populations for VL suppression are:

- Black/African American Males;
- Black/African American Females; and
- Haitian Males and Females.

Additionally, the Plan addresses overall health outcomes for special populations based on other social determinants of health and related disparities. Strategies and activities to address improved health outcomes for special populations are detailed in **NHAS Goal 2 Health Outcomes For Special Populations (SP)**, below. The special populations are:

- Women with HIV;
- Adults over age 50 with HIV;
- Transgender people with HIV;
- Homeless or unstably housed people with HIV;
- MSM with HIV;
- Youth (ages 13-24 years old) who are at risk of or living with HIV.

Section V: 2022-2026 Goals and Objectives

V.i. Goals and Objectives Description

In recognition of people-first language, **Section V** uses the acronym "MSM" (men who have sex with men) when referring to people, and "MMSC" (male-to-male sexual contact) when referring to modes of HIV transmission. Additionally, throughout this Plan, Hispanics includes persons who identify as Hispanic, Latina, Latino, and Latinx.

A detailed report of prevention workgroups, focus groups, other support groups, committees, and the online survey was compiled and used in development of the goals and activities.

Goals were organized under each of the National HIV/AIDS Strategy Goals. Strategies and activities were developed based on:

- 2022-2025 National HIV/AIDS Strategy (NHAS);
- 2017-2021 Integrated Plan (2017-2021 IP);
- 2022-2025 Integrated Plan Guidance;
- FDOH-Tallahassee Integrated Plan – Initial guidance received April, 2022 (State IP);
- FDOH-MDC Ending the HIV Epidemic (FDOH-EHE) initiatives;
- Ryan White HIV/AIDS Program Ending the HIV Epidemic (RWHAP-EHE) initiatives;
- Community input sessions, detailed above; and
- Joint Integrated Plan Review Team meetings (JIPRT) meeting presentations from January through August, 2022, including:
  - 2017-2021 IP Prevention Goals Progress Updates (HIV/STI Testing; Linkage to Care; Pregnant Women; PrEP and nPEP; Condom Distribution; and Outreach);
  - 2017-2021 IP Care and Treatment Goals Updates (Retention in Care, Disparities in Retention in Care, and Disparities in Viral Load Suppression);
  - Prevention Services Resource Inventory;
  - Care and Treatment Services Resource Inventory;
  - Four-Year Analysis of Linkage to Care for Newly Diagnosed Clients (201-2020);
  - Five-Year Analysis of Retention in Care and Viral Load Suppression for Priority Populations (2017-2021);
  - RWHAP Clinical Quality Management Performance Report Card (Fiscal Year 2021-2022);
  - "What will it take to 'End the HIV epidemic in the US': An economic modeling study in 6 US cities including Miami-Dade County," by Dr. Bohdan Nosyk, Associate Professor, St. Paul's Hospital CANFAR Chair in HIV/AIDS Research; and
  - General Discussion on Topics of Concern: Poverty, Housing, and Mental Health.

NHAS GOAL 1
PREVENT NEW HIV INFECTIONS
Prevention (P)

Objective P1. Increase the percentage of people living in MDC who are aware of their HIV status from the national baseline of 87% in 2019 to 90% by December 31, 2026.

- ***Strategy P1.1.*** *Implement HIV, HCV, and STI testing as part of routine medical care in all health care settings, including urgent care centers, FQHCs, small clinics, public hospitals, and emergency departments.*

Activities	Responsible Entities	Measurements
P1.1.a. Partner/ collaborate with healthcare facilities to increase routine HIV testing.	FDOH-MDC and partners (i.e., FOCUS, hospital settings, FQHCs, urgent care centers, medical practices, free clinics, hospitals)	**1.** # of healthcare facilities identified[1] for routine opt-out HIV testing in MDC **2.** # of healthcare facilities interested[2] in routinizing HIV testing in MDC **3.** # of healthcare facilities committed[3] to conduct routine opt-out HIV testing in MDC **4.** # of healthcare facilities implementing[4] routine opt-out HIV testing in MDC **5.** # of persons served[5] at a healthcare facility **6.** # of persons tested[6] at a healthcare facility **7.** # of HIV positive persons identified[7] through routine testing **8.** # of previously diagnosed HIV positive persons **9.** # of newly diagnosed HIV positive persons **10.** # of HIV tests integrated with viral hepatitis tests (HCV) **11.** # of HIV tests integrated with STI tests
P1.1.b. Utilize academic detailing to educate providers on routine testing inclusive of Hepatitis C virus (HCV) and sexually transmitted infections (STIs).	FDOH-MDC and partners RWHAP	**1.** # of providers/practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI) **2.** # of private providers educated on routine testing (i.e., HIV, HCV, STI) **3.** # of MOUs/agreements established with partners to serve as routine healthcare testing sites

- ***Strategy P1.1.*** *continued.*

Activities	Responsible Entities	Measurements
P1.1.c. Partner/ collaborate with healthcare facilities to offer STI testing.	FDOH-MDC and partners	**1.** # of healthcare facilities identified to conduct STI testing **2.** # of healthcare facilities committed to conduct STI testing **3.** # of MOUs signed with the healthcare facilities to offer STI testing **4.** # of healthcare facilities implementing STI testing **5.** # of STI tests done at healthcare facilities **6.** # of clients with a positive STI result **7.** # of clients newly diagnosed with a STI **8.** # of clients treated for STIs
P1.1.d. Partner/ collaborate with healthcare facilities to offer HCV testing.	FDOH-MDC and partners	**1.** # healthcare facilities identified to conduct HCV testing **2.** #819 HCV tests (integrated with HIV tests) done at healthcare facilities **3.** # of clients with a positive HCV result **4.** # of clients referred for HCV treatment.

Definitions

[1] **Identified facilities**: Facilities identified as not currently conducting routine opt-out testing as confirmed by the FDOH-MDC Academic Detailer (AD), and may or may not be interested in the future to conduct routine opt-out testing

[2] **Interested facilities**: Facilities identified as not currently doing routine opt-out testing which have been contacted by FDOH-MDC and have expressed willingness to be educated on the activity.

[3] **Committed facilities:** Facilities educated by AD, ready to start routinizing testing, and have signed a document to conduct routine opt-out testing.

[4] **Implementing facilities:** Facilities which are currently conducting routine testing.

[5] **Persons served:** Persons, regardless of age, who attended at least one medical appointment at the health care facility during the reporting period.

[6] **Persons tested:** Persons who had a positive or negative HIV test result.

[7] **Positive persons identified:** Persons who are newly HIV-positive, previously diagnosed HIV-positive infections, and those with unknown prior history.

Notes

1. Baseline is based on CDC national average.
2. Guidance on counting non-resident/previously diagnosed positivity rates (international travelers, transient persons, tourists) is pending from CDC.
3. HIV testing must include pre- and post-testing counseling components.
4. Consider simplified messaging and "old-fashioned" (1980s) counseling. Define four key points any healthcare worker can deliver, for example.
5. AHEAD Dashboard: defines "knowledge of HIV status" as " the estimated percentage of people with HIV who have received an HIV diagnosis", and the percentages are 86.8% in 2019, and 95% in 2026 https://ahead.hiv.gov/locations/miami-dade-county

- ***Strategy P1.2.*** *Expand HIV/STI testing in traditional and non-traditional settings.*

Activities	Responsible Entities	Measurements
P1.2.a. Increase the use of home HIV self-testing kits as an alternative option specially for hard-to reach populations including youth, transgender persons, sex workers, and men who have sex with men (MSM)	FDOH-MDC and partners	**1.** # of Persons Receiving ≥1 HIV Self-Test Kits **2.** # of persons who confirmed taking the test **3.** # of persons who reported a positive test result using the self-test kit **4.** # of persons with positive test result from a self-test kit, who took a confirmatory test at FDOH-MDC and partner facilities
P1.2.b. Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings (i.e., faith-based organizations, domestic violence/ human trafficking agencies)	FDOH-MDC and partners (i.e., faith-based organizations, domestic violence/ human trafficking agencies, CBOs, universities, FQHCs, and other non-traditional partners)	**1.** # of partners identified to conduct HIV/STI testing at in non-traditional settings **2.** # of partners interested in conducting HIV/STI testing at non-traditional settings **3.** # of partners committed to conducting HIV/STI testing at non-traditional settings **4.** # of partners implementing HIV/STI testing at non-traditional settings **5.** # of persons tested for HIV at non-traditional settings **6.** # of HIV positive persons at a non-traditional setting **7.** # of persons tested for STI at non-traditional settings **8.** # of persons newly diagnosed with STI at non-traditional settings **9.** # of previously diagnosed HIV positive persons, confirmed in surveillance at non-traditional settings **10.** # of newly diagnosed HIV positive persons
P1.2.c. Increase the number of mobile units offering HIV/STI testing in the community	FDOH-MDC and partners (i.e., CBOs, universities, FQHCs)	**1.** # of mobile units available to conduct HIV/STI testing **2.** # of HIV tests conducted at a mobile unit **3.** # STI tests conducted at a mobile unit **4.** # of HIV positive results from HIV tests conducted at a mobile unit **5.** # of STI positive results from STI tests conducted at a mobile unit **6.** # of people linked to PrEP at a mobile unit **7.** # of people linked to HIV care at a mobile unit **8.** # of people referred for STI treatment at a mobile unit
Notes **1.** Strategy aimed at reducing stigma. **2.** Non-traditional settings, includes, but is not limited to health fairs, faith-based organizations, domestic violence/ human trafficking agencies, retail stores, pharmacies, and mobile units. --Continued next page--		

