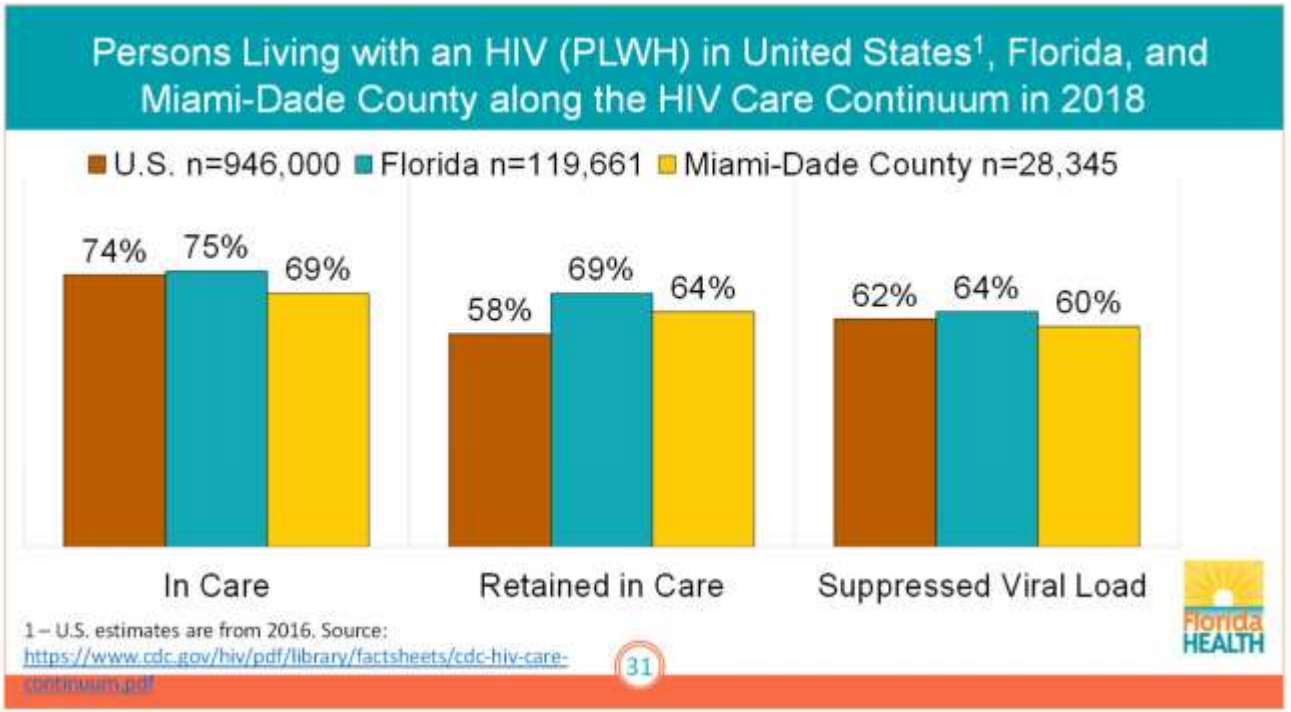
2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan
2019-2020 IMPLEMENTATION - FOURTH YEAR PLAN UPDATES



October 29, 2020

Unless otherwise specified in the text of a strategy or activity, all strategies and activities are continuous progressive activities from January 1, 2017 to December 31, 2021.

Acronyms and Terminology
2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan

