Integrated Plan Evaluation Workgroup Meeting
Miami-Dade County Main Library
101 West Flagler Street, Auditorium, Miami, FL 33130
April 11, 2023

Approved as posted, May 9, 2023

#	Members	Present	Absent		Guests	
1	Ferrer, Luigi	x			Gillens, Courtney	
2	Goldberg, David	x			Fernandez, Chad	
3	Hess, Amaris	x			Valle-Schwenk, Carla	
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		**Staff**	
12	Robinson, Joanna		x		Bontempo, Christina	
13	Sarmiento, Abril	x			Ladner, Robert	
14	Suarez, Sarah	x			Martinez, Susy	
15	Vacant				Morgan, Sima	
16	Vacant					
	Quorum = 6					

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 10:10 a.m.

II. Introductions

Attendees introduced themselves.

III. Housekeeping/Meeting Rules

Ms. Sarmiento, 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 member and Prevention Committee Vice Chair, Dr. Angela Mooss, 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: Luigi Ferrer Seconded: Sarah Suarez Motion: Passed

VI. Review/Approve Minutes of February 14, 2023

Members reviewed the minutes of February 14, 2032. Staff noted that the motion will indicate, "approved as posted," because the red-lined goals version of minutes were posted are online, not presented at the meeting.

Motion to approve the minutes of February 14, 2023 as posted.
Moved: Angela Machado Seconded: Dr. Angela Mooss Motion: Passed

VII. Standing Business

- **Officer Nominations and Elections**

Staff noted that since both officers elected for the workgroup are representatives of the Florida Department of Health, it would be more appropriate for the workgroup leaders to represent the diversity of the group. Sarah Suarez agreed to accept the nomination for Workgroup Chair, and Amaris Hess agreed to accept the nomination for Workgroup Vice Chair.

Motion to elect Sarah Suarez as Workgroup Chair, and Amaris Hess as Workgroup Vice Chair.
Moved: Angela Machado Seconded: Luigi Ferrer Motion: Passed

VIII. New Business

- **Breakout Sessions**

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

- Prevention: pages 4-17;
- Linkage: pages 18-xx; and
- Care and Treatment/Special Populations: pages xx-xx.

Prevention and Linkage groups will begin to fill in their Evaluation Plan at the next meeting. The Care and

Treatment/Special Populations group will continue review of activities at the next meeting.

Each breakout group was given a revised draft Evaluation Plan template and Progress Reporting template.

On the Evaluation Template, the "Who" category should include a person's name and contact. In order to keep the template concise, in the case of a group of providers, for instance, Ending the HIV Epidemic (EHE) providers, the template can read "EHE Providers" and the individuals and contact information can be listed separately.

On the Progress Report, several updates were suggested:

- Rename Progress Key to Quarterly Progress Key;
- Add Target # to each quarter of results
- Change "Pink" to "Blue" to provide greater contrast of the colors;
- Change Green definition to Target Met; and
- Change Yellow definition to 50% to 99% of the Target.

- **Report on Breakout Sessions**

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

- **Assignments for Next Meeting**

There were no assignments.

IX. Announcements

Staff announced Annual Needs Assessment and listening sessions; Get on Board Training; and Prevention Committee Summer meetings calendar.

X. Next Meeting

Ms. Hess announced the next meetings are Tuesday, May 9, 2023 at 10:00 a.m., and Tuesday, June 6, 2023 at 10:00 a.m., at the Miami-Dade County Main Library.

XI. Adjournment

Ms. Suarez adjourned the meeting at 12:48 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	**1.** # of providers/practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI) **2.** # of private providers educated on routine testing (i.e., HIV, HCV, STI) **3.** # of MOUs/agreements established with partners to serve as routine healthcare testing sites