3. Traditional settings: community-based orgs., testing sites, healthcare centers.
4. FDOH-EHE Activity: Increase the use of home HIV self-testing kits as an alternative option specially for hard-to-reach populations including youth, transgender persons, sex workers, and MSM.
5. AHEAD Dashboard: defines "knowledge of HIV status" as " the estimated percentage of people with HIV who have received an HIV diagnosis", and the percentages are 86.8% in 2019, and 95% in 2026 https://ahead.hiv.gov/locations/miami-dade-county

- ***Strategy P1.3.*** *Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative, and immediate linkage to HIV care and treatment for those who test positive.*

Activities	Responsible Entities	Measurements
P1.3.a. Provide training and education to community partners on status-neutral approach.	FDOH-MDC and partners	**1.** # of community partners trained and educated on the status neutral approach
P1.3.b. Increase the number of agencies implementing status neutral approach.	FDOH-MDC and partners	**1.** # of agencies implementing the status neutral approach

- ***Strategy P1.4.*** *Provide partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.*

Activities	Responsible Entities	Measurements
P1.4.a. Educate CBOs, FQHCs, and private providers on available partner services.	FDOH-MDC and partners	**1.** # of CBO's educated on partner services **2.** # of FQHCs educated on partner services **3.** # of private providers educated on partner services **4.** % of all named, notifiable partners identified through HIV partner services
P1.4.b. Partner with RWHAP and CBOs to educate patients about the importance of partner services.	FDOH-MDC and partners	**1.** # and % of notifiable partners identified through HIV partner services **2.** # and % of notifiable partners that were tested for HIV **3.** # of educational sessions conducted to providers regarding partner services **4.** # partnership with FDOH-MDC to offer partnered services **5.** # of providers educated on partner services **6.** # patients receiving partner services
P1.4.c. Establish private/public partnerships to offer partner services.	FDOH-MDC and partners	**1.** # of public/private partnership established

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).

- ***Strategy P2.1.*** *Increase awareness of healthcare providers of the opt-out HIV and STI screening for pregnant women per Florida Statute 64D-3.04.*

Activities	Responsible Entities	Measurements
P2.1.a. Conduct educational sessions on Florida Statute 64D-3.04 and Perinatal HIV Prevention protocols with medical professionals and agencies that provide care and treatment to women of childbearing age, and pregnant women with HIV and their exposed or HIV positive newborns.	FDOH-MDC and partners	**1.** # of educational sessions conducted with medical care providers **2.** # of educational sessions conducted with agencies
P2.1.b. Partner with the FDOH-MDC's Academic Detailing Program (ADP) to include Perinatal HIV Prevention and Opt-Out HIV/STI testing of pregnant women in their education sessions and through the Test Miami Providers' Corner link.	FDOH-MDC ADP and partners	**1.** # of educational sessions with medical care providers conducted by FDOH-MDC ADP **2.** # of updates added to the Test Miami Providers' Corner link
P2.1.c. Educate hospitals on Opt-Out HIV/STI testing of pregnant women according to the Florida Statute 64D-3.04, and the importance of submitting the High-Risk Notification Form to the Miami-Dade Perinatal HIV Prevention Program.	FDOH-MDC and partners	**1.** # of educational sessions conducted with hospitals **2.** # of High-Risk Notification Forms and/or notifications of pregnant women with HIV received from hospitals
P2.1.d. 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 Labor/Delivery/Emergency Department Perinatal Prevention Protocols, High Risk Pregnancy Notification, and Newborn Exposure Notification forms.	FDOH-MDC and partners	**1.** # of educational sessions conducted to hospitals (i.e., ERs), and urgent care centers **2.** # of High Risk Pregnancy Notification Forms received from hospitals (see P2.1.c. above) **3.** # of Newborn Exposure Notification Forms received from hospitals

- ***Strategy P2.2.*** *Increase awareness among women of childbearing age about HIV testing, prevention, prenatal care, and postpartum/family planning services.*

Activities	Responsible Entities	Measurements
P2.2.a. Provide linkage to prenatal care and HIV care for pregnant women with HIV.	FDOH-MDC and partners	**1.** # of HIV positive pregnant women who received HIV care **2.** # of HIV positive pregnant women who received prenatal care
P2.2.b. Provide follow-up medical and family planning services for post-partum women with HIV.	FDOH-MDC and partners	**1.** # of post-partum women with HIV who received family planning services

Objective P3. Increase the number of individuals prescribed pre-exposure prophylaxis (PrEP) from the hiv.gov AHEAD Dashboard baseline 53% in 2021 to 50% by December 31, 2026.

- ***Strategy P3.1.*** *Ensure access to and availability of PrEP.*

Activities	Responsible Entities	Measurements
P3.1.a. Increase PrEP access by expanding the number of partners offering PrEP services.	FDOH-MDC and partners (i.e., CBOs, FQHCs, agencies)	**1.** # of HIV-negative persons **2.** # of access points for PrEP **3.** # of individuals screened for PrEP **4.** # of individuals eligible for PrEP **5.** # of individuals referred to a PrEP provider **6.** # of individuals linked to a PrEP provider **7.** # of individuals prescribed PrEP
P3.1.b. Train peer educators and community health workers to promote the Ready, Set, PrEP (RSP) initiative to implement direct community outreach.	FDOH-MDC and partners (i.e., Peer educators and community health workers)	**1.** # of educational sessions conducted **2.** # of RSP sessions conducted **3.** # of RSP educational materials distributed
P3.1.c. Utilize FDOH-MDC ADP to engage and educate health care providers on PrEP to increase the number of PrEP prescribers.	FDOH-MDC ADP and partners [i.e., AIDS Education and Training Center (AETC), Gilead, HIP providers, FDOH-MDC private providers, FQHCs, pharmacies, CBOs]	**1.** # of educational sessions conducted specifically to health care providers **2.** # of providers recruited1 to provide PrEP services **3.** # of PrEP prescribers2
P3.1.d. Disseminate an updated comprehensive list of PrEP providers to share with community partners.	FDOH-MDC and partners (i.e., Pharmaceuticals, CBOs, retail pharmacy chains, medical providers, ERs, urgent care centers, clinics, testing sites)	**1.** # of organizations with access3 to the comprehensive list
P3.1.e. Identify and share best practices by agencies that have utilized TelePrEP to expand providers' capacity of offering TelePrEP services.	FDOH-MDC and partners (i.e., Pharmaceuticals, CBOs, retail pharmacy chains, medical providers, ERs, urgent care centers, clinics, testing sites)	**1.** # of providers offering TelePrEP services **2.** # of persons who received4 TelePrEP services

- ***Strategy P3.1.*** *continued.*

Activities	Responsible Entities	Measurements
P3.1.f. Create a PrEP referral network for clients to access PrEP services.	FDOH-MDC and partners	**1.** # clients accessing the PrEP referral network
P3.1.g. Increase the number of non-traditional partners offering PrEP (i.e., pharmacies, urgent care centers).	FDOH-MDC and non-traditional partners such as pharmacies, urgent care centers.	**1.** # of pharmacy clinics providing PrEP (MinuteClinic at CVS, and UHealth at Walgreens) **2.** # of urgent care centers providing PrEP **3.** # of hospitals providing PrEP

Definitions

[1] **Providers recruited:** Providers that signed the FDOH-MDC acknowledgement agreement to provide PrEP services.

[2] **PrEP prescribers:** Providers prescribing PrEP, including providers registered with FDOH-MDC and prescribers who do not want to register. Complete data is unavailable.

