MIAMI-DADE
HIV/AIDS PARTNERSHIP

WELCOME

Thank you for attending today's

Joint Integrated Plan Review Team Meeting

Please sign in to have your attendance recorded.

Please take a seat at one of the four Breakout Group tables.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Strategic Planning Committee and Prevention Committee Joint Integrated Plan Review Team Meeting

Tuesday, January 21, 2025

10:00 AM – 1:00 PM

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

AGENDA

I.	Call to Order	Virginia Muñoz
II.	Introductions	All
III.	Housekeeping	Dr. Diana Sheehan
IV.	Floor Open to the Public	Tajma Darlington
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 23, 2024	All
VII.	Reports (*posted on www.aidsnet.org*)	Staff

- Membership
- Partnership

VIII.	Standing Business	Staff

- Prevention Committee Business
- Strategic Planning Committee Business
  - Officer Nominations and Elections Schedule

IX.	New Business	All

- *Miami-Dade County 2027-2031 Integrated HIV Prevention & Care Plan*
  - Plan Guidance and Expectations for Plan Development
- *Miami-Dade County 2022-2026 Integrated HIV Prevention & Care Plan*
  Breakout Groups – Updates and Discussion (45-60 minutes)
  1. Prevention: HIV Testing; and Women, Infants, and Youth
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  4. Care: Disparities in Retention in Care and Disparities in Viral Load Suppression Rates Among Priority Populations
- Breakouts Recap (15 minutes)
- 2025 JIPRT Meeting Schedule and Next Steps

X.	Announcements and Open Discussion	All
XI.	Next Meeting Dates	Tajma Darlington

- February 14, 2025: Strategic Planning Committee at BSR
- February 27, 2025: Prevention Committee at FDOH Health District Center

XII.	Adjournment	Virginia Muñoz

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Meeting Housekeeping Joint Integrated Plan Review Team

Updated January 20, 2025

Behavioral Science Research

MIAMI-DADE HIV/AIDS PARTNERSHIP

BEHAVIORAL SCIENCE RESEARCH

Disclaimer & Code of Conduct

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

General Housekeeping

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

Language Matters!

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

Remember **People First** Language . . .

People with HIV, ***People*** with substance use disorders, ***People*** who are experiencing homelessness, etc.

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

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

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

About the Partnership

- The Miami-Dade HIV/AIDS Partnership is the official Ryan White Program **Planning Council** for Miami-Dade County.
- There Partnership is comprised of 6 Standing Committees and 1 Subcommittee.
- The Joint Integrated Plan Review Team (JIPRT) is comprised of members of the Partnership's Prevention Committee and Strategic Planning Committee.
- All Partnership and Standing Committee/Subcommittee members are volunteers and commit to abiding by the Partnership's Bylaws, including regular meeting attendance and completion of required training and paperwork.
- See staff after the meeting for additional details.

Meeting Participation

Everyone has a role to play!

- All attendees may address the board as time allows and at the discretion of the Chair.
- Please *share your expertise* on the current Agenda topics and motions. Remember to . . .
  - Raise your hand to be recognized by the Chair or added to the queue during discussions.
  - Avoid repeating points previously addressed.

Meeting Terminology

Meetings can be fast-paced and confusing!

- ❑ Terms and acronyms you might hear at today's meeting are included in your Breakout Group handouts.
- ❑ Please ask if you need more information!

Resources

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

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Floor Open to the Public

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

BSR has a dedicated line for statements to be read into the record.

(No statements were received.)

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Strategic Planning Committee and Prevention Committee
Joint Integrated Plan Review Team (JIPRT) Meeting
Miami-Dade County Main Library
101 West Flagler Street, Auditorium, Miami, FL 33130
July 23, 2024 Minutes

#	Members	Present	Absent
1	Bethel, Shakka		x
2	Buch, Juan	x	
3	Cardwell, Joanna		x
4	Darlington, Tajma	x	
5	Duberli, Francesco		x
6	Fernandez, Chad		x
7	Forrest, David	x	
8	Hunter, Tabitha	x	
9	Ichite, Amanda		x
10	Johnston, Jeremy		x
11	Ledain, Ron		x
12	Lopez, Crystal		x
13	Machado, Angela	x	
14	Marcelin, Dora	x	
15	Marqués, Jamie		x
16	Muñoz, Virginia	x	
17	Orozco, Eddie		x
18	Pereira, Daniel		x
19	Pierre, Ross	x	
20	Poblete, Karen	x	
21	Santiago, Grechen	x	
22	Sheehan, Diana M.		x
23	Shmuels, Diego		x
24	Singh, Hardeep	x	
25	Stonestreet, Stephanie	x	
26	Vertovec, Jack		x
Quorum = 10			

Guests
Adan, David
Carballo, Jorge
Castellano, Dennys
Coello, Erika
Edwards, Shawneaqua
Ferrer, Luigi
Gonzalez, Nilda
Holden, Queen E.
Jackie *(Care Resource)*
Jordahl, Lori
Lowe, Camille
Luna, Victor
Saxena, Praveena
Shapiro, Juliana
Thomas, Andrew
Valle-Schwenk, Carla
Villamizar, Kira
Williams, Stephen
Staff
Bontempo, Christina
Gattorno, Frank
Hilton, Karen
Ladner, Robert
Sergi, Sandra

Note: All documents referenced in these minutes were accessible to members and the public prior to and during the meeting, at www.aidsnet.org/the-partnership/. The meeting agenda and other working documents were distributed to all attendees; members also received committee-specific documents, such as the draft minutes. All meeting documents were projected on the meeting room projection screen, as needed.

I. Call to Order

Strategic Planning Committee Chair, Angela Machado, called the meeting to order at 10:25 a.m.

II. Introductions

Members, guests, and staff introduced themselves.

III. Housekeeping

Prevention Committee Chair, Virginia Muñoz, directed attendees to review the Housekeeping presentation in the meeting packets. She noted that the meeting is being recorded and that Behavioral Science Research (BSR) staff are the resource persons.

IV. Floor Open to the Public

Prevention Committee Vice Chair, Tajma Darlington, 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

Members reviewed the agenda and there were no changes. Ms. Machado called for a motion to approve the agenda.

Motion to approve the agenda as presented.
Moved: Juan Buch **Seconded: Grechen Santiago** **Motion: Passed**

VI. Review/Approve Minutes of February 13, 2024

Members reviewed the minutes of February 13, 2024, and there were no changes. Ms. Machado called for a motion to approve the minutes.

Motion to approve the minutes of February 13, 2024.
Moved: Tabitha Hunter **Seconded: Hardeep Singh** **Motion: Passed**

VII. Reports

- **Membership**

  Staff announced that the Mayor of Miami-Dade County appointed six new members to the Partnership including three members of the affected community. Attendees congratulated new members Nilda Gonzalez and Virginia Muñoz on their appointments. Staff noted that Ms. Gonzalez is taking the Partnership seat of Tabitha Hunter, who has reached her term limit. Members thanked Ms. Hunter for her years of service.

- **Partnership**

  Staff announced the next Partnership meeting is scheduled for August 19, 2024, and members were asked to RSVP as soon as possible to ensure quorum.

VIII. Standing Business

- **Prevention Committee Business**

Ms. Muñoz announced that the next Prevention Committee meeting is August 29. The focus of the meeting will be prevention efforts geared towards youth including review of Integrated Plan activities directed at youth. Anyone who has suggestions for guest speakers on this subject is asked to contact BSR staff.

- **Strategic Planning Committee Business**

Ms. Machado announced the next Strategic Planning Committee meeting is August 9 at BSR. Members will review the draft Annual Report and the draft Assessment of Administrative Mechanism report.

- **VMSG Database Update**

Staff announced that all the Integrated Plan activities have been loaded into the VMSG database. BSR and Florida Department of Health in Miami-Dade County staff will be working together in the coming weeks to enter data for future reporting.

IX. New Business

- ***Miami-Dade County 2022-2026 Integrated HIV Prevention & Care Plan* Breakout Groups**

All attendees were seated in one of four Breakout Groups:

1. Prevention: Know Your Status; and Women, Infants, and Youth;
2. Prevention: PrEP (Pre-Exposure Prophylaxis); Advertising; Condoms; and Syringe Services Program;
3. Care: Linkage to Care; Retention in Care; and Special Populations; or
4. Care: Disparities in Retention in Care and Disparities in Viral Load Suppression Rates Among Priority Populations.

Each group held introductions and designated a person to report back to the full meeting. Groups then reviewed their data sheets, including targets, progress toward targets, challenges to achieving targets, recommendations for improved outcomes, and successes.

- ***Breakouts Recap***

Following discussions, each group's spokesperson reported overall impressions to the full meeting:

1. **Prevention: Know Your Status; and Women, Infants, and Youth**; reported by Grechen Santiago.
   - In order to capture more accurate data, a resource inventory of all agencies is needed.
   - Many of the targets seem arbitrary and should be reconsidered, particularly based on the baselines and data points presented from December 2023.
   - A clear definition of non-traditional testing settings is needed to distinguish those settings from mobile testing units.
   - Outcome targets for women of childbearing age and pregnant women will be reconfigured as percentages instead of hard numbers since there is no way to know how many women of childbearing age and pregnant women the program will encounter.

2. **Prevention: PrEP; Advertising; Condoms; and Syringe Services Program**; reported by Erica Coello.
   - Targets for the number of persons educated on PrEP should be revisited and all targets and data sources should be reviewed; many targets need to be adjusted to reflect realistic outcomes.
   - Some activities are not inclusive of Ending the HIV Epidemic data and should be expanded to include all available data sources. Data collection should be inclusive of activities by ViiV, Gilead (FOCUS), and PrEP Connect. As much as possible, all data sources in the County should be included, such as those from hospitals and other PrEP distribution sites; this is an ongoing challenge.
   - Measurements should also include nPEP (Non-occupational Post-Exposure Prophylaxis) access and reference the PrEP Locator tool.
   - The condom distribution target has been surpassed and should be increased by 2% annually.

3. **Care: Linkage to Care; Retention in Care; and Special Populations;** reported by Frank Gattorno.
   - Ending the HIV Epidemic (EHE) brochures should be evaluated to determine if additional language versions are needed; QR codes should be added as another point of access.
   - EHE implementation is not as far along as it could be. EHE implementation dates are different from the Integrated Plan dates and should be reviewed to align them with the Plan.
   - The outcome of "in care" through EHE should be defined. The Ryan White Program (RWP) standards of care have a complete definition of Retained in Medical Care (RiMC) which might be applicable to EHE activities.
   - How transient populations impact RWP RiMC rates should be considered.
   - Viral suppression outcomes for people with HIV over 50 years old are good; however, there may be opportunities for RiMC Quality Improvement (QI) projects at some agencies for this population.
   - Due to the continued positive viral load suppression rates for the special population: Men Who Have Sex with Men (MSM) with co-occurring sexually transmitted infections, the group questioned if this population needs to continue to be tracked as a population of concern.

4. **Care: Disparities in Retention in Care and Disparities in Viral Load Suppression Rates Among Priority Populations;** reported by Dr. Robert Ladner.
   - RiMC targets are being met for Hispanic MSM in RWP care.
   - Viral load suppression targets are being met for Black/African-America and Hispanic males in RWP care.
   - The group discussed the challenges of developing QI projects, specifically to address trauma-informed care.
   - Hispanic MSM face unique barriers to care which need to be considered in possible QI projects, specifically language barriers and overcoming fears about immigration status.
   - Determining how stigma impacts viral load suppression among Haitian men and women is another possible QI project.

- ***2025 JIPRT Meeting Schedule and Next Steps***

Ms. Muñoz announced that the next Joint Integrated Plan Review Team (JIPRT) meeting will be in January 2025. In the meantime, BSR and the Florida Department of Health in Miami-Dade County (FDOH-MDC) will be working together to populate the VMSG database. In 2025, JIPRT meetings will be held quarterly in January, April, July, and October. Strategic Planning and Prevention committee members were reminded that the JIPRT meetings replace the regular monthly meeting. Specific dates will be announced later this year.

X. Announcements

There were no announcements.

XI. Next Meeting

Mr. Darlington announced the next meeting dates as:

- August 9, 2024: Strategic Planning Committee at BSR; and
- August 29, 2024: Prevention Committee at the Miami-Dade County Main Library.

XII. Adjournment

Ms. Muñoz called the meeting adjourned at 12:29 p.m.

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

January 3, 2025

The Miami-Dade HIV/AIDS Partnership

The official Ryan White Program Planning Council in Miami-Dade County and the Advisory Board for HIV/AIDS to the Miami-Dade County Mayor and Board of County Commissioners.

Opportunities for Ryan White Program Clients

5 *seats are available to Ryan White Program Clients who are not affiliated or employed by a Ryan White Program Part A funded service provider.*

Opportunities for General Membership

7 *seats are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the relevant knowledge, skills and expertise in these membership categories:*

Hospital or Health Care Planning Agency Representative
Mental Health Provider Representative
Housing, Homeless or Social Service Provider
Other Federal HIV Program Grantee Representative (Part F)
Other Federal HIV Program Grantee Representative (SAMHSA)
Non-Ryan White Program Miami-Dade County Representative
Part D Grantee Representative

Are you a Member?

Thank you for your service to people with HIV!
Be sure to bring a Ryan White client to your next meeting!

Do You Qualify for Membership?

If you answer "Yes" to these questions, you could qualify for membership!

Are you a resident of Miami-Dade County?

Are you a registered voter in Miami-Dade County?
Note: Some seats for people with HIV are exempt from this requirement.

Can you volunteer three to five hours per month for Partnership activities?

Get Started Today!
Scan the QR Code or contact
mdcpartnership@behavioralscience.com.

when you say Yes! good things happen.

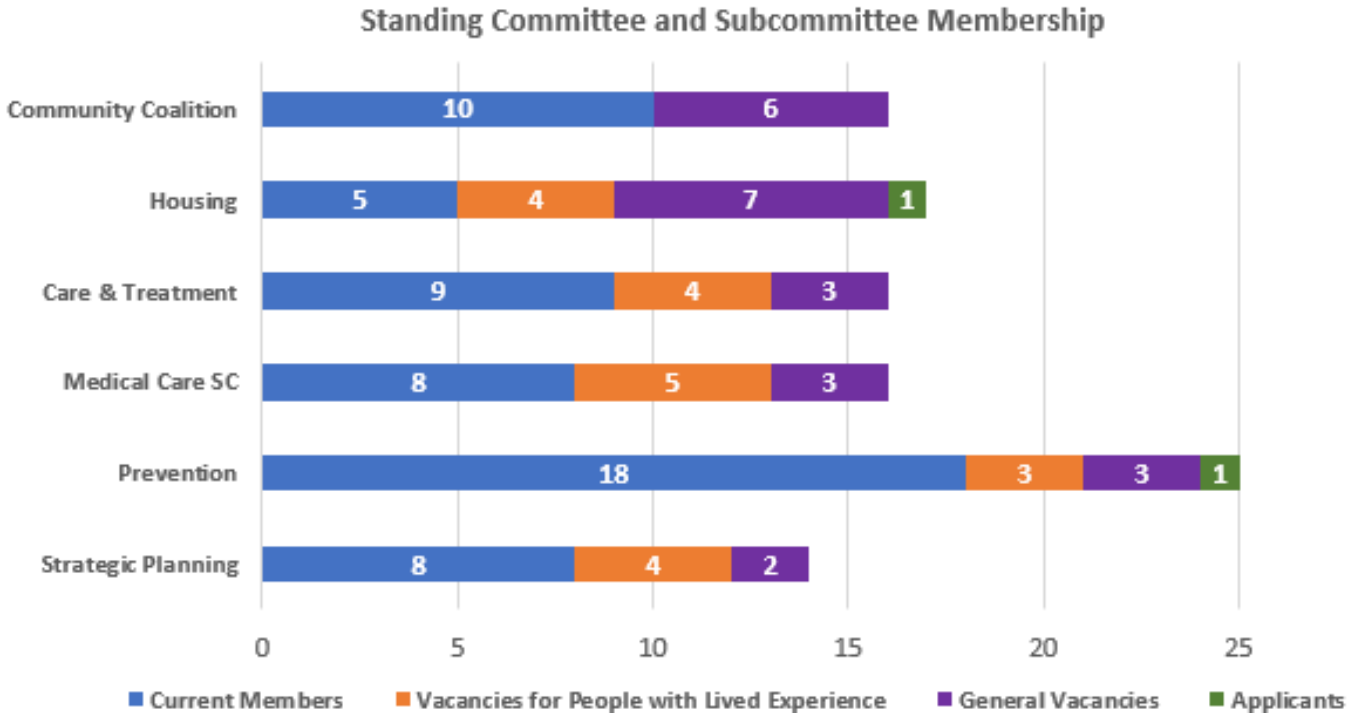
MEMBERSHIP

Committees

Work with a dedicated team of volunteers on these and more Partnership activities to better serve people with HIV in Miami-Dade County!
People with HIV are encouraged to join!

- Allocate more than $27 million in Ryan White Program funds with the **Care and Treatment Committee**
- Develop an Annual Report on the State of HIV and the Ryan White Program in Miami-Dade County with the **Strategic Planning Committee**
- Recruit and train new Partnership members with the **Community Coalition**
- Work with the City of Miami Housing Opportunities for Persons with AIDS Program to address housing challenges for people with HIV/AIDS with the **Housing Committee**
- Oversee updates and changes to medical treatment guidelines for the Ryan White Part/ MAI Program with the **Medical Care Subcommittee**
- Set priorities for Ryan White Program HIV health and support services in Miami-Dade County with the **Care and Treatment Committee**
- Share a meal and testimonials at Roundtables with the **Community Coalition**
- Develop and monitor the official HIV Prevention and Care Integrated Plan with the **Strategic Planning Committee** & **Prevention Committee**
- Develop your leadership skills and be a committee leader with the **Executive Committee**
- Oversee updates and changes to the Ryan White Prescription Drug Formulary with the **Medical Care Subcommittee**
- Develop and monitor local Ending the HIV Epidemic activities with the Florida Department of Health in Miami-Dade County with the **Prevention Committee** & **Strategic Planning Committee**
- Be in the know about the latest HIV activities of the Prevention Mobilization Workgroups with the **Prevention Committee**

Visit www.aidsnet.org/the-partnership/ for the complete list of applications and details on Partnership and committee membership opportunities. Contact us at mdcpartnerhsip@behavioralscience.com or 305-445-1076 for assistance.



MIAMI-DADE HIV/AIDS PARTNERSHIP

Partnership Report to Committees and Subcommittee
January 7, 2025 Meeting

Supporting documents related to motions in this report are available at www.aidsnet.org/the-partnership#partnership1, or from Behavioral Science Research Corporation (BSR) staff.

For more information, please contact mcdpartnership@behavioralscience.com.

Members heard regular reports and approved the following motions:

Executive Committee

1. Motion to accept the edits to the Miami-Dade HIV/AIDS Partnership Ryan White Planning Council Policies and Procedures Manual, as presented.
2. Motion to accept the 2025 Miami-Dade HIV/AIDS Partnership Bylaws, as presented.

The following meeting dates were announced:

- Friday, January 31, 2025, 12:00 PM-12:30 PM
  Report for Action! February Partnership Meeting Briefing
  Microsoft Teams, ID: 238 353 321 012; Passcode: pW9t2mR7
- Tuesday, February 4, 2025, 10 AM-12:00 PM
  Partnership Meeting
  Miami-Dade County Main Library, 101 West Flagler St., Auditorium, Miami, FL 33130

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XI.	Next Meeting Dates	Tajma Darlington

- February 14, 2025: Strategic Planning Committee at BSR
- February 27, 2025: Prevention Committee at FDOH Health District Center

XII.	Adjournment	Virginia Muñoz

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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Memo

To: Prevention Committee Members

From: Christina Bontempo

Date: October 24, 2024

Re: 2025 Officer Nominations and Elections

Annual nominations for the Prevention Committee Vice Chair (Officer) are scheduled for the October 24, 2024, Prevention Committee meeting. Elections will be held at the February 27, 2025, meeting.

