Thank you for joining today's

Integrated Plan Evaluation Work Group

Please sign in to have your attendance recorded.

Reference documents for today's meeting are on online at http://aidsnet.org/meeting-documents/

MIAMI-DADE HIV/AIDS PARTNERSHIP

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

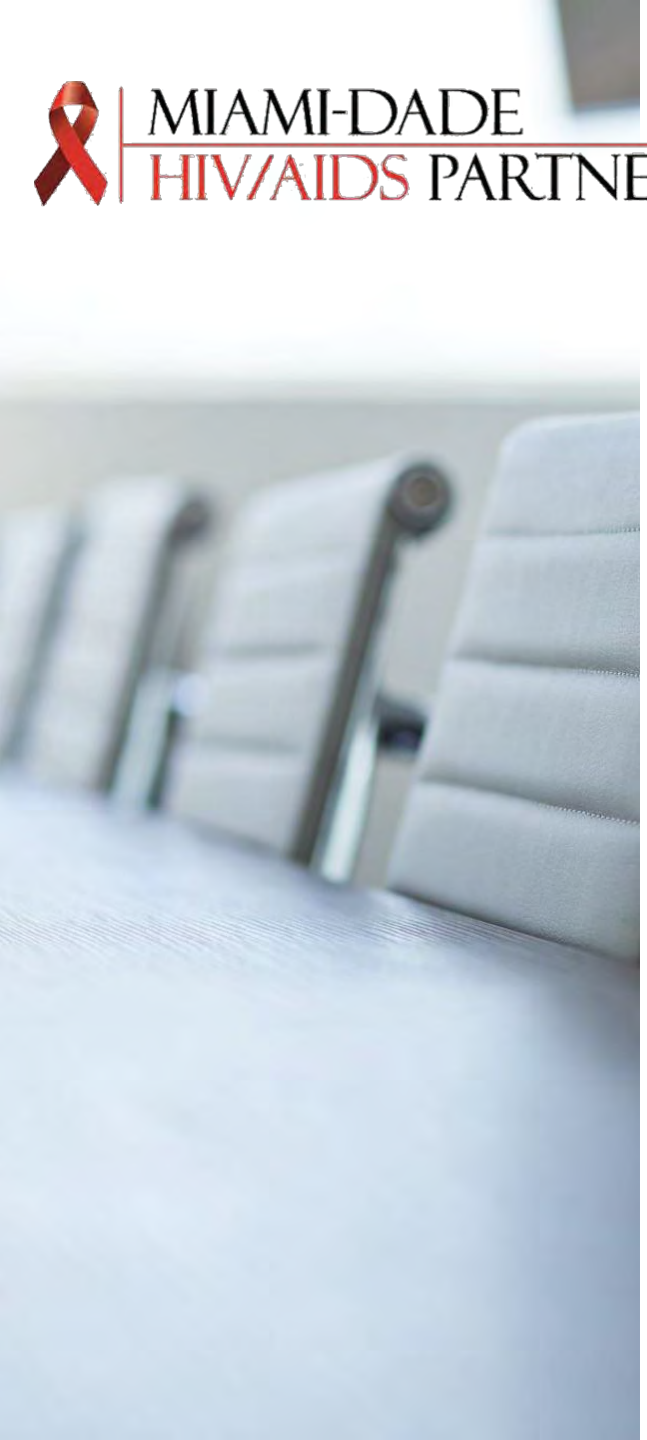
VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

MIAMI-DADE HIV/AIDS PARTNERSHIP



Meeting Housekeeping

Updated May 12, 2023

Miami-Dade County Main Library Version (P)

Disclaimer & Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business in a fair and equitable manner.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

Language Matters!

In today's world, there are many words that can be stigmatizing. Here are a few suggestions for better communication.

Remember **People First** Language . . .
People with HIV, ***People*** with substance use disorders, ***People*** who are homeless, etc.

Please don't say **RISKS** . . . Instead, say **REASONS.**
Please don't say, **INFECTED with HIV** . . . Instead, say **ACQUIRED HIV, DIAGNOSED with HIV,** or **CONTRACTED HIV.**

Please **do not** use these terms . . .

Dirty . . . Clean . . . Full-blown AIDS . . . Victim . . .

General Housekeeping

- You must sign in to be counted as present.
- Place cell phones on mute or vibrate - *If you must take a call, please excuse yourself from the meeting.*
- Have your Cultural Center Parking Garage ticket validated at the Library front desk for a reduced parking rate.
- Eligible committee members should see staff for a voucher at the end of the meeting

Meeting Participation

- Raise your hand if you need clarification about any terminology or acronyms used throughout the meeting.
- Raise your hand to be recognized by the Chair or added to the queue.
- Discussion should be limited to the current Agenda topic or motion.
- Speakers should not repeat points previously addressed.
- Any attendee may be permitted to address the board as time allows and at the discretion of the Chair.

Resources

- Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- See staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.
- Today's presentation and supporting documents are online at aidsnet.org/meeting-documents/.

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

Floor Open to the Public

“Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

“BSR has a dedicated line for statements to be read into the record. No statements were received.”

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

Integrated Plan Evaluation Workgroup Meeting
Miami-Dade County Main Library
101 West Flagler Street, Auditorium, Miami, FL 33130
May 9, 2023

#	Members	Present	Absent
1	Ferrer, Luigi	x	
2	Goldberg, David	x	
3	Hess, Amaris	x	
4	Hilton, Karen	x	
5	Ingram, Trillion		x
6	Llambes, Stephanie	x	
7	Lowe, Camille		x
8	Machado, Angela	x	
9	Marqués, Jamie	x	
10	Mooss, Angela	x	
11	Perez Bermudez, Alberto		x
12	Robinson, Joanna		x
13	Sarmiento, Abril	x	
14	Suarez, Sarah	x	
15	Vacant		
16	Vacant		
	Quorum = 6		

Guests	
Gillens, Courtney	
Mester, Brad	
Valle-Schwenk, Carla	
Villamizar, Kira	
Staff	
Bontempo, Christina	
Ladner, Robert	
Martinez, Susy	
Morgan, Sima	

Note: All documents referenced in these minutes were accessible to members and the public prior to and during the meeting, at www.aidsnet.org/meeting-documents. The meeting agenda was distributed to all attendees. Meeting documents related to action items were distributed to members. Meeting documents were projected on the meeting room projection screen. Referenced pages 4-79 of these minutes are online at www.aidsnet.org/meeting-documents/.

I. Call to Order

Workgroup Chair, Sarah Suarez, called the meeting to order at 10:10 a.m.

II. Introductions

Attendees introduced themselves.

III. Housekeeping/Meeting Rules

Staff reviewed the PowerPoint, *Meeting Housekeeping*, which included meeting disclaimer, code of conduct, resources, Language Matters, meeting participation, and protocol reminders.

IV. Floor Open to the Public

Workgroup Vice Chair, Amaris Hess, opened the floor to the public with the following statement:

"Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns. BSR has a dedicated telephone line as well as a general email address for statements to be read into the record. No statements were received via the telephone line or email."

There were no comments. The floor was then closed.

V. Review/Approve Agenda

Ms. Suarez asked members to review the agenda. There were no changes.

Motion to approve the agenda as presented.
Moved: Dr. Angela Mooss **Seconded: Abril Sarmiento** **Motion: Passed**

VI. Review/Approve Minutes of April 11, 2023

Members reviewed the minutes of April 11, 2023. Staff noted that the motion will indicate, "approved as posted," because the red-lined goals version of minutes were posted are online, not distributed at the meeting.

Motion to approve the minutes of April 11, 2023 as posted.
Moved: Dr. Angela Mooss **Seconded: Abril Sarmiento** **Motion: Passed**

VII. Standing Business

- **Breakout Sessions**

Members were seated in three breakout groups: Prevention and Linkage groups reviewed and edited their Evaluation Plan drafts; and the Care and Treatment/Special Populations group reviewed and edited their goals sheet. The pages below indicate approved deletions, insertions, comments, responses, and additional feedback:

- Prevention: pages 4-42;
- Linkage: pages 43-58; and
- Care and Treatment/Special Populations: pages 59-79.

- **Report on Breakout Sessions**

Changes by each group will be incorporated into the meeting minutes.

- **Assignments for Next Meeting**

There were no assignments.

VIII. New Business

There was no new business.

IX. Announcements

Staff announced the next Partnership meeting is May 9, 2023.

Courtney Gillens announced the Ending the HIV Epidemic (EHE) Initiative Request for Proposals has been released. Funding is available for organizations to provide the following EHE initiative services to people with HIV: 1) HealthTec; 2) Quick Connect; 3) Housing Stability; and 4) Mobile GO Teams services.

X. Next Meeting

Ms. Hess announced the next meeting is June 6, 2023 at the Miami-Dade County Main Library.

XI. Adjournment

Ms. Suarez adjourned the meeting at 12:34 p.m.

NHAS Goal 1: Prevent New HIV Infections

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.								
Activity P1.1.a. Partner/ collaborate with healthcare facilities to increase routine opt-out HIV testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of healthcare facilities identified for routine opt-out HIV testing in MDC								
2. # of healthcare facilities interested in ~~routinizing~~routine opt-out HIV testing in MDC								
3. # of healthcare facilities committed to conduct routine opt-out HIV testing in MDC								
4. # of healthcare facilities implementing routine opt-out HIV testing in MDC								
~~5. # of persons served at a healthcare facility~~								
~~6.~~5. ~~# of persons tested at a healthcare facility~~								

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.								
Activity P1.1.a. Partner/ collaborate with healthcare facilities to increase routine opt-out HIV testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
~~7.~~6. # of HIV positive persons identified through routine opt-out testing	*							
~~8.~~7. # of previously diagnosed HIV positive persons	*							
~~9.~~8. # of newly diagnosed HIV positive persons								
~~10.~~9. # of HIV tests integrated with viral hepatitis tests (HCV)								
~~11.~~10. # of HIV tests integrated with STI tests								
Notes								

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.								
Activity P1.1.b. Utilize academic detailing to educate providers on routine testing inclusive of Hepatitis C virus (HCV) and sexually transmitted infections (STIs).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of licensed clinical providers and practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI)								
2. # of ~~private~~ licensed clinical providers educated on routine testing (i.e., HIV, HCV, STI)								
3. # of MOUs/agreements established with partners to serve as routine healthcare testing sites								
Notes								

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.									
Activity P1.1.c. Partner and/or collaborate with healthcare facilities to offer STI testing.		**What**				**When**		**Who***	
		Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements									
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~~ organizations to offer STI testing									
4. # of healthcare ~~facilities~~ organizations implementing STI testing									
5. # of STI tests done at healthcare ~~facilities~~organizations									
6. # of clients with a positive STI result	Syphilis								
	Gonorrhea								
	Chlamydia								
~~7. # of clients newly diagnosed with a STI~~									
~~8.~~7. # of clients treated for STIs	Syphilis								
	Gonorrhea								
	Chlamydia								
Notes 1. Homestead Hospital only reports syphilis. 2. Track total surveillance and Homestead Hospital.									

