Integrated Plan Evaluation Workgroup Meeting
Miami-Dade County Main Library
101 West Flagler Street, Auditorium, Miami, FL 33130
February 14, 2023

Approved as posted, April 11, 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	
Reigada, Hector Jose	
Valle-Schwenk, Carla	
Staff	
Bontempo, Christina	
Ladner, Robert	
Martinez, Susy	

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 4-26 of these minutes are online at: aidsnet.org/wp-content/uploads/2023/03/021423ipewminutes-WITH-attachments-rl.pdf.

I. Call to Order

Workgroup Chair, Abril Sarmiento, called the meeting to order at 10:15 a.m.

II. Introductions

Attendees introduced themselves.

III. Housekeeping/Meeting Rules

Workgroup Vice Chair, David Goldberg, 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

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

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

VI. Review/Approve Minutes of January 23, 2023

Members reviewed the minutes of January 23, 2032. Several corrections were noted:

- Address should be Behavioral Science Research Corp., 2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134;
- Attendance should reflect Dr. Angela Mooss as present and Karen Hilton as absent; and
- Breakout assignments should reflect Carla Valle-Schwenk as a member of the Care and Treatment group and Courtney Gillens as a member of the Linkage group.

Motion to accept the minutes of January 23, 2023, with the corrections noted, above.
Moved: Alberto Perez-Bermudez **Seconded: Stephanie Llambes** **Motion: Passed**

VII. Standing Business

- **Review of Officer Elections**

Staff noted that both officers elected for the workgroup are representatives of the Florida Department of Health. Since the Integrated Plan is meant to represent a broad range of stakeholders, it would be more appropriate for the workgroup leaders to also represent this diversity. Members were asked to reconsider serving as Chair and Vice Chair. There were no nominations put forward.

VIII. New Business

- **Breakout Sessions**

Members were seated in three breakout groups: Prevention, Linkage, or Care and Treatment/Special Populations. Each group reviewed a red-lined version of their goals and provided feedback. The pages below indicate approved deletions, insertions, comments, responses, and additional feedback:

- Prevention: pages 4-9;
- Linkage: pages 10-15; and
- Care and Treatment/Special Populations: pages 16-23.

Members will continue this review at the next meeting.

Each breakout group also reviewed the draft Evaluation Plan template and Quarterly Reporting template. Suggested updates were shared with all members, as detailed in pages 24-26, below.

Members discussed how results should be reported, how achievements should be highlighted, and how to manage goals falling short of completion. This is a topic for further discussion after the Evaluation Plan and Quarterly Reporting templates are finalized.

- **Assignments for Next Meeting**

Members were asked to review drafts when posted to www.aidsnet.org.

IX. Announcements

Staff announced that the February 21 Partnership meeting will include a special presentation by Dr. Hansel Tookes, *Tele-Harm Reduction: In Pursuit of Destigmatizing HIV Care for Persons Who Inject Drugs.*

Ms. Sarmiento revisited the Review of Officer Elections item. Since no nominations were put forward, the item will be revisited at the next meeting.

X. Next Meeting

Mr. Goldberg announced the next meeting is March 14, 2023, from 10:00 a.m. to 1:00 p.m., at the Miami-Dade County Main Library.

XI. Adjournment

Ms. Sarmiento adjourned the meeting at 12:39 p.m.

NHAS GOAL 1
PREVENT NEW HIV INFECTIONS
Prevention (P)

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

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

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

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

Activities	Responsible Entities	Measurements
P1.3.a. Provide training and education to community partners on status neutral approach.	FDOH-MDC and partners	**1.** # of community partners trained and educated on the status neutral approach
P1.3.b. Increase the number of agencies implementing status neutral approach.	FDOH-MDC and partners	**2.** # of agencies implementing the status neutral approach
Notes 1. P1.3.a. to begin in Year 2. 2. P1.3.b. to begin in Year 3. 3. P1.3.b. Agencies may have multiple testing sites.		

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Staff comment

- As the IPEW works on this, please realize how strongly silo-ed the RWP is, both Part A and EHE.

Staff comment

- Does "agencies" refer to "testing sites?"

WG response

- Agencies may have multiple testing sites.

New WG comments

- The status neutral approach should be defined. The CDC definition is, "A status neutral approach to care and service delivery means that regardless of HIV status, people have access and support to stay on highly effective public and personal health interventions like PrEP and HIV treatment."
- Determining which agencies have completed status neutral approach training can be set up as a formal inquiry from the FDOH contract manager.
- Could be part of the cycle of trainings to become a Certified Health Educator, or could be a part of the 501 Update training.

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

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

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

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New WG comments

- What should the increase be per year?
  - 2,410,087 represents a 2% increase over 2022.
  - 2020 can be the baseline with 2% increase annually.
- Notes: The supply of condoms was impacted by supply chain limitation due to COVID-19.
- Notes: Approximately 10% of condoms distributed are female condoms.