Serving as an Officer provides you a great opportunity to enhance your leadership skills, add a new title to your resume, and become a more involved planning council member!

Committee Officers develop agendas with support staff, lead committee meetings, and serve as members of the Executive Committee. Staff provides comprehensive training for all Officers.

For your reference, I am providing the qualifications for Officers as they relate to this Committee, from the Miami-Dade HIV/AIDS Partnership Bylaws (Addendum C):

a. To the extent possible, the officers shall represent the diversity of the HIV/AIDS epidemic in Miami-Dade County, e.g., gender, ethnicity, sexual orientation.

b. The FDOH-MDC shall appoint a department employee, or a designated representative, as Chair of the committee. The term and tenure of this appointment shall be determined by the FDOH-MDC. [Note: There is no change in this appointment.]

c. The Vice-Chair shall be elected by PC members. The Vice-Chair shall be elected to serve a one (1) year term. The Vice-Chair may serve up to two (2) consecutive terms. The Vice-Chair must stand down for one (1) year before being eligible for another term as Vice-Chair. The election of the Vice-Chair shall coincide with the election of the Chair and Vice-Chair of the Partnership's standing committees as outlined in the Partnership Bylaws, which shall take place no later than January of each year.

d. The committee shall, through a nomination process, elect a Vice-Chair annually or as set forth in Section B.1.C. Committee members shall make nominations.

You are encouraged to add your name as a nominee in advance of the meeting; nominations will also be taken from the floor at the February 27, 2025, meeting. Current Officers who have served less than two years are eligible and encouraged to add their name to the ballot. If you are interested in this opportunity or if you have any questions, please contact me at (305) 445-1076 or by email at cbontempo@behavioralscience.com.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Memo

To: Strategic Planning Committee Members

From: Christina Bontempo

Date: October 11, 2024

Re: 2025 Officer Nominations and Elections

Annual nominations for the Strategic Planning Committee Chair and Vice Chair (Officers) are scheduled for the October 11, 2024, Strategic Planning Committee meeting. Elections will be held at the February 14, 2025, meeting.

Serving as an Officer provides you a great opportunity to enhance your leadership skills, add a new title to your resume, and become a more involved planning council member!

Committee Officers develop agendas with support staff, lead committee meetings, and serve as members of the Executive Committee. Staff provides comprehensive training for all Officers.

For your reference, I am providing the qualifications for Officers as they relate to this Committee, from the Miami-Dade HIV/AIDS Partnership Bylaws (Section 5.1):

- Each standing committee, subcommittee, or workgroup shall elect a Chair and a Vice-Chair from among its members; they shall serve at the will of the standing committee, subcommittee, or workgroup.
- Officers shall be full voting members.
- At least one (1) officer of each standing committee must be a Partnership member who shall be designated to report committee activities to the Partnership.
- Standing committees, committees, and workgroups shall strive to elect at least one (1) officer who is a person with HIV.
- No individual shall serve concurrent terms as an officer of the Partnership and an officer of a standing committee or subcommittee. The exception to this rule is for officers of workgroups, which may be led by the Chair as Chair or Vice-Chair of the committee under whose purview the workgroup was authorized.

You are encouraged to add your name as a nominee in advance of the meeting; nominations will also be taken from the floor at the February 14, 2025, meeting. Current Officers who have served less than two years are eligible and encouraged to add their name to the ballot. If you are interested in this opportunity or if you have any questions, please contact me at (305) 445-1076 or by email at cbontempo@behavioralscience.com.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Strategic Planning Committee and Prevention Committee Joint Integrated Plan Review Team Meeting

Tuesday, January 21, 2025

10:00 AM – 1:00 PM

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

AGENDA

I.	Call to Order	Virginia Muñoz
II.	Introductions	All
III.	Housekeeping	Dr. Diana Sheehan
IV.	Floor Open to the Public	Tajma Darlington
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 23, 2024	All
VII.	Reports (*posted on www.aidsnet.org*)	Staff

- Membership
- Partnership

VIII.	Standing Business	Staff

- Prevention Committee Business
- Strategic Planning Committee Business
  - Officer Nominations and Elections Schedule

IX.	New Business	All

- *Miami-Dade County 2027-2031 Integrated HIV Prevention & Care Plan*
  - Plan Guidance and Expectations for Plan Development
- *Miami-Dade County 2022-2026 Integrated HIV Prevention & Care Plan*
  Breakout Groups – Updates and Discussion (45-60 minutes)
  1. Prevention: HIV Testing; and Women, Infants, and Youth
  2. Prevention: PrEP; Advertising; Condoms; and Syringe Services Program
  3. Care: Linkage to Care; Retention in Care; and Special Populations
  4. Care: Disparities in Retention in Care and Disparities in Viral Load Suppression Rates Among Priority Populations
- Breakouts Recap (15 minutes)
- 2025 JIPRT Meeting Schedule and Next Steps

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Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2027- 2031

Division of HIV Prevention

National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

HIV/AIDS Bureau

Health Resources and Services Administration

December 2024

Executive Summary

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed this guidance to support the submission of the Integrated HIV Prevention and Care Plan (hereafter referred to as Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031 (hereafter referred to as Integrated Plan Guidance). This guidance builds upon the previous guidance issued in 2015 and 2021. That guidance allowed funded health departments and planning groups to submit one integrated HIV plan to lead the implementation of both HIV prevention and care services. As in 2021, the Integrated Plan Guidance for CY 2027-2031 meets all programmatic and legislative requirements associated with both CDC and HRSA funding. It reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. The Integrated Plan Guidance necessitates engagement from a wide range of collaborators and partners including communities disproportionately affected by the HIV epidemic and people with HIV. The Integrated Plan Guidance intends to accelerate progress towards meeting national goals while allowing each jurisdiction to design a HIV services delivery system that reflects local vision, values, and needs.

CDC and HRSA funded recipients will notice several key changes in the Integrated Plan Guidance for CY 2027-2031. These changes reflect feedback from internal and external collaborators, which include recipients and people with HIV as well as priorities detailed in the National HIV/AIDS Strategy 2022 – 2025 (NHAS) published in December 2021 and the implementation strategies outlined in the Ending the HIV Epidemic in the U.S. (EHE) initiative. Specifically, recipients who have already conducted extensive planning processes in response to the CDC's *High-Impact HIV Prevention and Surveillance Programs for Health Departments (PS24-0047)* program or through other jurisdictional efforts (e.g., Getting to Zero plans, Fast Track Cities, HIV Cluster Detection and Response plans) may submit portions of those plans to satisfy this Integrated Plan Guidance as long as the Integrated Plan submission addresses the broader needs of the geographic jurisdiction and applies to the entire HRSA and CDC HIV funding portfolio. To that end, additional details on key changes can be found in the *CY 2027– 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist (See Appendix 1)*. This checklist details submission requirements and allows each jurisdiction to determine which elements may require new content and which elements were developed as part of another jurisdictional plan.

Integrated Plan submissions address the broader needs of the geographic jurisdiction and apply to the entire HRSA and CDC HIV funding portfolio. Additionally, jurisdictions should submit plans that follow the goals and priorities as described in the NHAS and use data to devise strategies that reduce new HIV infections by 90% by 2030. Proposed strategies should include the implementation of activities that will diagnose all people with HIV as early as possible, treat all people with HIV rapidly and effectively to reach sustained viral suppression, prevent new HIV transmissions by using proven interventions, and respond quickly to potential outbreaks to get appropriate prevention and treatment services to people who need them.

Section I: Introduction

In the United States, we have the tools to end the HIV epidemic and continue to make progress toward that goal. From 2018 to 2022, estimated HIV infections in the U.S. decreased by 12 percent largely attributed to the decrease in new HIV infections among people aged 13 to 24.[1] The work of dedicated individuals across HIV prevention and care delivery systems have contributed to this decrease in HIV diagnoses and the increase in viral suppression rates for clients in the Ryan White HIV/AIDS Program (RWHAP) from 69.5 percent in 2010 to 89.7 percent in 2022.

Although rates of new HIV incidence have decreased overall and viral suppression continue to increase, racial and ethnic differences in diagnoses and treatment outcomes of HIV persist. Health disparities persist among gay, bisexual and other men who have sex with men, particularly Black, Latino, and American Indian/Alaska Native men; Black women; transgender women; youth aged 13-24 years; and people who inject drugs[2]. To reach the national goal of reducing new HIV infections, our systems of HIV prevention and care must work together in unprecedented ways to address health inequities that remain. This includes providing equal access to all available tools so that no population or geographic area is left behind and efforts to end the HIV epidemic are accelerated.

The Integrated Plan Guidance for CY 2027-2031 is the third five-year planning guidance developed by CDC and HRSA. This Integrated Plan Guidance builds on the previous iterations of the Integrated Plan Guidance by allowing each jurisdiction to develop new goals and objectives that align public and private sectors to leverage strengths from the last five years and to add or revise services to address local health inequities that may remain. The Integrated Plan Guidance speaks to the need for aggressive actions necessary to achieve the NHAS goals and targeted efforts to end the HIV epidemic in the U.S. by the year 2030.

Specifically, the Integrated Plan Guidance was designed to:

1. Coordinate HIV prevention and care activities by assessing resources and service delivery gaps and needs across HIV prevention and care systems to ensure the allocation of resources based on data (e.g., other payors, number of ADAP-eligible clients on health insurance coverage, in-depth analysis of needs assessment of people with HIV and people who can benefit from HIV prevention services or are vulnerable to HIV acquisition);

2. Address requirements for planning, community engagement, and coordination established by the RWHAP legislation as well as programmatic planning and community engagement requirements established by both HRSA and CDC through guidance;

[1] HV Surveillance Supplemental Report: Estimated HIV Incidence and Prevalence in the United States, 2018–2022

[2] Black is defined as African American or Black and Latino is defined as Latino or Hispanic (U.S. Department of Health and Human Services. 2021. National HIV/AIDS Strategy. (pp 19) Washington, DC

3. Improve health outcomes along the HIV care continuum by using data to prioritize those populations where systems of care are not adequately addressing high HIV morbidity and/or lower overall viral suppression rates;

4. Promote a whole-person approach[3] to help overcome structural and social barriers to care, eliminate stigma, and improve the health of people with HIV and people who can benefit from prevention services;

5. Reduce recipient burden by allowing jurisdictions to submit portions of other significant planning documents (e.g., EHE Plans, Fast Track Cities, Getting to Zero, or HIV Cluster Detection and Response plans) to meet Integrated Plan requirements and by aligning submission requirements and dates across HIV prevention and care funding;

6. Advance health equity by ensuring that government programs promote equitable delivery of services and engage people with lived experience in service delivery system design and implementation; and,

7. Leverage strategic partnerships to prioritize efforts, and focus resources and evidence informed interventions, to reach those who are diagnosed, but not engaged in care.

Relationship to other National Plans and Initiatives

HRSA and CDC recognize that many jurisdictions have established and implemented extended planning processes as part of other local initiatives including but not limited to EHE funding, Fast Track Cities, locally funded Getting to Zero initiatives, or Cluster Detection and Response Plans. To minimize burden and align planning processes, the jurisdiction may submit portions of these plans to satisfy the Integrated Plan Guidance requirements. Jurisdictions should review the NHAS or subsequent updates to the current national plan by visiting www.hiv.gov and subscribing to receive updates.

National Framework for Ending the HIV Epidemic

It is important to think about this Integrated Plan Guidance within the framework of national objectives and strategic plans that detail the principles, priorities, and actions that direct the national public health response and provide a blueprint for collective action across the federal government and other sectors (see *Appendix 5*). HRSA and CDC support the implementation of these strategies.

In January 2021, the U.S. Department of Health and Human Services (HHS) released the NHAS which creates a collective vision for HIV service delivery across the nation. Each jurisdiction should create Integrated Plans that address four goals[4]:

[3] A whole-person approach to HIV prevention and treatment considers the multitude of factors affecting a person's health. Source: https://www.cdc.gov/hiv/policies/strategic-priorities/hiv-and-whole-person-care/index.html#:~:text=A%20whole%2Dperson%20approach%20can,expand%20flexible%20and%20tailored%20interventions.

[4] U.S. Department of Health and Human Services. 2021. National HIV/AIDS Strategy (pp 3-10) Washington, DC.

- Prevent new HIV infections
- Improve HIV-related health outcomes of people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and collaborators

To achieve these goals, the NHAS identifies key priority populations, focus areas, and strategies. All plans submitted in response to the Integrated Plan Guidance should incorporate the national goals and strategies detailed in the NHAS. This should include activities that:

- Leverage public and private community resources toward meeting the goals;
- Address health inequities for priority populations including inequities related to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral health issues including but not limited to substance use disorders;
- Create strategic partnerships across a broad spectrum of service systems as a means to lessen the impact of social and structural determinants of health such as systemic racism, poverty, unstable housing and homelessness, stigma, and/or under- or un-employment;
- Implement innovative program models that integrate HIV prevention and care with other services and other service organizations as a means to address comorbid conditions and to promote a whole-person approach to care; and,
- Coordinates HIV prevention and care systems around key focus areas to strengthen the local response.

For more information on the NHAS, visit: https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf.

In 2020, HHS began implementation of the Ending the HIV Epidemic in the United States initiative coordinated around four strategies – diagnose, treat, prevent, and respond – that leverage highly successful programs, resources, and infrastructure. The EHE initiative aligns with the NHAS plan to reduce new HIV diagnoses in the United States, decreasing the number of new HIV infections to fewer than 3,000 per year. The EHE initiative focuses resources, expertise and technology in jurisdictions hardest hit by the HIV epidemic. For more information on the EHE initiative, visit: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview.

The Integrated Plan Guidance utilizes the HIV care continuum model and the whole-person approach. The HIV care continuum depicts the stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to reach viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner, thus providing an additional strategy to prevent new HIV infections. Effective strategies to address barriers within HIV prevention, care, and treatment systems are needed to increase the number of people with HIV that reach and maintain viral suppression.

The adoption of a whole-person approach can improve HIV prevention and care service delivery and outcomes. Persons with positive test results should be linked to HIV care, treatment, and other social support services; and persons testing negative should be linked, as needed, to biomedical HIV prevention services, such as PrEP, and other social support services.

The HIV care continuum allows recipients and planning groups to measure progress and to direct HIV resources most effectively. HRSA and CDC encourage jurisdictions to use the HIV care continuum to identify populations for whom the service system may not be adequately engaging in HIV prevention services or may not support improved HIV health outcomes. Additionally, all jurisdictions should include performance measures in their Integrated Plan submission including the core performance measures that measure progress along the HIV care continuum for all priority groups. Please see *Appendix 4* for links to suggested CDC and HRSA data sources, performance measures, and indicators.

Section II: Planning Requirements and Submission Guidelines

Integrated planning is a vehicle for jurisdictions to identify HIV prevention and care needs, existing resources, barriers and gaps, and outline local strategies to address them. The Integrated Plan submission should articulate existing and needed collaborations among people with HIV, service providers, funded program implementers, and other collaborators, including but not limited to other programs funded by the federal government, such as the Housing Opportunity for Persons with AIDS (HOPWA) program and providers from other service systems such as substance use prevention and treatment providers. The Integrated Plan submission should reflect current approaches and use the most recent data available. To ensure coordinated implementation of their Integrated Plan submission, each jurisdiction should include information on the persons or agencies responsible for developing the plan, implementing the plan, coordinating activities and funding streams, and monitoring the plan.

HIV Planning Requirements

All CDC DHP and HRSA HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a system-wide plan for the delivery of HIV prevention and care services and the establishment of an HIV planning group, planning council, or advisory group, also known as a planning body.

By design, the HIV planning body must engage people with different interests, responsibilities, and involvement with HIV to inform and support the development and implementation of an Integrated Plan submission that guides the delivery of HIV prevention and care services. CDC and HRSA recognize and understand the value of individuals who receive services actively participating in the planning process for HIV service delivery, as this drives services that are tailored to the needs of clients in the jurisdiction, and these individuals must be engaged in the development and implementation process.

For the development of the Integrated Plan, jurisdictions should include and use their existing local prevention and care HIV planning bodies, as consistent with CDC and HRSA planning group requirements, and engage traditional collaborators and community members (e.g., people with HIV, people with certain risk factors for acquiring HIV, AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics and local education agencies (LEAs)) to get input. In addition, recipients should broaden their existing group of partners and collaborators to include other federal, state, and local HIV programs, local organizations, and community groups not previously engaged for the purposes of improving data sources, leveraging services, and assisting with key portions of the plan, such as the HIV prevention and care inventories.

When developing the Integrated Plan submission, the planning body should collaborate with the recipient to review and analyze data (e.g., resource inventory, needs assessments, satisfaction surveys, listening sessions) for program action and decisions, prioritize resources to those jurisdictions at highest risk for HIV transmission and acquisition, and address health equity by improving both individual and population-based HIV health outcomes in those jurisdictions. Through strategic collaborations among collaborators, HIV planning is based on the principle that local planning is the best way to respond to local HIV prevention and care service delivery needs and priorities. Please refer to CDC's most recent HIV Planning Guidance (HPG) and the RWHAP Part A and Part B Manual for more details about HIV planning processes.

Integrated Plan Components

The Integrated Plan submission should demonstrate an understanding of and considerations for all funding sources, service delivery, and system integration (entire system of HIV prevention and care). It should include the following sections:

1. Introduction
2. Community Engagement and description of Jurisdictional Planning Process
3. Contributing Data Sets and Assessments, including:
    a. Epidemiologic Snapshot
    b. HIV Prevention, Care and Treatment Resource Inventory
    c. Needs Assessment
4. Situational Analysis Overview, including priority populations/groups
5. CY 2027-2031 Goals and Objectives to be organized by the goals in the NHAS and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond. See *Appendix 2* for examples.
6. Integrated Plan Workplan

In addition to these sections, please use the checklist attached, as *Appendix 1,* to ensure the jurisdiction submits all of the documents needed to meet submission requirements, including existing materials and newly developed materials needed for each required section.

As part of a complete Integrated Plan submission, jurisdictions must provide a signed letter from the planning body(ies) documenting concurrence, non-concurrence, or concurrence with reservations with the Integrated Plan submission. In RWHAP Part A jurisdictions that cross state lines, the Part A Planning Councils/Planning Bodies need to submit signed letters to all RWHAP

Part B jurisdictions included in the Part A jurisdiction. As part of the Integrated Plan submission, jurisdictions will need to outline the communities and collaborators represented in the planning and concurrence process (e.g., community members, people with HIV, service providers, governmental entities). Submissions that do not contain the required letters of concurrence will be deemed incomplete and returned for revisions.

See the table below for the required letters of concurrence depending upon the plan submission type. If there are additional planning bodies in the state/territory or jurisdiction, additional letters of concurrence should be submitted. Please see *Appendix 6* for a sample letter of concurrence.

Required Letters of Concurrence			
	Type of Plan		
Planning Body	Integrated State/City Prevention and Care Plan	Integrated State-Only Prevention and Care Plan	Integrated City-Only Prevention and Care Plan
RWHAP Part A Planning Council	✓	✓[5]	✓
RWHAP Part B Planning Group	✓	✓	
CDC Prevention Planning Group	✓	✓	✓

Submission

The Integrated Plan submission must include all the components outlined in this guidance and include a completed *CY 2027- 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be comprehensive to ensure that all HIV prevention and care funding work together to reduce new HIV diagnoses and to increase viral suppression among all people with HIV. The new plan should use existing documents such as an epidemiologic profile, if documents are current. Existing versions of documents may be updated or modified if needed during the current integrated planning process.