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.								
Activity P1.1.c. Partner and/or collaborate with healthcare facilities to offer STI testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
3. Organizations = # of facilities or sites								

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.								
Activity P1.1.d. Partner and/or collaborate with healthcare facilities to offer HCV testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # healthcare facilities identified to conduct HCV testing								
2. #~~819~~ HCV tests (integrated with HIV tests) done at healthcare facilities	JHS data							
3. # of clients with a positive HCV result	JHS data							
4. # of clients referred for HCV treatment	Can this baseline be established?							
Notes								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.a. Increase the use of home HIV self-testing kits as an alternative option.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of persons receiving one or more ~~≥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 testing community partner facilities								
Notes 1. Expect underestimates based on self-reporting.								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.b. Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of community testing partners implementing HIV/STI testing at non-traditional settings								
2. # of persons tested for HIV at non-traditional settings								
3. # of HIV positive persons at a non-traditional setting								
~~4. # of persons tested for STI at non-traditional settings~~	*[moved to #5 & #6]*							
~~5. # of persons newly diagnosed with STI at non-traditional settings~~								
~~6.~~4. # of previously diagnosed HIV positive persons, confirmed in surveillance at non-traditional settings								
~~7.~~5. # of newly diagnosed HIV positive persons								
6. # of persons tested for STI at non-traditional settings								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.b. Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
7. # of persons ~~newly~~ diagnosed with STI at non-traditional settings								
Notes								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.c. Increase the number of mobile units offering HIV/STI testing in the community. (This activity overlaps with P1.2.b.)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of operational mobile units conducting 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 ~~people~~persons linked to HIV care at a mobile unit								
6. # of ~~people~~persons linked to PrEP at a mobile unit								
~~5.~~7. # of STI positive results from STI tests conducted at a mobile unit								
~~6.1. # of people linked to PrEP at a mobile unit~~								
~~7.1. # of people linked to HIV care at a mobile unit~~								
8. # of people referred for STI treatment at a mobile unit								
Notes								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.c. Increase the number of mobile units offering HIV/STI testing in the community. (This activity overlaps with P1.2.b.)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								

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 P1.3. 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.								
Activity P1.3.a. Provide training and education to community partners on status neutral approach.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of community testing organizations trained and educated on the status neutral approach								
2. # of people trained and educated on the status neutral approach								
Notes 1. This is an EHE and HIPP requirement.								

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 P1.4. Provide Disease Intervention Specialist (DIS) partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.								
Activity P1.4.a. Educate community testing partners on -availability and importance of partner services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of ~~organizations~~ persons with HIV 501 certification								
Notes 1. Includes partner services.								

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 P1.4. Provide Disease Intervention Specialist (DIS) partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.								
Activity P1.4.b. ~~Partner with RWHAP and CBOs to~~ Educate clients about the importance of partner services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % of notifiable partners identified through HIV partner services				DIS				
~~Confirm which of these are measured at the individual level:~~								
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~~								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.1. Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).								
Activity P2.1.a. Conduct educational sessions 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted				Queen Holden				
2. # of persons trained								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.1. Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted								
2. # of persons trained								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.1. Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).								
Activity P2.1.c. Conduct educational sessions with hospitals, including emergency rooms and high-risk delivery hospitals, and urgent care centers.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted with hospitals								
2. # of educational sessions conducted with urgent care centers								
3. # of High-Risk Notification Forms and/or notifications of pregnant women with HIV received								
4. # of Newborn Exposure Notification Forms received								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.2. Increase awareness among women with HIV who are of childbearing age about mother to child transmission, prenatal care, postpartum care, and family planning services.								
Activity P2.2.a. Link pregnant women with HIV to HIV care and prenatal care.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of pregnant women with HIV who received HIV care								
2. # of pregnant women with HIV who received prenatal care								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.2. Increase awareness among women with HIV who are of childbearing age about mother to child transmission, prenatal care, postpartum care, and family planning services.								
Activity P2.2.b. Provide follow-up medical and family planning services for post-partum women with HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of post-partum women with HIV who received family planning services								
2. # of women with HIV who received post-partum care								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.a. Train peer educators and community health workers to promote the PrEP initiatives through direct community outreach.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
~~1. # of educational sessions conducted~~								
~~2.~~1. # of PrEP ~~training~~ educational sessions conducted								
~~3.~~2. # of PrEP educational materials distributed								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.b. Utilize FDOH-MDC ADP to engage and educate health care providers on PrEP to increase the number of PrEP prescribers.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted specifically to health care providers								
2. # of providers recruited to provide PrEP services								
3. # of PrEP prescribers								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.c. Identify and share best practices by agencies that have utilized TelePrEP to expand providers' capacity of offering TelePrEP services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of providers offering TelePrEP services								
2. # of persons who received TelePrEP services								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.d. Promote PrEP Locator (www.preplocator.org/) and AIDSVu (www. aidsvu.org) to access PrEP services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # people referred to PrEP Locator and AIDSu.								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.e. Disseminate an updated comprehensive list of PrEP providers to share with community partners.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of organizations with access to the comprehensive list								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.d~~f~~ Increase PrEP access by expanding the number of ~~partners~~ individuals receiving ~~offering~~ PrEP services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of HIV-negative ~~persons~~tests								
2. # of access points for PrEP								
3. # of individuals screened for PrEP	EHE/HIPP							
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								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.eg. Increase the number of non-traditional partners offering PrEP (i.e., pharmacies, urgent care centers).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

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.								
Activity P4.1.a. Increase the number of partners offering nPEP services	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of access points for nPEP								
1. # of pharmacy clinics (MinuteClinic at CVS, and UHealth at Walgreens) and other non-traditional organizations providing nPEP								
2. # of urgent care centers providing nPEP								
~~2.~~3. # of ~~people~~ persons screened								
4. # of persons who received nPEP								
Notes								

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.								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of nPEP educational sessions conducted								
2. ~~# of providers, urgent care centers, and ERs providing nPEP services~~								
Notes								

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.								
Activity P4.1.c. Disseminate an updated comprehensive list of nPEP providers to share with community partners and healthcare providers.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of organizations with accessibility to the comprehensive list of nPEP providers								
Notes								

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.								
Activity P4.1.d. Increase the number of non-traditional partners offering nPEP (i.e., pharmacies, urgent care centers).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1.5. # of pharmacy clinics providing nPEP (MinuteClinic at CVS, and UHealth at Walgreens)	MOVED TO 4.1.a.							
2.6. # of urgent care centers providing nPEP								
Notes								

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.								
Activity P5.1.a. Increase the number of condom distribution sites across the jurisdiction.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of condoms distributed by Zip Code (report using Zip Code map)								
2. # of Business Responds to AIDS (BRTA) sites.								
Notes								

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.								
Activity P6.1.a. Educate and refer high-risk individuals to local SSP.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of persons linked to IDEA Exchange								
2. # of referrals made to IDEA Exchange, by partners								
Notes								

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.								
Activity P6.1.b. Utilize social media platforms to promote services offered by SSP.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of social media posts by IDEA Exchange (Facebook, Instagram and Twitter)								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of overall impressions [media measurement] from knowing your status, getting into care while addressing stigma, HIV prevention and care marketing campaigns								
2. # of posts on knowing your status, getting into care while addressing stigma, HIV prevention and care								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity P7.1.b. Conduct outreach events that promote diversity (inclusive of multi-lingual messages), to reach out to priority populations in the community.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity 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).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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)								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity P7.1.d. Utilize representatives of the HIV-affected community to deliver messages to people with HIV, highlighting personal success and struggles, and empowering people with HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions about destigmatizing HIV, and empowering people with HIV # of media campaign types utilizing influencers or community representatives to promote HIV messages								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity P7.1.f. Collaborate with CBOs and engage non-traditional partners to support HIV prevention messages and further destigmatize HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of partnerships created that support prevention messages								
Notes								

Key to Person(s) Responsible for Gathering Data & Person(s) Responsible for Achieving Objectives			
Heading	**Heading**	**Heading**	**Heading**

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV

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.								
Activity L1.1.a. Identify new FDOH testing sites for vulnerable populations, i.e., Black/African American, Hispanic, and MSM.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of new testing sites serving vulnerable population	24 new			FDOH			Sandra Estevez	Sandra Estevez
2. # of clients enrolled in TTRA services (new to HIV care, new to Ryan White care)	~~228~~ ~~FY2022~~234			PE Miami			Frank Gattorno	~~Dennys~~Frank Gattorno
~~3.~~								
Notes **Rapid access- get ppl in treatment within 7 days** **#1 Go back pre covid to see the average # of new testing sites to calculate the average**								

~~**#1 Go back pre covid to see the average # of new testing sites to calculate the average**~~

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.								
Activity L1.1.b. Provide and develop information that promotes the benefits of HIV treatment adherence for vulnerable populations, i.e., Black/African American, Hispanic, and MSM.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and listing of specific campaigns for information dissemination to newly diagnosed people with HIV	1	1	1	PE Miami	Quarterly	Quarterly	Courtney Gillens	Courtney Gillens
2. # of trilingual (English, Spanish, and Creole) brochures designed for these specific campaigns	0	2	2	PE Miami	Quarterly	Quarterly	Courtney Gillens	Courtney Gillens
3. # of brochures provided to EHE Quick Connect and TTRA testing sites.	0	250 per language	1000	PE Miami	Quarterly	Quarterly	Courtney Gillens	Courtney Gillens
Notes								

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.								
Activity L1.1.c. Educate private providers during the academic detailing visits on the benefits of TTRA.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of ~~academic detailing visits to private providers~~ providers identified to be educated on routinized testing and TTRA services							Alejandro	Alejandro
2. # of ~~private providers committed to link clients to TTRA services~~ providers educated on routinized testing and TTRA services. ~~2.~~							Alejandro	Alejandro
3. # of providers committed to link clients to TTRA services (MOUs)							Alejandro	Alejandro
Notes								