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

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

Definitions

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

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

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

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

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

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

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

Notes

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

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

Activities	Responsible Entities	Measurements
P1.2.a. Increase the use of home HIV self-testing kits as an alternative option. ~~specially for hard to reach populations including youth, transgender persons, sex workers, and men who have sex with men (MSM)~~	FDOH-MDC and partners	**1.** # of ~~P~~persons r~~R~~eceiving ≥1 HIV s~~S~~elf-t~~T~~est k~~K~~its **2.** # of persons who confirmed taking the test **3.** # of persons who reported a positive test result using the self-test kit **4.** # of persons with positive test result from a self-test kit, who took a confirmatory test at FDOH-MDC and ~~partner~~ testing community partner facilities
P1.2.b. Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings. ~~(i.e., faith-based organizations, domestic violence/ human trafficking agencies)~~	FDOH-MDC and partners ~~(i.e., faith-based organizations, domestic violence/ human trafficking agencies, CBOs, universities, FQHCs, and other non-traditional partners)~~	~~**1.** # of partners identified to conduct HIV/STI testing at in non-traditional settings~~ ~~**2.** # of partners interested in conducting HIV/STI testing at non-traditional settings~~ ~~**3.** # of partners committed to conducting HIV/STI testing at non-traditional settings~~ ~~**4.**~~**1.** # of ~~partners~~ community testing partners implementing HIV/STI testing at non-traditional settings ~~**5.**~~**2.** # of persons tested for HIV at non-traditional settings ~~**6.**~~**3.** # of HIV positive persons at a non-traditional setting ~~**7.**~~**4.** # of persons tested for STI at non-traditional settings ~~**8.**~~**5.** # of persons newly diagnosed with STI at non-traditional settings ~~**9.**~~**6.** # of previously diagnosed HIV positive persons, confirmed in surveillance at non-traditional settings ~~**10.**~~**7.** # of newly diagnosed HIV positive persons
P1.2.c. Increase the number of mobile units offering HIV/STI testing in the community. (This activity overlaps with P1.2.b.)	FDOH-MDC and partners ~~(i.e., CBOs, universities, FQHCs)~~	**1.** # of operational mobile units ~~available to~~ 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 STI positive results from STI tests conducted at a mobile unit **6.** # of people linked to PrEP at a mobile unit **7.** # of people linked to HIV care at a mobile unit **8.** # of people referred for STI treatment at a mobile unit
Notes 1. Strategy aimed at reducing stigma.		

2. Reporting on self-testing is limited to self-reported feedback and may not capture all demographics.
3. Traditional partners: CBO's, FQHC's
~~1.~~4. Non-traditional partners include: faith-based organizations, domestic violence/ human trafficking agencies, universities, etc.
~~2.~~5. Non-traditional settings~~,~~ includes: ~~, but is not limited to~~ health fairs, faith-based organizations, domestic violence/ human trafficking agencies, retail stores, pharmacies, and mobile units, etc.~~.~~
~~Continued next page~~
~~3.~~6. Traditional settings: community-based orgs., testing sites, healthcare centers.
~~4.~~7. FDOH-EHE Activity: Increase the use of home HIV self-testing kits as an alternative option specially for hard-to-reach populations including youth, transgender persons, sex workers, and MSM.
~~5.~~8. AHEAD Dashboard: defines "knowledge of HIV status" as " the estimated percentage of people with HIV who have received an HIV diagnosis", and the percentages are 86.8% in 2019, and 95% in 2026 https://ahead.hiv.gov/locations/miami-dade-county

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- P1.2.b. : Abril Sarmiento and Luigi Ferrer will consult Kira Villamizar to confirm measurements.

- ***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 testing organizations~~partners~~ trained and educated on the status neutral approach ~~1.~~2. # of people 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.~~3. ~~# of agencies implementing the status neutral approach~~

Notes

1. The CDC defines status neutral approach as, "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."
2. Determining which agencies have completed status neutral approach training can be set up as a formal inquiry from the FDOH contract manager.
3. Could be part of the cycle of training to become a Certified Health Educator, or could be a part of the 501 Update training.