Each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated Plan and must include the following:

- Detailed information of who is responsible for developing the Integrated Plan within the jurisdiction (i.e., RWHAP Part A planning councils/body(ies), RWHAP Part B advisory groups, Integrated Planning Bodies and CDC HIV planning bodies).

- Well defined goals and objectives. Each jurisdiction should provide a descriptive detail and process for how it will address HIV prevention, care, and treatment needs in its service areas and accomplish the goals of the NHAS.

[5] RWHAP Part A recipients needed to submit letters of concurrence to all states where 10% or more of the HIV cases in their jurisdiction reside.

All funded jurisdictions (funded by both CDC DHP and HRSA HAB) must submit an Integrated Plan and address all sections as outlined in the guidance. State and/or local jurisdictions (municipalities) have the option to submit to CDC and HRSA:

- Integrated state/city prevention and care plan,
- Integrated state-only prevention and care plan, and/or
- Integrated city-only prevention and care plan.

NOTE: All submissions should demonstrate an integrated prevention and care plan as a method to better coordinate a response to HIV among all partners and collaborators. Per legislative and programmatic requirements, CDC and HRSA expect coordination among funded entities and community collaborators in the development of the Integrated Plan.

The Integrated Plan submission may include several jurisdictions (e.g., the state, the RWHAP Part A jurisdiction(s) in that state, CDC directly funded cities in that state). Each HRSA and CDC-funded jurisdiction must participate in the completion and submission of the Integrated Plan.

- For jurisdictions submitting city-only plan, the city Integrated Plan should complement the state Integrated Plan, including the SCSN.
- Both the city-only and state-only Integrated Plans should describe how the jurisdictions will coordinate actions to prevent duplication.
- Both city-only and state-only plans should include and address the HIV epidemic within its jurisdiction.

The jurisdiction's Integrated Plan submission is due to CDC DHP and HRSA HAB ***no later than 11:59 PM ET on June 30, 2026***. Submissions should be no longer than 100 pages, not including the completed checklist, and no smaller than 11pt font.

The submission package must contain the following documents:

- A CY 2027 – 2031 Integrated Plan that includes all components outlined in this guidance;
- A completed *CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist* detailing where CDC and HRSA may find each of the required elements; and
- A signed letter from all jurisdictional HIV planning groups/bodies indicating concurrence, concurrence with reservations, or non-concurrence with the plan.

Further detailed instructions on how to submit your jurisdiction's Integrated Plan will be addressed during the upcoming webinar. You may also reach out to your CDC and HRSA project officers for questions or concerns regarding your Integrated Plan.

While there is not a standard template for the Integrated Plan submission, the plan submitted must include all the components outlined in this guidance and include a completed *CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist*. Plans must be broad enough to ensure that all HIV prevention and care funding work together to reduce new HIV diagnoses and to increase viral suppression among all people with HIV. The new written plan should not redevelop existing products such as epidemiologic profiles, if these products are current and up-to-date. Existing versions of these documents may be updated or modified if needed for the current integrated planning process.

Workplan Monitoring

The Integrated Plan Workplan provides an overarching vehicle to coordinate approaches for addressing HIV prevention and care needs at the state and local levels. The Integrated Plan Workplan must contain goals, SMART (specific, measurable, achievable, relevant and time-bound) objectives, specific activities, responsible parties, key partners, and performance measures that address both HIV prevention and care needs.

In addition, the goals and objectives must be in alignment with both the NHAS goals and the four EHE strategies, listed below:

- Diagnose all people with HIV as early as possible
- Treat people with HIV rapidly and effectively to reach sustained viral suppression
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs)
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Monitoring the Integrated Plan Workplan will assist recipients and planning bodies with identifying ways to measure progress toward goals and objectives; selecting strategies for collecting information; and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction. Jurisdictions must identify how they will provide regular updates to the planning bodies and collaborators on the progress of plan implementation, solicit feedback, and use the feedback from collaborators for plan improvements. Each jurisdiction also will need to use surveillance and program data to assess and improve health outcomes, health disparities, and the quality of the HIV service delivery systems, including strategic long-range planning.

The Integrated Plan, including the Integrated Plan Workplan, is a "living document" and must be reviewed and updated at least annually or as needed. The process for annual review should include the identification of relevant data and data systems, analysis of data on performance measures, the inclusion of planning bodies in the ongoing evaluation of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process.

To ensure progress on Integrated Plan activities and the Integrated Plan's alignment with funding strategies, CDC and HRSA will engage in monitoring workplan activities both independently and jointly. Recipients will use established reporting requirements (i.e., applications, annual progress

reports) to document progress on achieving the objectives presented in the Integrated Plan. These reporting updates should include the jurisdiction's plan to monitor and evaluate implementation of the goals, strategies, and objectives included in the Integrated Plan. Project Officers will also utilize the Integrated Plan Workplan as a tool in monitoring and supporting the jurisdiction's progress. Additionally, CDC and HRSA project officers will continue to monitor progress during regularly scheduled calls and will conduct periodic joint monitoring calls with recipients.

CDC DHP and HRSA HAB remain committed to our ongoing partnership and the provision of technical assistance (TA) services. For TA services around integrated planning, please contact your respective project officers.

MIAMI-DADE HIV/AIDS PARTNERSHIP

2025 Agenda Setting Calendar
Joint Integrated Plan Review Team
Strategic Planning Committee and Prevention Committee
As of January 21, 2025

Date, Time Location	Integrated Planning
Tuesday, January 21 10:00 a.m.-1:00 p.m. MDC Main Library	Joint Integrated Plan Review Team (JIPRT) Meeting - 2022-2026 Integrated Plan **Progress Reports** - 2027-2031 Integrated Plan Guidance
February Stand-Alone Meetings	- Review JIPRT recommendations
March Stand-Alone Meetings	- Review Progress on 2027-2031 Integrated Plan
Tuesday, April 22 10:00 a.m.-12:00 p.m. MDC Main Library	Joint Integrated Plan Review Team Meeting - 2027-2031 Integrated Plan **Development** - 2022-2026 Integrated Plan Progress Reports
May Stand-Alone Meetings	- Review JIPRT recommendations
June Stand-Alone Meetings	- Review Progress on 2027-2031 Integrated Plan
Tuesday, July 22 10:00 a.m.-1:00 p.m. MDC Main Library	Joint Integrated Plan Review Team Meeting - 2022-2026 Integrated Plan **Progress Reports** - 2027-2031 Integrated Plan Development
August Stand-Alone Meetings	- Review JIPRT recommendations
September Stand-Alone Meetings	- Review Progress on 2027-2031 Integrated Plan
Tuesday, October 21 10:00 a.m.-1:00 p.m. MDC Main Library	Joint Integrated Plan Review Team Meeting - Draft 2027-2031 Integrated Plan **Review** - 2022-2026 Integrated Plan Progress Reports

RSVP to cbontempo@behavioralscience.com.
Meeting materials are available at www.aidsnet.org/the-partnership
All meeting dates and locations are subject to change.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Strategic Planning Committee and Prevention Committee Joint Integrated Plan Review Team Meeting

Tuesday, January 21, 2025

10:00 AM – 1:00 PM

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

AGENDA

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- Membership
- Partnership

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- Strategic Planning Committee Business
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- February 14, 2025: Strategic Planning Committee at BSR
- February 27, 2025: Prevention Committee at FDOH Health District Center

XII.	Adjournment	Virginia Muñoz

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

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Group 1
Breakout Group Guide
HIV Testing; and Women, Infants, and Youth
JIPRT Meeting, January 21, 2025

1. Introductions - Get to know your group!
2. Designate a person to report during the Breakouts Recap.
3. On each handout, review the NHAS Goal --> Objective --> Strategy --> Activity --> Measurement --> Data
4. Consider some questions to guide discussions:
    a. What is our data source?
    b. Who is responsible for achieving the Objectives?
    c. What is the target?
    d. Are we on track to achieve the target by December 31, 2026?
    e. What challenges are keeping us from achieving our targets?
    f. What can we do to improve our outcomes?
    g. Where are we having success and how can we ensure we stay on track?
    h. Should we adjust our target?
5. What overall impressions do you want to report to the JIPRT during Breakouts Recap?

Acronyms and Terminology

- EHE: Ending the HIV Epidemic
- FDOH: Florida Department of Health
- FDOH-MDC: Florida Department of Health in Miami-Dade County
- FQHC: Federally Qualified Health Center
- HCSF: Health Council of South Florida
- HCV: Hepatitis C
- JMH: Jackson Medical Health System
- NHAS: National HIV/AIDS Strategy
- PrEP: Pre-Exposure Prophylaxis
- STI: Sexually Transmitted Infection
- TBD: To be determined - Data were not available at the time of the meeting (possible discussion points)

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.1: 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: 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 1.1.1: Partner/collaborate with health care facilities to increase routine opt-out HIV testing.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024 (Jan-Jun 2024 as noted)	Target (Dec 2026)
1.1.1.1	Number of healthcare facilities identified for routine opt-out HIV testing in MDC	123	208	249	1,200
1.1.1.2	Number of healthcare facilities interested in routine opt-out HIV testing in MDC	123	208	249	1,200
1.1.1.3	Number of healthcare facilities committed to conducting routine opt-out HIV testing in MDC	36	73	49	574
1.1.1.4	Number of healthcare facilities implementing routine opt-out HIV testing in MDC	16	87	69	1,440
1.1.1.5	Number of HIV positive persons identified through routine opt-out testing	432 HCSF and Hospitals	818 Total ▪ 714 – HCSF and Hospitals ▪ 104 – EHE	1189 Hospitals and HCSF (Jan-Jun 2024)	TBD
		1,582 FDOH EHE	1,714 FDOH EHE	719 FDOH EHE	TBD
1.1.1.6	Number of previously diagnosed HIV positive persons	▪ 337 HCSF and Hospitals) ▪ 444 (FDOH EHE)	610 Total	1025 Hospitals and HCSF (Jan-Jun 2024)	TBD
1.1.1.7	Number of newly diagnosed HIV positive persons	88 HCSF and Hospitals	87 Total ▪ 82 – Hospitals ▪ 5 – EHE	143 Hospitals and HCSF (Jan-Jun 2024)	TBD
1.1.1.8	Number of HIV tests integrated with viral hepatitis tests (HCV)	14,102 EHE agencies and JMH	1,996 – EHE	668 (Jan-Jun 2024)	TBD
1.1.1.9	Number of HIV tests integrated with STI tests	3,047 – EHE agencies	3,233 – EHE	1138 (Jan-Jun 2024)	TBD

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.1: 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: Expand HIV/STI testing in traditional and non-traditional settings.

Activity 1.1.2: Utilize academic detailing to educate providers on routine testing inclusive of Hepatitis C virus (HCV) and sexually transmitted infections (STIs).

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.1.2.1	Number of licensed clinical providers and practitioners identified to be educated on routine testing (i.e., HIV, HCV, STI)	242	489	531	1776
1.1.2.2	Number of licensed clinical providers educated on routine testing (i.e., HIV, HCV, STI)	228	489	531	1776
1.1.2.3	Number of registrations/agreements established with partners to serve as routine healthcare testing sites	35	73	49	888

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.2: 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: Expand HIV/STI testing in traditional and non-traditional settings.

Activity 1.2.1: Increase the use of home HIV self-testing kits as an alternative option.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.2.1.1	Number of persons receiving one or more HIV self-test kits	207	693, including 193 from EHE funds	728	2,000
1.2.1.2	Number of persons who confirmed taking a self-test	76	109	163	380
1.2.1.3	Number of persons who reported a positive test result using the self- test kit	1	1	3	5
1.2.1.4	Number of persons with a positive HIV test result from a self-test kit, who took a confirmatory test at FDOH-MDC and/or testing community partner facilities	1	1	2	5

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.2: 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: Expand HIV/STI testing in traditional and non-traditional settings.

Activity 1.2.2: Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.2.2.1	Number of community testing partners implementing HIV/STI testing at non-traditional settings	1 – Test Miami 7 – EHE	1 – Test Miami mobile unit 7 – EHE	1	1
1.2.2.2	Number of persons tested for HIV at non-traditional settings	1,057	923	1792	4,000
1.2.2.3	Number of HIV positive persons at a non-traditional setting	17	24	29	40
1.2.2.5	Number of newly diagnosed HIV positive persons at non-traditional settings	12	14	4	40
1.2.2.5	Number of persons tested for STIs at non-traditional settings	2,989	999	2207	4,000
1.2.2.6	Number of persons diagnosed with an STI at non-traditional settings	17	79	634	320

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.2: 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: Expand HIV/STI testing in traditional and non-traditional settings.

Activity 1.2.3: Increase the number of mobile units offering HIV/STI testing in the community.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.2.3.1	Number of operational mobile units conducting HIV/STI testing	1	1	1	1
1.2.3.2	Number of HIV tests conducted at a mobile unit	1,057	923	1,182	4,000
1.2.3.3	Number of HIV positive results from HIV tests conducted at a mobile unit	12	24	48	40
1.2.3.5	Number of persons linked to HIV care at a mobile unit	19	10	27	40
1.2.3.6	Number of STI tests conducted at a mobile unit	2,989	999	977	4,000
1.2.3.7	Number of STI positive results from STI tests conducted at a mobile unit	31	79	99	100
1.2.3.8	Number of people referred for STI treatment at a mobile unit	265	167	66	320
1.2.3.9	Number of persons linked to PrEP at a mobile unit	94	42	55	160

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.3: 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: Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative, and immediate linkage to HIV care and treatment for those who test positive.

Activity 1.3.1: Provide training and education to community partners on the status neutral approach.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.3.1.1	Number of community testing organizations trained and educated on the status neutral approach	0 - Activity started in January 2023	18	35	TBD
1.3.1.2	Number of counselors trained and educated on the status neutral approach	0 - Activity started in January 2023	220	339	1,200

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.3: 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: Provide Disease Intervention Specialist (DIS) partner services to people diagnosed with HIV and STIs, and their sexual or needle-sharing partners.

Activity 1.4.1: Educate community testing partners on availability and importance of partner services.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.4.1.1	Number of counselors trained and educated on the importance of partner services	204	206	318	1,440

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.5: Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).

Strategy: Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).

Activity 1.5.1: Conduct educational sessions with medical professionals and agencies that provide care and treatment to women of childbearing age, and pregnant women with HIV and their exposed or HIV positive newborns.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.5.1.1	Number of educational sessions conducted (by FDOH and Perinatal Prevention Staff)	66	208	13 (perinatal) + 249 (academic detailing) = 262	1,220
1.5.1.2	Number of persons trained	297	489	89 (perinatal) + 531 (academic detailing) = 620	1,876

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.5: Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).

Strategy: Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).

Activity 1.5.2: 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.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.5.2.1	Number of educational sessions conducted	111	208	249	1,220
1.5.2.2	Number of persons trained	111	489	531	1,776

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.5: Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).

Strategy: Increase awareness by healthcare providers of the opt-out HIV and STI screening and Perinatal HIV Prevention protocols for pregnant women per Florida Statute 64D-3.04 (FS 64D-3.04).

Activity 1.5.3: Conduct educational sessions with hospitals, including emergency rooms and high-risk delivery hospitals, and urgent care centers.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.5.3.1	Number of in person educational sessions conducted with hospitals	4	2 (revised from 22)	2	5 (revised from 20 in January 2025)
1.5.3.2	Number of educational sessions conducted with urgent care centers	0	*There were no urgent care centers identified for educational sessions*	0	2
1.5.3.3	Percent of High-Risk Notification Forms and/or notifications of pregnant women with HIV received directly from providers	97.6%	100% *Only 78 live births were born to 77 moms out of the 99 pregnancies therefore, 100 percent of notifications were received*	98.5%	100%
1.5.3.4	Percent of Newborn Exposure Notification Forms received	98.6%	98%	99.5%	100%

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.6: Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).

Strategy: Increase awareness among women with HIV who are of childbearing age about mother to child transmission, prenatal care, postpartum care, and family planning services

Activity 1.6.1: Link pregnant women with HIV to HIV care and prenatal care.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.6.1.1	Number of pregnant women with HIV who were linked to HIV care within 30 days of the initial notification date	73	98%	Data pending	90
1.6.1.2	Percent of pregnant women with HIV who were linked to HIV care within 30 days of the initial notification date	None	98.9%	94.5%	95%
1.6.1.3	Number of pregnant women with HIV who received prenatal care	69	74	Data pending	90
1.6.1.4	Percent of pregnant women with HIV who received prenatal care	92%	(96%) *Of the 77 pregnant women who continued their pregnancy, three (3) pregnancies were determined at delivery or weeks before delivery.*	84.75%	95%

NOTE on Measurements 1.6.1.3 and 1.6.1.4: The term "adequate care" was changed to "care" in July 2024. The goal is to get women into prenatal care regardless of the time frame. "Adequate prenatal care" only includes women who initiated prenatal care within the first four months of pregnancy and completed at least 80% of expected visits.

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.6: Maintain the number of infants born with HIV in Miami-Dade County each year at zero (0).

Strategy: Increase awareness among women with HIV who are of childbearing age about mother to child transmission, prenatal care, postpartum care, and family planning services

Activity 1.6.2: Provide follow-up medical and family planning services for post-partum women with HIV.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.6.2.1	Number of post-partum women with HIV who received family planning services	73	88% *Out of the 77 women who continued their pregnancy, some were incarcerated, moved out of town or refused contraception/family planning/postpartum services after delivery. (88% and 92%, respectively)*		90
1.6.2.2	Percent of post-partum women with HIV who received family planning services	95 % (revised from 97.3%)		93.5%	95%
1.6.2.3	Number of women with HIV who received post-partum care	73	71 *Out of the 77 women who continued their pregnancy, some were incarcerated, moved out of town or refused contraception/family planning/postpartum services after delivery. (88% and 92%, respectively)*		90
1.6.2.4	Percent of women with HIV who received post-partum care	95 % (revised from 97.3%)		93.5%	95%

Group 2
Breakout Group Guide
PrEP; Advertising; Condoms; and Syringe Services Program
JIPRT Meeting, January 21, 2025

1. Introductions - Get to know your group!
2. Designate a person to report during the Breakouts Recap.
3. On each handout, review the NHAS Goal --> Objective --> Strategy --> Activity --> Measurement --> Data
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5. What overall impressions do you want to report to the JIPRT during Breakouts Recap?

Acronyms and Terminology

- CBO: Community-Based Organization
- IDEA Exchange: Infectious Disease Elimination Act
- NHAS: National HIV/AIDS Strategy
- NHAS: National HIV/AIDS Strategy
- PrEP: Pre-Exposure Prophylaxis
- SSP: Syringe Services Program
- TBD: To be determined - Data were not available at the time of the meeting (possible discussion points)

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.7: Increase the percentage of persons screened for PrEP who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.

Strategy: Ensure access to and availability of PrEP.

Activity 1.7.1: Train peer educators and community health workers to promote the PrEP initiatives through direct community outreach.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.7.1.2	Number of PrEP educational sessions conducted	23	208 + 360 = 568	249+ 330 (other community partners) = 579	1,200
1.7.1.2	Number of PrEP educational materials distributed	23	208 + 360 = 568	249 + 330 (other community partners) = 579	1,200

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.7: Increase the percentage of persons screened for PrEP who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.

Strategy: Ensure access to and availability of PrEP.