[3] **Organizations with access to the comprehensive list of PrEP prescribers:** Healthcare facilities for which a list was provided, and/or are aware of the PrEPlocator.org website.

[4] **Persons who received TelePrEP services:** An outcome of the referral or linkage of a PrEP eligible person to a PrEP provider, indicated by attendance at the first telehealth appointment and verified through reviews of medical records or other data systems or self-report by the client. Denominator is number of persons who received PrEP services.

Notes

1. Regarding "# of pharmacy clinics providing PrEP," data sources include aidsvu.org/services/#/prep and preplocator.org/, which indicate locations but not necessarily pharmacy clinics.
2. PrEP services: Help navigating through the system, i.e., the application process.
3. Objective data: from AHEAD Dashboard which displays goals of 29.9% in 2019, and 50% for 2026 https://ahead.hiv.gov/locations/miami-dade-county.

Objective P4. Increase the number of agencies offering nPEP (Non-occupational Post-Exposure Prophylaxis) in the community from 7 in 2021 to 10 by December 31, 2026.

- ***Strategy P4.1.*** *Ensure access to and availability of nPEP.*

Activities	Responsible Entities	Measurements
P4.1.a. Increase the number of partners offering nPEP services.	FDOH-MDC and partners (i.e., FDOH, CBOs, FQHCs, agencies)	**1.** # of individuals screened for nPEP **2.** # of individuals eligible for nPEP **3.** # of nPEP prescriptions (if able to capture data) **4.** # of access points for nPEP
P4.1.b. Utilize FDOH-MDC ADP to engage and educate providers, urgent care centers, and ERs on nPEP to increase the number of nPEP prescribers.	FDOH-MDC ADP and partners	**1.** # of nPEP educational sessions conducted **2.** # of providers, urgent care centers, and ERs providing nPEP services
P4.1.c. Disseminate an updated comprehensive list of nPEP providers to share with community partners and healthcare providers.	FDOH-MDC and partners	**1.** # of organizations with accessibility to the comprehensive list of nPEP providers
P4.1.d. Increase the number of non-traditional partners offering nPEP (i.e., pharmacies, urgent care centers).	FDOH-MDC and non-traditional partners such as pharmacies, urgent care centers.	**1.** # of pharmacy clinics providing nPEP (MinuteClinic at CVS, and UHealth at Walgreens) **2.** # of urgent care centers providing nPEP
Notes **1.** Some agencies only screen for nPEP, others refer and/or provide nPEP.		

Objective P5. Increase the number of free condoms distributed from 1,929,715 in 2021 to 2,026,200 by December 31, 2026.

- ***Strategy P5.1.*** *Continue free condom distribution.*

Activities	Responsible Entities	Measurements
P5.1.a. Increase the number of condom distribution sites across the jurisdiction.	FDOH-MDC and partners	**1.** # of condoms provided to high-risk populations **2.** # of condoms distributed within the jurisdiction **3.** # of condoms distributed at bar/clubs **4.** # of condoms distributed at CBOs **5.** # of condoms distributed at clinical/medical settings **6.** # of condoms distributed at college/schools **7.** # of condoms distributed at faith-based organizations **8.** # of condoms distributed at prevention/ intervention sessions **9.** # of condoms distributed at private businesses **10.** # of condoms distributed at street outreach
Notes **1.** 2021 baseline of condoms distributed and 2026 target are pending further data collection.		

Objective P6. Support the local Syringe Service Program (SSP) – locally, the Infectious Disease Elimination Act (IDEA Exchange) – and ensure access to harm reduction services.

- ***Strategy P6.1.*** *Inform HIV service providers and the community about IDEA Exchange services.*

Activities	Responsible Entities	Measurements
P6.1.a. Educate and refer high-risk individuals to local SSP.	FDOH-MDC, IDEA Exchange, and partners	**1.** # of persons linked to IDEA Exchange (see Note #3) **2.** # of referrals made to IDEA Exchange, by partners
P6.1.b. Utilize social media platforms to promote services offered by SSP.	FDOH-MDC, IDEA Exchange, and partners	**1.** # of social media posts by IDEA Exchange (Facebook, Instagram and Twitter)

Notes

1. As of July 2022, one RWHAP MAI subrecipient is using IDEA Exchange as an access point to its MAI HIV services.
2. IDEA Exchange provides an annual report to FDOH-Tallahassee.
3. Basic enrollment is anonymous so it would be difficult to know if a person who was referred by a local agency was enrolled at IDEA.

Objective P7. Increase the number of advertisement types[1] to expand culturally appropriate messaging concerning HIV prevention, testing, and treatment from four (4) in 2021, to six (6) by December 31, 2026.

- ***Strategy P7.1.*** *Expand community engagement efforts (i.e., outreach events, media campaigns) for populations most at risk in Miami-Dade County.*

Activities	Responsible Entities	Measurements
P7.1.a. Build innovative media campaigns, i.e., billboards, TV/radio, social media, to highlight the importance of knowing your status, getting into care, addressing stigma, HIV prevention and care.	FDOH-MDC and partners	**1.** # of advertising types1 on knowing your status, getting into care while addressing stigma, HIV prevention and care (e.g., print; digital/ internet-based; radio; television; out-of-home advertising) **2.** # of overall impressions2 [media measurement] from knowing your status, getting into care while addressing stigma, HIV prevention and care marketing campaigns **3.** # of posts on knowing your status, getting into care while addressing stigma, HIV prevention and care
P7.1.b. Conduct outreach events that promote diversity (inclusive of multi-lingual messages), to reach out to priority populations in the community.		**1.** # of agencies conducting outreach events for each priority population (identify priority populations) **2.** # of outreach events conducted **3.** # of contacts created at outreach events
P7.1.c. Develop and support culturally tailored prevention messages to destigmatize HIV (i.e., HIV.gov Believe, Test Miami, Undetectable = Untransmittable (U=U), I Am A Work of ART).	FDOH-MDC and partners	**1.** # of overall impressions from U=U, and other destigmatizing HIV marketing campaigns **2.** # of posts on prevention messages to destigmatize HIV **3.** # of advertising/media types (e.g., print; digital/internet-based; radio; television; out-of-home advertising) **4.** # of hashtags **5.** # of shares **6.** # of QR code hits

- ***Strategy P7.1.*** *continued.*

Activities	Responsible Entities	Measurements
P7.1.d. Utilize RWHAP peer educators and representatives of the HIV community to deliver messages to people with HIV, highlighting personal success and struggles, and empowering people with HIV to thrive despite their status.	FDOH-MDC and partners RWHAP Part A RWHAP-EHE	**1.** # of educational sessions conducted by peer educators about destigmatizing HIV, and empowering people with HIV to thrive their status **2.** # of media campaign types utilizing influencers or community representatives to promote HIV messages
P7.1.e. Develop culturally appropriate messaging on pre-exposure prophylaxis (PrEP)/ nonoccupational post-exposure prophylaxis (nPEP), and the Ready, Set, PrEP initiative to at-risk populations, with an inclusive message.	FDOH-MDC and partners	**1.** # of overall impressions from PrEP/nPEP marketing campaign(s) **2.** # of PrEP/nPEP advertisements (e.g., print; digital/internet-based; radio; television; out-of-home advertising) **3.** # of Ready, Set, PrEP initiative, PrEP/nPEP posts
P7.1.f. Collaborate with CBOs and engage non-traditional partners to support HIV prevention messages and further destigmatize HIV.	FDOH-MDC and partners	**1.** # of partnerships created that support prevention messages

Definitions

[1] **Advertisement types:** Out-of-Home (OOH): outdoor media: includes billboards, transit ads on buses/trains, wallscapes, and posters seen while "on the go" or in the community, place-based advertising which are those at medical centers, airports, stores, or buildings/facilities.

[2] **Impressions:** The number of times your content is displayed/shown, no matter if it was clicked or not.

Notes

1. Ensure campaigns are culturally sensitive and appropriate for the target audiences, featuring "people who look like us."
2. Target the undocumented population with information about specific resources available to them and for which they are actually eligible.
3. Refer to six (6) types of advertising media channels (video advertising: TV and YouTube, audio channels: radio and podcast advertising, newspapers, print and digital publications: magazines, out-of-home: billboards, murals, and social media) https://www.marketingevolution.com/marketing-essentials/advertising-media-guide.