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

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

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

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

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

Definitions

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

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

Notes

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

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Staff comments

- P7.1.d.The functions outlined here are not part of the RWP billable activities for peers

WG response

- Agreed to deletions as indicated, above.

New WG comments

- Track posts, impressions, and platforms related to each EHE Pillar.
- How is FDOH advertising funding spent? In what neighborhoods/Zip Codes?
- Measurements: Use High Impact Prevention (HIP) categories for tracking.
- Definitions (1): Define additional OOH categories.
- Notes: Discussion of COMMANDO, and LGBTQ+ marketing agency.
- Notes: Explore geofencing.

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

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

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

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

		~~6.~~3. # ~~of private practices that have stablished a process to connect clients with TTRA services~~

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Staff comment

- Staff recommends keeping the activities focused on testing and engagement in care.

WG response

- See edits, above.

Staff comment

- L1.1.a. – There are two issues here, and the linkage group may need to add or modify the activities, entities and measurements to (a) place responsibility for new testing in the hands of the FDOH-MDC, and (b) place responsibility for culturally-sensitive engagement in care in the hands of the RWP.

WG response

- The linkage group accepted the deletion of TTRA access points.

New WG comments

- L1.1.b. – Add Borinquen Medical Centers: currently the sole EHE provider funded for this activity.
- L1.1.c. – Remove measurements 3-6; these are not realistic or achievable.

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

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

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Staff comment

- L1.1.d. – The linkage group will need to unpack these activities and measurements to differentiate between (a) testing and referral to TTRA and (b) provision of TTRA services

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New WG comments

- L1.1.d. – PE Miami does not currently include a referral from field. We need to add a "referral from" field to capture who referred the client to the TTRA site.

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

Activities	Responsible Entities	Measurements
L1.1.ef. Implement the use of EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms. (RWHAP-EHE)	RWHAP-EHE and partners (i.e., FQHCs, Pharma)	**1.** # of people with HIV in the EMA who contact or are contacted by an EHE Quick Connect team. (baseline and every 4 months) **2.** # of people with HIV linked to HIV medical care in the 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

1. Linked to Care TTRA Standard: A person who tests positive will receive the following within 7 days of preliminary diagnosis:
   - **a.** Physician visit resulting in request for authorized lab test;
   - **b.** CD4/VL (minimum) and other TTRA-allowable labs, as needed; *and*
   - **c.** Provision of initial ART medication to the newly diagnosed client.

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

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

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

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Staff comment

- L2.1.a. – This flowcharting, as well as the associated designation of markers within Provide Enterprise, will need to clarify the linkage between the roles of the FDOH-MDC and the RWP in this entire L.2.1 process.

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

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

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Staff comment

- L2.2.c. The measurement specified here should either designate other payer sources or concentrate on ADAP.

WG response

- Edited as noted, above.

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

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

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

Activities	Responsible Entities	Measurements
R1.1.a. Establish early MCM lost to care trigger point warnings in Provide for high-acuity clients (60 days no MCM contact) and non-high-acuity clients (75 days no MCM contact).	RWHAP Recipient RWHAP Part A/MAI MCM subrecipients	1 # and % of RWHAP MCM clients with no contact in 60 or 75 days, by subrecipient. 2. # and % of RWHAP MCM clients with no contact in 90 days (CQM Report Card, by subrecipient) Current standard: at least 75% of MCM clients are contacted every 90 days. ~~a.~~ Target: at least 95% of MCM clients will be contacted every 90 days by 12/31/26
R1.1.b. Identify lost to care clients.	RWHAP Part A/MAI MCM subrecipients	**1.** # and % recontacted within 30 days (after 90 days no contact) **2.** # and % closed or out of jurisdiction (not eligible for re-engagement) **3.** # and % still in MDC and eligible for reengagement in RWHAP
R1.1.c. Identify lost to care clients through Data to Care Project.	FDOH DTC RWHAP Part A/MAI - MCM subrecipients	**1.** % DTC information within 30 days (after 90 days no contact) **2.** #/% closed or out of jurisdiction (not eligible for re-engagement) **3.** #/% still in MDC and eligible for reengagement in RWHAP
R1.1.d. Reengage a minimum of 75% of identified eligible clients within 30 days of contact.	RWHAP MCM subrecipients	**1.** #/% eligible clients located and re-engaged

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

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

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New WG comments

- R1.2.a. Workgroup discussed that this activity is not necessary because the Client Satisfaction Survey only gathers information from clients who are still in care or returned to care; proposed new activity.