Activity 1.7.2: Utilize FDOH-MDC Academic Detailing Program to engage and educate health care providers on PrEP to increase the number of PrEP prescribers.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.7.2.1	Number of educational sessions conducted specifically to health care providers	88	208	249+ 124 (other community partners) = 373	1,200
1.7.2.2	Number of providers recruited to provide PrEP services	25	159	92	1,100
1.7.2.3	Number of PrEP prescribers	25	134	112 +171 (other community partners) = 283	1,100

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.7: Increase the percentage of persons screened for PrEP who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.

Strategy P3.1: Ensure access to and availability of PrEP.

Activity 1.7.3: Identify and share best practices by agencies that have utilized TelePrEP to expand providers' capacity of offering TelePrEP services.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.7.3.1	Number of providers offering TelePrEP services	3	3	3+ 21 (other community partners) = 24	12
1.7.3.2	Number of persons who received TelePrEP services	122	603	47 (Jan-Jun 2024)	600

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.7: Increase the percentage of persons screened for PrEP who are prescribed PrEP from 53% in 2021 to 75% by December 31, 2026.

Strategy P3.1: Ensure access to and availability of PrEP.

Activity 1.7.4: Increase PrEP access by expanding the number of individuals receiving PrEP services.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024 (unless otherwise noted)	Target (Dec 2026)
1.7.4.1	Number of HIV-negative tests	170,772 (revised from 11,656) 55,256 (DOH testing data) + 115,516 (FOCUS data)	217,156 (revised from 52,944) 52,944 (DOH testing sites) + 164,212 (FOCUS data)	168,866 60,749 (DOH testing sites) + 108,117 (FOCUS data missing December)	TBD
1.7.4.2	Number of access points for PrEP	8 (EHE)	9	9	TBD
1.7.4.3	Number of individuals screened for PrEP	7,599	7,711	5143	TBD
1.7.4.4	Number of individuals referred to a PrEP provider	2,363	2,898	2696 (Jan-Jun 2024)	TBD
1.7.4.5	Number of individuals linked to a PrEP provider	760	197	387	TBD
1.7.4.6	Number of individuals prescribed PrEP	670	6,825	6,867 (as of October 2024) community partners	1,200

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.8: Increase the number of agencies offering nPEP in the community from 7 in 2021 to 10 by December 31, 2026.

Strategy: Ensure access to and availability of nPEP.

Activity 1.8.2: Utilize FDOH-MDC Academic Detailing Program to engage and educate providers, urgent care centers, and Emergency Rooms on nPEP to increase the number of nPEP prescribers.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	2024	Target (Dec 2026)
1.8.2.1	Number of nPEP educational sessions conducted	23	208	249 + 10 community partners = 259	1,200

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.9: Increase the number of free condoms distributed from 1,929,715 in 2021 to 2,026,200 by December 31, 2026

Strategy: Continue free condom distribution.

Activity 1.9.1: Increase the number of condom distribution sites across the jurisdiction.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.9.1.1	Number of condoms distributed by Zip Code (report using Zip Code map)	2,362,830 *Increase by 1%*	2,380,408	2,262,183	2,386,458
1.9.1.2	Number of Business Responds to AIDS (BRTA) sites	30 *Increase by 10%*	65	43	60

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.10: Support the local Syringe Service Program (SSP)– locally, the Infectious Disease Elimination Act: (IDEA Exchange) – and ensure access to harm reduction services.

Strategy: Inform HIV service providers and the community about IDEA Exchange services.

Activity 1.10.1: Educate and refer high-risk individuals to local SSP.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.10.1.1	Number of persons linked to IDEA Exchange	TBD	864	Due 7/1/25	TBD

Activity 1.10.2: Utilize social media platforms to promote services offered by SSP.

VMSG Number	Measurement	Baseline (Jan 2022)	July 2022-June 2023	July 2023 – June 2024	Target (Dec 2026)
1.10.2.1	Number of social media posts by IDEA Exchange (Facebook, Instagram and Twitter)	107	62	TBD (pending data)	TBD

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.11: Increase the number of advertisement types to expand culturally appropriate messaging concerning HIV prevention, testing, and treatment from four (4) in 2021, to six (6) by December 31, 2026.

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

Activity 1.11.1: 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.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.11.1.1	Number of overall impressions [media measurement] from knowing your status, getting into care while addressing stigma, HIV prevention and care marketing campaigns	46,791,818	300,071	457,858	TBD
1.11.1.2	Number of posts on knowing your status, getting into care while addressing stigma, HIV prevention and care	997	1787	1511	TBD

Activity 1.11.2: Conduct outreach events that promote diversity (inclusive of multi-lingual messages), to reach out to priority populations in the community.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	Jan – Jun 2024	Target (Dec 2026)
1.11.2.1	Number of agencies conducting outreach events for each priority population (identify priority populations)	13	9	8 (EHE)	TBD
1.11.2.2	Number of outreach events conducted	718	TBD	690 (EHE)	TBD
1.11.2.3	Number of contacts created at outreach events	23,444	TBD	24,988 (EHE)	TBD

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.11: Increase the number of advertisement types to expand culturally appropriate messaging concerning HIV prevention, testing, and treatment from four (4) in 2021, to six (6) by December 31, 2026.

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

Activity 1.11.3: 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).

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024 (unless otherwise noted)	Target (Dec 2026)
1.11.3.1	Number of overall impressions from U=U, and other destigmatizing HIV marketing campaigns	61,339,800	TBD	1,296,109 (Jan- May 2024)	TBD
1.11.3.2	Number of posts on prevention messages to destigmatize HIV	200	TBD	870 (Jan-May)	TBD
1.11.3.3	Number of advertising/media types (e.g., print; digital/internet-based; radio; television; out-of-home advertising)	4	TBD	2	TBD

Activity 1.11.4: Utilize representatives of the HIV-affected community to deliver messages to people with HIV, highlighting personal success and struggles, and empowering people with HIV.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.11.4.1	Number of educational sessions about destigmatizing HIV, and empowering people with HIV	912	TBD	499	TBD
1.11.4.2	Number of media campaign types utilizing influencers or community representatives to promote HIV messages	4	TBD	0	TBD

NHAS Goal 1: Prevent New HIV Infections

Prevention Objective 1.11: Increase the number of advertisement types to expand culturally appropriate messaging concerning HIV prevention, testing, and treatment from four (4) in 2021, to six (6) by December 31, 2026.

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

Activity 1.11.5: 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.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024 (unless otherwise noted)	Target (Dec 2026)
1.11.5.1	Number of overall impressions from PrEP/nPEP marketing campaign(s)	56,340,217	TBD	56,940 (Jan- Jun 2024)	TBD
1.11.5.2	Number of PrEP/nPEP advertisements type (e.g., print; digital/internet-based; radio; television; out-of-home advertising)	4	TBD	TBD	TBD
1.11.5.3	Number of Ready, Set, PrEP initiative, PrEP/nPEP posts	340	TBD	TBD	TBD

Activity 1.11.6: Collaborate with CBOs and engage non-traditional partners to support HIV prevention messages and further destigmatize HIV.

VMSG Number	Measurement	Baseline (Jan 2022)	December 2023	December 2024	Target (Dec 2026)
1.11.6.1	Number of partnerships created that support prevention messages	13	14 (revised from 5)	12	12

Group 3
Breakout Group Guide
Linkage to Care; Retention in Care; and Special Populations
JIPRT Meeting, January 21, 2025

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Group 3
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JIPRT Meeting, January 21, 2025

Acronyms and Terminology

- AHRQ: Agency for Healthcare Research and Quality
- B/AA: Black/African American
- EHE: Ending the HIV Epidemic
- EMA: Eligible Metropolitan Area; locally, Miami-Dade County
- Hispanic: Includes persons who identify as Latina, Latino, and Latinx
- JIPRT: Joint Integrated Plan Review Team - Miami Dad HIV/AIDS Partnership Prevention and Strategic Planning Committees
- MAI: Minority AIDS Initiative
- MCM: Medical Case Management or Medical Case Manager
- MSM: Gay, bisexual, and other men who have sex with men
- NHAS: National HIV/AIDS Strategy
- OAHS: Outpatient/Ambulatory Health Services (doctor visits)
- PE Miami: Provide Enterprise® (RWP client database)
- RiMC: Retention in Medical Care or Retained in Medical Care; defined as two or more instances of a billed medical visit, copay, or Viral Load lab test, reported at least 90 days apart in the measurement period
- RWHAP or RWP: Ryan White HIV/AIDS Program - Part A/MAI, unless otherwise noted
- STI: Sexually Transmitted Infection
- TTRA: Test and Treat / Rapid Access (local "rapid start" project)
- VL: Viral Load: VL Suppression is defined as having less than 200 copies of HIV per milliliter of blood in the most recent test

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

Strategy L1.1: Expand capacity and access to local TTRA.

Activity 2.1.3: Provide and develop information that promotes the benefits of HIV treatment adherence for vulnerable populations, i.e., B/AA, Hispanic, and MSM.

Measurement 2.1.3.1
No. and listing of specific campaign for information dissemination to newly identified positive people with HIV.

Reporting Period	Campaigns	Target
January 1, 2022 – June 30, 2022	0	In Progress
July 1, 2022 – December 31, 2022	0	In Progress
January 1, 2023 – June 30, 2023	1	On Target
January 2025 Update	One campaign: "Let's Link Up"	On Target

TARGET = 1
December 31, 2026

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

Strategy L1.1: Expand capacity and access to local TTRA.

Activity 2.1.3: Provide and develop information that promotes the benefits of HIV treatment adherence for vulnerable populations, i.e., B/AA, Hispanic, and MSM.

Measurement 2.1.3.2
No. of trilingual (English, Spanish, and Creole) ~~brochures~~ educational folders designed for these specific campaigns.

Reporting Period	Brochures Designed	Target
January 1, 2022 – June 30, 2022	0	In Progress
July 1, 2022 – December 31, 2022	0	In Progress
January 1, 2023 – June 30, 2023	2 Total • 1 targeted towards clients • 1 targeted toward providers	On Target
January 2025 Update	**1,156 HIV educational folders** provided to EHE Quick Connect and TTRA testing sites	On Target

TARGET = 2
December 31, 2026

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

Strategy: Expand capacity and access to local TTRA.

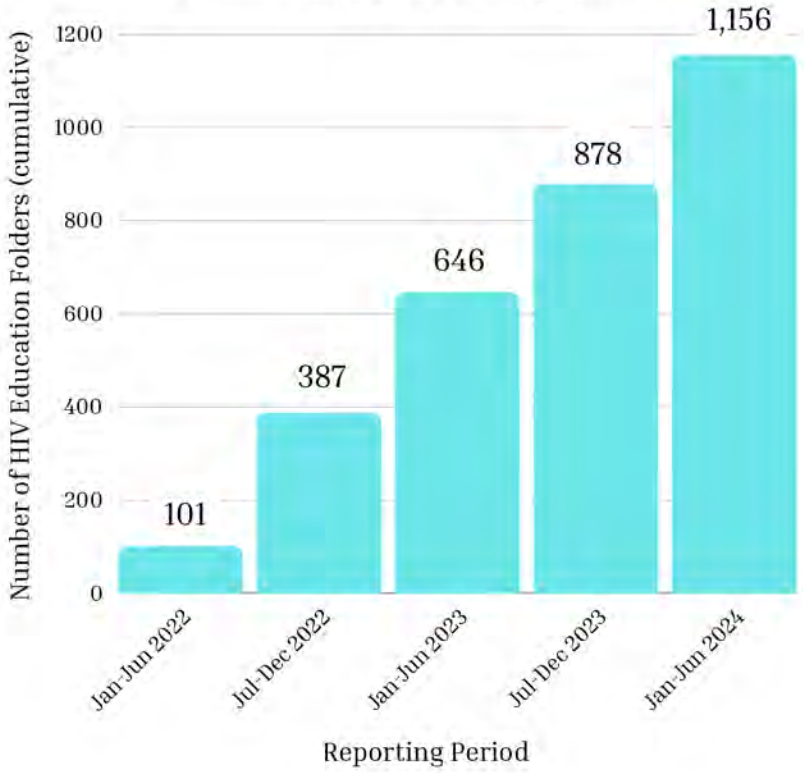
Activity 2.1.3: Provide and develop information that promotes the benefits of HIV treatment adherence for vulnerable populations, i.e., B/AA, Hispanic, and MSM.

BASELINE
January 1, 2022

0
HIV Education Folders

EHE Quick Connect
- Expanding TTRA protocol to ensure access to medical care and antiretroviral therapy (ART) within 7 days.
- Educating providers on HIV treatment guidelines, the benefits of routinized opt-out HIV testing at hospitals and clinics.
- Engaging the community in HIV testing through social marketing and media campaigns throughout the county.

Measurement 2.1.3.3
No. of HIV education folders provided to EHE Quick Connect and TTRA testing sites.



TARGET
December 31, 2026

2000
HIV Education Folders

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

Strategy: Expand capacity and access to local TTRA.

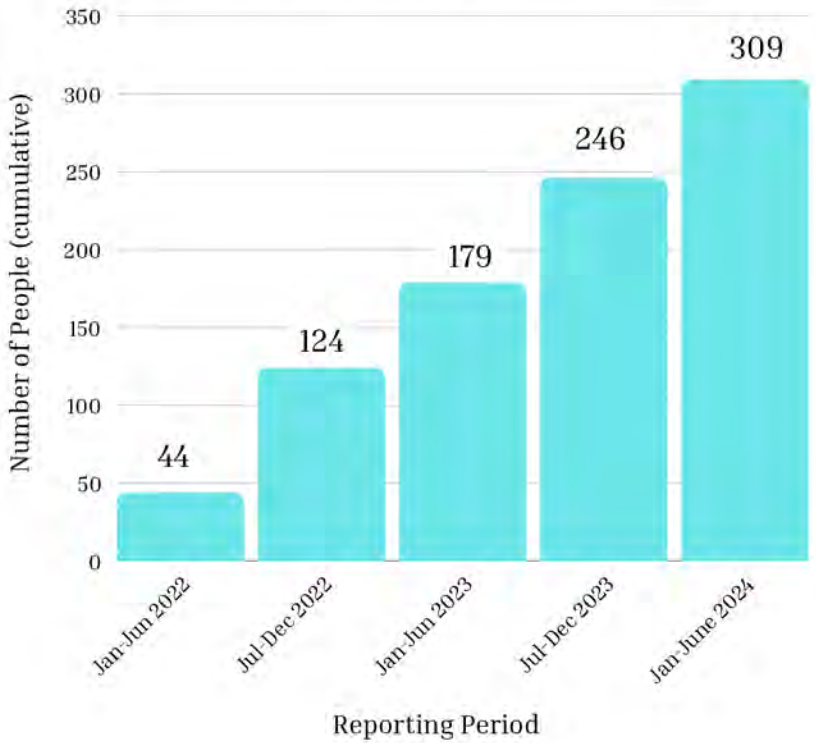
Activity 2.1.5: Expand the use of telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients; (mobile units).

BASELINE
January 1, 2022

0
People identified as eligible for EHE HealthTec

EHE HealthTec
Enhancing telehealth services for medical care, medical case management, mental health counseling, substance use disorder services, prescription drugs, and more.

Measurement 2.1.5.1
Number of people with HIV in the EMA who are identified as eligible for EHE HealthTec



TARGET
December 31, 2026

550
People identified as eligible for EHE HealthTec

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

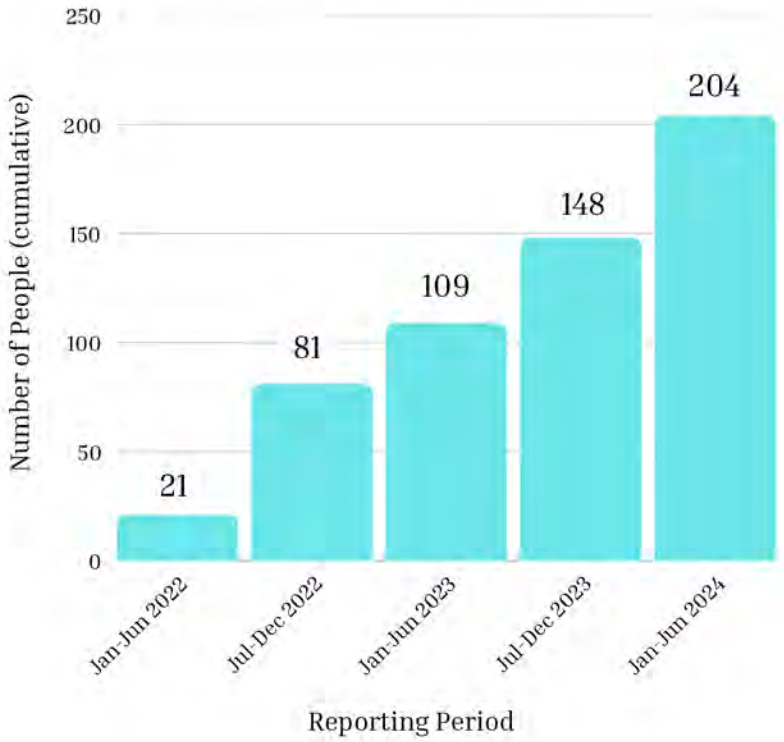
Strategy: Expand capacity and access to local TTRA.

Activity 2.1.5: Expand the use of telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients; (mobile units).

BASELINE
January 1, 2022

0
People enrolled throughout 5-Year performance period

Measurement 2.1.5.2
Number 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



TARGET
December 31, 2026

412
People enrolled throughout 5-Year performance period

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

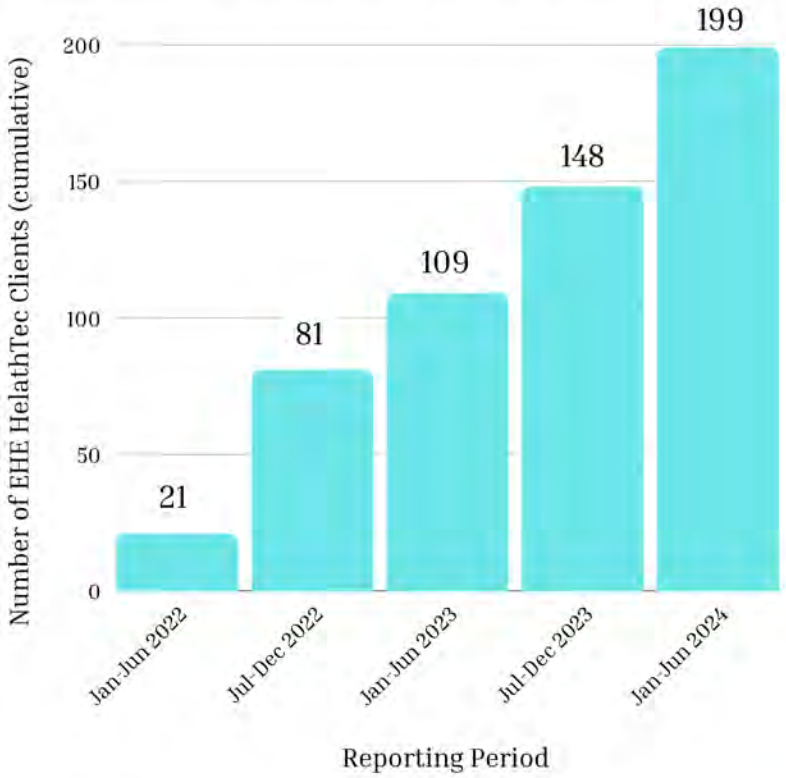
Strategy: Expand capacity and access to local TTRA.

Activity 2.1.5: Expand the use of telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients; (mobile units).