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.								
Activity L1.1.d. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of patients enrolled in TTRA from hospitals or urgent care centers (~~this would include programming in PE Miami to add a "referral from" field~~programming in PE was completed.)	0			PE Miami	Semi-annually	Ongoing	Frank Gattorno	FDOH and RW Part A
2. ~~# of hospitals and urgent care centers that have established a process to connect clients to TTRA services~~								
Notes **#2 was deleted because it is redundant with activity L1.1.c**								

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.								
Activity L1.1.e. Expand the use of Telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients. (Mobile units)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of people with HIV in the EMA who are identified as eligible for EHE HealthTec. (baseline and every 4 months)							Courtney Gillens	Courtney Gillens
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)							Courtney Gillens	Courtney Gillens
3. # of EHE HealthTec clients continuing this process (i.e., one or more medical visits, CD4 tests, or VL tests within 30 days of the 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)							Courtney Gillens	Courtney Gillens
4. # of clients with ~~a~~ an HIV viral load less than 200 copies/mL at last viral load test during the measurement year							Courtney Gillens	Courtney Gillens

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.								
Activity L1.1.e. Expand the use of Telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients. (Mobile units)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
Notes								

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.								
Activity L1.1.f. Implement the use of EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms. (RWHAP-EHE)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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 RWHAP Part A/MAI; 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								

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.								
Activity L2.1.a. Track the 30 day linkage for medical care for clients with a preliminary HIV test result among the C&T sites.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of positive HIV tests								
2. # of persons with HIV who did not complete the medical visit within 30 days from the preliminary test result (out of care).								
Notes **Reports from Lorene**								

Commented [SA1]: REVISE language→ Kira gets report monthly. Change the language to include the whole county and aggregate test.

However, the report Kira gets is for internal use only! Kira wants to set a call with Lory Maddox

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.								
Activity L2.1.b. Identify the C&T sites with lower than the average linkage rates.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites that fall below the average linkage percentage. (Data source surveillance report)								
2. # of C&T sites engaged in a quality improvement project to increase the linkage rate								
3. Increase the linkage percentage rate by 5% from the baseline measure for lower-performing C&T sites								
Notes **Sandra- positivity rate from providers, Dr. Llau run report to see if there are evidence of CD4 and VL**								

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.								
Activity L2.1.c. Measure the success of the selected C&T site's quality improvement projects.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites who participated in the QI projects with an increase of 5% from the baseline measure.								
2. #of C&T sites who did not meet the 5% increase from the baseline.								
3. Repeat the QI cycle for C&T sites that did not meet the 5% increase or continue performing below the average linkage percentage.								
Notes								

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.								
Activity L2.1.d. The C&T sites with QI projects will adopt the identified "change idea" at their site.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites who adopted the QI project "change idea"								
Notes								

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.								
Activity L.2.1.e The C&T sites will present their QI projects to other C&T sites to share best practices to replicate.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T site attendees who participated in meetings/training on best practices								
2. # of meetings/training conducted each year								
Notes								

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 L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA enrollment.)								
Activity L2.2.a. Update and standardize warm handoff process. (See Notes for AHRQ website reference.)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites and Part A subrecipients who are currently implementing the warm handoff process as described in the reference https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html								
2. Process updated for consistency across provider network								
3. Providers trained on the process								

Notes

1. This is Test and Treat- when a person is diagnosed at our clinic, they are referred to another agency (Borinquen, etc.)
2. Warm Handoff: Intervention | Agency for Healthcare Research and Quality (ahrq.gov): https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html

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 L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA enrollment.)								
Activity 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. The mental health visit may be in-person or virtual (tele mental health).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Current intake protocol across service providers reviewed								
2. Updated intake protocol developed for consistency across provider network								
3. # of providers trained on updated protocol								
Notes								

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 L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA enrollment.)								
Activity L2.2.c. Enroll clients in ADAP (or other payer source as appropriate) within 14 days of diagnosis.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. % of clients enrolled in ADAP within 14 days of diagnosis								
Notes								

Key to Person(s) Responsible for Gathering Data & Person(s) Responsible for Achieving Objectives			

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 89% in December 2022 to 95% by December 31, 2026.

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

Activities	Responsible Entities	Measurements
R1.1.a. Establish early MCM lost to care trigger point warning in Provide at 75 days without MCM contact, and alert MCMs through Provide.	RWHAP Recipient RWHAP Part A/MAI MCM subrecipients	1 # and % of RWHAP MCM clients with no contact in 75 days, by subrecipient. 2. # and % of RWHAP MCM clients with no contact in 90 days (CQM Report Card, M7, by subrecipient). 3. # and % of clients with no MCM contact in 90 days who are referred to Outreach by MCMs, as tracked in Provide. Current baseline: 90% of MCM clients are contacted every 90 days. Target: at least 95% of MCM clients will be contacted every 90 days by 12/31/26
R1.1.b. Reengage a minimum of 75% of identified eligible clients by MCMs within 30 days of report of client eligibility by Outreach worker.	RWHAP Part A/MAI MCM Outreach subrecipients	1. # and % of unreached clients with contact attempted by Outreach within 30 days of receiving referral from MCM. ~~1.~~2. # and % of clients in #1, contacted by Outreach, whose cases may be closed by the MCM (e.g., left RWP, moved from M-DC). ~~2.~~3. # and % of clients in #1, contacted by Outreach, with updated M-DC contact info and eligible for reengagement by MCM. ~~3.~~4. # and % of eligible clients in #3 located and re-engaged by the MCM after Outreach follow-up

NOTES

R1.1.a: MCM providers do not use a uniform acuity measure. The 75-day "pre-90-day" measure is a trigger to remind MCMs of the pending 90-day contact.

R1.1.b, c: The Data to Care process -- linking FDOH and RWP Part As across Florida – is still in the process of implementation as of this writing (5/13/23).

R1.1.b – c: references to measurement or tracking of activities related to FDOH have no data points in Provide and will need to be provided by FDOH.

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

Activities	Responsible Entities	Measurements
R1.2.a. Convene listening sessions among peers and peer supervisors in CY 2023 to identify areas of increased peer involvement with client care, peer skill development / capacity building, peer skill certification.	RWHAP Part A/MAI Recipient, Staff Support contractor	1. # of listening sessions conducted in CY 2023 2. # of peers and peer supervisors attending sessions 3. # of areas of peer support identified for expansion
R1.2.b. Develop criteria for advanced peer certification training, identify training resources, conduct training and award certifications	RWHAP Part A/MAI Recipient, Care and Treatment Committee, Staff Support/ Staff Support ~~QI~~ contractor and training partners	**1.** # of advanced certification areas approved by Recipient **2.** # of certification trainings conducted by close of 2023 and ~~annual~~annually **3.** # of peers trained and certified by close of 2023 and ~~annual~~annually **4.** % of clients with documented peer contact with certified and uncertified peers, retained in care and with suppressed VLs (2023 baseline, ~~annual~~annual measurement).
R1.2.c Review and revise local RWHAP-Part A Service Delivery Manual/Service Description for Peer Education and Support Network.	RWHAP Part A/MAI Recipient, Staff Support contractor, Care and Treatment Committee	1. Peer service delivery manual revised by Part A/MAI Recipient and Staff Support contractor. 2. ~~Annual~~Annual review conducted by Care and Treatment Committee
R1.2.d. Increase client care involvement target for Peers from 50% to 75%.	RWHAP Part A/MAI PESN subrecipient providers, Staff Support contractor	**1.** # of subrecipients employing Peers and % of time each subrecipient directs Peers toward billable client support activities (2023 baseline, ~~annual~~annual measurement) **2.** % of clients with documented peer contact retained in care, and with suppressed VLs (2023 baseline, ~~annual~~annual measurement)

- ***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 Recipient	**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. Review and revise local MCM standards of care to address protocols for addressing social determinants of health (e.g., childcare, housing, food insecurity, domestic violence, discrimination) in treatment plans and external referrals.	RWHAP Recipient, Care and Treatment Committee	3. MCM service delivery manual revised by Part A/MAI Recipient. **1.** ~~Annual~~Annual review conducted by Care and Treatment Committee.
R1.3.b.1. Develop a protocol for how mental health services are introduced to clients to normalize the experience.	RWHAP Recipient, Care and Treatment Committee	**1.** # of protocols developed. **2.** # of subrecipients documenting the application of normalizing protocols
R1.3.b.2. Train MCMs on protocol for addressing social determinants of health and ensure compliance.	RWHAP Recipient, Care and Treatment Committee	**1.** # and % of MCMs trained on protocol each year, by subrecipient MCM provider **2.** % of clients referred each year, by subrecipient provider
R1.3.b.3. Identify a Miami-Dade community information resource hub to serve as an MCM resource for whole-client referrals	RWHAP Care and Treatment Committee FDOH-MDC	**1.** # of resource hubs identified and approved by RWHAP Care and Treatment Cmte, and FDOH-MDC **2.** # and % of MCM subrecipient providers committed to using (and connected to) resource hub(s)

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 PrEP for women (baseline for 2022, number of PSAs for 2023) **2.** Increased # of STI clinics with messages targeting PrEP for women (baseline for 2022, number of PSAs for 2023)
SP1.1.b. Expand interface between community childcare programs and RWHAP to help women stay in care.	RWHAP and partners FDOH-MDC-EHE (TAP-in)	**1.** # of community agencies identified and linked with the RWHAP that offer childcare services to women with HIV **2.** # of RWHAP subrecipients offering episodic childcare/babysitting on site during appointments
SP1.1.c. Identify, educate/sensitize and train RWHAP subrecipients and medical care providers on special dynamics of women with HIV – acquisition, disease management, and stigma -- to help women stay in care.	RWHAP Staff Support contractor	**1.** # of RWHAP subrecipients with training in designated areas
SP1.1.d Examine client outcome data specifically for women in order to identify potential QI opportunities to improve service to women.	RWHAP QI Contractor, MCM / OAHS Subrecipients	**1.** # of MCM and OAHS providers with identified women sub-populations with identified sub-par treatment outcomes **2.** # of women-oriented QI projects completed per year

February 2023

New WG comments

- SP1.1.c. measurement - Workgroup needs to determine the training desired and the provider of the training. SF-SEAETC may have modules available targeted toward care and treatment of women with HIV.