ACA	Affordable Care Act
Acuity	Any of a number of co-occurring conditions or adherence issues contributing to an increased need for MCM attention
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center; or South Florida Southeast (SF-SE) AETC
ART	Antiretroviral Therapy
BSR	Behavioral Science Research Corp., (Admin/CQM Subrecipient)
C&T	Miami-Dade HIV/AIDS Partnership's Care & Treatment Committee
CQM	Clinical Quality Management Program at BSR, including CQMC and MAI CQM Team
CQMC	Ryan White Program CQM Committee
CY	Calendar Year
DIS	Disease Intervention Specialist at FDOH-MDC
DTC	Data To Care
FDOH-MDC	Florida Dept. of Health in Miami-Dade County
FPL	Federal Poverty Level
IDU	Injection Drug Use / Injection Drug User
MAI	Minority AIDS Initiative, part of the RWP
MAI CQM Team	Minority AIDS Initiative Clinical Quality Management Team; see CQM
MCM	RWP Medical Case Management or Medical Case Managers
MMSC	Male-to-Male Sexual Contact (formerly Men Who Have Sex With Men/MSM)
NHAS	National HIV/AIDS Strategy
OAHS	Outpatient/Ambulatory Health Services, provided by the RWP
Part A/MAI	Part A and the Minority AIDS Initiative of the RWP
PE	Provide Enterprise (RWP client database)
PrEP/nPEP	Pre-Exposure Prophylaxis/non-occupational Post-Exposure Prophylaxis
PrEP WG	FDOH-MDC PrEP Work Group
PRIM	Pre-Natal Immunology Clinic, w/in the University of Miami
QI	Quality Improvement
RiC	Retention in Care
Risk Factor	Self-reported mode of initial HIV/AIDS diagnosis
RWP	Miami-Dade County Ryan White Program Part A/MAI
STD	Sexually Transmitted Disease
Subrecipients	See below
TA	Technical Assistance
TTRA	Test and Treat / Rapid Access
VL	Viral Load

Ryan White Program Part A Subrecipients (*MAI Subrecipients)

- 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
- MBCHC/St. Luke's Addiction Recovery Center
- Miami Beach Community Health Center*
- New Hope C.O.R.P.S.
- Public Health Trust/Jackson Health System (all clinics)
- University of Miami*

National HIV/AIDS Strategy (NHAS) 2020 GOAL #1: REDUCE NEW HIV INFECTIONS (2018 IMPLEMENTATION)							
PREVENTION							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
P1. By 2021, reduce new HIV infection rate by at least 25%, from 50.7 per 100,000 population in 2015 to 40.8 per 100,000 population in 2021, so that Miami-Dade County is no longer among the top three metropolitan areas with the highest incidence of new HIV infections.	**PROGRESS TOWARD OBJECTIVE: Baseline 50.7 per 100,000 population in 2015, reduced to 40.8 per 100,000 in 2021.**						
	P1.1 Increase access to condoms by HIV positive persons and HIV-vulnerable populations, including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men.	**P1.1a** Increase the number of condom distribution sites. (added 2018 Q1)	Florida Department of Health in Miami-Dade County (FDOH-MDC) Partners	How many condoms were distributed to persons living with or at risk for HIV?	**#** of condoms distributed		Condom Distribution Coordinator Monthly reports
		P1.1b Develop an annual condom distribution map to identify new points of service (added Q3 2017)	FDOH-MDC and Partners				
		P1.1c Based on P1.1b data, recruit annually a new location or host an event to provide condom distribution services in the identified underserved area. (added 2018 Q1)	FDOH-MDC and Partners				
		P1.1d Increase the availability and accessibility of condom distribution by 2.0 million a year	FDOH-MDC and Partners				

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PREVENTION							
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P1. By 2021, reduce new HIV infection rate by at least 25%, from 50.7 per 100,000 population in 2015 to 40.8 per 100,000 population in 2021, so that Miami-Dade County is no longer among the top three metropolitan areas with the highest incidence of new HIV infections.	**P1.2** Implement sexually transmitted disease (STD) and HIV testing to raise STD and HIV prevention awareness among HIV-vulnerable populations, including but not limited to IDU, Trans-identified persons, gay and bisexual men.	**P1.2a** Conduct HIV testing events in Miami Dade County. **P1.2b** Conduct STD testing events in Miami Dade County. **P1.2c** Partner with healthcare settings (e.g. hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care. **P1.2d** Increase the number of registered testing sites to ensure that HIV testing is more readily available and accessible.	FDOH-MDC and Partners	Was there an increase in HIV and STD testing among persons at risk? Was there an increase in the identification of HIV-negative persons at risk of HIV? Was there an increase in the number of persons living with HIV who are aware of their HIV or STD status? Was there an increase in # of registered testing sites?	**#** of HIV tests **%** of tests that are newly diagnosed with HIV # of STD tests % of tests that are newly diagnosed with an STD **%** of tests that are among persons at risk for HIV **%** of tests stratified by priority target population (e.g. Hispanic Male-to-Male Sexual Contact (MMSC), IDU, Transgender persons, etc.) "# of new registered testing sites recruited		1628 Testing Forms