~~1.~~4. P1.3.a. to begin in Year 2.
~~2.~~5. Agencies may have multiple testing sites.
~~3. Agencies may have multiple testing sites.~~
~~4. P1.3.b. to begin in Year 3.~~
~~5. P1.3.b. Agencies may have multiple testing sites.~~

- ***Strategy P1.4.*** *Provide Disease Intervention Specialist (DIS) partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.*

Activities	Responsible Entities	Measurements
P1.4.a. Educate community testing partners on ~~CBOs, FQHCs, and private providers on~~ availability and importance of~~le~~ partner services.	FDOH-MDC and partners	~~1. # of CBO's educated on partner services~~ ~~2. # of FQHCs educated on partner services~~ ~~3. # of private providers educated on partner services~~ 1. # of organizations with HIV 501 certification ~~4. % of all named, notifiable partners identified through HIV partner services~~
P1.4.b. Partner with RWHAP and CBOs to educate ~~patients~~ clients about the importance of partner services.	FDOH-MDC and partners	Confirm the Federal language (also, #4, above) **1.** # and % of notifiable partners identified through HIV partner services 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
~~**P1.4.c.** Establish private/public partnerships to offer partner services.~~	~~FDOH-MDC and partners~~	**1.** ~~# of public/private partnership established~~

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

- ***Strategy P2.1.*** *Increase awareness ~~of~~ 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).*

Activities	Responsible Entities	Measurements
P2.1.a. Conduct educational sessions ~~on Florida Statute 64D-3.04 and Perinatal HIV Prevention protocols~~ with medical professionals and agencies that provide care and treatment to women of childbearing age, and pregnant women with HIV and their exposed or HIV positive newborns.	FDOH-MDC and partners	1. # of educational sessions conducted ~~with medical care providers~~ ~~1.~~2. # of persons trained ~~2. # of educational sessions conducted with agencies~~
P2.1.b. Partner with the FDOH-MDC's Academic Detailing Program (ADP) to include Perinatal HIV Prevention and Opt-Out HIV/STI testing of pregnant women in their education sessions. ~~and through the Test Miami Providers' Corner link.~~	FDOH-MDC ADP and partners	~~1.~~ # of educational sessions conducted ~~with medical care providers conducted by FDOH-MDC ADP~~ 1. ~~# of updates added to the Test Miami Providers' Corner link~~ 2. # of persons trained
P2.1.c. Conduct educational sessions ~~Educate~~ with hospitals, including emergency rooms and high-risk delivery hospitals, and urgent care centers. ~~on Opt-Out HIV/STI testing of pregnant women according to the Florida Statute 64D-3.04, and the importance of submitting the High-Risk Notification Form to the Miami-Dade Perinatal HIV Prevention Program.~~	FDOH-MDC and partners	1. # of educational sessions conducted with hospitals ~~1.~~2. # of educational sessions conducted with urgent care centers 3. # of High-Risk Notification Forms and/or notifications of pregnant women with HIV received ~~from hospitals~~ ~~2.~~4. # of Newborn Exposure Notification Forms received
~~**P2.1.d.** Conduct educational rounds with emergency rooms, urgent care centers, and classified high-risk delivery hospitals, to increase provider awareness of their responsibility to utilize the Labor/Delivery/Emergency Department Perinatal Prevention Protocols, High Risk Pregnancy Notification, and Newborn Exposure Notification forms.~~	~~FDOH-MDC and partners~~	~~1. # of educational sessions conducted to hospitals (i.e., ERs), and urgent care centers~~ ~~2. # of High Risk Pregnancy Notification Forms received from hospitals (see P2.1.c. above)~~ ~~3. # of Newborn Exposure Notification Forms received from hospitals~~

- ***Strategy P2.2.*** *Increase awareness among women with HIV who are of of childbearing age about HIV testing, prevention, mother to child transmission, prenatal care, and postpartum care, and /family planning services.*

Activities	Responsible Entities	Measurements
P2.2.a. ProvideLink pregnant women with HIV linkage to HIV care and prenatal care. and HIV care for pregnant women with HIV.	FDOH-MDC and partners	**1.** # of pregnant women with HIV positive pregnant women who received HIV care **2.** # of pregnant women with HIV positive pregnant women who received prenatal care
P2.2.b. Provide follow-up medical and family planning services for post-partum women with HIV.	FDOH-MDC and partners RWHAP Part D	**1.** # of post-partum women with HIV who received family planning services 1.**2.** # of women with HIV who received post-partum care
Notes 1. Prenatal care/services are defined as:		

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- Ask Queen Holden to review measurements.