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. Conduct "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 interviews conducted with clients over 50 years of age during special-emphasis client satisfaction needs assessment survey in FY 2023 **2.** # focus groups, listening sessions or other fast-track projects supported by RWHAP **3.** # Community Coalition Roundtable meetings focused on 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.	RWHAP Recipient, Partnership, Care and Treatment Committee RWHAP Staff Support contractor	**1.** # of guidelines generated by Care and 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. Develop and implement training protocols for MCMs to assist older persons with HIV in the process of transitioning medical services from RWHAP to Medicare.	RWHAP Recipient	**1.** Protocol created and approved by the Recipient **2.** # and % of RWHAP MCMs trained in assisting clients over 60 with transitioning to Medicare **3.** # and % of RWHAP clients over 65 in each subrecipient MCM provider agency ~~over 65~~ who have successfully transitioned to Medicare
SP2.1.d Examine client outcome data specifically for persons over 50 in order to identify potential QI opportunities to improve service to this population~~women~~.	RWHAP QI Contractor, MCM / OAHS Subrecipients	**1.** # of MCM and OAHS providers with identified over-50 sub-populations with identified sub-par treatment outcomes **2.** # of over-50-oriented QI projects completed per year
Notes **1.** In FY 2021, 4,209 clients over 50 years of age were in care in the Miami-Dade EMA ~~in FY 2021,~~ of whom only 292 (7%) were also long-term survivors of HIV (diagnosed before 1995). This Plan		

therefore will concentrate on the aging population with HIV rather than long-term survivors ~~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. Conduct basic and ~~annual~~annual trainings for~~to~~ RWHAP subrecipient~~'~~s' ~~and FDOH-MDC provider's front li~~MCM/Peer, front desk ~~ne~~ and medical staff on issues related to sexual identity, gender identity, and providing service to transgender persons.	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.b. Identify a transgender advocate within each RWHAP subrecipient and FDOH-MDC providers.	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-MDC providers
SP3.1.c Identify and engage an experienced and credible entity to conduct unbiased evaluations and certifications of the "transgender-friendliness" of RWHAP subrecipient service providers	RWHAP Recipient Integrated Plan Evaluation Workgroup Care and Treatment subgroup	**1.** Determination of transgender-friendliness review and certification agency **2.** Providing support for a periodic review of trans-friendliness among all RWHAP MCM and OAHS providers
SP3.1.d~~e~~ Review ~~Audit~~ and certify all RWHAP subrecipients ~~and FDOH-MDC providers~~ for transgender-friendliness on an agency level ~~sexual identity and gender identity training~~.	~~FDOH-MDC,~~ RWHAP, ~~TransSOCIAL~~	**1.** # of RWHAP subrecipient ~~eligible~~ agencies agreeing to ~~annual~~ transgender-friendly review and certification~~audit~~ **2.** # and % of agencies passing transgender-friendly review and certification ~~audit~~
Notes		

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 and co-occurring STIs in Ryan White Care.

- ***Strategy SP5.1.*** *Expand existing programs and collaborations to address specific needs of MSM with HIV and sexually transmitted infections as 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 annual LGBT cultural competency/cultural humility trainings for RWHAP and FDOH-MDC funded agencies.	FDOH-MDC's Education Team, RWHAP	**1.** # and % of agencies that have completed at least one annual~~1~~ training completed.~~, per staff~~ **2.** % of agencies that have conducted the trainings **3.** # of agencies providing trainings
SP5.1.b. Identify barriers to care or below-average client treatment outcomes~~Operationalize adherence difficulties~~ among MSM clients with STIs as co-occurring conditions~~and identify MSM clients with adherence difficulties.~~	RWHAP QI contractor	**1.** Facilitate access for BSR to use Part B or ADAP medical care data in Provide to determine accurate STI status of MSM clients receiving OAHS. **2.** # of MSM clients identified with STIs as co-morbidities. **3.** # and % of MSM + STI clients with unsuppressed VL ~~**1.**~~**4.** # and % of MSM + STI clients identified with other co-morbidities or treatment barriers that may contribute to poor outcome.
SP5.1.c. Provide service enhancements ~~s~~ to improve treatment outcomes~~overcome~~ among MCM clients with STIs. ~~adherence barriers.~~	RWHAP	**1.** # of MSM clients with STIs~~clients~~ with improved ~~suppressed~~ viral load after receiving services to overcome barriers to care. ~~**1.**~~**2.** # of MSM clients with STIs with improved other health care conditions after receiving services to overcome barriers to care~~.~~
	~~RWHAP subrecipients and FDOH-MDC~~	~~**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.		

May ~~February~~ 2023

Staff comment

- Task group applauded the below activity, but did not see it belonging in this Objective. ~~Staff recommends close attention to SP 3 and SP 5 population activities and measurements~~.

SP5.1.d. Implement support groups addressing topics of sexual/emotional health; safer sex; dating; relationships; substance use disorders; and mental health needs.	RWHAP subrecipients and FDOH-MDC	**1.** # of groups implemented **2.** # of clients completing groups **3.** # of clients entering formal counseling

Objective SP6. Improve HIV prevention and testing efforts ~~health out~~toward ~~comes for~~ youth (ages 13-18 and 19-24) who are at risk of or living with HIV. *(Please note: after deliberation, the work group recommended moving this to Prevention, because the responsible parties are FDOH-MDC entities)*

- ***Strategy SP6.1.*** *Expand existing programs and collaborations to address HIV prevention and testing~~specific needs~~ among ~~of~~High-School-Age persons ~~youth~~ (ages 13-18~~24~~) who are at risk or 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.a~~b~~. Collaborate with MDC Public School Health Programs[1] targeting school-age youth.	FDOH-MDC, 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.b~~c~~. Identify and explore other options for HIV/STI~~D~~ testing among high-school aged youth.	~~RWHAP Part D,~~ FDOH-MDC, MDC school board, Healthy Teen Expos (collaboration between FDOH-MDC~~,~~ and other agencies), other partners	**1.** # of ancillary sites established for HIV/STI~~D~~ 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 Part D, FDOH-MDC, other partners~~	~~1. # of ancillary sites established for HIV/STD testing.~~ ~~2. # tests conducted~~
SP6~~1~~.1~~2~~.c~~e~~. Improve advertisements concerning PrEP, condoms and other prevention messages for youth 13-24 years of age.~~.~~	FDOH-MDC and partners	1. # of PSAs targeting youth ~~1.~~2. # of other communication efforts targeting youth ~~2.~~3. # of impressions on advertisements targeting youth, on PrEP ~~3.~~4. # of impressions on advertisements targeting youth, on condoms ~~4.~~5. # 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.

- ***Strategy SP6.2.*** *Expand existing programs and collaborations to address specific needs of college-age youth (ages 19-24) who are living with or at risk of HIV.*

Activities	Responsible Entities	Measurements
SP6.2.a. Identify and explore other options for HIV/STD testing among young adults 19-24 years of age.	FDOH-MDC, other partners	~~3.~~1. # of ancillary sites established for HIV/STD testing. ~~4.~~2. # tests conducted
SP6.2.b. Improve advertisements concerning PrEP, condoms and other prevention messages for young adults 19-24 years of age.	FDOH-MDC and partners	1. # of PSAs targeting 19-24 y/o persons with or at risk of HIV ~~1.~~2. # of other communication efforts targeting 19-24 y/o persons ~~2.~~3. # of impressions on advertisements targeting 19-24 y/o, on PrEP ~~3.~~4. # of impressions on advertisements targeting 19-24 y/o, on condoms ~~4.~~5. # of impressions on advertisements targeting 19-24 y/o, on other prevention messages

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 MCM/Peers, front desk personnel and medical providers in RWHAP and FDOH agencies that address stigma, discrimination and unrecognized ethnic, racial, gender, and HIV-status bias.	RWHAP FDOH-MDC	**1.** # of agencies providing capacity building trainings to healthcare professionals (i.e., medical providers, clinical staff, HIV counselors, medical case managers)
S1.1.b. Require ~~annual~~annual stigma/ discrimination and unrecognized bias training for RWHAP and FDOH agencies.	RWHAP FDOH-MDC	**1.** #/% providers with ~~annual~~annual training **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.c~~c~~. Create a "safe space" hotline channel for clients to report stigmatizing or discriminating behaviors outside of the subrecipients~~.~~	RWHAP Recipient or designee FDOH-MDC or designee	**1.** "Safe space" hotline and reporting protocol established, including tracking and response ~~1.~~**2.** # and ~~/~~% of providers with palm cards, posters or other public information on the ~~with a~~ safe space reporting protocol.
S1.1.d~~d~~. Develop and disseminate response protocol for addressing stigmatizing behaviors throughout the system of care.	RWHAP FDOH-MDC	**1.** # and ~~/~~ % providers with response protocol

NOTE:

A "secret shopper" protocol was suggested by the task group as a new IP Activity. This needs more detail to be integrated into the Integrated Plan, especially with the recommendation to move the "safe space hotline" (S1.1.c) out of the subrecipients and into a centralized function with greater confidentiality.

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. Semi-a~~A~~nnually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males.	RWHAP	**1.** ~~Annual~~Semi-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~~Semi-annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population
DR1.1.b. D~~Annually d~~ocument 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. C~~Annually c~~onduct 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. ~~Annual~~Semi-annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females.	RWHAP	**1.** ~~Annual~~Semi-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~~Semi-annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population
DR1.2.b. D~~Annually d~~ocument 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. ~~Annual~~ C~~ly c~~onduct 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. ~~Annual~~Semi-annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Hispanic MSM clients.	RWHAP	**1.** ~~Annual~~Semi-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~~Semi-annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population
DR1.3.b. D~~Annually d~~ocument 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. ~~Annual~~C~~ly c~~onduct 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 Undetectable 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. ~~Annual~~Semi-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~~Semi-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~~Semi-annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.1.b. D~~Annually d~~ocument 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. C~~Annually c~~onduct 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. Semi-~~Annually~~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~~Semi-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~~Semi-annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.2.b. D~~Annually d~~ocument 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 c~~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. ~~Annual~~Semi-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~~Semi-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~~Semi-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~~Semi-annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.3.b. ~~Annual~~D~~ly d~~ocument 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. ~~Annual~~C~~ly c~~onduct 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.