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

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

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
P3. Reduce the number of infants born with HIV in Miami-Dade County each year from three (3) to zero (0) by 2021.	**P3.1** Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women.	**P3.1b** Conduct in-person educational sessions directed toward medical professionals who participate in the care of pregnant women with HIV, educating them about the requirements of Florida law and ensuring they are aware of community services available for women living with HIV and HIV exposed infants.	FDOH-MDC	Was there an increase in screening and active referral to prenatal HIV care among pregnant women living with diagnosed HIV?	**%** HIV positive post-partum women linked to family planning services / contraception services # of HIV positive pregnant women in HIV care **%** of HIV positive pregnant women in HIV care # of HIV positive pregnant women in prenatal care		Perinatal Coordinator Quarterly Reports
		P3.1c Conduct educational rounds with emergency rooms, urgent care centers, and classified high-risk delivery hospitals, to increase provider awareness of their responsibility to utilize the *High Risk Pregnancy Notification* and *Newborn Exposure Notification* forms and act on behalf of the pregnant women living with HIV and their HIV exposed babies.	FDOH-MDC				
		P3.1d Participate in an action-oriented community process to improve service systems and community resources for families.	FDOH-MDC and HBTF				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
P3. Reduce the number of infants born with HIV in Miami-Dade County each year from three (3) to zero (0) by 2021.	**P3.2** Conduct targeted public information campaigns toward pregnant women at risk of HIV, to have access to OB/GYN providers, HIV prevention materials and information on community services for women with HIV/AIDS.	**P3.2a** Conduct community outreach and promote information campaigns towards women of child-bearing age living with HIV.	FDOH-MDC	How many agencies are providing post-partum family planning services to women living with HIV?	# of agencies		
		P3.2b Create linkage services assuring at least 90% of post-partum women living with HIV have access to contraceptive/ family planning and preconception care services after delivery (no baseline).	FDOH-MDC Pre-Natal Immunology Clinic, w/in the University of Miami (PRIM)				

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS							
LINKAGE TO CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
L1. Increase the percentage of newly diagnosed persons linked to HIV medical care within one month (30 days) of diagnosis to 85% by 2021. *[Staff note: FDOH linkage data does not depend on RWP measurement. This statement is consistent with NHAS indicators]*	L1.1 Improve existing FDOH-Part A diagnosis-to-linkage client management process.	PROGRESS TOWARD OBJECTIVE: Increase the newly-diagnosed people with HIV linkage rate from 55% linked within 90 days of initial diagnosis in 2015, to 85% linked within 30 days by 2021.					
		L1.1a Monitor and improve the processes for linking all newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.	FDOH-MDC/ Partners	Is there an increase in the percentage of newly-diagnosed people with HIV linked to care within 30 days of diagnosis? [2018 linkage rate: 78%] What percentage of TTRA clients initiated ART within 7 days of TTRA enrollment? What % of TTRA clients enrolled in AIDS Drug Assistance Program (ADAP) within 30 days of the first Outpatient/Ambulatory Health Services (OAHS) visit? *TTRA is defined as immediate entry in HIV OAHS primary care & initiation of ART.	***Outputs provided by FDOH-MDC:*** # newly diagnosed people with HIV, reported quarterly % increase in newly-diagnosed people with HIV linked to care within 30 days of diagnosis # newly diagnosed people with HIV linked to medical care with 30 days # TTRA clients enrolled in ADAP within 30 days of the first OAHS visit % TTRA clients enrolled in ADAP within 30 days of the first OAHS visit # and % of TTRA clients who received initial 30 day supplies of ART within 7 days of date of diagnosis % of testing counselors compliant with the annual training requirement(s)		
		L1.1b Measure the success the local Test & Treat/Rapid Access (TTRA)* process for newly diagnosed persons linked to immediate entry in HIV primary care and initiation of Antiretroviral Therapy (ART).	FDOH-MDC				
		L1.1c Hold FDOH-MDC trainings for testing counselors that are targeted to improving linkage to care.	FDOH-MDC				