- ***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. Ensure that MCM standards of care address protocols for addressing social determinants of health (e.g., childcare, housing, food insecurity, domestic violence, discrimination) in treatment plans and external referrals.	RWHAP ~~Part A/MAI~~ Recipient, QI contractor, Care and Treatment Committee	3. MCM service delivery manual revised by Part A/MAI Recipient and QI contractor. **1.** Annual review conducted by Care and Treatment Committee.
R1.3.c. Develop a protocol for how mental health services are introduced to clients to normalize the experience.	RWHAP ~~Part A/MAI~~	**1.** # of protocols developed. **2.** # of subrecipients documenting the application of normalizing protocols
R1.3.d. Train MCMs on protocol for addressing social determinants of health ~~(Standard of Care)~~ and ensure compliance.	RWHAP ~~Part A/MAI~~ QI contractor and training partners	**1.** # of MCMs trained on protocol each year **2.** % of clients referred each year
R1.3.e. Connect subrecipient MCMs to a community information/referral resource hub such as https://go.findhelp.com/florida.	RWHAP FDOH-MDC	**1.** # of agencies connected to resource hub

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New WG comments

- R1.3.d. Need to look at activities L2.2.a. and L2.2.b and determine whether these activities overlap or need to be consolidated in some way.
- R1.3.d. and R1.3.e. These activities require further discussion at the next meeting.

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

Objective SP1. Improve health outcomes for women with HIV.

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

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

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New WG comments

- SP1.1.c. measurement - Workgroup needs to determine the training desired and the provider of the training.

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

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

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

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

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

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

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

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

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

Notes

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

Objective SP5. Improve health outcomes for MSM with HIV.

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

Activities	Responsible Entities	Measurements
SP5.1.a. Provide LGBT cultural competency/cultural humility trainings for RWHAP and FDOH-MDC funded agencies.	FDOH-MDC's Education Team, RWHAP	**1.** # of agencies that have completed at least 1 training completed, per staff **2.** % of agencies that have conducted the trainings **3.** # of agencies providing trainings
SP5.1.b. Operationalize adherence difficulties and identify MSM clients with adherence difficulties.	RWHAP	**1.** # of clients identified
SP5.1.c. Provide services to overcome adherence barriers.	RWHAP	**1.** # of clients with suppressed viral load after receiving services to overcome barriers.
SP5.1.d. Implement support groups addressing topics of sexual/emotional health; safer sex; dating; relationships; substance use disorders; and mental health needs.	RWHAP 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.		

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Staff comment

- Staff recommends close attention to SP 3 and SP 5 population activities and measurements.

Sample Evaluation Plan

NHAS Goal 1: Prevent New HIV Infections: Prevention (P)

Evaluation Period January 1, 2023 – December 31, 2023

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	**Short Term Target 2023**	**Final Target 2026**	**Data Source ~~Collection Method~~**	**Data Collection Frequency**	**How Often is Data Available?**	**Person(s) Responsible for Gathering Data**	**Person(s) Responsible for Achieving Objectives**
Output / Outcome Measures								
1. # of providers/ practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI)	10 providers: 2021 data	20 providers: Add 10 per year	50 providers	Count by FDOH	Quarterly		Name(s), email(s)	Name(s), email(s)
2. # of private providers educated on routine testing (i.e., HIV, HCV, STI)								

EXAMPLE – NOT REAL DATA

SEE 02/14/23 Meeting Feedback, next page

Notes

Sample Evaluation Plan

Comments

Data Collection Frequency

- This may vary for each output.
- How often is data available?
- Indicate how often data is available to demonstrate why data might not be gathered as frequently for some measurements as for others.

Person(s) Responsible for Gathering Data

- Is this the person(s) who will gather the data or who will enter the data into the Quarterly Report?
- Who will have access to the VMSG database?

Person(s) Responsible for Achieving Objectives

- Since staffing can change, instead of indicating a person, indicate the organization name and the title.
- Who is the activity champion/owner?

Other

- "Internal tracking spreadsheet"
- Need to include a list of subrecipients related to each measurement
- What documents are we using to gather information?

Sample Quarterly Report

NHAS Goal 1: Prevent New HIV Infections: Prevention (P)

Evaluation Period January 1, 2023 – December 31, 2023

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.

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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**		**Results**				
	Baseline	**2023 Target**	~~Qtr. 1~~ January - March 25% of Target	~~Qtr. 2~~ April - June 50% of Target	~~Qtr. 3~~ July - September 75% of Target	~~Qtr. 4~~ October – December 100% of Target	**Annual**
Output / Outcome Measures							
1. # of providers/ practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI)	2021: 10 providers	20: Add 10 per year	13	14	14	20	20
2. # of private providers educated on routine testing (i.e., HIV, HCV, STI)	**EXAMPLE – NOT REAL DATA**						
3. # of MOUs/agreements established with partners to serve as routine healthcare testing sites							

Notes

☐ Check here if this activity is a State, Federal, or other requirement.

Revised Results Key

HOT PINK	**Win! Exceeding target**
GREEN	**On target**
YELLOW	**More than 50% of target**
RED	**Below 50% of target**
GREY	**Not yet started or not reported in this time period**