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - ☐ Prevention: Final Evaluation Plan Review
  - ☐ Linkage: Final Evaluation Plan Review
  - ☐ Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - ☐ NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - ☐ NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

NHAS Goal 1: Prevent New HIV Infections
Objective 1

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.								
Activity P1.1.a. Partner/ collaborate with healthcare facilities to increase routine opt-out HIV testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of healthcare facilities identified for routine opt-out HIV testing in MDC								
2. # of healthcare facilities interested in routine opt-out HIV testing in MDC								
3. # of healthcare facilities committed to conduct routine opt-out HIV testing in MDC								
4. # of healthcare facilities implementing routine opt-out HIV testing in MDC								

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.								
Activity P1.1.a. Partner/ collaborate with healthcare facilities to increase routine opt-out HIV testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
5. # of HIV positive persons identified through routine opt-out testing	*							
6. # of previously diagnosed HIV positive persons	*							
7. # of newly diagnosed HIV positive persons								
8. # of HIV tests integrated with viral hepatitis tests (HCV)								
9. # of HIV tests integrated with STI tests								
Notes								

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.								
Activity P1.1.b. Utilize academic detailing to educate providers on routine testing inclusive of Hepatitis C virus (HCV) and sexually transmitted infections (STIs).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of licensed clinical providers and practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI)								
2. # of licensed clinical providers educated on routine testing (i.e., HIV, HCV, STI)								
3. # of MOUs/agreements established with partners to serve as routine healthcare testing sites								
Notes								

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.

Activity P1.1.c. Partner and/or collaborate with healthcare facilities to offer STI testing.		**What**				**When**		**Who***	
		Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements									
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 organizations to offer STI testing									
4. # of healthcare organizations implementing STI testing									
5. # of STI tests done at healthcare organizations									
6. # of clients with a positive STI result	Syphilis								
	Gonorrhea								
	Chlamydia								
7. # of clients treated for STIs	Syphilis								
	Gonorrhea								
	Chlamydia								

Notes

1. Homestead Hospital only reports syphilis.
2. Track total surveillance and Homestead Hospital.
3. Organizations = # of facilities or sites.

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.								
Activity P1.1.d. Partner and/or collaborate with healthcare facilities to offer HCV testing.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # healthcare facilities identified to conduct HCV testing								
2. #HCV tests (integrated with HIV tests) done at healthcare facilities	JHS data							
3. # of clients with a positive HCV result	JHS data							
4. # of clients referred for HCV treatment	Can this baseline be established?							
Notes								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.a. Increase the use of home HIV self-testing kits as an alternative option.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of persons receiving one or more 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 testing community partner facilities								
Notes 1. Expect underestimates based on self-reporting.								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.b. Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of community testing partners implementing HIV/STI testing at non-traditional settings								
2. # of persons tested for HIV at non-traditional settings								
3. # of HIV positive persons at a non-traditional setting								
4. # of previously diagnosed HIV positive persons, confirmed in surveillance at non-traditional settings								
5. # of newly diagnosed HIV positive persons								
6. # of persons tested for STI at non-traditional settings								
7. # of persons diagnosed with STI at non-traditional settings								
Notes								

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 P1.2. Expand HIV/STI testing in traditional and non-traditional settings.								
Activity P1.2.c. Increase the number of mobile units offering HIV/STI testing in the community. (This activity overlaps with P1.2.b.)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of operational mobile units conducting 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 persons linked to HIV care at a mobile unit								
6. # of persons linked to PrEP at a mobile unit								
7. # of STI positive results from STI tests conducted at a mobile unit								
8. # of people referred for STI treatment at a mobile unit								
Notes								

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 P1.3. 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.								
Activity P1.3.a. Provide training and education to community partners on status neutral approach.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of community testing organizations trained and educated on the status neutral approach								
2. # of people trained and educated on the status neutral approach								
Notes 1. This is an EHE and HIPP requirement.								

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 P1.4. Provide Disease Intervention Specialist (DIS) partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.								
Activity P1.4.a. Educate community testing partners on availability and importance of partner services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of persons with HIV 501 certification								
Notes 1. Includes partner services.								

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 P1.4. Provide Disease Intervention Specialist (DIS) partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.								
Activity P1.4.b. Educate clients about the importance of partner services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % of notifiable partners identified through HIV partner services				DIS				
2. # and % of notifiable partners that were tested for HIV								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 2

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.1. Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).								
Activity P2.1.a. Conduct educational sessions 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted				Queen Holden				
2. # of persons trained								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.1. Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted								
2. # of persons trained								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.1. Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).								
Activity P2.1.c. Conduct educational sessions with hospitals, including emergency rooms and high-risk delivery hospitals, and urgent care centers.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted with hospitals								
2. # of educational sessions conducted with urgent care centers								
3. # of High-Risk Notification Forms and/or notifications of pregnant women with HIV received								
4. # of Newborn Exposure Notification Forms received								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.2. Increase awareness among women with HIV who are of childbearing age about mother to child transmission, prenatal care, postpartum care, and family planning services.								
Activity P2.2.a. Link pregnant women with HIV to HIV care and prenatal care.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of pregnant women with HIV who received HIV care								
2. # of pregnant women with HIV who received prenatal care								
Notes								

Objective P2. Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).								
Strategy P2.2. Increase awareness among women with HIV who are of childbearing age about mother to child transmission, prenatal care, postpartum care, and family planning services.								
Activity P2.2.b. Provide follow-up medical and family planning services for post-partum women with HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of post-partum women with HIV who received family planning services								
2. # of women with HIV who received post-partum care								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 3

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.a. Train peer educators and community health workers to promote the PrEP initiatives through direct community outreach.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of PrEP educational sessions conducted								
2. # of PrEP educational materials distributed								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.b. Utilize FDOH-MDC ADP to engage and educate health care providers on PrEP to increase the number of PrEP prescribers.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions conducted specifically to health care providers								
2. # of providers recruited to provide PrEP services								
3. # of PrEP prescribers								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.c. Identify and share best practices by agencies that have utilized TelePrEP to expand providers' capacity of offering TelePrEP services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of providers offering TelePrEP services								
2. # of persons who received TelePrEP services								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.d Increase PrEP access by expanding the number of individuals receiving PrEP services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of HIV-negative tests								
2. # of access points for PrEP								
3. # of individuals screened for PrEP	EHE/HIPP							
4. # of individuals referred to a PrEP provider								
5. # of individuals linked to a PrEP provider								
6. # of individuals prescribed PrEP								
Notes								

Objective P3. Increase the percentage of persons screened for pre-exposure prophylaxis (PrEP) who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.								
Strategy P3.1. Ensure access to and availability of PrEP.								
Activity P3.1.e. Increase the number of non-traditional partners offering PrEP (i.e., pharmacies, urgent care centers).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 4

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.								
Activity P4.1.a. Increase the number of partners offering nPEP services	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of access points for nPEP								
1. # of pharmacy clinics (MinuteClinic at CVS, and UHealth at Walgreens) and other non-traditional organizations providing nPEP								
2. # of urgent care centers providing nPEP								
3. # of persons screened								
4. # of persons who received nPEP								
Notes								

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.								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of nPEP educational sessions conducted								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 5

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.								
Activity P5.1.a. Increase the number of condom distribution sites across the jurisdiction.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of condoms distributed by Zip Code (report using Zip Code map)								
2. # of Business Responds to AIDS (BRTA) sites.								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 6

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.								
Activity P6.1.a. Educate and refer high-risk individuals to local SSP.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of persons linked to IDEA Exchange								
2. # of referrals made to IDEA Exchange, by partners								
Notes								

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.								
Activity P6.1.b. Utilize social media platforms to promote services offered by SSP.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of social media posts by IDEA Exchange (Facebook, Instagram and Twitter)								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 7

Objective P7. Increase the number of advertisement types 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.								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of overall impressions [media measurement] from knowing your status, getting into care while addressing stigma, HIV prevention and care marketing campaigns								
2. # of posts on knowing your status, getting into care while addressing stigma, HIV prevention and care								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity P7.1.b. Conduct outreach events that promote diversity (inclusive of multi-lingual messages), to reach out to priority populations in the community.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity 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).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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)								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity P7.1.d. Utilize representatives of the HIV-affected community to deliver messages to people with HIV, highlighting personal success and struggles, and empowering people with HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of educational sessions about destigmatizing HIV, and empowering people with HIV # of media campaign types utilizing influencers or community representatives to promote HIV messages								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

Objective P7. Increase the number of advertisement types 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.								
Activity P7.1.f. Collaborate with CBOs and engage non-traditional partners to support HIV prevention messages and further destigmatize HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of partnerships created that support prevention messages								
Notes								

NHAS Goal 1: Prevent New HIV Infections
Objective 8

Objective P8. Improve HIV prevention and testing efforts toward youth (ages 13-18 and 19-24) who are at risk of or living with HIV.								
Strategy P8.1. Expand existing programs and collaborations to address HIV prevention and testing among high school age persons (ages 13-18) who are at risk or living with HIV.								
Activity P8.1.a. Collaborate with MDC Public School Health Programs targeting school-age youth.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes 1. This objective was originally included as Special Population (Objective SP6); moved to Prevention objectives in June 2023. 2. Partners may include: Children's Trust, School Board Advisory Group, colleges and universities.								

Objective P8. Improve HIV prevention and testing efforts toward youth (ages 13-18 and 19-24) who are at risk of or living with HIV.								
Strategy P8.1. Expand existing programs and collaborations to address HIV prevention and testing among high school age persons (ages 13-18) who are at risk or living with HIV.								
Activity P8.1.b. Identify and explore other options for HIV/STI testing among high-school aged youth.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of ancillary sites established for HIV/STI testing, nearby schools but not on school property								
2. # schools conducting or permitting on-site testing for HIV/STDs								
3. # tests conducted								
Notes 1. Partners may include: Children's Trust, School Board Advisory Group, colleges and universities.								

Objective P8. Improve HIV prevention and testing efforts toward youth (ages 13-18 and 19-24) who are at risk of or living with HIV.								
Strategy P8.1. Expand existing programs and collaborations to address HIV prevention and testing among high school age persons (ages 13-18) who are at risk or living with HIV.								
Activity P8.1.c. Improve advertisements concerning PrEP, condoms and other prevention messages for youth 13-24 years of age.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of PSAs targeting youth								
2. # of other communication efforts targeting youth								
3. # of impressions on advertisements targeting youth, on PrEP								
4. # of impressions on advertisements targeting youth, on condoms								
5. # of impressions on advertisements targeting youth, on other prevention messages								
Notes 1. Partners may include: Children's Trust, School Board Advisory Group, colleges and universities.								