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

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

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV							
RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R1. Increase the percentage of RWP Medical Case Management (MCM) clients and Outpatient Ambulatory Health Service (OAHS) clients who had at least two (2) instances of either (a) Miami-Dade County Ryan White Program (RWP) OAHS visits, or (b) CD4/Viral Load (VL) lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021.	**R1.1** Identify RWP client target populations who are at greatest risk for dropping out of care.	**R1.1a** Identify RWP subrecipients with highest and lowest Retention in Care (RiC) rates, identify potential Quality Improvement (QI) problem areas to remediate and QI best practices to replicate.	RWP CQM	What are the RiC rates by demographic characteristics? What are the RiC rates by risk factors? What are the RiC rates by co-occurring conditions/ acuities? What are the potential problem areas to remediate? What is the impact of replication of a subrecipient best practice for improving RiC rates on actual RiC?	# of RWP clients receiving MCM and OAHS at the beginning of evaluation period. % of RWP clients RiC by subrecipient at 6 and 12 months thereafter. % of RWP clients RiC by demographic characteristics. % of RWP clients RiC by risk factors. % of RWP clients RiC by co-occurring conditions/acuities.	Presented at October 30, 2020 JIPRT Meeting	Provide Enter-prise (PE) CQM
		R1.1b Identify RWP client demographic characteristics (ethnicity, gender, age) and risk factor(s) associated with low RiC rates and track RiC rates by demographic and risk factor groups across and within subrecipients.	RWP CQM				
		R1.1c Develop assessments of acuities (e.g. substance use, mental illness, incidence of missed appointments or other non-adherence) associated with RiC; track and refine measurements in subsequent years.	RWP CQM				
		How does the Strategic Planning Committee work more closely with the Clinical Quality Management (CQM) Committee and MAI CQM Team in measuring outcomes and planning QI interventions?					

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV							
RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R1. Increase the percentage of RWP MCM and OAHS clients who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021.	**R1.2** Provide continuous improvements in MCM and OAHS that meet the needs and identified vulnerabilities of people with HIV in care.	**R1.2a** Evaluate quality and appropriateness of MCM and OAHS clinical care through client satisfaction surveys and targeted reviews of PE data, and provide technical assistance to assist subrecipients in self-correction (e.g., on site QI technical assistance (TA), AIDS Education and Training Center (AETC), etc.). Provide subrecipient-based data to the Recipient and CQMC to make recommendations in service delivery processes.	RWP CQM	Are the RWP OAHS and MCM subrecipients fully engaged in review and response to Service Delivery Guidelines updates? **How do we generate an "output" for this?** What areas are identified as needing improvement?	# of OAHS and MCM subrecipients. # of MCM subrecipients identified with service delivery issues resulting in record reviews. **What can be done to improve RWP client satisfaction?**	Presented at October 30, 2020 JIPRT Meeting	PE CQM client surveys CQM record reviews
		R1.2b Review and update RWP Service Delivery Guidelines for RWP OAHS and MCM services annually.	RWP CQM C&T OMB				
		R1.2c Conduct targeted QI record reviews of RWP OAHS and MCM subrecipients with below-standard scores to ensure adherence to Public Health Standards and RWP Service Delivery Guidelines and lay groundwork for QI interventions.	RWP CQM SF-SE AETC				