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.*

Activities	Responsible Entities	Measurements
P3.1.~~b~~a. Train peer educators and community health workers to promote the ~~Ready, Set,~~ PrEP ~~(RSP)~~ initiatives ~~to implement~~through direct community outreach.	FDOH-MDC and partners (i.e., Peer educators and community health workers)	**1.** # of educational sessions conducted **2.** # of ~~RSP~~ PrEP training sessions conducted **3.** # of ~~RSP~~ PrEP educational materials distributed
P3.1.~~e~~b. Utilize FDOH-MDC ADP to engage and educate health care providers on PrEP to increase the number of PrEP prescribers.	FDOH-MDC ADP and partners [i.e., AIDS Education and Training Center (AETC), Gilead, HIP providers, FDOH-MDC private providers, FQHCs, pharmacies, CBOs]	**1.** # of educational sessions conducted specifically to health care providers **2.** # of providers recruited[1] to provide PrEP services **3.** # of PrEP prescribers[2]
P3.1.~~e~~c. Identify and share best practices by agencies that have utilized TelePrEP to expand providers' capacity of offering TelePrEP services.	FDOH-MDC and partners (i.e., Pharmaceuticals, CBOs, retail pharmacy chains, medical providers, ERs, urgent care centers, clinics, testing sites)	**1.** # of providers offering TelePrEP services **2.** # of persons who received4 TelePrEP services
P3.1.~~f~~d. ~~Create a PrEP referral network for clients to access PrEP services.~~ Promote PrEP Locator (www.preplocator.org/) and AIDSVu (www. aidsvu.org) to access PrEP services	FDOH-MDC and partners	**1.** # ~~clients~~ people ~~accessing~~ referred to PrEP Locator and AIDSu.~~the PrEP referral network~~
P3.1.~~d~~e. Disseminate an updated comprehensive list of PrEP providers to share with community partners.	FDOH-MDC and partners (i.e., Pharmaceuticals, CBOs, retail pharmacy chains, medical providers, ERs, urgent care centers, clinics, testing sites)	**1.** # of organizations with access[3] to the comprehensive list
P3.1.~~a.~~f Increase PrEP access by expanding the number of partners offering PrEP services.	FDOH-MDC and partners (i.e., CBOs, FQHCs, agencies)	**1.** # of HIV-negative persons **2.** # of access points for PrEP **3.** # of individuals screened for PrEP **4.** # of individuals eligible for PrEP **5.** # of individuals referred to a PrEP provider **6.** # of individuals linked to a PrEP provider **7.** # of individuals prescribed PrEP
P3.1.g. Increase the number of non-traditional partners offering PrEP (i.e., pharmacies, urgent care centers).	FDOH-MDC and non-traditional partners such as pharmacies, urgent care centers.	**1.** # of pharmacy clinics providing PrEP (MinuteClinic at CVS, and UHealth at Walgreens) **2.** # of urgent care centers providing PrEP **3.** # of hospitals providing PrEP
Definitions [1] **Providers recruited:** Providers that signed the FDOH-MDC acknowledgement agreement to provide PrEP services.		

[2] **PrEP prescribers:** Providers prescribing PrEP, including providers registered with FDOH-MDC and prescribers who do not want to register. Complete data is unavailable.
[3] **Organizations with access to the comprehensive list of PrEP prescribers:** Healthcare facilities for which a list was provided, and/or are aware of the PrEPlocator.org website.
[4] **Persons who received TelePrEP services:** An outcome of the referral or linkage of a PrEP eligible person to a PrEP provider, indicated by attendance at the first telehealth appointment and verified through reviews of medical records or other data systems or self-report by the client. Denominator is number of persons who received PrEP services.

Notes

1. PrEP (Pre-Exposure Prophylaxis) is a comprehensive HIV prevention strategy that involves the daily use of antiretroviral medications to reduce the risk of HIV infection in HIV-negative individuals.
~~1.~~2. Regarding "# of pharmacy clinics providing PrEP," data sources include aidsvu.org/services/#/prep and preplocator.org/, which indicate locations but not necessarily pharmacy clinics.
~~2.~~3. PrEP services: Help navigating through the system, i.e., the application process.
~~3.~~4. Objective data: from AHEAD Dashboard which displays goals of 29.9% in 2019, and 50% for 2026 https://ahead.hiv.gov/locations/miami-dade-county.