Objective P8. Improve HIV prevention and testing efforts toward youth (ages 13-18 and 19-24) who are at risk of or living with HIV.								
Strategy P8.2. Expand existing programs and collaborations to address specific needs of college-age youth (ages 19-24) who are living with or at risk of HIV.								
Activity P8.2.a. Identify and explore other options for HIV/STD testing among young adults 19-24 years of age.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of ancillary sites established for HIV/STD testing								
2. # tests conducted								
Notes								

Objective P8. Improve HIV prevention and testing efforts toward youth (ages 13-18 and 19-24) who are at risk of or living with HIV.								
Strategy P8.2. Expand existing programs and collaborations to address specific needs of college-age youth (ages 19-24) who are living with or at risk of HIV.								
Activity P8.2.b. Improve advertisements concerning PrEP, condoms and other prevention messages for young adults 19-24 years of age.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of PSAs targeting 19-24 y/o persons with or at risk of HIV								
2. # of other communication efforts targeting 19-24 y/o persons								
3. # of impressions on advertisements targeting 19-24 y/o, on PrEP								
4. # of impressions on advertisements targeting 19-24 y/o, on condoms								
5. # of impressions on advertisements targeting 19-24 y/o, on other prevention messages								
Notes								

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV

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.								
Activity L1.1.a. Identify new FDOH testing sites for vulnerable populations, i.e., Black/African American, Hispanic, and MSM.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of new testing sites serving vulnerable population	24 new			FDOH			Sandra Estevez	Sandra Estevez
2. # of clients enrolled in TTRA services (new to HIV care, new to Ryan White care)	234			PE Miami			Frank Gattorno	Frank Gattorno
Notes 1. Rapid access- get ppl in treatment within 7 days. **2.** #1 - Go back pre-Covid to see the average # of new testing sites to calculate the average.								

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.								
Activity L1.1.b. Provide and develop information that promotes the benefits of HIV treatment adherence for vulnerable populations, i.e., Black/African American, Hispanic, and MSM.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and listing of specific campaign for information dissemination to newly diagnosed people with HIV	1	1	1	PE Miami	Quarterly	Quarterly	Courtney Gillens	Courtney Gillens
2. # of trilingual (English, Spanish, and Creole) brochures designed for these specific campaigns	0	2	2	PE Miami	Quarterly	Quarterly	Courtney Gillens	Courtney Gillens
3. # of brochures provided to EHE Quick Connect and TTRA testing sites.	0	250 per language	1000	PE Miami	Quarterly	Quarterly	Courtney Gillens	Courtney Gillens
Notes								

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.								
Activity L1.1.c. Educate private providers during the academic detailing visits on the benefits of TTRA.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of providers identified to be educated on routinized testing and TTRA services							Alejandro	Alejandro
2. # of providers educated on routinized testing and TTRA services.							Alejandro	Alejandro
3. # of providers committed to link clients to TTRA services (MOUs)							Alejandro	Alejandro
Notes								

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.								
Activity L1.1.d. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of patients enrolled in TTRA from hospitals or urgent care centers (programming in PE was completed.)	0			PE Miami	Semi-annually	Ongoing	Frank Gattorno	FDOH and RW Part A
Notes **1.** #2 was deleted because it was redundant with activity L1.1.c.								

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.								
Activity L1.1.e. Expand the use of Telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients. (Mobile units)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of people with HIV in the EMA who are identified as eligible for EHE HealthTec. (baseline and every 4 months)							Courtney Gillens	Courtney Gillens
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)							Courtney Gillens	Courtney Gillens
3. # of EHE HealthTec clients continuing this process (i.e., one or more medical visits, CD4 tests, or VL tests within 30 days of the 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)							Courtney Gillens	Courtney Gillens
4. # of clients with an HIV viral load less than 200 copies/mL at last viral load test during the measurement year							Courtney Gillens	Courtney Gillens
Notes								

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.								
Activity L1.1.f. Implement the use of EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms. (RWHAP-EHE)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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 RWHAP Part A/MAI; 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								

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.

Activity L2.1.a. Track the 30 day linkage for medical care for clients with a preliminary HIV test result among the C&T sites.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of positive HIV tests								
2. # of persons with HIV who did not complete the medical visit within 30 days from the preliminary test result (out of care)								

Notes

1. Reports from Lorene
2. REVISE language of "C&T sites" Kira gets report monthly. Change the language to include the whole county and aggregate test. However, the report Kira gets is for internal use only! Kira wants to set a call with Lory Maddox.

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.								
Activity L2.1.b. Identify the C&T sites with lower than the average linkage rates.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites that fall below the average linkage percentage. (Data source surveillance report)								
2. # of C&T sites engaged in a quality improvement project to increase the linkage rate								
3. Increase the linkage percentage rate by 5% from the baseline measure for lower-performing C&T sites								
Notes 1. Sandra - positivity rate from providers, Dr. Llau run report to see if there are evidence of CD4 and VL.								

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.								
Activity L2.1.c. Measure the success of the selected C&T site's quality improvement projects.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites who participated in the QI projects with an increase of 5% from the baseline measure.								
2. #of C&T sites who did not meet the 5% increase from the baseline.								
3. Repeat the QI cycle for C&T sites that did not meet the 5% increase or continue performing below the average linkage percentage.								
Notes								

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.								
Activity L2.1.d. The C&T sites with QI projects will adopt the identified "change idea" at their site.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites who adopted the QI project "change idea"								
Notes								

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.								
Activity L.2.1.e The C&T sites will present their QI projects to other C&T sites to share best practices to replicate.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T site attendees who participated in meetings/training on best practices								
2. # of meetings/training conducted each year								
Notes								

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 L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA enrollment.)								
Activity L2.2.a. Update and standardize warm handoff process. (See Notes for AHRQ website reference.)	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of C&T sites and Part A subrecipients who are currently implementing the warm handoff process as described in the reference https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html								
2. Process updated for consistency across provider network								
3. Providers trained on the process								

Notes

1. This is Test and Treat- when a person is diagnosed at our clinic, they are referred to another agency (Borinquen, etc.)
2. Warm Handoff: Intervention | Agency for Healthcare Research and Quality (ahrq.gov): https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html

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 L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA enrollment.)								
Activity 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. The mental health visit may be in-person or virtual (tele mental health).	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Current intake protocol across service providers reviewed								
2. Updated intake protocol developed for consistency across provider network								
3. # of providers trained on updated protocol								
Notes								

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 L2.2. Provide same-day or rapid start of antiretroviral therapy. (Within 30 days for clients who decline TTRA enrollment.)								
Activity L2.2.c. Enroll clients in ADAP (or other payer source as appropriate) within 14 days of diagnosis.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. % of clients enrolled in ADAP within 14 days of diagnosis								
Notes								

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 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.1. Identify and reengage clients in danger of being lost to RWHAP MCM care.								
Activity R1.1.a. Establish early MCM lost to care trigger point warning in Provide at 75 days without MCM contact, and alert MCMs through Provide.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % of RWHAP MCM clients with no contact in 75 days, by subrecipient								
2. # and % of RWHAP MCM clients with no contact in 90 days (CQM Report Card, M7, by subrecipient)								
3. # and % of clients with no MCM contact in 90 days who are referred to Outreach by MCMs, as tracked in Provide								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.1. Identify and reengage clients in danger of being lost to RWHAP MCM care.								
Activity R1.1.a. Establish early MCM lost to care trigger point warning in Provide at 75 days without MCM contact, and alert MCMs through Provide.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Current baseline: 90% of MCM clients are contacted every 90 days. Target: at least 95% of MCM clients will be contacted every 90 days by 12/31/26 2. MCM providers do not use a uniform acuity measure. The 75-day "pre-90-day" measure is a trigger to remind MCMs of the pending 90-day contact.								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.1. Identify and reengage clients in danger of being lost to RWHAP MCM care.								
Activity R1.1.b. Reengage a minimum of 75% of identified eligible clients by MCMs within 30 days of report of client eligibility by Outreach worker.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % of unreached clients with contact attempted by Outreach within 30 days of receiving referral from MCM.								
2. # and % of clients in #1, contacted by Outreach, whose cases may be closed by the MCM (e.g., left RWP, moved from M-DC).								
3. # and % of clients in #1, contacted by Outreach, with updated M-DC contact info and eligible for reengagement by MCM.								
4. # and % of eligible clients in #3 located and re-engaged by the MCM after Outreach follow-up								
Notes 1. The Data to Care process, linking FDOH and RWP Part A's across Florida, is still in the process of implementation as of this writing (5/13/23). 2. References to measurement or tracking of activities related to FDOH have no data points in Provide and will need to be provided by FDOH.								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.2. Increase Peer (PESN) involvement in client care to improve retention and viral load suppression.								
Activity R1.2.a. Convene listening sessions among peers and peer supervisors in CY 2023 to identify areas of increased peer involvement with client care, peer skill development / capacity building, peer skill certification.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of listening sessions conducted in CY 2023								
2. # of peers and peer supervisors attending sessions								
3. # of areas of peer support identified for expansion								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.2. Increase Peer (PESN) involvement in client care to improve retention and viral load suppression.								
Activity R1.2.b. Develop criteria for advanced peer certification training, identify training resources, conduct training and award certifications	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of advanced certification areas approved by Recipient								
2. # of certification trainings conducted by close of 2023 and annually								
3. # of peers trained and certified by close of 2023 and annually								
4. % of clients with documented peer contact with certified and uncertified peers, retained in care and with suppressed VLs (2023 baseline, annual measurement).								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.2. Increase Peer (PESN) involvement in client care to improve retention and viral load suppression.								
Activity R1.2.c. Review and revise local RWHAP-Part A Service Delivery Manual/Service Description for Peer Education and Support Network.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Peer service delivery manual revised by Part A/MAI Recipient and Staff Support contractor								
2. Annual review conducted by Care and Treatment Committee								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
Strategy R1.2. Increase Peer (PESN) involvement in client care to improve retention and viral load suppression.								
Activity R1.2.d. Increase client care involvement target for Peers from 50% to 75%.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of subrecipients employing Peers and % of time each subrecipient directs Peers toward billable client support activities (2023 baseline, annual measurement)								
2. % of clients with documented peer contact retained in care, and with suppressed VLs (2023 baseline, annual measurement)								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
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.]								
Activity 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
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.]								
Activity R1.3.b. Review and revise local MCM standards of care to address protocols for addressing social determinants of health (e.g., childcare, housing, food insecurity, domestic violence, discrimination) in treatment plans and external referrals.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. MCM service delivery manual revised by Part A/MAI Recipient								
2. Annual review conducted by Care and Treatment Committee								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
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.]								
Activity R1.3.c. Develop a protocol for how mental health services are introduced to clients to normalize the experience.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of protocols developed.								
2. # of subrecipients documenting the application of normalizing protocols								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
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.]								
Activity R1.3.d. Train MCMs on protocol for addressing social determinants of health and ensure compliance.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % of MCMs trained on protocol each year, by subrecipient MCM provider								
2. % of clients referred each year, by subrecipient provider								
Notes								