BASELINE
January 1, 2022

0
EHE HealthTec clients continuing the process

Measurement 2.1.5.3
Number of EHE HealthTec clients continuing this process (i.e., one or more medical visits, CD4 tests, or VL tests within 30 days of the initial client orientation date, documented via follow-up with client or provider) throughout the remainder of the five-year period of performance



TARGET
December 31, 2026

330
EHE HealthTec clients continuing the process

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

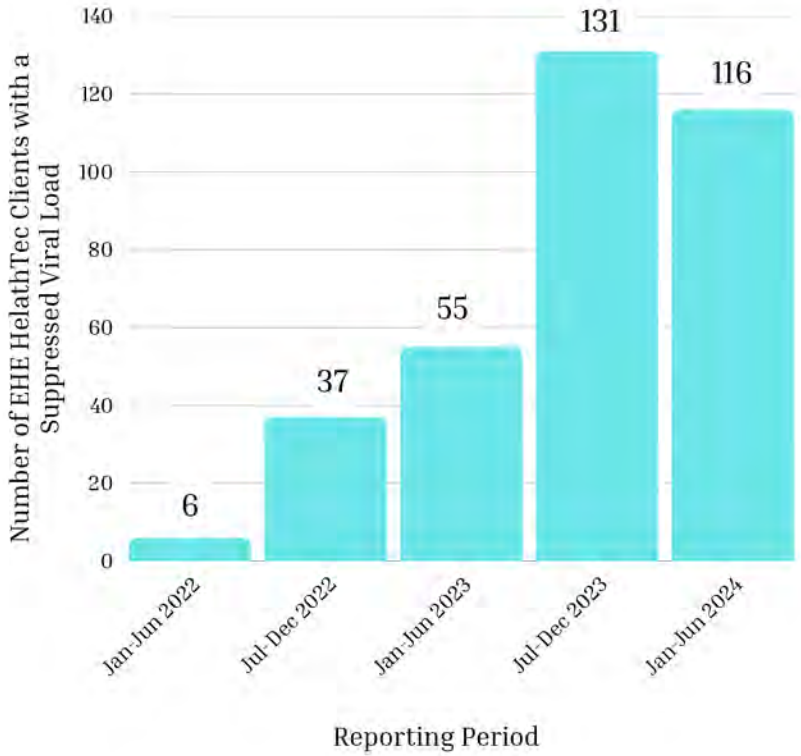
Strategy: Expand capacity and access to local TTRA.

Activity 2.1.5: Expand the use of telehealth (HealthTec) to agencies and clients to reduce barriers to care for eligible patients; (mobile units).

BASELINE
January 1, 2022

0
EHE HealthTec clients with a suppressed viral load

Measurement 2.1.5.4
Number of EHE HealthTec clients with a suppressed viral load at last viral load test during the measurement year



TARGET
December 31, 2026

297
EHE HealthTec clients with a suppressed viral load

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

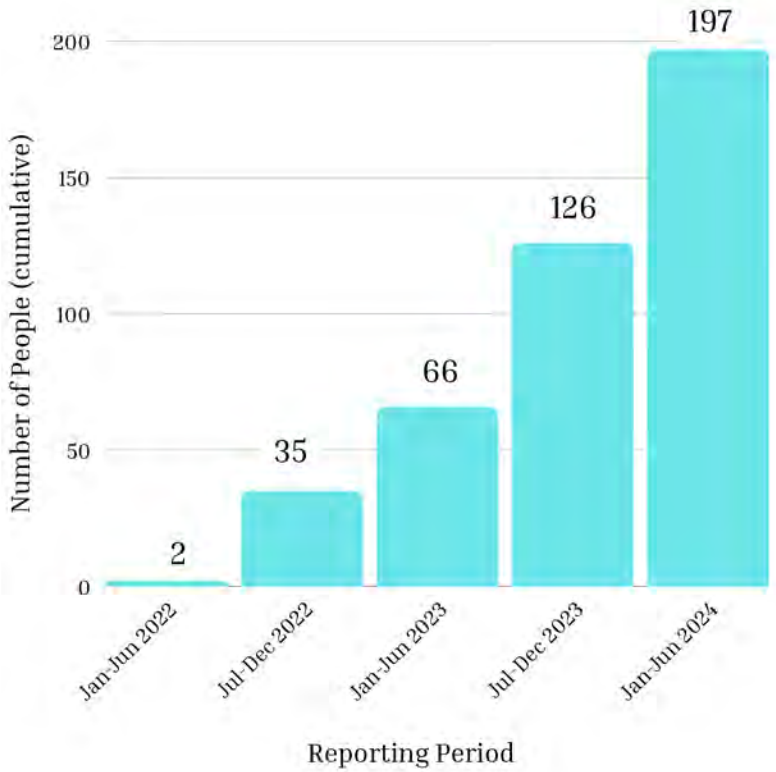
Strategy: Expand capacity and access to local TTRA.

Activity 2.1.6: Implement the use of RWHAP-EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms.

BASELINE
January 1, 2022

0
People who contact or are contacted by EHE Quick Connect team

Measurement 2.1.6.1
Number of people with HIV in the EMA who contact or are contacted by an EHE Quick Connect team



TARGET
December 31, 2026

430
People who contact or are contacted by EHE Quick Connect team

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

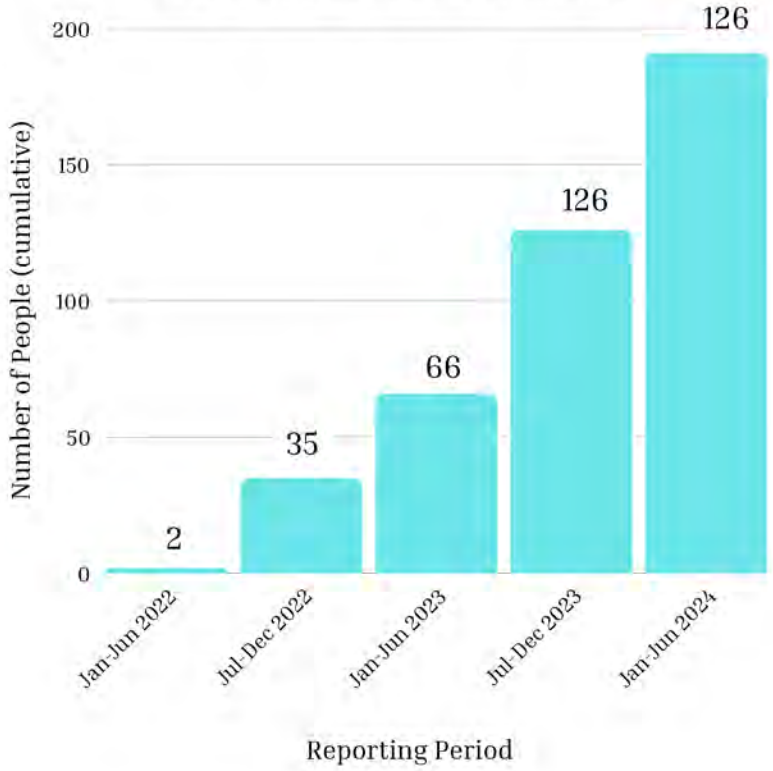
Strategy: Expand capacity and access to local TTRA.

Activity 2.1.6: Implement the use of RWHAP-EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms.

BASELINE
January 1, 2022

0
People linked to medical care

Measurement 2.1.6.2
Number of people with HIV linked to HIV medical care in the RWHAP Part A/MAI; other community programs; or private insurance



TARGET
December 31, 2026

430
People linked to medical care

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

Linkage to Care Objective 2.1: Increase the percentage of newly identified positive persons with HIV who are linked to care through initial TTRA protocol within seven (7) days from 68% in 2021 to 80% by December 31, 2026.

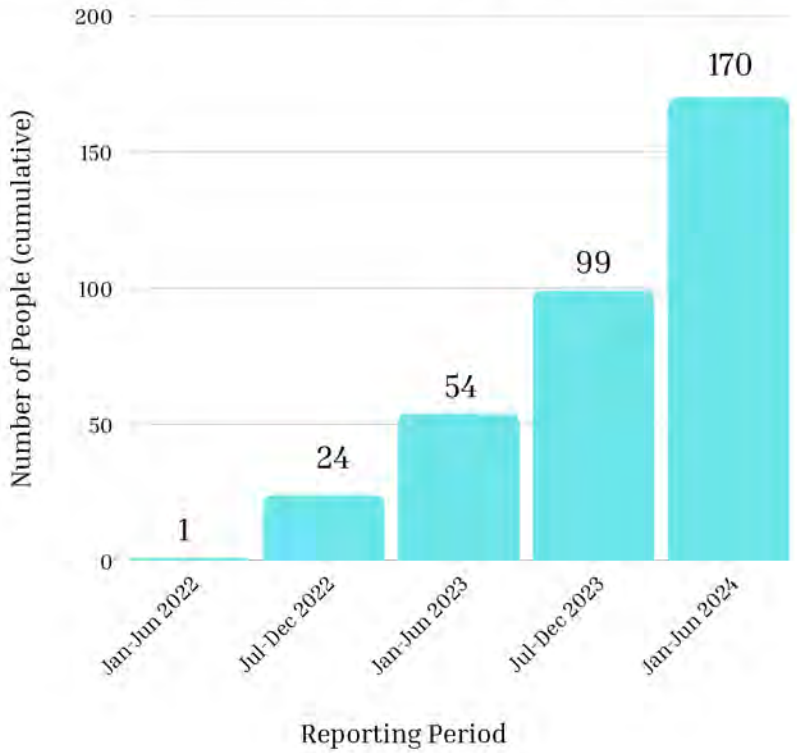
Strategy: Expand capacity and access to local TTRA.

Activity 2.1.6: Implement the use of RWHAP-EHE Quick Connect services in hospitals, clinics, urgent care centers, and emergency rooms.

BASELINE
January 1, 2022

0
Clients utilizing the EHE Quick Connect process

Measurement 2.1.6.3
Number 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



TARGET
December 31, 2026

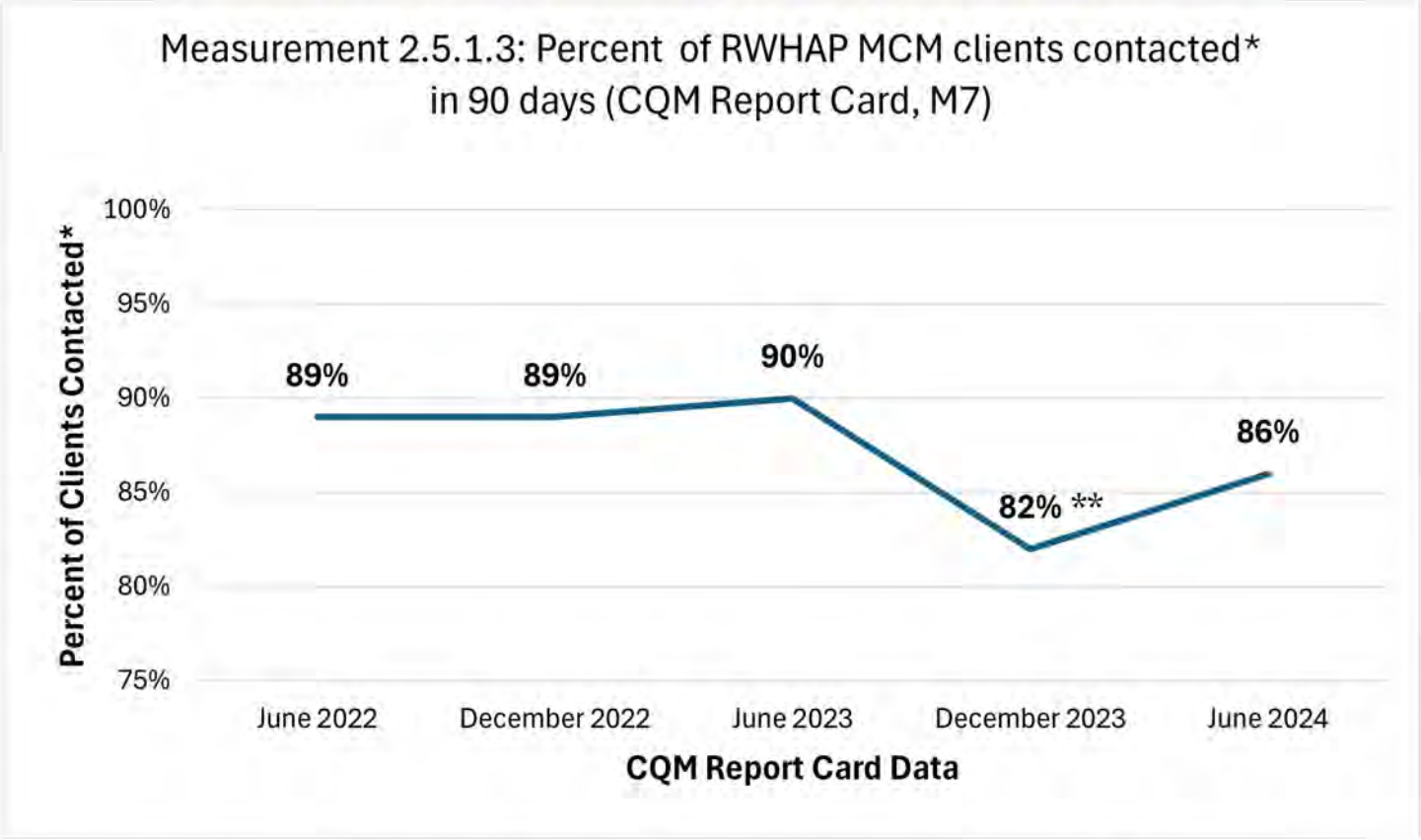
322
Clients utilizing the EHE Quick Connect process

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

Retention in Care Objective 2.5: 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: Identify and reengage clients in danger of being lost to RWHAP MCM care.

Activity 2.5.1: Establish early MCM lost to care trigger point warning in PE Miami at 60 days without MCM contact, and alert MCMs through PE-Miami



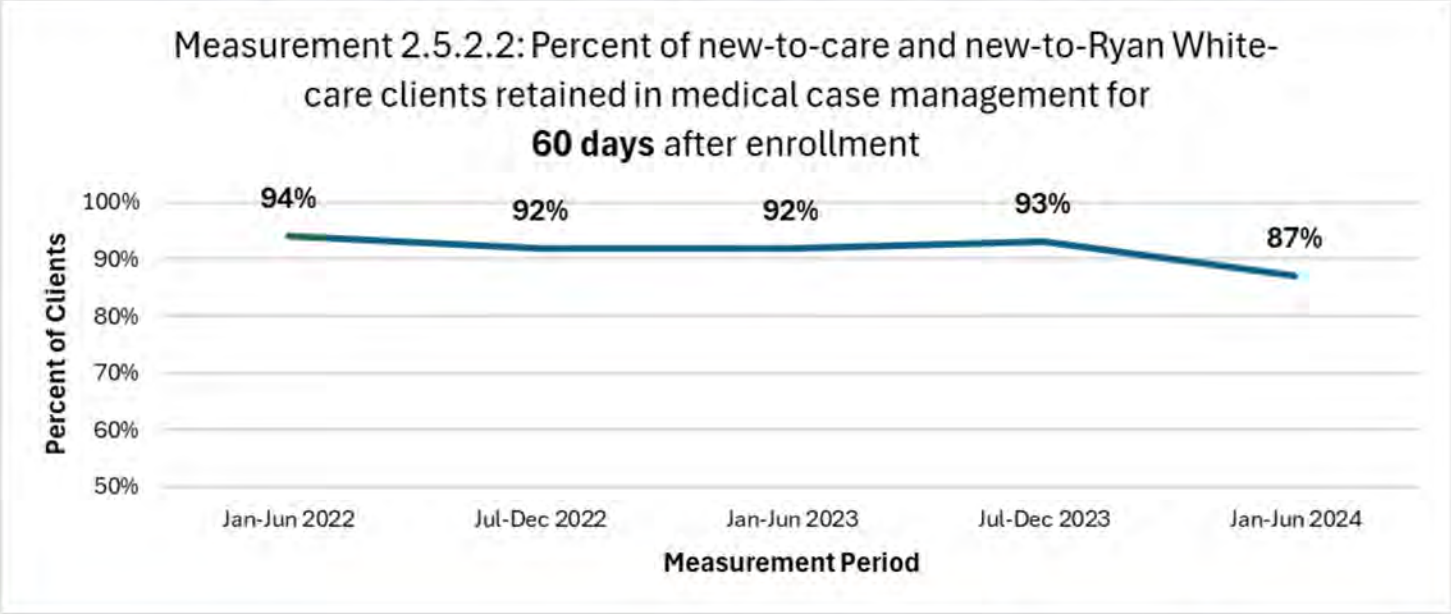
* The actual Measurement is written as the percent of clients "with no contact". Data is shown to reflect the inverse.
** Starting in December 2023 and going forward, Plan of Care (POC) was removed as a measurement for indicating client contact.

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

Retention in Care Objective 2.5: 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: Identify and reengage clients in danger of being lost to RWHAP MCM care.

Activity 2.5.2: Retain a minimum of 75% of newly enrolled Ryan White clients in MCM for a minimum of six months (180 days) after enrollment in the Ryan White Program.



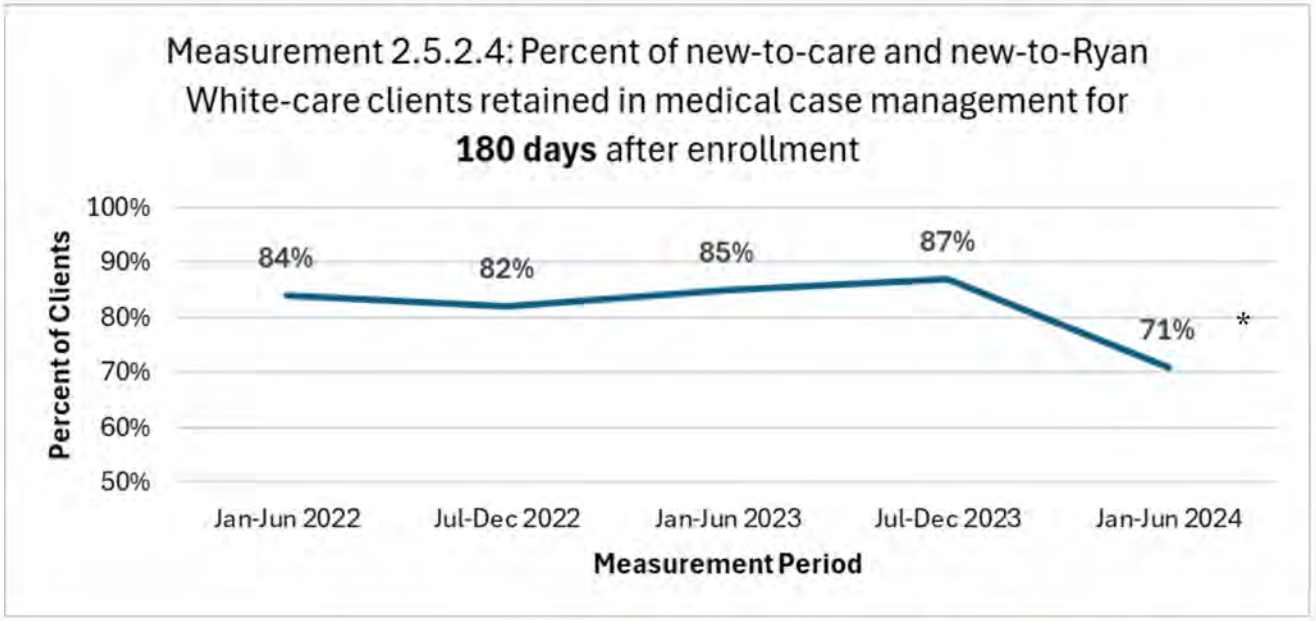
Measurement 2.5.2.1	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Number of newly enrolled Ryan White-care clients retained in medical case management for **60 days** after enrollment	545	477	514	561	474
Total number of newly enrolled Ryan White-care clients	579	518	557	606	544

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

Retention in Care Objective 2.5: 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: Identify and reengage clients in danger of being lost to RWHAP MCM care.