NHAS GOAL 2
IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV
Linkage to Care (L)

Objective L1. Increase the percentage of newly diagnosed persons with HIV who are linked to care through initial Test and Treat/Rapid Access (TTRA) protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

- ***Strategy L1.1.*** *Expand capacity and access to local TTRA.*

Activities	Responsible Entities	Measurements
L1.1.a. Identify new access points for TTRA for vulnerable populations, i.e., Black/African-American, Hispanic, and MSM.	FDOH-MDC, RWHAP-Part A and partners (i.e., EHE Quick Connect, FQHCs, Medicaid, Community Health Centers, Health Choice Network, Florida Association of Free and Charitable Clinics, hospitals, medical providers, insurance plans, pharmaceutical companies, etc.) FDOH-EHE	**1.** # of TTRA access points serving vulnerable population **2.** # of clients enrolled in TTRA services
L1.1.b. Identify or develop information that promotes the benefits of HIV treatment adherence for vulnerable populations, i.e., Black/African-American, Hispanic, and MSM.	FDOH-MDC RWHAP-EHE	**1.** # and listing of specific campaigns for information dissemination to newly-diagnosed people with HIV **2.** # of brochures designed for these specific campaigns **3.** # of brochures provided to EHE Quick Connect and TTRA testing sites.
L1.1.b. Educate private providers on cultural humility and the benefits of TTRA.	RWHAP-Part A and partners (i.e., FDOH-MD, Ryan White Program, FQHCs, Medicaid, CHCs, Health Choice Network, Florida Association of Free and Charitable Clinics, hospitals, medical providers, insurance plans, insurance companies, pharmaceutical companies, etc.); FDOH-EHE; RWHAP-EHE	**1.** # of academic detailing visits to private providers **2.** # of private providers committed to link clients to TTRA services **3.** # of private providers implementing TTRA services **4.** # of clients linked in TTRA services **5.** # of patients who received medical care and treatment within 7 days **6.** # of private practices that have stablished a process to connect clients with TTRA services

- ***Strategy L1.1.*** *continued.*

Activities	Responsible Entities	Measurements
L1.1.c. Work with hospitals and urgent care centers that routinely test for HIV/HCV to ensure a streamlined path to TTRA for patients in ER and urgent care settings.	FDOH-MDC, RWHAP-Part A and partners (i.e., ERs, urgent care centers, lead healthcare organizations, HIV on the Frontlines of Communities in the United States (FOCUS), etc.)	**1.** # of patients enrolled in TTRA in a hospital or urgent care center **2.** # of hospitals and urgent care centers that have established a process to connect clients with TTRA services
L1.1.d. Expand the use of Telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients. (Mobile units)	RWHAP-EHE and partners	**1.** # of people with HIV in the EMA who are identified as eligible for EHE HealthTec. (baseline and every 4 months) **2.** # of people with HIV identified as eligible for EHE HealthTec who enroll in this process throughout the remainder of the five-year period of performance. (baseline and every 4 months) **3.** # of EHE HealthTec clients continuing this process (i.e., one or more medical visits, CD4 tests, or VL tests within 30 days of initial client orientation date, documented via follow-up with client or provider) throughout the remainder of the five-year period of performance (baseline and every 4 months) **4.** # of clients with a HIV viral load less than 200 copies/mL at last viral load test during the measurement year

- ***Strategy L1.1.*** *continued.*

Activities	Responsible Entities	Measurements
L1.1.e. Implement the use of EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms. (RWHAP-EHE)	RWHAP-EHE and partners (i.e., FQHCs, Pharma)	**1.** # of people with HIV in the EMA who contact or are contacted by an EHE Quick Connect team. (baseline and every 4 months) **2.** # of people with HIV linked to HIV medical care in the Ryan White Part A/MAI Program; other community programs; or private insurance (baseline and every 4 months) **3.** # of EHE Quick Connect clients utilizing this process (i.e., one or more medical visits, CD4 tests, or VL tests within 30 days or less, documented via follow-up with client or provider) throughout the remainder of the five-year period of performance (baseline and every 4 months)

Notes

1. Linked to Care TTRA Standard: A person who tests positive will receive the following within 7 days of preliminary diagnosis:
   - **a.** Physician visit resulting in request for authorized lab test;
   - **b.** CD4/VL lab test; *and*
   - **c.** Provision of initial ART medication.

Objective L2. Increase the percentage of newly diagnosed persons with HIV who are linked to care outside TTRA within thirty (30) days of preliminary positive diagnosis, from 54% in 2021 to 90% by December 31, 2026.

- ***Strategy L2.1.*** *Improve linkage to HIV health care within 30 days for all persons who test positive for HIV.*

Activities	Responsible Entities	Measurements
L2.1.a. Monitor the processes for linking all newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.	RWHAP Part A, Part B, and partners	**1.** Flowchart linkage process, and determine gaps and dropout-risk points within the process. # of persons with HIV dropping out of linkage process at each of the dropout-risk points
L2.1.b. Improve the processes for linking eligible newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.	RWHAP Part A, Part B, and partners	**1.** # and identification of specific linkage sites designated as test sites for QI process improvement. **2.** # and identification of linkage sites serving as control group. **3.** Develop QI modifications in linkage process based on data generated under L.2.1.a, above, and document same.
L2.1.c. Measure the success of the improved process linking eligible newly-diagnosed persons to HIV medical care within 30 days of initial HIV test result.	RWHAP Part A, Part B, and partners	**1.** # of persons with HIV dropping out of 30-day enrollment process at designated QI test sites after 180 days, compared to # of persons dropping out in the QI linkage control group. **2.** Repeat QI cycle as needed to achieve minimum of 90% of eligible clients linked within 30 days. **3.** Modify the linkage process flowchart based on the QI cycles in #2
L2.1.d. Within 12 months of the completed linkage process improvement cycle, implement changes in linkage protocol at all testing/linkage sites.	RWHAP Part A and Part B, FDOH-MDC, and partners	**1.** # of sites implementing the improved protocols within 12 months of the modification of the linkage process flowchart.
L.2.1.e Train FDOH-MDC and Part A personnel in the revised linkage protocol and refresh training annually.	Part A, Part B, FDOH-MDC and partners	**1.** # of initial trainings in the revised protocol conducted at testing/linkage sites **2.** # of refresher trainings conducted each year

- ***Strategy L2.2.*** *Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA access.)*

Activities	Responsible Entities	Measurements
L2.2.a. Update and standardize warm handoff process; reference: https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html	FDOH-MDC and partners	**1.** Current processes across service providers reviewed **2.** Process updated for consistency across provider network **3.** Providers trained on process
L2.2.b. Implement intake protocol to include a warm handoff between service providers (either between departments or between agencies) where a person-to-person link is created between the mental health provider and the individual receiving care. This could be an in-person meeting, setting up the first appointment time together or at the very minimum a three-way phone call.	RWHAP-A and FDOH-MDC	**1.** Current intake protocol across service providers reviewed **2.** Updated intake protocol developed for consistency across provider network **3.** Providers trained on updated protocol
L2.2.c. Enroll clients in ADAP (or other payer source as appropriate) within 14 days of diagnosis.	RWHAP-A and FDOH-MDC	**1.** % of clients enrolled in ADAP or other payor source within 14 days of diagnosis

NHAS GOAL 2
IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV
Retention in Care (R)

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 81% in August 2022 to 90% by December 31, 2026.

- ***Strategy R1.1.*** *Identify and reengage clients in danger of being lost to RWHAP care.*

Activities	Responsible Entities	Measurements
R1.1.a. Set "in danger" indicator as no contact by MCM for 90 days. [CQM Report Card - M7]	RWHAP Part A and MCM subrecipients	**1.** # of RWHAP MCM clients contacted every 90 days (CQM Report Card, by subrecipient) a. Current standard: at least 75% of MCM clients are contacted every 90 days. b. Target: at least 95% of MCM clients will be contacted every 90 days by 12/31/26
R1.1.b. Identify lost to care clients through RWHAP Outreach subrecipients.	RWHAP Part A RWHAP MCM subrecipients RWHAP Outreach subrecipients	**1.** #/% recontacted within 30 days (after 90 days no contact) **2.** #/% closed or out of jurisdiction (not eligible for re-engagement) **3.** #/% still in MDC and eligible for reengagement in RWHAP
R1.1.c. Identify lost to care clients through Data to Care Project.	FDOH DTC Part A-MCM Part A-Outreach	**1.** % DTC information within 30 days (after 90 days no contact) **2.** #/% closed or out of jurisdiction (not eligible for re-engagement) **3.** #/% still in MDC and eligible for reengagement in RWHAP
R1.1.d. Reengage a minimum of 75% of identified eligible clients within 30 days of contact.	RWHAP MCM subrecipients	**1.** #/% eligible clients located and re-engaged