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

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

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

Notes

1. nPEP (Non-occupational Post-Exposure Prophylaxis) is short-term treatment started as soon as possible after high-risk non-occupational exposure to an infectious agent, such as HIV, hepatitis B virus (HBV), or hepatitis C virus (HCV).

~~1.~~2. Some agencies only screen for nPEP, others refer and/or provide nPEP.

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

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

Activities	Responsible Entities	Measurements
P5.1.a. Increase the number of condom distribution sites across the jurisdiction.	FDOH-MDC and partners	**1.** # of condoms distributed by Zip Code (report using Zip Code map) **2.** # of Business Responds to AIDS (BRTA) sites.
Notes **1.** 2021 baseline of condoms distributed and 2026 target are pending further data collection.		

February 2023

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

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

Activities	Responsible Entities	Measurements
P6.1.a. Educate and refer high-risk individuals to local SSP.	FDOH-MDC, IDEA Exchange, and partners	**1.** # of persons linked to IDEA Exchange (see Note #3) **2.** # of referrals made to IDEA Exchange, by partners
P6.1.b. Utilize social media platforms to promote services offered by SSP.	FDOH-MDC, IDEA Exchange, and partners	**1.** # of social media posts by IDEA Exchange (Facebook, Instagram and Twitter)
Notes **1.** As of July 2022, one RWHAP MAI subrecipient is using IDEA Exchange as an access point to its MAI HIV services. **2.** IDEA Exchange provides an annual report to FDOH-Tallahassee. **3.** Basic enrollment is anonymous so it would be difficult to know if a person who was referred by a local agency was enrolled at IDEA.		

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

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

Activities	Responsible Entities	Measurements
P7.1.a. Build innovative media campaigns, i.e., billboards, TV/radio, social media, to highlight the importance of knowing your status, getting into care, addressing stigma, HIV prevention and care.	FDOH-MDC and partners	**1.** # of overall impressions[2] [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
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)

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

Activities	Responsible Entities	Measurements
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.	FDOH-MDC and partners RWHAP-EHE	**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
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 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, etc.) FDOH-EHE	**1.** # of new testing sites serving vulnerable population **2.** # of clients enrolled in TTRA services
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.	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.c. Educate private providers during the academic detailing visits on the benefits of TTRA.	FDOH-MDC, 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	**1.** # of academic detailing visits to private providers **2.** # of private providers committed to link clients to TTRA services ~~**3.**~~ #

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Strategy L1.1. *continued.*

Activities	Responsible Entities	Measurements
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.	FDOH-MDC 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 from hospitals or urgent care centers (this would include programming in PE Miami to add a "referral from" field.) 2. # of hospitals and urgent care centers that have established a process to connect clients to TTRA services ~~2.~~
L1.1.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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- ***Strategy L1.1.*** *continued.*

Activities	Responsible Entities	Measurements
L1.1.f. 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.		

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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.

- 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.

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

---

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.~~ Track the 30 day linkage for medical care for clients with a preliminary HIV test result among the C&T sites.	~~RWHAP Part A,~~ FDOH-MDC ~~,~~ and partners	~~1. Flowchart linkage process, and determine gaps and dropout-risk points within the process.~~ 1. ~~# of persons with HIV dropping out of linkage process at each of the dropout-risk points~~ # of positive HIV tests 2. # of persons with HIV who did not complete the medical visit within 30 days from the preliminary test result.
L2.1.b. ~~Improve the processes for linking eligible newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.~~ Identify the C&T sites with lower than the average linkage rates.	~~RWHAP Part A,~~ FDOH-MDC, 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.~~ 1. ~~Develop QI modifications in linkage process based on data generated under L.2.1.a, above, and document same~~ 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 ~~3.~~
L2.1.c. Measure the success of the selected C&T site's quality improvement projects. ~~improved process linking eligible newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.~~	~~RWHAP Part A,~~ FDOH-MDC, and partners	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. ~~1.~~ Repeat the QI cycle for C&T sites that did not meet the 5% increase or continue performing below the average linkage percentage. ~~# 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~~