Activity 2.5.2: Retain a minimum of 75% of newly enrolled Ryan White clients in MCM for a minimum of six months (180 days) after enrollment in the Ryan White Program.



Measurement 2.5.2.3	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Number of newly enrolled Ryan White-care clients retained in medical case management for **180 days** after enrollment	486	423	476	528	387
Total number of newly enrolled Ryan White-care clients	579	518	557	606	544

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

Special Populations Objective 2.9: Improve health outcomes for adults over age 50 with HIV.

Strategy: Improve health outcomes for adults over age 50 with HIV.

Activity 2.9.1: Examine client outcome data specifically for persons over 50 in order to identify potential QI opportunities to improve service to this population.

VMSG Number	Measurement	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
2.9.1.1	Number of RWP MCM providers with identified 50+ sub-populations with RiMC rates below RWP system target rates	9	8	5	7	6
2.9.1.2	Number of RWP OAHS providers with identified 50+ sub-populations with RiMC rates below RWP system target rates	5	7	4	5	3
2.9.1.3	Number of RWP MCM providers with identified 50+ sub-populations with Viral Load Suppression rates below RWP system target rates	4	4	3	0	8*
2.9.1.4	Number of RWP OAHS providers with identified 50+ sub-populations with Viral Load Suppression rates below RWP system target rates	3	3	3	1	8*

VL Suppression
TARGET = 95%
December 31, 2026

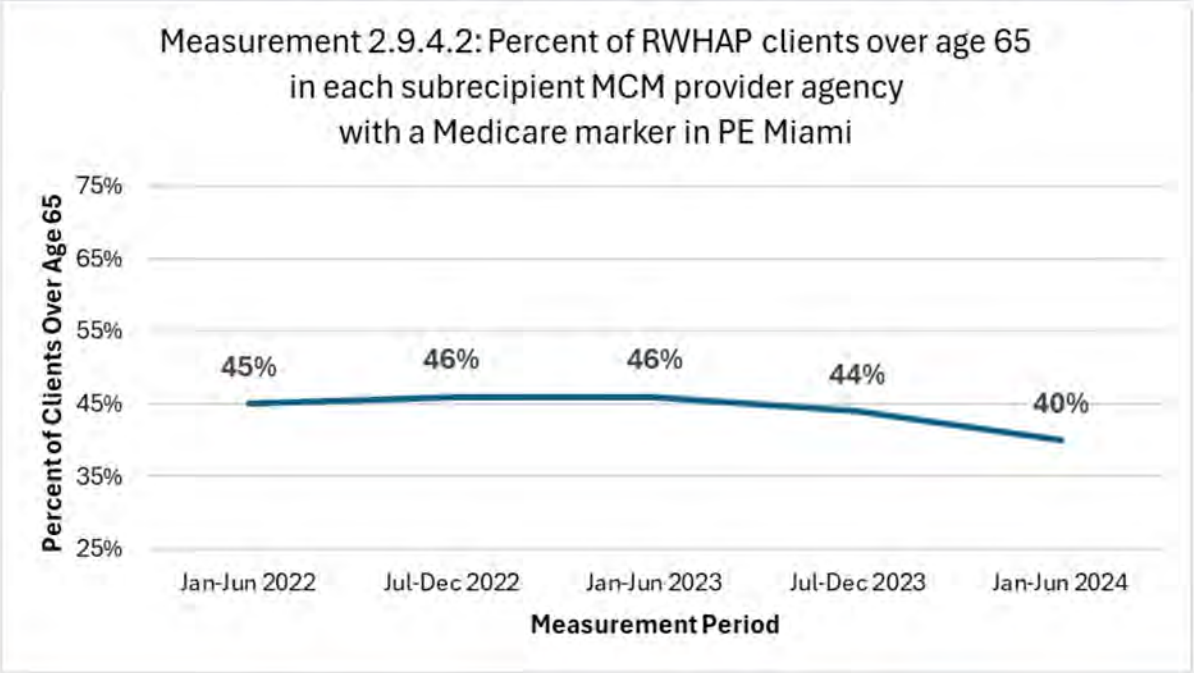
* This is based on the new 95% target for VL suppression. Previous numbers were based on a target of 90%. Four agencies have a VL suppression rate >90% but <95% for this period.

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

Special Populations Objective 2.9: Improve health outcomes for adults over age 50 with HIV.

Strategy: Improve health outcomes for adults over age 50 with HIV.

Activity 2.9.4: Determine the need for Medicare transition assistance for RWP clients aged 65 and older.



Measurement 2.9.4.1	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Number of RWHAP clients over age 65 with a Medicare marker in PE Miami	190	201	204	205	235
Total number of Ryan White clients over age 65	422	238	447	461	590

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

Special Populations Objective 2.13: Improve health outcomes for MSM with HIV and co-occurring STIs in Ryan White Care.

Strategy: Expand existing programs and collaborations to address specific needs of MSM with HIV and sexually transmitted infections as co-occurring health conditions.

Activity 2.13.2: Identify barriers to care or below-average client treatment outcomes among MSM clients with STIs as co-occurring conditions.

VMSG Number	Measurement	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
2.13.2.2	Number of RWP MSM clients identified with STIs as co-morbidities	1653	1783	1811	1915	2031
2.13.2.3	Number of MSM/STI clients with an unsuppressed VL	155	159	159	114	140
2.13.2.4	Percent of MSM/STI clients with an unsuppressed VL	9%	9%	9%	6%	7%

Group 4
Breakout Group Guide
Disparities in Retention in Care and Disparities in Viral Load Suppression Rates Among Priority Populations
JIPRT Meeting, January 21, 2025

1. Introductions - Get to know your group!
2. Designate a person to report during the Breakouts Recap.
3. On each handout, review the NHAS Goal --> Objective --> Strategy --> Activity --> Measurement --> Data
4. Consider some questions to guide discussions:
    a. What is our data source?
    b. Who is responsible for achieving the Objectives?
    c. What is the target?
    d. Are we on track to achieve the target by December 31, 2026?
    e. What challenges are keeping us from achieving our targets?
    f. What can we do to improve our outcomes?
    g. Where are we having success and how can we ensure we stay on track?
    h. Should we adjust our target?
5. What overall impressions do you want to report to the JIPRT during Breakouts Recap?

Acronyms and Terminology

- B/AA: Black/African American
- Hispanic: Includes persons who identify as Latina, Latino, and Latinx
- JIPRT: Joint Integrated Plan Review Team - Miami Dad HIV/AIDS Partnership Prevention and Strategic Planning Committees
- MAI: Minority AIDS Initiative
- MCM: Medical Case Management or Medical Case Manager
- MSM: Gay, bisexual, and other men who have sex with men
- NHAS: National HIV/AIDS Strategy
- OAHS: Outpatient/Ambulatory Medical Services (doctor visits)
- RiMC: Retention in Medical Care or Retained in Medical Care; defined as two or more instances of a billed medical visit, copay, or Viral Load lab test, reported at least 90 days apart in the measurement period
- RWHAP or RWP: Ryan White HIV/AIDS Program - Part A/MAI, unless otherwise noted
- VL: Viral Load: VL Suppression is defined as having less than 200 copies of HIV per milliliter of blood in the most recent test

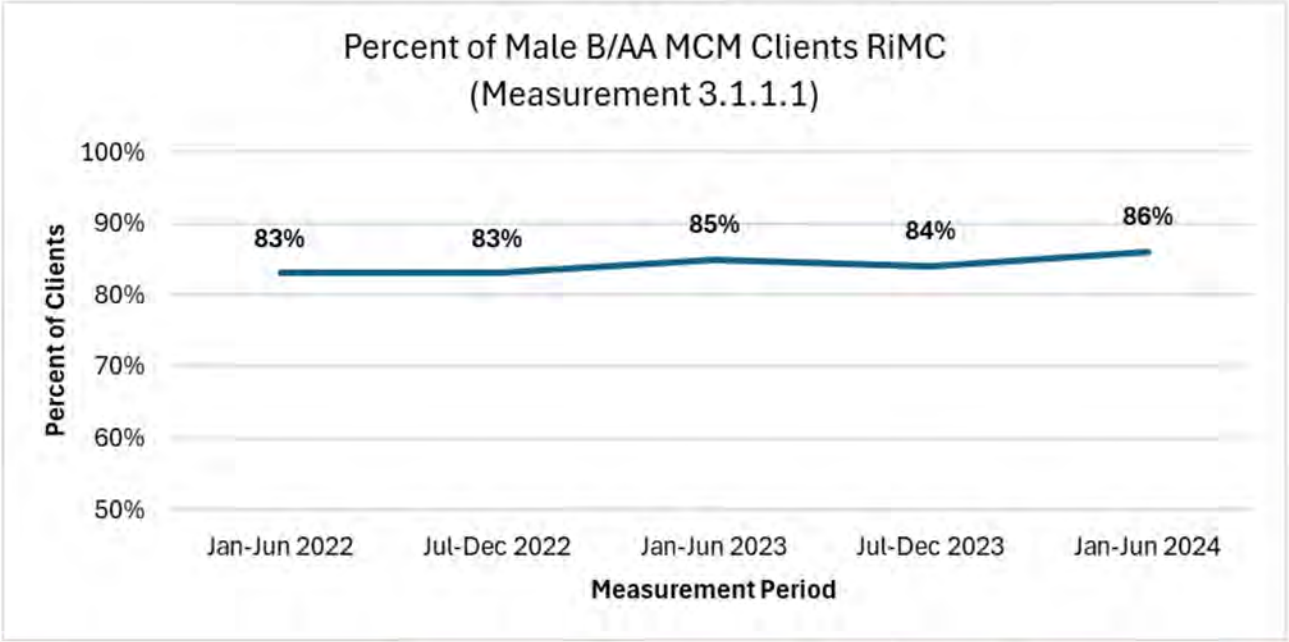
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care - Objective 3.1: Increase RWHAP RiMC rates among priority populations.

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

Activity 3.1.1: Semi-annually track RiMC rates among RWHAP providers of MCM and OAHS services to B/AA Males.

BASELINE
January 1, 2022
81%
B/AA Males RiMC



TARGET
December 31, 2026

90%
B/AA Males RiMC

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Male B/AA MCM Clients RiMC	481	533	574	642	703
Total Male B/AA MCM Clients	581	644	677	767	814
Number of MCM subrecipients with 90% RiMC for B/AA Males	5	2	4	4	5
Total number of MCM subrecipients with Male B/AA clients	13	13	13	13	13

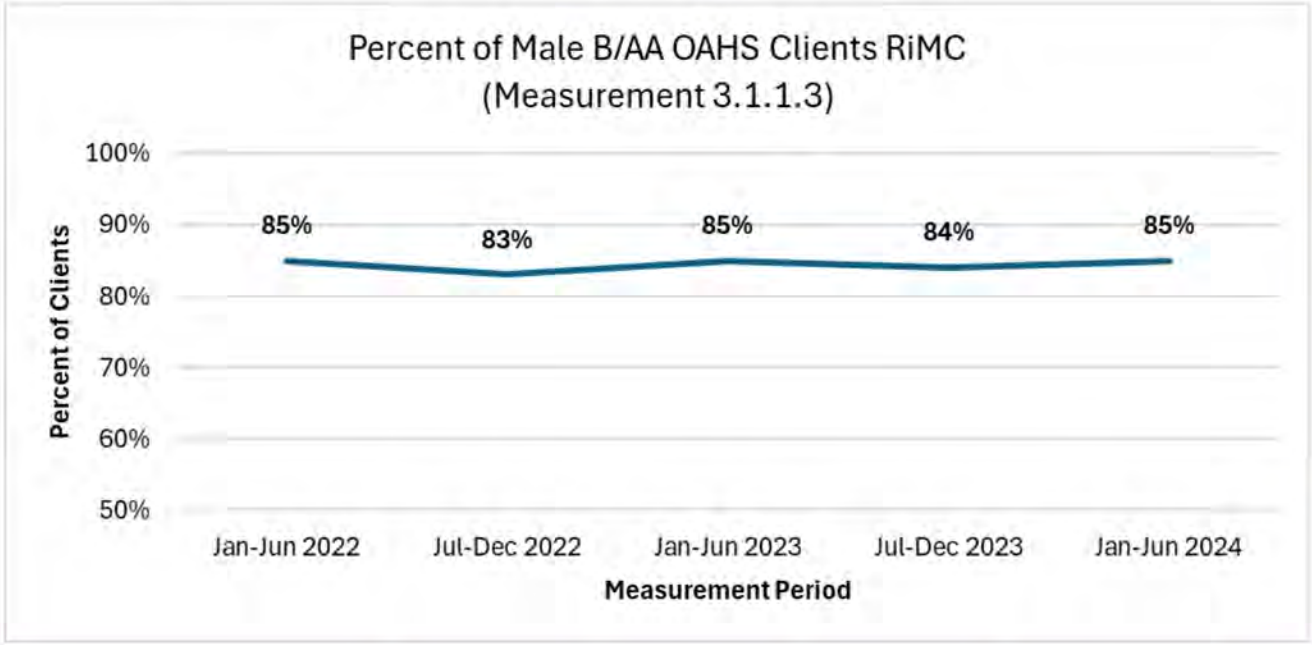
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care - Objective 3.1: Increase RWHAP RiMC rates among priority populations.

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

Activity 3.1.1: Semi-annually track RiMC rates among RWHAP providers of MCM and OAHS services to B/AA Males.

BASELINE
January 1, 2022
81%
B/AA Males RiMC



TARGET
December 31, 2026

90%
B/AA Males RiMC

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Male B/AA OAHS Clients RiMC	332	357	383	402	419
Total Male B/AA OAHS Clients	391	428	450	476	493
Number of OAHS subrecipients with 90% RiMC for B/AA Males	4	1	5	5	4
Total number of OAHS subrecipients with Male B/AA clients	11	11	11	11	11

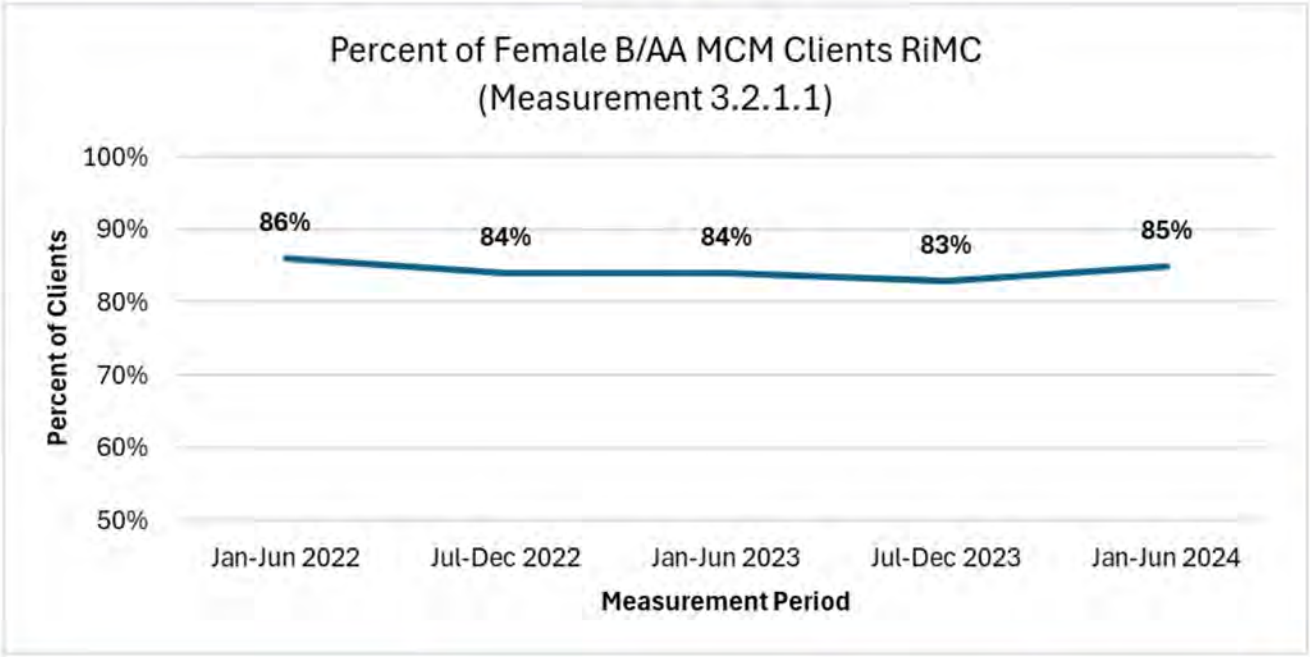
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care - Objective 3.2: Increase RWHAP RiMC rates among priority populations.

Strategy: Increase RiMC rates from 88% in 2021 to 90% by December 31, 2026, for Black/African American (B/AA) Females.

Activity 3.2.1: Semi-annually track RiMC rates among RWHAP providers of MCM and OAHS services to B/AA Females.

BASELINE
January 1, 2022
88%
B/AA Females RiMC



TARGET
December 31, 2026

90%
B/AA Females RiMC

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Female B/AA MCM Clients RiMC	242	254	266	306	344
Total Female B/AA MCM Clients	281	303	315	368	404
Number of MCM subrecipients with 90% RiMC for B/AA Females	4	4	6	3	3
Total number of MCM subrecipients with Female B/AA clients	12	12	12	12	12

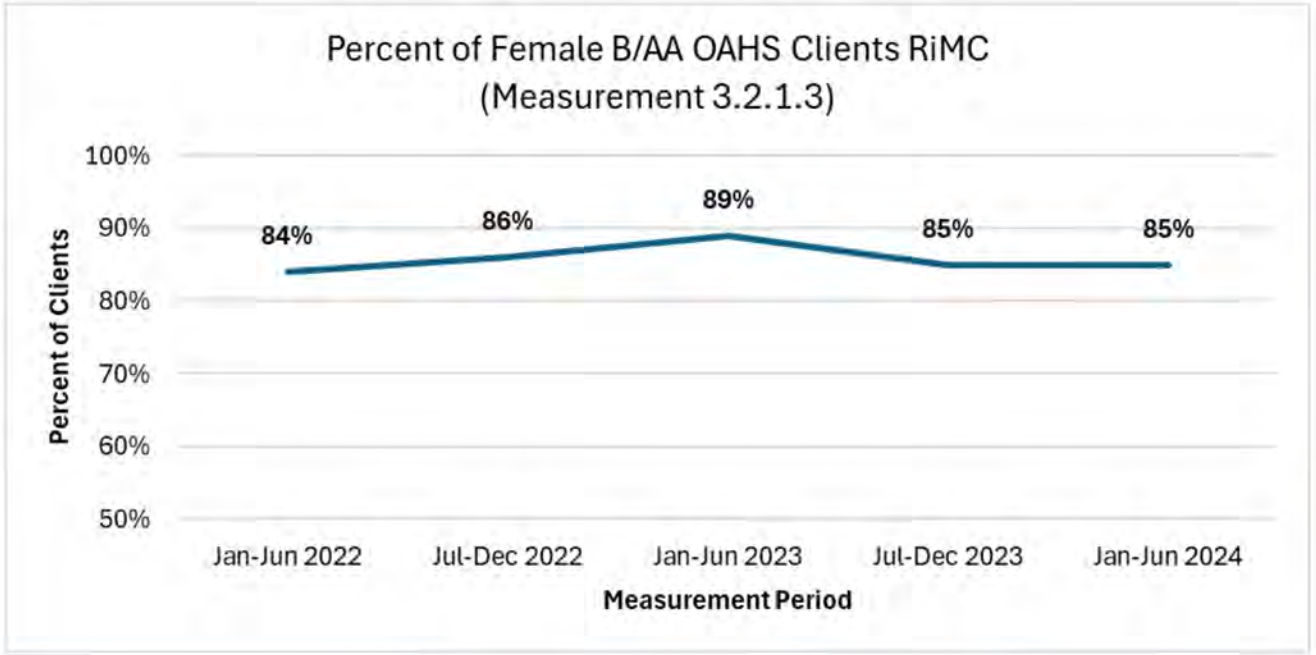
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care - Objective 3.2: Increase RWHAP RiMC rates among priority populations.