- ***Strategy R1.2.*** *Increase Peer (PESN) involvement in client care to improve retention and viral load suppression.*

Activities	Responsible Entities	Measurements
R1.2.a. Review RWHAP Client Satisfaction Survey results for reasons clients fall out of care.	RWHAP Part A and partners	**1.** # client satisfaction surveys conducted annually, with reasons clients fall out of care, with particular emphasis on areas of peer involvement in client support for retention and VL suppression
R1.2.b. Review local RWHAP-Part A Service Delivery Manual of Peer Education and Support Network position.	RWHAP Part A and partners	**1.** # annual review conducted
R1.2.c. Increase clinical involvement threshold for Peers from 50% to 75%.	RWHAP Part A and partners	**1.** # of subrecipients employing Peers **2.** % of time each subrecipient directs Peers toward client support activities **3.** % of clients with documented peer contact retained in care, and with suppressed VLs
R1.2.d. Implement Peer client care certification training, including gender-affirming care, and cultural competency training, twice annually.	RWHAP Part A and partners	**1.** # of trainings

- ***Strategy R1.3.*** *Ensure a "whole person," holistic treatment approach that recognizes that care for RWHAP clients must go beyond viral load suppression and retention in care. [See Community Network goals.]*

Activities	Responsible Entities	Measurements
R1.3.a. Develop guidelines and procedures related to EHE HealthTec to facilitate access to a medical practitioner; mental health provider; substance abuse treatment provider; daily treatment adherence confirmation; client enrollment and re-enrollment in Part A Program; and daily treatment adherence confirmation for program clients.	RWHAP-EHE	**1.** # of process flowcharts developed, related to HealthTec **2.** # of guidelines developed, related to HealthTec **3.** # of providers with access to the guidelines and process flowchart
R1.3.b. Ensure that MCM standards of care address social determinants of health (e.g., childcare, housing, food insecurity, domestic violence, discrimination) in treatment plans and external referrals.	RWHAP-Part A/MAI	**1.** MCM standards of care reviewed and revised as needed.
R1.3.c. Develop a protocol for how mental health services are introduced to clients to normalize the experience.	RWHAP Part A/MAI	**1.** # of protocols developed. **2.** # of subrecipients documenting the application of normalizing protocols
R1.3.d. Train MCMs on protocol (Standard of Care) and ensure compliance.	RWHAP Part A/MAI	**1.** # of MCMs trained on protocol each year **2.** % of clients referred each year
R1.3.e. Connect to a community information/referral resource hub such as https://go.findhelp.com/florida.	RWHAP FDOH-MDC	**1.** # of agencies connected to resource hub

NHAS GOAL 2
IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV
Health Outcomes For Special Populations (SP)

Objective SP1. Improve health outcomes for women with HIV.

- ***Strategy SP1.1.*** *Expand existing programs and collaborations for women with HIV.*

Activities	Responsible Entities	Measurements
SP1.1.a. Improve messaging concerning PrEP for women.	FDOH-MDC and partners	**1.** Increased # of PSAs targeting women **2.** Increased frequency of messaging
SP1.1.b. Expand interface between community childcare programs and RWHAP to help women stay in care.	RWHAP and partners RWHAP-EHE (TAP-in)	**1.** # of community agencies linked with the RWHAP to offer childcare services to women with HIV **2.** # of RWHAP subrecipients offering episodic childcare/babysitting on site during appointments
SP1.1.c. Educate/sensitize providers on special dynamics of women with HIV – acquisition, disease management, and stigma to help women stay in care.	RWHAP and FDOH	**1.** # of RWHAP subrecipients with training in designated areas

Objective SP2. Improve health outcomes for adults over age 50 with HIV.

- *Strategy SP2.1. Improve health outcomes for adults over age 50 with HIV.*

Activities	Responsible Entities	Measurements
SP2.1.a. Systematic "Aging HIV Community" needs assessments to determine special social, mental health, and pharmacy issues of older people with HIV.	RWHAP Community Coalition Roundtable	**1.** # targeted over-50 interviews conducted during special-emphasis client satisfaction needs assessment survey in FY 2023 **2.** # interviews conducted by members of the Partnership's Community Coalition Roundtable with persons in the affected community over 50 years of age
SP2.1.b. Based on SP2.1.a., develop special mental health and social services guidelines and protocols for older persons with HIV – dealing with isolation, loneliness, depression, problems with adult children, more expenses and less money, and polypharmacy issues.	RWHAP	**1.** # of guidelines generated by Care & Treatment Committee and Partnership, with input from stakeholders and RWHAP clients over 50. **2.** # of subrecipient MCM and OAHS providers with RiMC and/or VL suppression rates for clients over 50 that are lower than the agency averages
SP2.1.c. Help older persons with HIV in the process of transitioning from RWHAP to Medicare.	RWHAP	**1.** # RWHAP MCMs trained in assisting clients over 60 with transitioning to Medicare **2.** # of RWHAP clients over 65 who have successfully transitioned to Medicare
Notes **1.** An analysis of RWHAP clients in care revealed 4,209 clients over 50 years of age in the Miami-Dade EMA in FY 2021, of whom 292 were also long-term survivors of HIV (diagnosed before 1995), only 7% of the persons with HIV over 50. This Plan therefore will concentrate on the aging population with HIV as a special target population.		

Objective SP3. Improve health outcomes for transgender people with HIV.

- ***Strategy SP3.1.*** *Expand existing programs and collaborations to address specific needs of transgender people with HIV.*

Activities	Responsible Entities	Measurements
SP3.1.a. Provide basic and annual LGBTQ cultural competency/cultural humility trainings for RWHAP subrecipient and FDOH provider.	FDOH-MDC, RWHAP	**1.** # of agencies or departments that have conducted at least one annual training **2.** % of agencies or departments that have conducted the trainings
SP3.1.b. Identify a transgender advocate within each RWHAP subrecipient and FDOH provider.	FDOH-MDC, RWHAP	**1.** #/% of agencies with identified advocate/ champion. **2.** # of transgender advocates identified within RWHAP subrecipients **3.** # of transgender advocates identified within FDOH providers
SP3.1.c. Conduct basic and annual trainings to RWHAP subrecipient and FDOH provider front-line and medical staff on transgender persons.	FDOH-MDC, RWHAP	**1.** # of trainings conducted to front-line staff **2.** # of trainings conducted to medical staff **3.** #/% of front-line staff that received the training **4.** #/% of medical staff that received the training
SP3.1.d Audit and certify all RWHAP subrecipients and FDOH providers for sexual identity and gender identity training.	FDOH-MDC, RWHAP, TransSOCIAL	**1.** # of eligible agencies agreeing to annual transgender-friendly audit **2.** # and % of agencies passing transgender-friendly audit
Notes **1.** Partners to include MDC LGBTQ Advisory Board.		

Objective SP4. Improve health outcomes for homeless or unstably housed people with HIV.

- ***Strategy SP4.1.*** *Expand existing programs and collaborations to address specific needs of people with HIV experiencing homelessness or housing instability.*

Activities	Responsible Entities	Measurements
SP4.1.a. Reorganize the Partnership's Housing Committee to identify and administrate housing assistance beyond HOPWA.	Partnership RWHAP MDC Emergency Rental Assistance Program (ERAP)	**1.** List of resources identified **2.** List of resources distributed **3.** # of additional grants awarded in the EMA **4.** # of opportunities for short term housing assistance identified outside RWHAP and HOPWA limitations **5.** # of opportunities for long term housing assistance identified outside RWHAP and HOPWA limitations
SP4.1.b. Review RWHAP MCM protocols for identifying housing needs and connecting homeless or unstably housed to secure housing and support services.	RWHAP	See Notes

Notes

1. This Plan recognizes homelessness and housing instability as a community-wide crisis, not specific to people with HIV.
2. Following are additional suggested activities which require further exploration as to feasibility, responsible entities, and measurements:
   - Identify short-term housing while people are on the HOPWA waiting list or need short-term housing (under 2 years);
   - Identify non-federally funded, non-traditional, less restrictive partners;
   - Advocate for Department of Housing and Urban Development (HUD) increases in rental limitations to allow a greater number of people to qualify for Section 8 and other reduced-housing opportunities;
   - Identifying landlords willing to accept third-party payments for rent, specifically for people with HIV; and
   - Coordinating with realtors and housing navigators to find safe and affordable housing.
   - Develop "whole person" approach to housing: move-in costs, acquiring furniture, moving truck rental, understanding lease negotiation and renters' rights.