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV							
RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R1. Increase the percentage of RWP MCM and OAHS clients who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021.	**R1.3** Track and assess the quality of OAHS care provided to RWP clients who transition to Affordable Care Act (ACA)-provided outpatient medical care.	**R1.3a** Revise and streamline ACA enrollment and re-enrollment processes to increase the number of ACA-eligible RWP clients transitioned to ACA from 50% (2015 baseline) to 70%.	RWP CQM	Is care delivered through the ACA doing an effective job of maintaining and improving clinical outcomes for RWP clients in care? Is client satisfaction higher among ACA enrollees vs. RWP? Are VL suppression rates higher among ACA enrollees vs. RWP? Are differences in clinical outcomes shown between ACA-enrolled clients and RWP clients related to: a) differences in the characteristics of people with HIV who can or cannot enroll in ACA, *or* b) differences in the levels of care provided through ACA coverage vs. RWP care?	# of RWP clients determined eligible for ACA enrollment, as of annual enrollment period. # of RWP clients enrolled in ACA plans as of annual enrollment period. % of ACA-eligible people with HIV enrolled in ACA. Client outcome data (VL suppression, RiC) for clients eligible for ACA, vs. clients enrolled in ACA, vs. RWP clients not eligible for ACA.	Presented at October 30, 2020 JIPRT Meeting	PE
		R1.3b Require all RWP clients enrolled in ACA and receiving RWP MCM to report VL levels at a minimum once every six (6) months, in order to assess and track clinical health outcomes of RWP clients receiving OAHS through an ACA Marketplace insurance plan.	RWP CQM				
		R1.3c Compare rates of missing VL data and VL suppression rates among people with HIV treated through the ACA with missing VL data and VL suppression rates among people with HIV receiving OAHS through the RWP to identify disparities.	RWP CQM				
		R1.3d Increase the percentage of clients transitioned from RWP-funded OAHS to ACA medical care who are retained in ACA-provided medical care for two (2) years after enrollment from 60% enrolled in 2015 and continuously enrolled in 2017 to 75% enrolled in 2019 and continuously enrolled in 2021. (Using VL data as proxy for ACA OAHS)	RWP CQM				

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV							
RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R2. Increase the proportion of "lost to care" RWP MCM clients who are relinked to care, from 40% in 2017 to 60% by 2021.	**R2.1** RWP MCM subrecipients will partner with FDOH-MDC to detect clients in danger of being lost to care, update contact information on vulnerable RWP clients, and use both FDOH and RWP outreach specialists to relink clients in care.	**R2.1a** FDOH and RWP will develop data-sharing protocols and feedback mechanisms to provide updated contact information to RWP on clients at risk for being lost to care, as well as provide case closure data to FDOH for clients with 6, 9, and 12 months since the most recent VL measurement or on-site RWP OAHS contact.	FDOH-MDC RWP CQM	Are there key client groups (risk factors, demographic, acuity, co-occurring conditions) that are more likely to be lost to care? After QI intervention, are there demonstrable improvements in relinkage rates among subrecipients with low relinkage rates? After best practice intervention, are there improvements in RiC and relinkage?	# of people with HIV at each MCM subrecipient at beginning of evaluation period. % of people with HIV with certifiably closed cases at each MCM subrecipient site at 6 and 12 months. % of people with HIV identified as RiC risks, at each MCM subrecipient site. % of people with HIV who are lost to care, at each MCM subrecipient site, at 6 and 12 months.	Presented at October 30, 2020 JIPRT Meeting	PE
		R2.1b Identify RWP MCM subrecipients with lowest and highest relinkage rates and determine QI interventions and best practices.	RWP CQM				
		R2.1c Develop 6-month RiC measurements and protocols for new-in care clients based on the RiC Report Card data prioritized by the CQMC.	RWP CQM				

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV							
VIRAL LOAD SUPPRESSION							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
V1. Increase the percentage of people with HIV in the EMA who are virally suppressed (<200 copies/mL) from 67% in 2015 to at least 80% by 2021. **In FY2020, the percent of RWP clients with suppressed VL was 82% (89% among MCM clients, 86% among OAHS clients)**	**V1.1** Expand role of RWP MCM and OAHS subrecipients in detecting persistent unsuppressed viral loads (VL) and initiate appropriate responses.	**V1.1a** On a monthly basis, detect RWP clients with persistent unsuppressed VL over two semi-annual measurements ("virologic failure") and notify RWP MCM and OAHS subrecipients to enable their targeted response. Monitor improvement in VL suppression levels to ensure efficacy of subrecipient response. **Note:** OAHS data will be limited to RWP OAHS subrecipients only.	RWP CQM	Which MCM and OAHS subrecipients have the highest proportion of clients with new or continued persistent unsuppressed VL? Can alerting RWP subrecipients about clients with persistent unsuppressed VL produce internal responses to address client VL issues? What type of QI interventions work best at reducing persistent unsuppressed VL?	% of clients served by MCM and OAHS subrecipients who show persistent unsuppressed VL. % of identified clients with persistent unsuppressed VL among MCM and OAHS subrecipients, and whose VL levels show improvement at next semi-annual measurement.	Presented at October 30, 2020 JIPRT Meeting	PE