Objective R1. Increase the percentage of people with HIV retained in RWHAP Medical Case Management from 89% in December 2022 to 95% by December 31, 2026.								
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.]								
Activity R1.3.e. Identify a Miami-Dade community information resource hub to serve as an MCM resource for whole-client referrals.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of resource hubs identified and approved by RWHAP Care and Treatment Committee, and FDOH-MDC								
2. # and % of MCM subrecipient providers committed to using (and connected to) resource hub(s)								
Notes								

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV
Health Outcomes for Special Populations (SP)
Women with HIV

Objective SP1. Improve health outcomes for women with HIV.								
Strategy SP1.1. Expand existing programs and collaborations for women with HIV.								
Activity SP1.1.a. Improve messaging concerning PrEP for women.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Increased # of PSAs targeting PrEP for women (baseline for 2022, number of PSAs for 2023)								
2. Increased # of STI clinics with messages targeting PrEP for women (baseline for 2022, number of PSAs for 2023)								
Notes								

Objective SP1. Improve health outcomes for women with HIV.								
Strategy SP1.1. Expand existing programs and collaborations for women with HIV.								
Activity SP1.1.b. Expand interface between community childcare programs and RWHAP to help women stay in care.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of community agencies identified and linked with the RWHAP that offer childcare services to women with HIV								
2. # of RWHAP subrecipients offering episodic childcare/babysitting on site during appointments								
Notes								

Objective SP1. Improve health outcomes for women with HIV.								
Strategy SP1.1. Expand existing programs and collaborations for women with HIV.								
Activity SP1.1.c. Identify, educate/sensitize and train RWHAP subrecipients and medical care providers on special dynamics of women with HIV – acquisition, disease management, and stigma -- to help women stay in care.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of RWHAP subrecipients with training in designated areas								
Notes 1. IPEW needs to determine the training desired and the provider of the training. SF-SEAETC may have modules available targeted toward care and treatment of women with HIV.								

Objective SP1. Improve health outcomes for women with HIV.								
Strategy SP1.1. Expand existing programs and collaborations for women with HIV.								
Activity SP1.1.d. Examine client outcome data specifically for women in order to identify potential QI opportunities to improve service to women.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of MCM and OAHS providers with identified women sub-populations with identified sub-par treatment outcomes								
2. # of women-oriented QI projects completed per year								
Notes								

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV
Health Outcomes for Special Populations (SP)
Adults Over 50 with HIV

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.								
Activity SP2.1.a. Conduct "Aging HIV Community" needs assessments to determine special social, mental health, and pharmacy issues of older people with HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # targeted interviews conducted with clients over 50 years of age during special-emphasis client satisfaction needs assessment survey in FY 2023								
2. # focus groups, listening sessions or other fast-track projects supported by RWHAP								
3. # Community Coalition Roundtable meetings focused on persons in the affected community over 50 years of age								
Notes 1. In FY 2021, 4,209 clients over 50 years of age were in care in the Miami-Dade EMA , of whom only 292 (7%) were also long-term survivors of HIV (diagnosed before 1995). This Plan therefore will concentrate on the aging population with HIV rather than long-term survivors.								

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.								
Activity SP2.1.b. Based on SP2.1.a., develop special mental health and social services guidelines and protocols for older persons with HIV.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of guidelines generated by Care and 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								
Notes 1. In FY 2021, 4,209 clients over 50 years of age were in care in the Miami-Dade EMA , of whom only 292 (7%) were also long-term survivors of HIV (diagnosed before 1995). This Plan therefore will concentrate on the aging population with HIV rather than long-term survivors.								

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.								
Activity SP2.1.c. Develop and implement training protocols for MCMs to assist older persons with HIV in the process of transitioning medical services from RWHAP to Medicare.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Protocol created and approved by the Recipient								
2. # and % of RWHAP MCMs trained in assisting clients over 60 with transitioning to Medicare								
3. # and % of RWHAP clients over 65 in each subrecipient MCM provider agency who have successfully transitioned to Medicare								
Notes 1. In FY 2021, 4,209 clients over 50 years of age were in care in the Miami-Dade EMA , of whom only 292 (7%) were also long-term survivors of HIV (diagnosed before 1995). This Plan therefore will concentrate on the aging population with HIV rather than long-term survivors.								

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.								
Activity SP2.1.d. Examine client outcome data specifically for persons over 50 in order to identify potential QI opportunities to improve service to this population.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of MCM and OAHS providers with identified over-50 sub-populations with identified sub-par treatment outcomes								
2. # of over-50-oriented QI projects completed per year								
Notes 1. In FY 2021, 4,209 clients over 50 years of age were in care in the Miami-Dade EMA , of whom only 292 (7%) were also long-term survivors of HIV (diagnosed before 1995). This Plan therefore will concentrate on the aging population with HIV rather than long-term survivors.								

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV
Health Outcomes for Special Populations (SP)
Transgender People with HIV

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.								
Activity SP3.1.a. Conduct basic and annual trainings for RWHAP subrecipients' MCM/Peer, front desk and medical staff on issues related to sexual identity, gender identity, and providing service to transgender persons.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

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.								
Activity SP3.1.b. Identify a transgender advocate within each RWHAP subrecipient and FDOH-MDC providers.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. #/% of agencies with identified advocate/ champion.								
2. # of transgender advocates identified within RWHAP subrecipients								
3. # of transgender advocates identified within FDOH-MDC providers								
Notes								

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.								
Activity SP3.1.c. Identify and engage an experienced and credible entity to conduct unbiased evaluations and certifications of the "transgender-friendliness" of RWHAP subrecipient service providers	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Determination of transgender-friendliness review and certification agency								
2. Providing support for a periodic review of trans-friendliness among all RWHAP MCM and OAHS providers								
Notes								

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.								
Activity SP3.1.d. Review and certify all RWHAP subrecipients for transgender-friendliness on an agency level.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of RWHAP subrecipient agencies agreeing to transgender-friendly review and certification								
2. # and % of agencies passing transgender-friendly review and certification								
Notes								

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV
Health Outcomes for Special Populations (SP)
People with HIV who are Homeless or Unstably Housed

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.								
Activity SP4.1.a. Reorganize the Partnership's Housing Committee to identify and administrate housing assistance beyond HOPWA.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
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								
Notes								

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.								
Activity SP4.1.b. Review RWHAP MCM protocols for identifying housing needs and connecting homeless or unstably housed to secure housing and support services.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. 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.

NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV
Health Outcomes for Special Populations (SP)
MSM with HIV and Co-occurring STIs in Ryan White Care

Objective SP5. Improve health outcomes for MSM with HIV and co-occurring STIs in Ryan White Care.								
Strategy SP5.1. Expand existing programs and collaborations to address specific needs of MSM with HIV and sexually transmitted infections as co-occurring health conditions.								
Activity SP5.1.a. Provide annual LGBT cultural competency/cultural humility trainings for RWHAP and FDOH-MDC funded agencies.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % of agencies that have completed at least one annual training completed								
2. % of agencies that have conducted the trainings								
3. # of agencies providing trainings								
Notes								

Objective SP5. Improve health outcomes for MSM with HIV and co-occurring STIs in Ryan White Care.								
Strategy SP5.1. Expand existing programs and collaborations to address specific needs of MSM with HIV and sexually transmitted infections as co-occurring health conditions.								
Activity SP5.1.b. Identify barriers to care or below-average client treatment outcomes among MSM clients with STIs as co-occurring conditions.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Facilitate access for BSR to use Part B or ADAP medical care data in Provide to determine accurate STI status of MSM clients receiving OAHS.								
2. # of MSM clients identified with STIs as co-morbidities.								
3. # and % of MSM + STI clients with unsuppressed VL								
4. # and % of MSM + STI clients identified with other co-morbidities or treatment barriers that may contribute to poor outcome.								
Notes								

Objective SP5. Improve health outcomes for MSM with HIV and co-occurring STIs in Ryan White Care.								
Strategy SP5.1. Expand existing programs and collaborations to address specific needs of MSM with HIV and sexually transmitted infections as co-occurring health conditions.								
Activity SP5.1.c. Provide service enhancements to improve treatment outcomes among MCM clients with STIs.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of MSM clients with STIs with improved viral load after receiving services to overcome barriers to care								
2. # of MSM clients with STIs with improved other health care conditions after receiving services to overcome barriers to care								

Notes

1. Review Human Rights Campaign LGBTQ Healthcare Equality Index, https://www.hrc.org/resources/healthcare-equality-index for criteria and means of accreditation.
2. Consider addressing Activity SP5.1.d. in another section: **Activity SP5.1.d.** *Implement support groups addressing topics of sexual/emotional health; safer sex; dating; relationships; substance use disorders; and mental health needs.*
3. NHAS Goal 2: *Improve HIV-Related Health Outcomes of People with HIV: Health Outcomes for Special Populations (SP) Youth (ages 13-18 and 19-24) who are at Risk of or are Living with HIV* has been moved to Prevention Objective P8.