Objective SP5. Improve health outcomes for MSM with HIV.

- ***Strategy SP5.1.*** *Expand existing programs and collaborations to address specific needs of MSM with HIV and co-occurring health conditions. [See also Goal 3: Disparities in Retention in Care (DR) Disparities in Viral Load Suppression Rates and Goal 3: Undetectable Viral Load (DV).]*

Activities	Responsible Entities	Measurements
SP5.1.a. Provide LGBT cultural competency/cultural humility trainings for RWHAP and FDOH funded agencies.	FDOH's Education Team, RWHAP	**1.** # of agencies that have completed at least 1 training completed, per staff **2.** % of agencies that have conducted the trainings **3.** # of agencies providing trainings
SP5.1.b. Identify MSM clients with adherence difficulties.	RWHAP	**1.** # of clients identified
SP5.1.c. Provide services to overcome adherence barriers.	RWHAP	**1.** # of clients with suppressed viral load after receiving services to overcome barriers.
SP5.1.d. Implement support groups addressing topics of sexual/emotional health; safer sex; dating; relationships; substance use disorders; and mental health needs.	RWHAP	**1.** # of groups implemented **2.** # of clients completing groups **3.** # of clients entering formal counseling
Notes **1.** Review Human Rights Campaign LGBTQ Healthcare Equality Index, https://www.hrc.org/resources/healthcare-equality-index for criteria and means of accreditation.		

Objective SP6. Improve health outcomes for youth (ages 13-24) who are at risk of or living with HIV.

- ***Strategy SP6.1.*** *Expand existing programs and collaborations to address specific needs of youth (ages 13-24) who are living with HIV.*

Activities	Responsible Entities	Measurements
SP6.1.a. Identify and recruit MDC Public Schools Representative for the Miami-Dade HIV/AIDS Partnership.	RWHAP, Partnership staff support	**1.** Date of member's appointment **2.** # of meetings attended
SP6.1.b. Collaborate with MDC Public School Health Programs[1] targeting youth.	FDOH, Schools, Hospitals, CBOs, Clinics, Institutions	**1.** # of schools participating at the Miami-Dade Public School Health Program **2.** # of youth referred by the school's health team for HIV/STI testing **3.** # of youth referred by the school's health team for HIV/STI education **4.** # of youth educated on HIV/STI by FDOH-MDC/CBOs
SP6.1.c. Identify and explore other options for HIV/STD testing among high-school aged youth.	RWHAP, FDOH, MDC school board, Healthy Teen Expos (collaboration between FDOH, and other agencies), other partners	**1.** # of ancillary sites established for HIV/STD testing, nearby schools but not on school property **2.** # schools conducting or permitting on-site testing for HIV/STDs **3.** # tests conducted
SP6.1.d. Identify and explore other options for HIV/STD testing among young adults.	RWHAP, FDOH, other partners	**1.** # of ancillary sites established for HIV/STD testing. **2.** # tests conducted
SP1.2.e. Improve advertisements concerning PrEP, condoms and other prevention messages for youth.	FDOH-MDC and partners	**1.** # of PSAs targeting youth **2.** # of impressions on advertisements targeting youth, on PrEP **3.** # of impressions on advertisements targeting youth, on condoms **4.** # of impressions on advertisements targeting youth, on other prevention messages
Definitions [1] A collaboration between FDOH-MDC and CBOs to conduct HIV and STI testing, and health fairs at 20 MDCPS		
Notes **1.** Partners may include: Children's Trust, School Board Advisory Group, colleges and universities.		

NHAS GOAL 3
REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES
Stigma (S)

Objective S1. Reduce HIV-related stigma and discrimination.

- ***Strategy S1.1.*** *Increase awareness of stigmatizing behaviors throughout the system of care. (FDOH-EHE Goal: Partner with Capacity Building Assistance providers (CBA), and the private sector to train STD/HIV staff on HIV stigma, and discrimination).*

Activities	Responsible Entities	Measurements
S1.1.a. Develop and/or identify training curricula for RWHAP and FDOH agencies that address stigma, discrimination and unrecognized ethnic, racial, gender, and HIV-status bias, trauma-informed care, status-neutral care, and patient-centered care from front office through entire service system.	RWHAP FDOH-MDC	**1.** # of agencies providing capacity building trainings to healthcare professionals (i.e., medical providers, clinical staff, HIV counselors, medical case managers) **2.** # of unique educational materials distributed to healthcare professionals **3.** # of healthcare professionals trained at FDOH-MDC **4.** # of healthcare professionals trained at RWHAP
S1.1.b. Require annual stigma/ discrimination and unrecognized bias training for RWHAP and FDOH agencies.	RWHAP FDOH-MDC	**1.** #/% providers with annual training
S1.1.c. Create a safe space for clients to report stigmatizing or discriminating behaviors.	RWHAP FDOH-MDC	**1.** #/% providers with a safe space reporting protocol
S1.1.d. Develop and disseminate response protocol for addressing stigmatizing behaviors throughout the system of care.	RWHAP FDOH-MDC	**1.** #/% providers with response protocol

NHAS GOAL 3
REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES
Disparities in Retention in Care (DR)

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.

- ***Strategy DR1.1.*** *Increase RiMC rates from 81% in 2021 to 90% by December 31, 2026 for Black/African-American (B/AA) Males.*

Activities	Responsible Entities	Measurements
DR1.1.a. Annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males.	RWHAP	**1.** Annual measurement of RiMC rates for B/AA males, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population
DR1.1.b. Annually document and disseminate best practices for RiMC for B/AA males among OAHS and MCM providers with top-quintile RiMC rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DR1.1.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for low RiMC for B/AA males among OAHS and MCM providers with bottom-quintile RiMC rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

- ***Strategy DR1.2.*** *Increase RiMC rates from 88% in 2021 to 90% by December 31, 2026 for B/AA Females.*

Activities	Responsible Entities	Measurements
DR1.2.a. Annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females.	RWHAP	**1.** Annual measurement of RiMC rates for B/AA females, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population
DR1.2.b. Annually document and disseminate best practices for RiMC for B/AA females among OAHS and MCM providers with top-quintile RiMC rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DR1.2.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for low RiMC for B/AA females among OAHS and MCM providers with bottom-quintile RiMC for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

- ***Strategy DR1.3.*** *Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026 for Hispanic MSM clients.*

Activities	Responsible Entities	Measurements
DR1.3.a. Annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Hispanic MSM clients.	RWHAP	**1.** Annual measurement of RiMC rates for Hispanic MSM clients, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population
DR1.3.b. Annually document and disseminate best practices for RiMC for Hispanic MSM clients among OAHS and MCM providers with top-quintile RiMC rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DR1.3.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for low RiMC for Hispanic MSM clients among OAHS and MCM providers with bottom-quintile RiMC for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

NHAS GOAL 3
REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES
Disparities in Viral Load Suppression Rates and 44Undetectable Viral Load (DV)

Objective DV1. Increase the annual viral load (VL) suppression rates among priority populations.

- ***Strategy DV1.1.*** *Increase the annual VL suppression rates from 81% in 2021 to 90% by December 31, 2026 for B/AA Males*

Activities	Responsible Entities	Measurements
DV1.1.a. Annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males.	RWHAP	**1.** Annual measurement of VL suppression rates for B/AA males, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.1.b. Annually document and disseminate best practices for VL suppression for B/AA males among OAHS and MCM providers with top-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DV1.1.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for B/AA males among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

- ***Strategy DV1.2.*** *Increase the annual VL suppression rates from 84% in 2021 to 90% by December 31, 2026 for B/AA Females.*

Activities	Responsible Entities	Measurements
DV1.2.a. Annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females.	RWHAP	**1.** Annual measurement of VL suppression rates for B/AA females, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.2.b. Annually document and disseminate best practices for VL suppression for B/AA females among OAHS and MCM providers with top-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DV1.2.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for B/AA females among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

- ***Strategy DV1.3.*** *Increase the annual VL suppression rates from 86% in 2021 to 90% by December 31, 2026 for Haitian Males and Females.*

Activities	Responsible Entities	Measurements
DV1.3.a. Annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Haitian males and females.	RWHAP	**1.** Annual measurement of VL suppression rates for Haitian males, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual measurement of VL suppression rates for Haitian females, by subrecipient service site providing OAHS and/or MCM services to this target population **3.** Annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.3.b. Annually document and disseminate best practices for VL suppression for Haitian males and females among OAHS and MCM providers with top-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DV1.3.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for Haitian males and females among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

NHAS Goal 4
ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS
Integrated Plan Coordination (IPC)

Objective IPC1. Develop strong community partnerships to leverage available services and funding for ongoing HIV care and treatment and to be able to respond quickly to HIV outbreaks.