Strategy: Increase RiMC rates from 88% in 2021 to 90% by December 31, 2026, for Black/African American (B/AA) Females.

Activity 3.2.1: Semi-annually track RiMC rates among RWHAP providers of MCM and OAHS services to B/AA Females.

BASELINE
January 1, 2022
88%
B/AA Females RiMC



TARGET
December 31, 2026

90%
B/AA Females RiMC

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Female B/AA OAHS Clients RiMC	129	132	147	166	182
Total Female B/AA OAHS Clients	153	153	165	195	213
Number of OAHS subrecipients with 90% RiMC for B/AA Females	5	4	5	4	4
Total number of OAHS subrecipients with Female B/AA clients	12	12	12	12	12

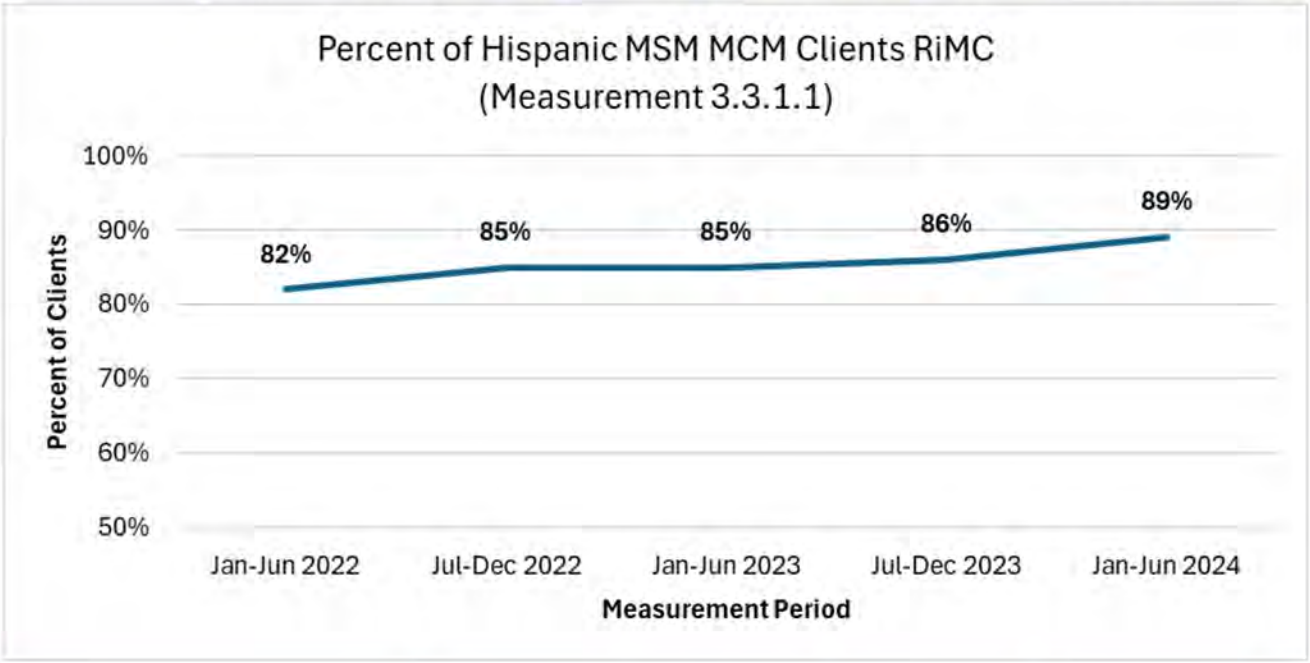
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care - Objective 3.3: Increase RWHAP RiMC rates among priority populations.

Strategy: Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026, for Hispanic Men Who Have Sex With Men (MSM).

Activity 3.3.1: Semi-annually track RiMC rates among RWHAP providers of MCM and OAHS services to Hispanic MSM.

BASELINE
January 1, 2022
85%
Hispanic
MSM RiMC



TARGET
December 31, 2026

90% Hispanic
MSM RiMC

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Hispanic MSM MCM Clients RiMC	2115	2412	2601	2929	3190
Total Hispanic MSM MCM Clients	2572	2836	3047	3388	3576
Number of MCM subrecipients with 90% RiMC for Hispanic MSM	1	2	3	3	6
Total number of MCM subrecipients with Hispanic MSM clients	13	13	13	13	13

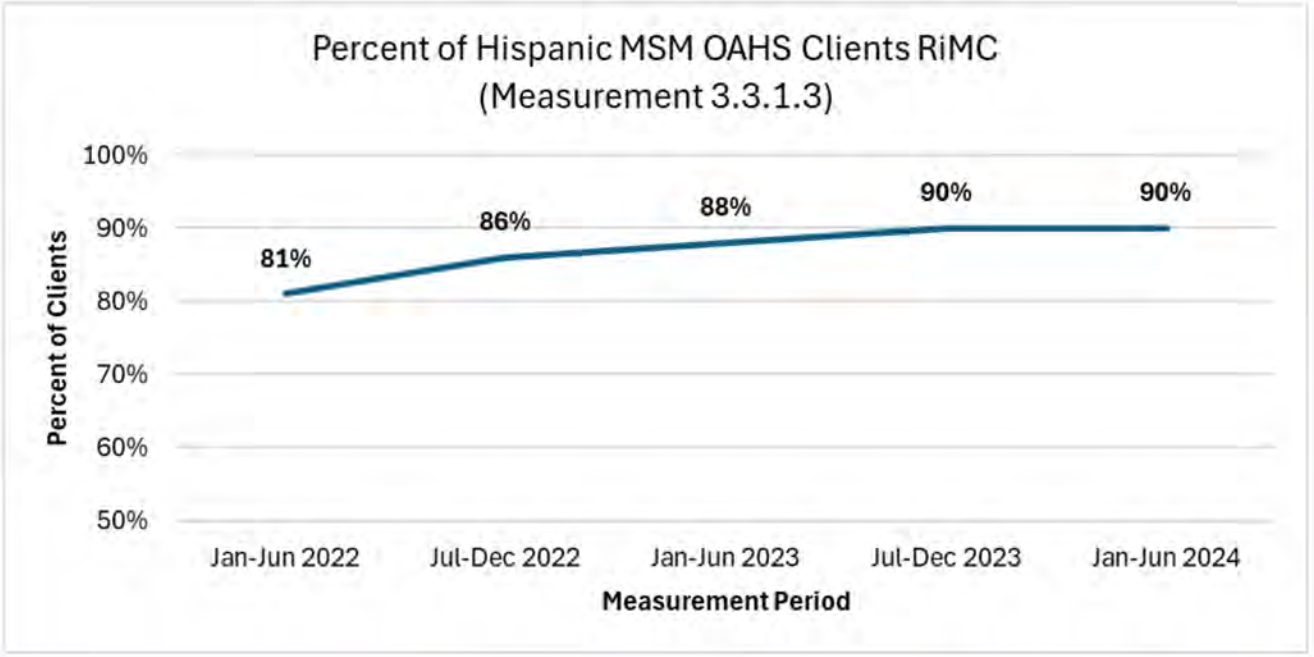
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Retention in Care - Objective 3.3: Increase RWHAP RiMC rates among priority populations.

Strategy: Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026, for Hispanic Men Who Have Sex With Men (MSM).

Activity 3.3.1: Semi-annually track RiMC rates among RWHAP providers of MCM and OAHS services to Hispanic MSM.

BASELINE
January 1, 2022
85%
Hispanic
MSM RiMC



TARGET
December 31, 2026

90% Hispanic
MSM RiMC

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
Hispanic MSM OAHS Clients RiMC	1099	1286	1422	1535	1576
Total Hispanic MSM OAHS Clients	1353	1493	1623	1708	1751
Number of OAHS subrecipients with 90% RiMC for Hispanic MSM	4	3	5	8	9
Total number of OAHS subrecipients with Hispanic MSM clients	12	12	12	12	12

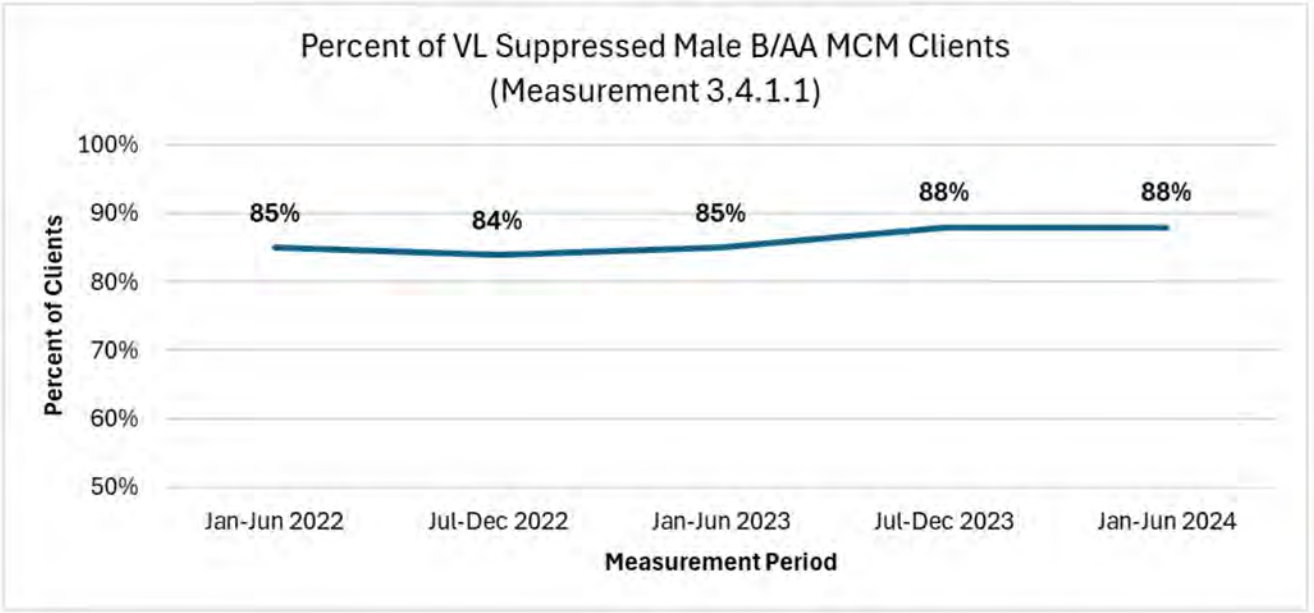
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression - Objective 3.4: Increase the VL suppression rates among priority populations.

Strategy: Increase VL suppression rates from 81% in 2021 to 95% by December 31, 2026, for Black/African American (B/AA) Males.

Activity 3.4.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to B/AA Males.

BASELINE
January 1, 2022
81%
B/AA Males VL Suppression Rate



TARGET
December 31, 2026

95%
B/AA Males VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Male B/AA MCM Clients	495	543	577	675	717
Total Male B/AA MCM Clients	581	644	677	767	814
Number of MCM subrecipients with 90% VL Suppression for B/AA Males (Target is 95% after June 2024)	2	1	4	6	6
Total number of MCM subrecipients with B/AA Male clients	13	13	13	13	13

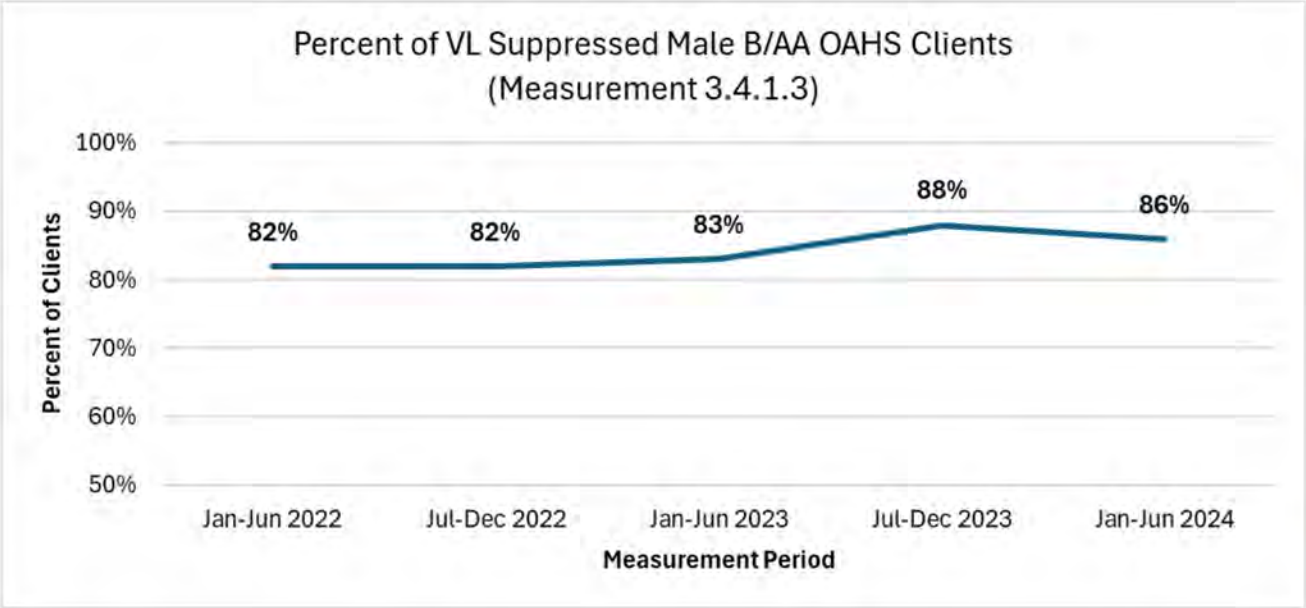
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression - Objective 3.4: Increase the VL suppression rates among priority populations.

Strategy: Increase VL suppression rates from 81% in 2021 to 95% by December 31, 2026, for Black/African American (B/AA) Males.

Activity 3.4.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to B/AA Males.

BASELINE
January 1, 2022
81%
B/AA Males VL Suppression Rate



TARGET
December 31, 2026

95%
B/AA Males VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Male B/AA OAHS Clients	320	351	372	420	426
Total Male B/AA OAHS Clients	391	428	450	476	493
Number of OAHS subrecipients with 90% VL Suppression for B/AA Males (Target is 95% after June 2024)	2	2	3	5	3
Total number of OAHS subrecipients with B/AA Male clients	11	11	11	11	11

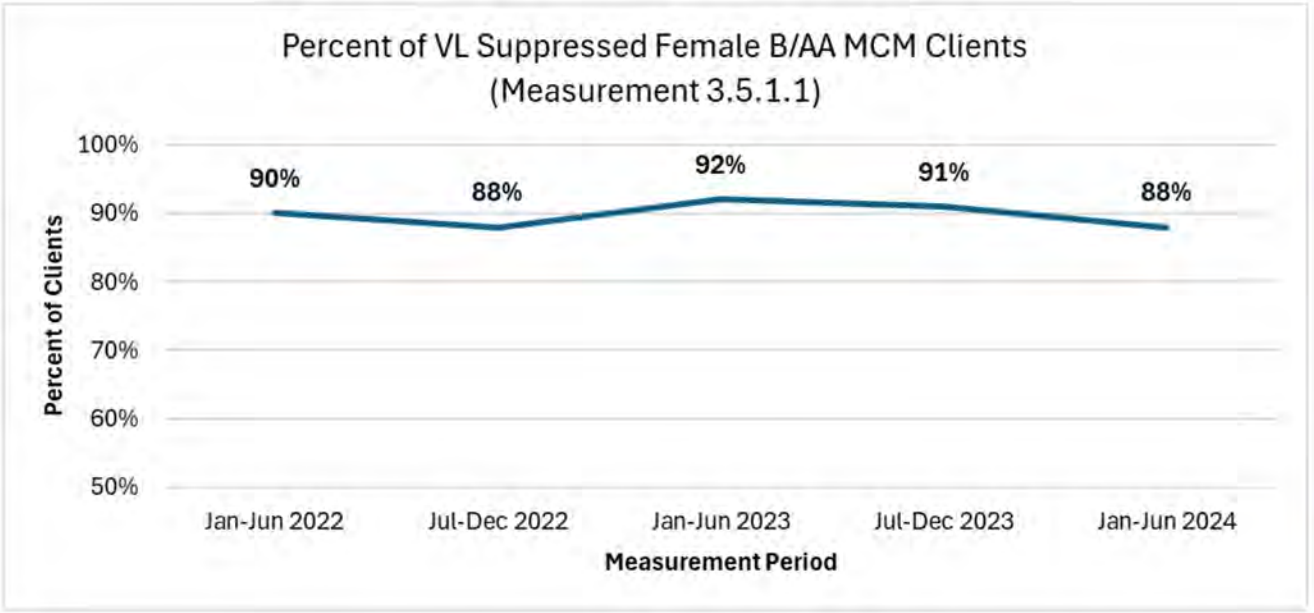
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression - Objective 3.5: Increase the VL suppression rates among priority populations.

Strategy: Increase VL suppression rates from 84% in 2021 to 95% by December 31, 2026, for Black/African American (B/AA) Females.

Activity 3.5.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to B/AA Females.

BASELINE
January 1, 2022
84%
B/AA Females VL Suppression Rate



TARGET
December 31, 2026

95%
B/AA Females VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Female B/AA MCM Clients	252	268	290	334	357
Total Female B/AA MCM Clients	281	303	315	368	404
Number of MCM subrecipients with 90% VL Suppression for B/AA Females (Target is 95% after June 2024)	7	5	8	7	6
Total number of MCM subrecipients with B/AA Female clients	12	12	12	12	12

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

Disparities in Viral Load Suppression - Objective 3.5: Increase the VL suppression rates among priority populations.

Strategy: Increase VL suppression rates from 84% in 2021 to 95% by December 31, 2026, for Black/African American (B/AA) Females.

Activity 3.5.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to B/AA Females.