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities
Disparities in Retention in Care (DR)
Black/African American Males

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.								
Activity DR1.1.a. Semi-annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Semi-annual measurement of RiMC rates for B/AA males, by subrecipient service site providing OAHS and/or MCM services to this target population								
2. Semi-annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population								
Notes								

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.								
Activity DR1.1.b. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

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.								
Activity DR1.1.c. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care (DR)

Black/African American Females

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.								
Strategy DR1.2. Increase RiMC rates from 88% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Females.								
Activity DR1.2.a. Semi-annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Semi-annual measurement of RiMC rates for B/AA females, by subrecipient service site providing OAHS and/or MCM services to this target population								
2. Semi-annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population								
Notes								

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.								
Strategy DR1.2. Increase RiMC rates from 88% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Females.								
Activity DR1.2.b. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.								
Strategy DR1.2. Increase RiMC rates from 88% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Females.								
Activity DR1.2.c. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care (DR)

Hispanic Men Who Have Sex with Men (MSM)

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.								
Strategy DR1.3. Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026 for Hispanic MSM clients.								
Activity DR1.3.a. Semi-annually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Hispanic MSM clients.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Semi-annual measurement of RiMC rates for Hispanic MSM clients, by subrecipient service site providing OAHS and/or MCM services to this target population								
2. Semi-annual # and % of OAHS and MCM service sites that have attained 90% RiMC for this target population								
Notes								

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.								
Strategy DR1.3. Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026 for Hispanic MSM clients.								
Activity DR1.3.b. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

Objective DR1. Increase RWHAP Retention in Medical Care (RiMC) rates among priority populations.								
Strategy DR1.3. Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026 for Hispanic MSM clients.								
Activity DR1.3.c. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression Rates and Undetectable Viral Load (DV)

Black/African American Males

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.1. Increase the VL suppression rates from 81% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Males								
Activity DV1.1.a. Semi-annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Semi-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. Semi-annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population								
Notes								

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.1. Increase the VL suppression rates from 81% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Males								
Activity DV1.1.b. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.1. Increase the VL suppression rates from 81% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Males								
Activity DV1.1.c. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression Rates and Undetectable Viral Load (DV)

Black/African American Females

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.2. Increase the VL suppression rates from 84% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Females.								
Activity DV1.2.a. Semi-annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Semi-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. Semi-annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population								
Notes								

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.2. Increase the VL suppression rates from 84% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Females.								
Activity DV1.2.b. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.2. Increase the VL suppression rates from 84% in 2021 to 90% by December 31, 2026 for Black/African American (B/AA) Females.								
Activity DV1.2.c. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression Rates and Undetectable Viral Load (DV)

Haitian Males and Females

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.3. Increase the VL suppression rates from 86% in 2021 to 90% by December 31, 2026 for Haitian Males and Females.								
Activity DV1.3.a. Semi-annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Haitian males and females.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Semi-annual measurement of VL suppression rates for Haitian males, by subrecipient service site providing OAHS and/or MCM services to this target population								
2. Semi-annual measurement of VL suppression rates for Haitian females, by subrecipient service site providing OAHS and/or MCM services to this target population								
3. Semi-annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population								
Notes								

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.3. Increase the VL suppression rates from 86% in 2021 to 90% by December 31, 2026 for Haitian Males and Females.								
DV1.3.b. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

Objective DV1. Increase the viral load (VL) suppression rates among priority populations.								
Strategy DV1.3. Increase the VL suppression rates from 86% in 2021 to 90% by December 31, 2026 for Haitian Males and Females.								
Activity DV1.3.c. 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.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership								
Notes								

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities
Stigma (S)

Objective S1. Reduce HIV-related stigma and discrimination. *This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.*								
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).								
Activity S1.1.a. Develop and/or identify training curricula for MCM/Peers, front desk personnel and medical providers in RWHAP and FDOH agencies that address stigma, discrimination and unrecognized ethnic, racial, gender, and HIV-status bias.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # of agencies providing capacity building trainings to healthcare professionals (i.e., medical providers, clinical staff, HIV counselors, medical case managers)								
Notes								

Objective S1. Reduce HIV-related stigma and discrimination.
This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.

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).

Activity S1.1.b. Require annual stigma/ discrimination and unrecognized bias training for RWHAP and FDOH agencies.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. #/% providers with annual training								
2. # of unique educational materials distributed to healthcare professionals								
3. # of healthcare professionals trained at FDOH-MDC								
4. # of healthcare professionals trained at RWHAP								
Notes								

Objective S1. Reduce HIV-related stigma and discrimination.
This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.

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).

Activity S1.1.c. Create a "safe space" hotline channel for clients to report stigmatizing or discriminating behaviors outside of the subrecipients	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. "Safe space" hotline and reporting protocol established, including tracking and response								
2. # and % of providers with palm cards, posters or other public information on the safe space reporting protocol.								

Notes

1. A "secret shopper" protocol was suggested by the task group as a new IP Activity. This needs more detail to be integrated into the Integrated Plan, especially with the recommendation to move the "safe space hotline" (S1.1.c) out of the subrecipients and into a centralized function with greater confidentiality.

Objective S1. Reduce HIV-related stigma and discrimination.
This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.

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).

Activity S1.1.d. Develop and disseminate response protocol for addressing stigmatizing behaviors throughout the system of care.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. # and % providers with response protocol								
Notes								

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.
This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.

Strategy IPC1.1. Maintain and develop community partnerships.

Activity IPC1.1.a. Identify community stakeholders to broaden the base of Integrated Plan implementation and referrals for client needs.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. By close of Year 1, establish working Integrated Plan Evaluation Workgroup to engage community stakeholders in planning and evaluating IP services								

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.

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. *This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.*								
Strategy IPC1.1. Maintain and develop community partnerships.								
Activity IPC1.1.b. Develop schedule for regular communication with stakeholders.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Progress report on scheduling								
Notes								

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. *This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.*								
Strategy IPC1.1. Maintain and develop community partnerships.								
Activity IPC1.1.c. Develop plan among stakeholders for addressing HIV outbreaks.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Progress report on plan								
Notes								

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. *This Objective is a cross-over of Prevention, Linkage, and Care & Treatment/Special Populations.*								
Strategy IPC1.1. Maintain and develop community partnerships.								
Activity IPC1.1.d. Coordinate data sharing between RWHAP Parts A, B, D, F; General Revenue (GR); and ADAP; and between the RWHAP and Medicaid.	**What**				**When**		**Who***	
	Baseline (December 31, 2022 unless otherwise noted)	**Short Term Target 2023**	**Final Target 2026**	**Data Source**	**Data Collection Frequency**	**How Often are Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Measurements								
1. Progress report on data sharing agreements								
Notes								

Key to Person(s) Responsible for Gathering Data & Person(s) Responsible for Achieving Objectives			

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

AUGUST 2023

RYAN WHITE PART A/MAI PROGRAM AND MIAMI-DADE HIV/AIDS PARTNERSHIP CALENDAR

Monday	Tuesday	Wednesday	Thursday	Friday
Southern HIV/AIDS Awareness Day (Sunday, August 20)	**1**	**2**	**3** **Care & Treatment Committee** 10:00 AM to 1:00 PM at MDC Main Library	**4**
7	**8** **Integrated Plan Evaluation Work Group** 10:00 AM to 12:00 PM at MDC Main Library	**9** **Miami-Dade HIV/AIDS Partnership New Member Orientation** 2:00 PM to 5:00 PM via Zoom	**10**	**11** **Strategic Planning Committee** 10:00 AM to 12:00 PM at MDC Main Library
14	**15**	**16**	**17** **Housing Committee** 2:00 PM to 4:00 PM at BSR Corp.	**18** RWP 33rd Anniversary **Clinical Quality Management Committee** 9:30 AM to 11:30 AM via Zoom
21 **Miami-Dade HIV/AIDS Partnership** 10:00 AM to 12:00 PM at MDC Main Library	**22**	**23**	**24** **Prevention Committee** 10:00 AM to 12:00 PM at MDC Main Library	**25** **Medical Care Subcommittee** 9:30 AM to 11:30 AM at BSR Corp.
28 **Community Coalition Roundtable** 5:30 PM to 7:30 PM at Pridelines	**29** National Faith HIV/AIDS Awareness Day	**30** **Executive Committee** *Meets as needed*	**31**	**SPECIAL MEETING LOCATION** **Pridelines,** 6360 NE 4th Court, Miami, FL 33138

REGULAR MEETING LOCATIONS

BSR Corp. - Behavioral Science Research Corp., 2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134
MDC Main Library - Miami-Dade County Main Library, 101 West Flagler Street, Auditorium, Miami, FL 33130

All events listed on this calendar are open to the public.

People with HIV are encouraged to attend!

Are you attending a meeting or training?

Your RSVP lets us know if we have the necessary participants to hold the activity and ensures we have enough materials for distribution.

To attend, RSVP to:
(305) 445-1076 or
hiv-aidsinfo@behavioralscience.com

Visit our website for more information
www.aidsnet.org

Version 05/02/23
Information on this calendar is subject to change

MIAMI-DADE HIV/AIDS PARTNERSHIP

Meeting Documents

MIAMI-DADE HIV/AIDS PARTNERSHIP

Integrated Plan Evaluation Workgroup

Tuesday, June 6, 2023

10:00 AM – 1:00 PM

Miami-Dade County Main Library, 101 West Flagler Street,
Auditorium, Miami, FL 33130

AGENDA

10:00 AM – 10:30 AM

I.	Call to Order	Sarah Suarez
II.	Introductions	All
III.	Housekeeping	Sarah Suarez
IV.	Floor Open to the Public	Amaris Hess
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of May 9, 2023	All

10:30 AM – 11:30 AM

VII. Standing Business

- Breakout Sessions — All
  - Prevention: Final Evaluation Plan Review
  - Linkage: Final Evaluation Plan Review
  - Care & Special Populations: Final Evaluation Plan Review

11:30 AM – 12:40 PM

- Group Session — All
  - NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities - Stigma
  - NHAS Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among Partners - Integrated Plan Coordination

12:40 PM – 1:00 PM

VIII.	New Business	All
IX.	Announcements	All
X.	Next Meeting: August 8, 2023, at Miami-Dade County Main Library	Amaris Hess
XI.	Adjournment	Sarah Suarez

Please mute or turn off all cellular devices.

For more information about the Integrated Plan Evaluation Workgroup, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership


thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
obrigado
merci
спасибо
Баярлалаа
рахмат
bedankt
dziękuję
sukriya
kop khun krap
go raibh maith agat
mochchakkeram
tapadh leat
dank je
grazie
arigatô
takk
dakujem
terima kasih
мерси
хвала
감사합니다
ありがとう
ευχαριστώ
hvala
mauruuru
sagolun
taiku
kiitos
dankie
nanni
nandri
dhanyavad
gracie
bayarlalaa
koszonom
enkosi
sobodi
dekuji
mesi
didi madloba
najis tuke
kam sah hamnida
rahmat
tanemirt
rahmet
diolch
dhanyavadagalu
shukriya
merce
trugarez
xiexie
chnorakaloutioun
gracies
sulpay
akun dankon
mersi
kia ora
barka
welalin
tack
spas
taafetai lava
vinaka
blagodaram
misaotra
matondo
paldies
mahalo
asante
manana
lenki
murakoze
mamnun
djiere dieuf
tau