- ***Strategy IPC1.1.*** *Maintain and develop community partnerships.*

Activities	Responsible Entities	Measurements
IPC1.1.a. Identify community stakeholders to broaden the base of Integrated Plan implementation and referrals for client needs.	FDOH-MDC RWHAP	**1.** By close of Year 1, establish working Integrated Plan Evaluation Workgroup to engage community stakeholders in planning and evaluating IP services
IPC1.1.b. Develop schedule for regular communication with stakeholders.	FDOH-MDC RWHAP	**1.** Progress report on scheduling
IPC1.1.c. Develop plan among stakeholders for addressing HIV outbreaks.	RWHAP	**1.** Progress report on plan
IPC1.1.d. Coordinate data sharing between RWHAP Parts A, B, D, F; General Revenue (GR); and ADAP; and between the RWHAP and Medicaid.	RWHAP Parts A, B, D, F; GR; ADAP; Medicaid.	**1.** Progress report on data sharing agreements

Notes

1. A comprehensive list of actual contacts and a commitment from each stakeholder is needed.
2. Need to account for all Zip Codes to ensure outbreak teams can be mobilized in any location.
3. Suggested stakeholders include:
- Police departments/first responders;
- Celebrity/social media personalities;
- Domestic violence prevention organizations; and
- Business Respond to AIDS (BRTA) organizations.

V.i. (a) Updates to Other Strategic Plans Used to Meet Requirements

This section is not applicable.

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

VI.i. 2022-2026 Integrated Planning Implementation

Implementation, Monitoring, Evaluation, and Improvement will begin January 1, 2023 and continue through December 31, 2026, as outlined below. All processes will involve the FDOH-MDC, RWHAP, EHE teams, JIPRT members, members of the affected community, and additional stakeholders.

The implementation, measurement and evaluation processes for this Plan will be managed by a special Integrated Plan Evaluation Workgroup (IPEG) of the Miami-Dade HIV/AIDS Partnership, serving as an independent coordinating and steering group to shepherd this Plan through its initial implementation and ongoing execution. The IPEG is intended to be an agile, independent, multidisciplinary, and stakeholder-sensitive workgroup combining community input and ongoing project management, evaluation, and quality improvement input to the process (see below). *Please note that "IPEG" is a working title for this workgroup: the group itself will determine their name as part of their initial activities.*

The IPEG will track Plan progress to identify areas where the Plan is performing optimally and where progress is falling behind. Findings and recommendations will be reported to the noted participants through quarterly JIPRT meetings.

VI.i. (a) Implementation

Formation of the Workgroup

The IPEG will be formed in accordance with the Partnership's Bylaws which detail the process for creating workgroups and appointing members. All members of the IPEG will serve in accordance with the Bylaws. Up to 16 members may be appointed, including members of the Strategic Planning and Prevention Committees, representatives from EHE, non-affiliated community stakeholders, and representatives of the affected community. Membership opportunities will be widely advertised; any person who meets the qualifications may be appointed to fill vacancies by Partnership approval. The proposed timeline for IPEG formation is:

- November 2022: IPEG is formed upon recommendation of the JIPRT and approval by the Partnership.
- December 2022: Membership opportunities are advertised and candidates are identified.
- January 2022: Members are appointed by the Partnership.
- January 2022 – March 2022: Initial meeting(s) of the IPEG.

Functions of the Workgroup

The initial function of the IPEG is to review and operationalize the activities and measurements outlined in the Integrated Plan. IPEG members will function as the quantifiers, monitors, and evaluators of Plan progress, and will take responsibility for the next steps, below.

Activities to be conducted between January 2022 – March 2022 will include:

- Completing a thorough review of the Plan objectives, strategies, activities, and measurements.

- Ensuring logical congruence between objectives, strategies, activities and data elements to be used for measurement.
- Ensuring that all activities are measurable, and that measurements facilitate achievement of the objectives.
- Specifying key individuals who will be accountable for implementing the activities and strategies within the designated responsible entities. This will include careful fiscal planning and coordination between RWHAP and FDOH-MDC, both of which are identified as responsible entities throughout the plan.
- Establishing timetables for assessment and evaluation, with the understanding that different data sets are variably available monthly, quarterly, semi-annually, or annually.
- Identifying strengths, weaknesses, and recommended improvements for presentation to the JIPRT by April 2023.

The work of the IPEG will be disseminated to the JIPRT for review and approval in April 2023 and will be forwarded to the Partnership at its April 2023 meeting.

VI.i. (b) Monitoring

Plan monitoring begins during the second calendar quarter of 2023, following completion of the IPEG activities noted above. The experience of the EMA with the 2017-2022 Integrated Plan leads us to anticipate a period of interdepartmental adjustments in the strategies and activities of the Plan during these early months. While the IPEG – as an interdepartmental and community stakeholder-driven evaluation group – is tasked with taking the temperature of the implementation and monitoring process, the JIPRT is the major forum for sharing issues in implementation and data generation, and determining early response strategies by both the RWHAP and FDOH-MDC.

FDOH-MDC and RWHAP staff will interface with the provider entities and subrecipients to specify sources of program progress data, including data from PE-Miami, the AHEAD Dashboard, FDOH-MDC, and FDOH statewide data.

Findings will be consolidated by BSR with the ultimate goal of inputting data into the Vision Mission Services Goals Dashboard (VMSG) project management system, a real-time public health performance management system used by health departments nationwide.

Baseline levels for activities will be presented to the JIPRT in July 2023. The JIPRT will continue to meet quarterly (October 2023, January 2024, etc.) to review changes in the Plan based on implementation issues raised by the IPEG; see **VI.i. (c) Evaluation**, and **Table 11**, below, for further timeline details.

IPEG monitoring of treatment outcomes and process progress measures articulated during the first calendar year Implementation include:

- Second calendar quarter, CY 2023 (April – June 2023) measurement;
- Third calendar quarter, CY 2023 (July – September 2023) measurement; and
- Six-month CY 2023 progress summary presented to the JIPRT in October 2023 (April-September data).

VI.i. (c) Evaluation

Evaluation of progress in the Plan activities will be at six-month intervals during the first two years of the Plan, and annually thereafter.

The measurements for each set of objectives, strategies, and activities are outlined in **Section V: 2022-2026 Goals and Objectives**, above, including several HRSA/HAB performance measures. Activities of the responsible entities are measured with a number of process measures as well.

The monitoring and evaluation timelines will be evaluated in October 2023 and may be shifted in CY 2024. Also, based on reviews by and reports from the IPEG and JIPRT, the Partnership may request to engage an independent, third party entity to evaluate the effectiveness of the IPEG and Plan processes within the first year and beyond, if needed.

VI.i. (d) Improvement

Throughout the implementation and execution of this Plan, the JIPRT will be the primary venue for review and recommendation of Plan modifications and improvement, providing these recommendations to the Partnership. As noted above, input from the IPEG, FDOH-MDC, and RWHAP, as well as the third party evaluator (if assigned), is expected to result in revisions to the Plan during the first year of implementation, and these revisions will be the work of the JIPRT in meetings in July 2023 (after six months of implementation) and January 2024 (after 12 months of implementation). JIPRT revisions to the plan will be annually thereafter, as needed.

Partnership workgroups are normally established for a one-year session. However, should the work of the IPEG need to continue into CY 2024, the JIPRT can bring a recommendation for the continuation of the IPEG to the Partnership at that time. It is expected that the IPEG will complete its implementation activities within CY 2023, and the JIPRT will be the forum for monitoring, evaluating and improving the conduct of the various processes and activities that make up the Plan going forward. Therefore, within CY 2023, it will be incumbent upon the IPEG to identify:

- Weaknesses in implementation, measurement, and processes;
- How well the RWHAP and FDOH-MDC and their responsible entities are doing to advance the Plan;
- What parts of the Plan are working well or are falling behind; and
- Where technical assistance should be provided.

Likewise, it will be the responsibility of the JIPRT and Partnership to address those issues in a timely manner, to ensure all responsible entities are on track for continued Plan execution. Namely, the quality improvement strengths of the IPEG will be a vital part of this improvement process, but the community input represented by the JIPRT will provide a broader base for considering modifications in the Plan.