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES (2018 IMPLEMENTATION)							
DISPARITIES IN RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DR1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match overall RWP MCM and OAHS retention levels.	**DR1.1** Identify RiC vulnerabilities of RWP Part A/MAI **Black/African American Male-to-Male Sexual Contact (B/AA MMSC)** MCM and OAHS clients and address them with specific interventions: **Increase RiC among B/AA MMSC RWP MCM and OAHS clients to 90% in CY 2021.**	**DR1.1a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average RiC rates for B/AA MMSC clients.	RWP CQM	What are the acuity-related RiC rates for B/AA MMSC MCM and OAHS clients? What contributes to B/AA MMSC RiC successes among RWP MCM and OAHS subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for B/AA MMSC MCM and/or OAHS clients? What is the impact of replication of a Part A/MAI subrecipient best practice on RiC rates for B/AA MMSC?	% RiC for B/AA MMSC by individual MCM and OAHS subrecipients. % RiC for B/AA MMSC by individual MCM and OAHS subrecipients by infection risk factors and acuities. % RiC for B/AA MMSC clients of Part A MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for B/AA MMSC clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DR1.1b Determine risk factors and acuities contributing to low RiC rates among B/AA MMSC MCM and OAHS clients.	RWP CQM				
		DR1.1c Identify RWP Part A/MAI subrecipient RiC initiatives directed toward B/AA MMSC MCM and OAHS clients, and track RiC rates annually.	RWP CQM				

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES (2018 IMPLEMENTATION)							
DISPARITIES IN RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DR1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match overall RWP MCM and OAHS retention levels.	**DR1.2** Identify RiC vulnerabilities of RWP Part A/MAI **Black/African American male (B/AAM) heterosexual MCM and OAHS** clients and address them with specific interventions: **Increase RiC among B/AAM heterosexual RWP MCM and OAHS clients to 90% by CY 2021.**	**DR1.2a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average RiC rates for B/AA heterosexual clients.	RWP CQM	What are the acuity-related RiC rates for B/AAM heterosexual MCM and OAHS clients? What contributes to B/AAM heterosexual's RiC successes among RWP subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for B/AAM heterosexual MCM and/or OAHS clients? What is the impact of replication of a RWP subrecipient best practice on RiC rates for B/AAM heterosexuals?	% RiC for B/AAM heterosexuals by individual MCM and OAHS subrecipients. % RiC for B/AAM heterosexual clients by MCM and OAHS subrecipients by risk factors and acuities. % RiC for B/AAM heterosexual clients of MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for B/AAM heterosexual clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DR1.2b Determine risk factors and acuities contributing to low RiC rates among B/AA heterosexual MCM and OAHS clients.	RWP CQM				
		DR1.2c Identify RWP Part A/MAI subrecipient RiC initiatives directed toward B/AA heterosexual MCM and OAHS clients, and track RiC rates annually.	RWP CQM				

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DISPARITIES IN RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DR1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match overall RWP MCM and OAHS retention levels.	**DR1.3** Identify RiC vulnerabilities of RWP Part A/MAI **Black/African American female (B/AAF) MCM and OAHS** clients and address them with specific interventions: **Increase RiC rates for B/AAF to 90% by CY 2021.**	**DR1.3a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average RiC rates for B/AAF clients.	RWP CQM	What are the acuity-related RiC rates for B/AAF MCM and OAHS clients? What contributes to B/AAF RiC successes among RWP subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for B/AAF MCM and/or OAHS clients? What is the impact of replication of a RWP subrecipient best practice on RiC rates for B/AAF?	% RiC for B/AAF by individual MCM and OAHS subrecipients. % RiC for B/AAF clients by MCM and OAHS subrecipients by risk factors and acuities. % RiC for B/AAF clients of MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for B/AAF clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DR1.3b Determine risk factors and acuities contributing to low RiC rates among B/AAF MCM and OAHS clients.	RWP CQM				
		DR1.3c Identify RWP Part A/MAI subrecipient RiC initiatives directed toward B/AAF MCM and OAHS clients, and track RiC rates annually.	RWP CQM				