		3. ~~1. Repeat QI cycle as needed to achieve minimum of 90% of eligible clients linked within 30 days~~ ~~2. 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.~~ The C&T sites with QI projects will adopt the identified "change idea" at their site.	~~RWHAP Part A,~~ FDOH-MDC, and partners	1. # of C&T sites who adopted the QI project "change idea"~~# 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.~~The C&T sites will present their QI projects to other C&T sites to share best practices to replicate.	~~RWHAP Part A, Part B,~~ FDOH-MDC and partners	1. # of C&T site attendees who participated in meetings/training on best practices ~~1. of initial trainings in the revised protocol conducted at testing/linkage sites~~ 2. # of ~~refresher~~ meetings/~~trainings~~ training conducted each year

~~**February 2023**~~

~~**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.)*

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, RWHAP-Part A and partners	~~1. Current processes across service providers reviewed~~ 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 ~~3.~~
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~~The mental health visit may be in-person ~~meeting, setting up the first appointment time together or at the very minimum a three-way phone call.~~or virtual (tele mental health).	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.** # of ~~P~~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 within 14 days of diagnosis

February 2023

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 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.~~Identify first-stage lost to care clients through Outreach and re-engage.~~	RWHAP Part A/MAI MCM Outreach subrecipients	**1.** # and % with contact attempted by RWHAP Outreach personnel within 30 days of receiving referral from MCM (see #3, above) **2.** # and % of clients in #1 whose cases may be closed by the MCM (left RWP, moved from MDC). **3.** # and % of clients in #1 with MDC contact info and eligible for reengagement by MCM. ~~3.~~**4.** # and % of eligible clients located and re-engaged initial Outreach follow-up
~~**R1.1.c.** Identify second-stage lost to care clients through FDOH Data to Care Project.~~	~~FDOH DTC~~ ~~RWHAP Part A/MAI MCM subrecipients~~	~~1. # and % of clients in #4~~5 ~~referred to FDOH DTC, with data received by Outreach within 30 days of referral.~~

		2. # and % of clients determined by DTC as not eligible for re-engagement and may be closed by MCM 3. # and % of clients determined by DTC as still in MDC and eligible for reengagement by MCM 4.1. # and % of clients in #1 with no data generated by DTC.
R1.1.d. Reengage a minimum of 75% of identified eligible clients by MCMs within 30 days of report of client eligibility by Outreach worker.	RWHAP MCM subrecipients	**1.** # and % of eligible clients located and re-engaged after initial Outreach follow-up (R1.1.b) and post DTC follow-up to Outreach.

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: References to Data to Care as the entity in FDOH that is following up with un-locatable clients need to be confirmed with FDOH.

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, ~~RWHAP~~ Staff Support ~~QI~~ 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/ QI contractor and training partners	**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).
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, ~~RWHAP~~ Staff Support ~~QI~~ contractor, Care and Treatment Committee	1. Peer service delivery manual revised by Part A/MAI Recipient and Staff Support~~QI~~ contractor. 2. 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 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~~	~~RWHAP Part A/MAI Recipient, Care and Treatment Committee, QI contractor and training partners~~	~~# of advanced certification areas approved by Recipient~~ ~~# of certification trainings conducted by QI contractor or partners, by close of 2023 and annually~~ ~~# of peers trained and certified by close of 2023 and annually~~ ~~% of clients with documented peer contact with certified and uncertified peers, retained in care and with suppressed VLs (2023 baseline, 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 ~~Ensure that~~ 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, ~~QI contractor,~~ Care and Treatment Committee	1. MCM service delivery manual revised by Part A/MAI Recipient ~~and QI contractor~~. **1.** Annual review conducted by Care and Treatment Committee.
R1.3.b.1~~c~~. 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. ~~d.~~ Train MCMs on protocol for addressing social determinants of health and ensure compliance.	RWHAP Recipient, Care and Treatment Committee ~~QI contractor and training partners~~	**1.** # of MCMs trained on protocol each year **2.** % of clients referred each year
R1.3.b.3. ~~e.~~ Identify a Miami-Dade community information resource hub to serve as an MCM resource for whole-client referrals ~~Connect subrecipient MCMs to a community information/referral resource hub such as https://go.findhelp.com/florida.~~	RWHAP Care and Treatment Committee FDOH-MDC	**1.** # of resource hubs identified and approved by RWHAP Care and Treatment Cmte, and FDOH-MDC ~~1.~~**2.** # of MCM agencies committed to using (and connected to) resource hub(s)