VI.i. (e) Reporting and Dissemination

Progress in the implementation and execution of this Plan will be shared at the quarterly JIPRT meetings, reported to the Partnership as part of regular committee reporting, and reported to other Partnership committees and subrecipients, as appropriate. Groups who participated in community engagement activities and other community stakeholders will also be advised of updates and will be encouraged to contribute to ongoing planning and execution of the Plan goals. Special presentations may be made to any community stakeholders, as appropriate or by request. Reports will be posted on a

dedicated page on www.aidsnet.org. Printed copies may be distributed at meetings, and are always available by request. Findings will also be incorporated into the Annual Report provided to the MDC Mayor and Board of County Commissioners.

VI.i. (f) Updates to Other Strategic Plans Used to Meet Requirements

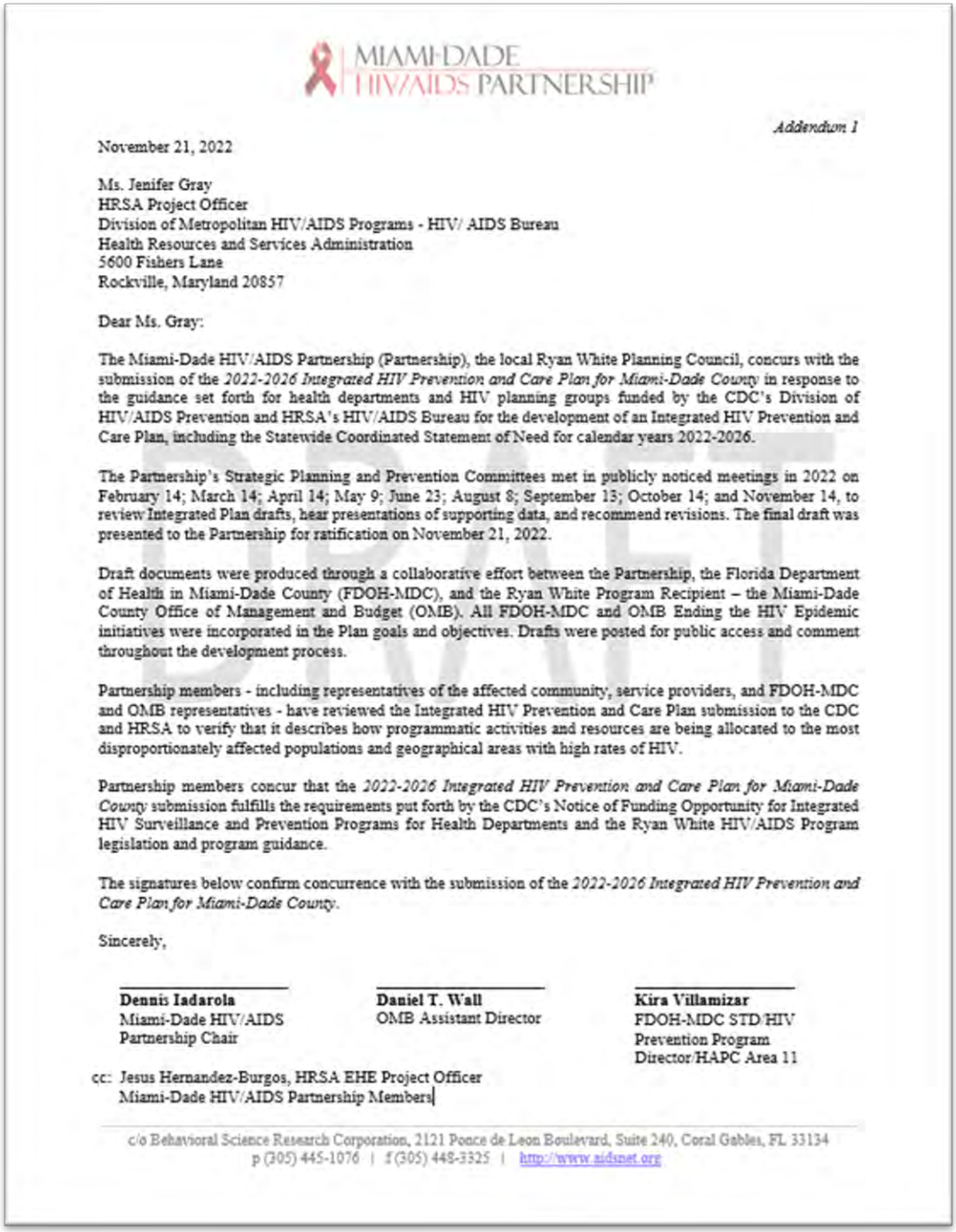
This section is not applicable.

Table 11: Monthly Timetable of Integrated Plan to Implement, Monitor, Evaluate, and Improve

Timeframe	Activities
November-December 2022	**Implement** ▪ Establish Integrated Plan Evaluation Workgroup (IPEG), with representation from JIPRT, FDOH-MDC, RWHAP, affected community, other stakeholders
January -March 2023	**Implement** ▪ IPEG quantifies IP activities, in consultation with responsible entities
April 2023	**Improve** ▪ JIPRT reviews and ratifies IPEG modifications to the IP activities and measurements
May 2023	**Monitor** ▪ IPEG establishes data sources from responsible entities
June 2023	**Monitor** ▪ Baseline data are compiled (input into VMSG, if available)
July-December 2023	**Monitor** ▪ Data are compiled (input into VMSG, if available)
July 2023	**Evaluate** ▪ IPEG data and Plan Implementation process review **Improve** ▪ JIPRT reviews baseline data, IP implementation, and presents progress to Partnership
September 2023	**Evaluate** ▪ IPEG reviews compiled data and six-month 2022 progress
October 2023	**Improve** ▪ CY 2023: JIPRT reviews IPEG progress and recommendations
January 2024-December 2026	**Monitor** ▪ Data are compiled (input into VMSG, if available)
January 2024	**Improve** ▪ IPEG reinstated by JIPRT recommendation and Partnership action, if needed ▪ JIPRT review of 2023 data
Quarterly 2024 – 2026	**Evaluate** ▪ IPEG quarterly data and Plan Implementation process review – note: JIPRT will review if IPEG is not renewed **Improve** ▪ Data reported to Partnership as part of regular committee reporting

Section VII: Letter of Concurrence from the RWHAP Part A Planning Council

The approved Letter of Concurrence is attached as **Addendum 1**. The letter is signed by the collaborative partners representing the Partnership, the RWP Recipient, and FDOH-MDC. A copy of the complete Plan, including the letter, will be forwarded to the HRSA EHE Project Officer and Partnership members.



MIAMI-DADE HIV/AIDS PARTNERSHIP

Addendum 1

November 21, 2022

Ms. Jenifer Gray
HRSA Project Officer
Division of Metropolitan HIV/AIDS Programs - HIV/ AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Gray:

The Miami-Dade HIV/AIDS Partnership (Partnership), the local Ryan White Planning Council, concurs with the submission of the *2022-2026 Integrated HIV Prevention and Care Plan for Miami-Dade County* in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention and HRSA's HIV/AIDS Bureau for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need for calendar years 2022-2026.

The Partnership's Strategic Planning and Prevention Committees met in publicly noticed meetings in 2022 on February 14; March 14; April 14; May 9; June 23; August 8; September 13; October 14; and November 14, to review Integrated Plan drafts, hear presentations of supporting data, and recommend revisions. The final draft was presented to the Partnership for ratification on November 21, 2022.

Draft documents were produced through a collaborative effort between the Partnership, the Florida Department of Health in Miami-Dade County (FDOH-MDC), and the Ryan White Program Recipient – the Miami-Dade County Office of Management and Budget (OMB). All FDOH-MDC and OMB Ending the HIV Epidemic initiatives were incorporated in the Plan goals and objectives. Drafts were posted for public access and comment throughout the development process.

Partnership members - including representatives of the affected community, service providers, and FDOH-MDC and OMB representatives - have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV.

Partnership members concur that the *2022-2026 Integrated HIV Prevention and Care Plan for Miami-Dade County* submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The signatures below confirm concurrence with the submission of the *2022-2026 Integrated HIV Prevention and Care Plan for Miami-Dade County*.

Sincerely,

Dennis Iadarola
Miami-Dade HIV/AIDS
Partnership Chair

Daniel T. Wall
OMB Assistant Director

Kira Villamizar
FDOH-MDC STD/HIV
Prevention Program
Director/HAPC Area 11

cc: Jesus Hernandez-Burgos, HRSA EHE Project Officer
Miami-Dade HIV/AIDS Partnership Members

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