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DISPARITIES IN RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DR1. By 2021, increase the percentage of RWP MCM clients in key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match RWP total levels.	**DR1.4** Identify RiC vulnerabilities of RWP Part A/MAI **Hispanic MMSC (HMMSC) MCM and OAHS** clients and address them with specific interventions: **Increase RiC rates among HMMSC to 90% in CY 2021.**	**DR1.4a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average RiC rates for HMMSC clients.	RWP CQM	What are the acuity-related RiC rates for HMMSC MCM and OAHS clients? What contributes to HMMSC RiC successes among RWP subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for HMMSC MCM and/or OAHS clients? What is the impact of replication of a RWP subrecipient best practice on RiC rates for HMMSC?	% RiC for HMMSC by individual MCM and OAHS subrecipients. % RiC for HMMSC clients by MCM and OAHS subrecipients by risk factors and acuities. % RiC for HMMSC clients of MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for HMMSC clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DR1.4b Determine risk factors and acuities contributing to low RiC rates among HMMSC MCM and OAHS clients.	RWP CQM				
		DR1.4c Identify RWP Part A/MAI subrecipient RiC initiatives directed toward HMMSC MCM and OAHS clients, and track RiC rates annually.	RWP CQM				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall RWP MCM and OAHS VL suppression rates.	**DV1.1** Identify VL suppression vulnerabilities of RWP Part A/MAI **Black/African American MMSC (B/AA MMSC)** MCM and OAHS clients and address them with specific interventions: **Increase VL suppression levels among B/AAM MMSC to 80% by CY 2021.**	**DV1.1a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average VL suppression rates for B/AA MMSC clients.	RWP CQM	What are the acuity-related VL suppression rates for B/AA MMSC MCM and OAHS clients? What contributes to B/AA MMSC VL suppression successes among RWP MCM and OAHS subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for B/AA MMSC MCM and/or OAHS clients? What is the impact of replication of a Part A/MAI subrecipient best practice on VL suppression rates for B/AA MMSC?	% RiC for B/AA MMSC by individual MCM and OAHS subrecipients. % RiC for B/AA MMSC by individual MCM and OAHS subrecipients by infection risk factors and acuities. % RiC for B/AA MMSC clients of Part A MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for B/AA MMSC clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DV1.1b Determine risk factors and acuities contributing to low VL suppression rates among B/AA MMSC MCM and OAHS clients.	RWP CQM				
		DV1.1c Identify RWP Part A/MAI subrecipient VL suppression initiatives directed toward B/AA MMSC MCM and OAHS clients, and track VL suppression rates annually.	RWP CQM				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall RWP MCM and OAHS VL suppression rates.	**DV1.2** Identify VL suppression vulnerabilities of RWP Part A/MAI **Black/African American male (B/AAM) heterosexual** MCM and OAHS clients and address them with specific interventions: **Increase VL suppression levels among B/AAM heterosexuals to 80% by CY 2021.**	**DV1.2a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average VL suppression rates for B/AAM heterosexual clients.	RWP CQM	What are the acuity-related VL suppression rates for B/AAM heterosexual MCM and OAHS clients? What contributes to B/AAM heterosexual's VL suppression successes among RWP MCM and OAHS subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for B/AAM heterosexual MCM and/or OAHS clients? What is the impact of replication of a Part A/MAI subrecipient best practice on VL suppression rates for B/AAM heterosexuals?	% RiC for B/AAM heterosexuals by individual MCM and OAHS subrecipients. % RiC for B/AAM heterosexuals by individual MCM and OAHS subrecipients by infection risk factors and acuities. % RiC for B/AAM heterosexual clients of Part A MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for B/AAM heterosexual clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DV1.2b Determine risk factors and acuities contributing to low VL suppression rates among B/AAM heterosexual MMSC MCM and OAHS clients.	RWP CQM				
		DV1.2c Identify RWP Part A/MAI subrecipient VL suppression initiatives directed toward B/AAM heterosexual MMSC MCM and OAHS clients, and track VL suppression rates annually.	RWP CQM				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall RWP MCM and OAHS VL suppression rates.	**DV1.3** Identify VL suppression vulnerabilities of RWP Part A/MAI **Black/African American female (B/AAF)** MCM and OAHS clients and address them with specific interventions: **Increase B/AAF VL suppression levels to 80% by CY 2021.**	**DV1.3a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average VL suppression rates for B/AAF clients.	RWP CQM	What are the acuity-related VL suppression rates for B/AAF MCM and OAHS clients? What contributes to B/AAF VL suppression successes among RWP MCM and OAHS subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for B/AAF MCM and/or OAHS clients? What is the impact of replication of a Part A/MAI subrecipient best practice on VL suppression rates for B/AAF?	% RiC for B/AAF by individual MCM and OAHS subrecipients. % RiC for B/AAF by individual MCM and OAHS subrecipients by infection risk factors and acuities. % RiC for B/AAF clients of Part A MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for B/AAF clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DV1.3b Determine risk factors and acuities contributing to low VL suppression rates among B/AAF MCM and OAHS clients.	RWP CQM				
		DV1.3c Identify RWP Part A/MAI subrecipient VL suppression initiatives directed toward B/AAF MCM and OAHS clients, and track VL suppression rates annually.	RWP CQM				