~~**February 2023**~~

~~**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 Forfor 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)frequency of messaging
SP1.1.b. Expand interface between community childcare programs and RWHAP to help women stay in care.	RWHAP and partners FDOH-MDCRWHAP-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, eEducate/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 ~~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 interviews conducted with clients over 50 years of age during special-emphasis client satisfaction needs assessment survey in FY 2023 ~~1.~~2. # focus groups, listening sessions or other fast-track projects supported by RWHAP ~~2.~~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. ~~dealing with isolation, loneliness, depression, problems with adult children, more expenses and less money, and polypharmacy issues.~~	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~~Help~~ older persons with HIV in the process of transitioning medical services from RWHAP to Medicare~~/Medicaid~~.	RWHAP Recipient	1. Protocol created and approved by the Recipient ~~1.~~2. # and % of RWHAP MCMs trained in assisting clients over 60 with transitioning to Medicare ~~2.~~3. # and % of RWHAP clients 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 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. 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. Conduct basic and annual trainings to RWHAP subrecipient's and FDOH-MDC provider's front-line and medical staff on transgender persons.~~**SP3.1.a.** Provide basic and annual LGBTQ cultural competency/cultural humility trainings for RWHAP subrecipients and FDOH-MDC providers.~~	FDOH-MDC, RWHAP~~FDOH-MDC, RWHAP SF-SEAETC~~	**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 ~~**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 subrecipient~~s~~ 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.c~~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.*

<table>
<tr><th>Activities</th><th>Responsible Entities</th><th>Measurements</th></tr>
<tr><td>SP4.1.a. Reorganize the Partnership’s Housing Committee to identify and administrate housing assistance beyond HOPWA.</td><td>Partnership
RWHAP
MDC Emergency Rental Assistance Program (ERAP)</td><td>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</td></tr>
<tr><td>SP4.1.b. Review RWHAP MCM protocols for identifying housing needs and connecting homeless or unstably housed to secure housing and support services.</td><td>RWHAP</td><td>See Notes</td></tr>
<tr><td colspan="3">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.</td></tr>
</table>

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.		

February 2023

Staff comment

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

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

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

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

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

Objective S1. Reduce HIV-related stigma and discrimination.

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

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

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

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

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

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

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

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

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

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

NHAS GOAL 3
REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES
Disparities in Viral Load Suppression Rates and 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. Annually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males.	RWHAP	**1.** Annual measurement of VL suppression rates for B/AA males, by subrecipient service site providing OAHS and/or MCM services to this target population **2.** Annual # and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population
DV1.1.b. Annually document and disseminate best practices for VL suppression for B/AA males among OAHS and MCM providers with top-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership
DV1.1.c. Annually conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for B/AA males among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.	RWHAP MCM and OAHS subrecipients	**1.** # of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership

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

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

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

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

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

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

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

Activities	Responsible Entities	Measurements
IPC1.1.a. Identify community stakeholders to broaden the base of Integrated Plan implementation and referrals for client needs.	FDOH-MDC RWHAP	**1.** By close of Year 1, establish working Integrated Plan Evaluation Workgroup to engage community stakeholders in planning and evaluating IP services
IPC1.1.b. Develop schedule for regular communication with stakeholders.	FDOH-MDC RWHAP	**1.** Progress report on scheduling
IPC1.1.c. Develop plan among stakeholders for addressing HIV outbreaks.	RWHAP	**1.** Progress report on plan
IPC1.1.d. Coordinate data sharing between RWHAP Parts A, B, D, F; General Revenue (GR); and ADAP; and between the RWHAP and Medicaid.	RWHAP Parts A, B, D, F; GR; ADAP; Medicaid.	**1.** Progress report on data sharing agreements
Notes **1.** A comprehensive list of actual contacts and a commitment from each stakeholder is needed. **2.** Need to account for all Zip Codes to ensure outbreak teams can be mobilized in any location. **3.** Suggested stakeholders include: ▪ Police departments/first responders; ▪ Celebrity/social media personalities; ▪ Domestic violence prevention organizations; and ▪ Business Respond to AIDS (BRTA) organizations.		