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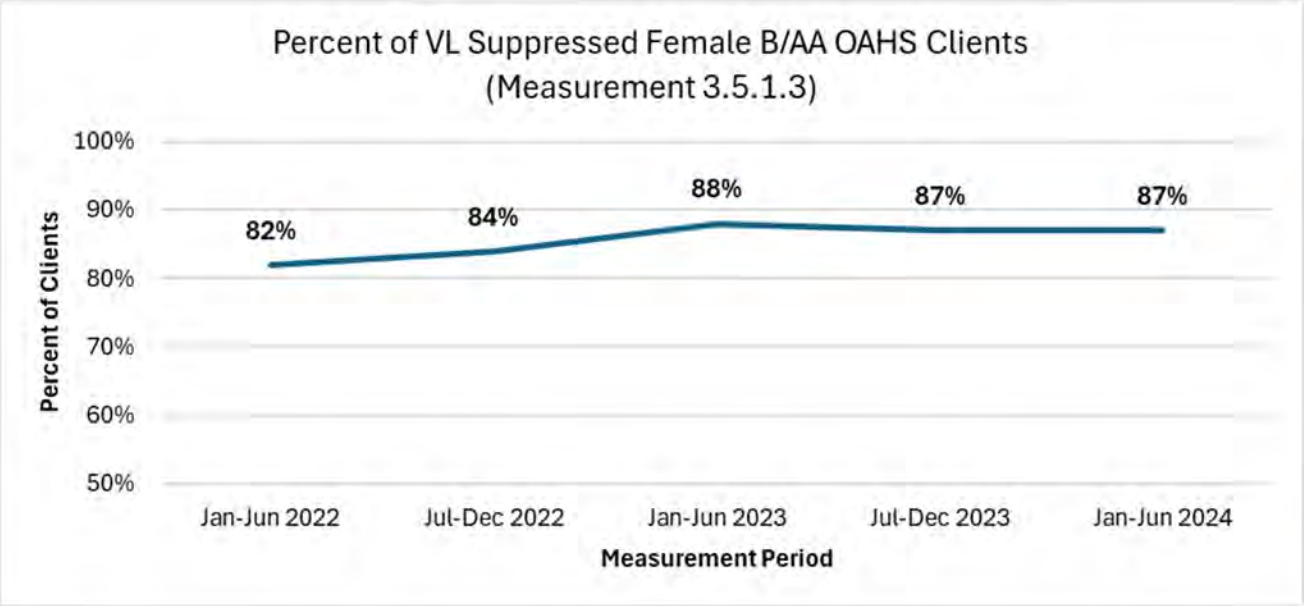
January 1, 2022
84%
B/AA Females VL Suppression Rate



TARGET
December 31, 2026

95%
B/AA Females VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Female B/AA OAHS Clients	126	129	146	170	186
Total Female B/AA OAHS Clients	153	153	165	195	213
Number of OAHS subrecipients with 90% VL Suppression for B/AA Females (Target is 95% after June 2024)	3	4	5	5	4
Total number of OAHS subrecipients with B/AA Female clients	12	12	12	12	12

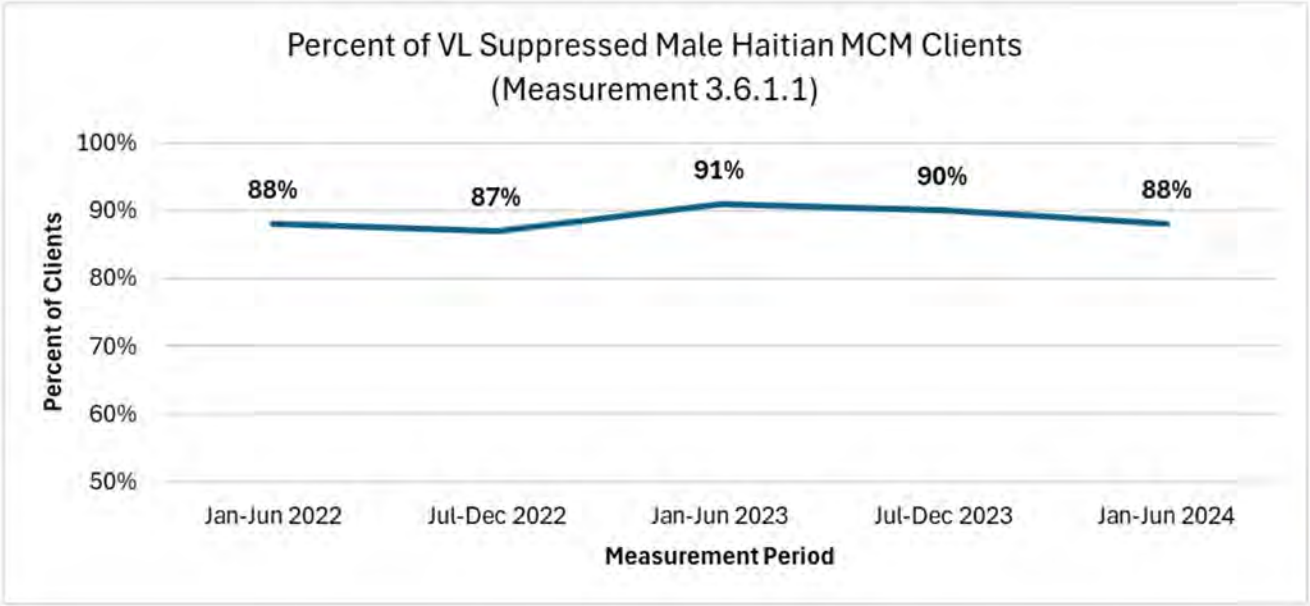
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression - Objective 3.6: Increase the VL suppression rates among priority populations.

Strategy: Increase VL suppression rates from 86% in 2021 to 95% by December 31, 2026, for Haitian Males.

Activity 3.6.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to Haitian Males.

BASELINE
January 1, 2022
86%
Haitian Males VL Suppression Rate



TARGET
December 31, 2026

95%
Haitian Males VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Male Haitian MCM Clients	235	253	272	300	304
Total Male Haitian MCM Clients	268	292	300	335	347
Number of MCM subrecipients with 90% VL Suppression for Haitian Males (Target is 95% after June 2024)	5	2	7	5	4
Total number of MCM subrecipients with Haitian Male clients	11	11	11	11	11

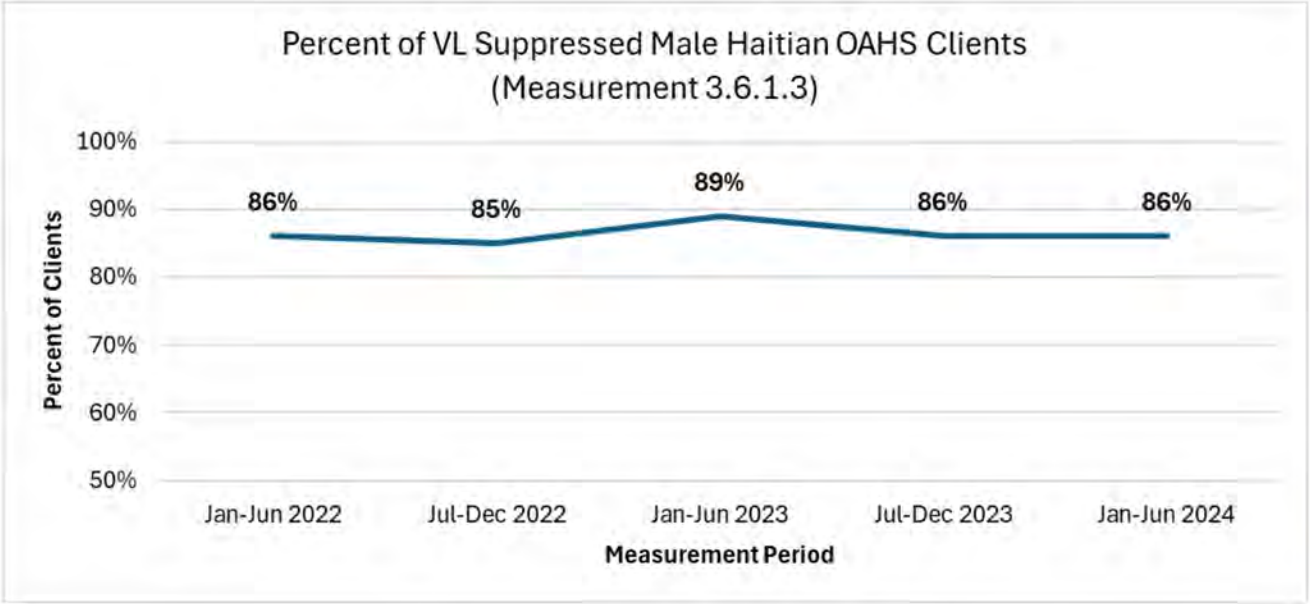
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Disparities in Viral Load Suppression - Objective 3.6: Increase the VL suppression rates among priority populations.

Strategy: Increase VL suppression rates from 86% in 2021 to 95% by December 31, 2026, for Haitian Males.

Activity 3.6.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to Haitian Males.

BASELINE
January 1, 2022
86%
Haitian Males VL Suppression Rate



TARGET
December 31, 2026

95%
Haitian Males VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Male Haitian OAHS Clients	133	135	149	157	164
Total Male Haitian OAHS Clients	155	158	167	182	190
Number of OAHS subrecipients with 90% VL Suppression for Haitian Males (Target is 95% after June 2024)	3	3	6	5	4
Total number of OAHS subrecipients with Haitian Male clients	11	11	11	11	11

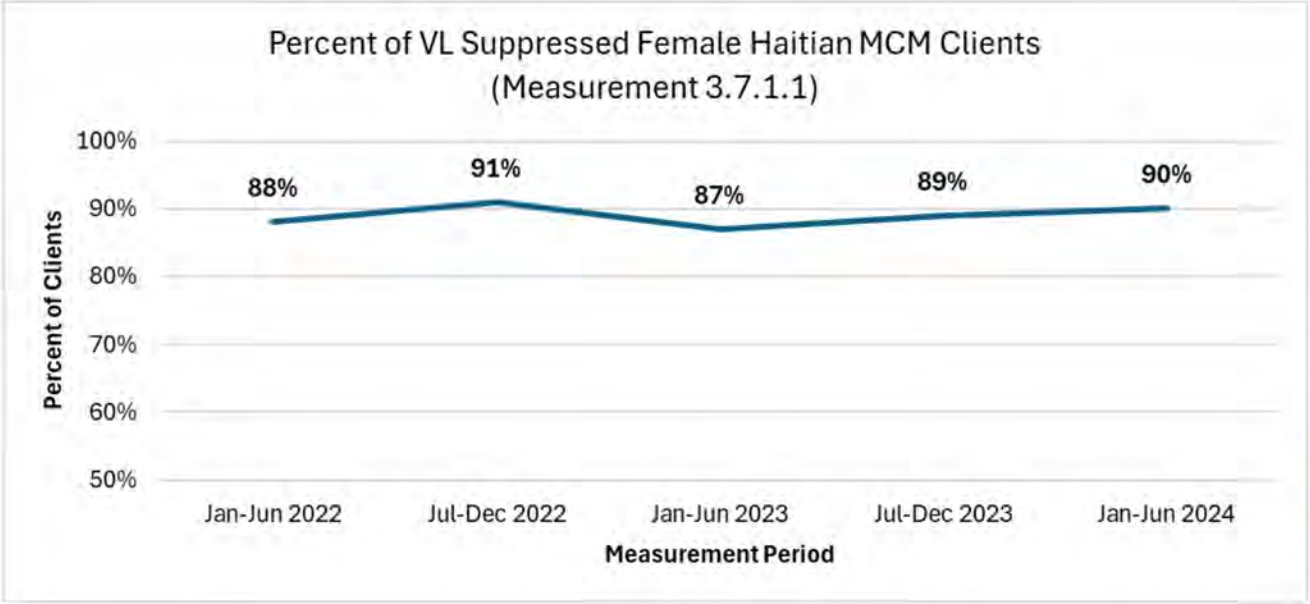
NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

Objective 3.7 (DV1) Increase the VL suppression rates among priority populations.

Strategy DV1.4: Increase VL suppression rates from 86% in 2021 to 95% by December 31, 2026, for Haitian Females.

Activity 3.7.1: Track VL suppression rates among RWHAP providers of MCM and OAHS services to Haitian Females.

BASELINE
January 1, 2022
86%
Haitian Females VL Suppression Rate



TARGET
December 31, 2026

95%
Haitian Females VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Female Haitian MCM Clients	235	251	246	286	319
Total Female Haitian MCM Clients	268	277	283	320	355
Number of MCM subrecipients with 90% VL Suppression for Haitian Females (Target is 95% after June 2024)	3	4	1	5	6
Total number of MCM subrecipients with Haitian Female clients	11	11	11	11	11

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

Objective 3.7 (DV1) Increase the VL suppression rates among priority populations.

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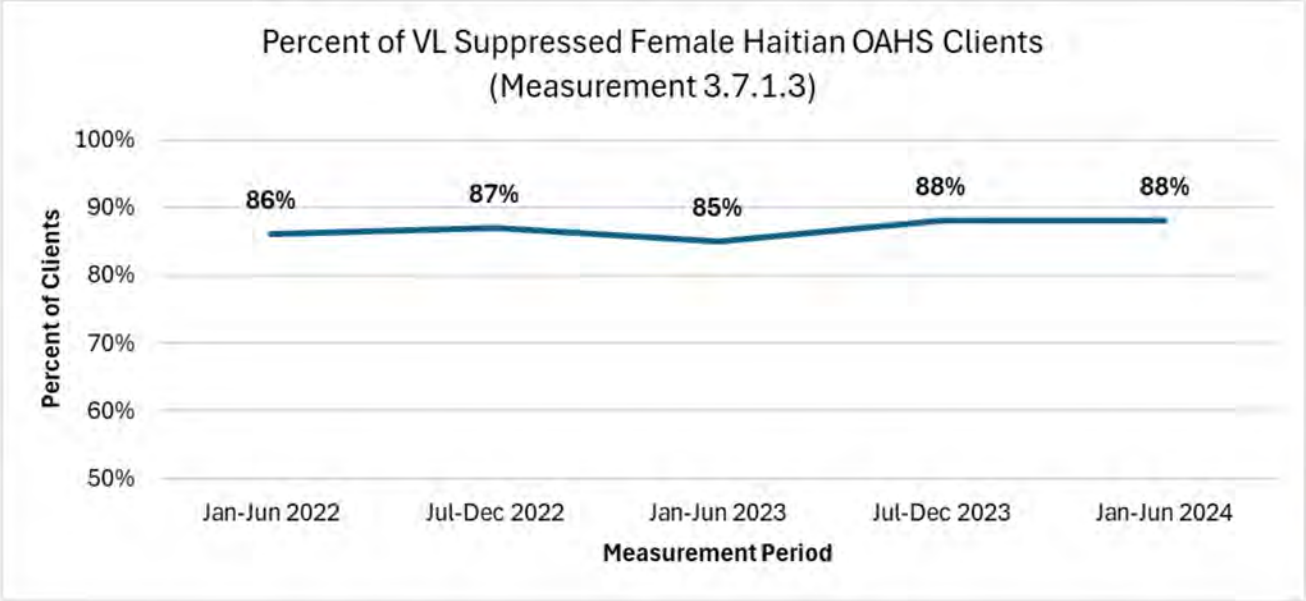

TARGET
December 31, 2026

95%
Haitian Females VL Suppression Rate

Measurements	Jan-Jun 2022	Jul-Dec 2022	Jan-Jun 2023	Jul-Dec 2023	Jan-Jun 2024
VL Suppressed Female Haitian OAHS Clients	121	115	117	154	165
Total Female Haitian OAHS Clients	141	132	137	175	187
Number of OAHS subrecipients with 90% VL Suppression for Haitian Females (Target is 95% after June 2024)	2	4	5	5	5
Total number of MCM subrecipients with Haitian Female clients	11	11	11	11	11

MIAMI-DADE HIV/AIDS PARTNERSHIP

Strategic Planning Committee and Prevention Committee Joint Integrated Plan Review Team Meeting

Tuesday, January 21, 2025

10:00 AM – 1:00 PM

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

AGENDA

I.	Call to Order	Virginia Muñoz
II.	Introductions	All
III.	Housekeeping	Dr. Diana Sheehan
IV.	Floor Open to the Public	Tajma Darlington
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 23, 2024	All
VII.	Reports (*posted on www.aidsnet.org*)	Staff

- Membership
- Partnership

VIII. Standing Business — Staff

- Prevention Committee Business
- Strategic Planning Committee Business
  - Officer Nominations and Elections Schedule

IX. New Business — All

- *Miami-Dade County 2027-2031 Integrated HIV Prevention & Care Plan*
  - Plan Guidance and Expectations for Plan Development
- *Miami-Dade County 2022-2026 Integrated HIV Prevention & Care Plan*
  Breakout Groups – Updates and Discussion (45-60 minutes)
  1. Prevention: HIV Testing; and Women, Infants, and Youth
  2. Prevention: PrEP; Advertising; Condoms; and Syringe Services Program
  3. Care: Linkage to Care; Retention in Care; and Special Populations
  4. Care: Disparities in Retention in Care and Disparities in Viral Load Suppression Rates Among Priority Populations
- Breakouts Recap (15 minutes)
- 2025 JIPRT Meeting Schedule and Next Steps

X.	Announcements and Open Discussion	All
XI.	Next Meeting Dates	Tajma Darlington

- February 14, 2025: Strategic Planning Committee at BSR
- February 27, 2025: Prevention Committee at FDOH Health District Center

XII.	Adjournment	Virginia Muñoz

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

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~ FEBRUARY 2025 ~ Miami-Dade HIV/AIDS Partnership Calendar ~

MEETING LOCATIONS

BSR Corp. ~ Behavioral Science Research Corp., 2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134
Care 4 U Community Health Center, 4690 NW 7th Avenue, Miami, FL 33127
Care Resource Community Health Centers, Midtown Miami, 3510 Biscayne Boulevard, 1st Floor Community Room, Miami, FL 33137
FDOH-Health District Center, 1350 NW 14th Street, Conference Room 401B, Miami, FL 33125
Miami-Dade County Main Library, 101 West Flagler Street, Auditorium, Miami, FL 33130
Report for Action! Microsoft Teams, ID: 238 353 321 012; Passcode: pW9t2mR7

Monday	Tuesday	Wednesday	Thursday	Friday
3	**4** **Miami-Dade HIV/AIDS Partnership** 10:00 AM to 12:00 PM at MDC Main Library	**5** **Get on Board! Planning Council Member Enrichment Training** 12:00 PM to 1:00 PM via Microsoft Teams	**6**	**7** National Black HIV/AIDS Awareness Day
10	**11**	**12**	**13** **Care & Treatment Committee** 10:00 AM to 12:00 PM at Care Resource	**14** **Strategic Planning Committee** 10:00 AM to 12:00 PM at BSR Corp.
17 President's Day (BSR Offices Closed)	**18**	**19**	**20** **Housing Committee** 2:00 PM to 4:00 PM at Care Resource	**21**
24 **Community Coalition Roundtable** 5:00 PM to 7:00 PM (Dinner at 4:30 PM) at Care 4 U	**25**	**26** **Executive Committee** **As Needed**	**27** **Prevention Committee** 10:00 AM to 12:00 PM at FDOH-Health District Center	**28** HIV Is Not A Crime Day **Medical Care Subcommittee** 9:30 AM to 11:30 PM at BSR Corp. **Report for Action! March Partnership Meeting Briefing** 12:00 PM to 12:30 PM via Microsoft Teams

MIAMI-DADE HIV/AIDS PARTNERSHIP

The Miami-Dade HIV/AIDS Partnership is the Official Ryan White Program Planning Council in Miami-Dade County. Our members are people with HIV and people who care about people with HIV!

People with HIV are encouraged to participate!

All events on this calendar are open to the public.

RSVP

Your participation matters! Please let us know if you're coming to the meeting!

RSVP to (305) 445-1076 or mdcpartnership@behavioralscience.com

Be prepared!

Go to www.aidsnet.org or click on your meeting for agendas, minutes, and meeting documents.

Stay connected!

Information on this calendar is subject to change. **Version 12/19/24**

MIAMI-DADE HIV/AIDS PARTNERSHIP

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