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DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall RWP MCM and OAHS VL suppression rates.	**DV1.4** Identify VL suppression vulnerabilities of RWP Part A/MAI **Haitian Male (HM)** MCM and OAHS clients and address them with specific interventions: **Increase HM VL suppression levels to 80% in CY 2021.**	**DV1.4a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average VL suppression rates for HM clients.	RWP CQM	What are the acuity-related VL suppression rates for HM MCM and OAHS clients? What contributes to HM VL suppression successes among RWP MCM and OAHS subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for HM MCM and/or OAHS clients? What is the impact of replication of a Part A/MAI subrecipient best practice on VL suppression rates for HM?	% RiC for HM by individual MCM and OAHS subrecipients. % RiC for HM by individual MCM and OAHS subrecipients by infection risk factors and acuities. % RiC for HM clients of Part A MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for HM clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DV1.4b Determine risk factors and acuities contributing to low VL suppression rates among HM MCM and OAHS clients.	RWP CQM				
		DV1.4c Identify RWP Part A/MAI subrecipient VL suppression initiatives directed toward HM MCM and OAHS clients, and track VL suppression rates annually.	RWP CQM				

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DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP Part A/MAI MCM and OAHS clients in key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall RWP MCM and OAHS VL suppression rates.	**DV1.5** Identify VL suppression vulnerabilities of RWP Part A/MAI **Haitian Female (HF)** MCM and OAHS clients and address them with specific interventions: **Increase HF VL suppression levels to 80% in CY 2021.**	**DV1.5a** Determine best practices of RWP Part A/MAI MCM and OAHS subrecipients with higher than average VL suppression rates for HF clients.	RWP CQM	What are the acuity-related VL suppression rates for HF MCM and OAHS clients? What contributes to HF VL suppression successes among RWP MCM and OAHS subrecipients? Are there best practices that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for HF MCM and/or OAHS clients? What is the impact of replication of a Part A/MAI subrecipient best practice on VL suppression rates for HF?	% RiC for HF by individual MCM and OAHS subrecipients. % RiC for HF by individual MCM and OAHS subrecipients by infection risk factors and acuities. % RiC for HF clients of Part A MCM and OAHS subrecipients with identified best practices and/or MAI-funded program initiatives. % RiC for HF clients of Part A MCM and OAHS subrecipients where best practices and/or MAI-funded initiatives have been replicated.	Presented at October 30, 2020 JIPRT Meeting	PE
		DV1.5b Determine risk factors and acuities contributing to low VL suppression rates among HF MCM and OAHS clients.	RWP CQM				
		DV1.5c Identify RWP Part A/MAI subrecipient VL suppression initiatives directed toward HF MCM and OAHS clients, and track VL suppression rates annually.	RWP CQM				