Miami-Dade County 2027-2031 Integrated HIV Prevention and Care Plan

A collaboration between the Miami-Dade HIV/AIDS Partnership, the Florida Department of Health in Miami-Dade County, the Miami-Dade County Office of Management and Budget Grants Coordination/Ryan White Program, and community partners.

TABLE OF CONTENTS

ACRONYMS AND TERMINOLOGY

Section I: Introduction of Integrated Plan and SCSN

I.1. Introduction

For over a decade, the Miami-Dade County (MDC) Eligible Metropolitan Area (EMA) has been a national HIV/AIDS hot spot. Despite substantial progress with prevention and care efforts and significant improvements in health outcomes, the EMA continues to lead the state of Florida in the total number of people with HIV (HIV prevalence). A total of 30,074 people with HIV – almost 23% of the entire state's population of people with HIV – lived in the EMA in calendar year (CY) 2024, the latest year of complete surveillance data available from the Florida Department of Health (FDOH).

Florida's 2022 Statewide Coordinated Statement of Need (SCSN) identified four key areas of need in the EMA. The revised SCSN is expected to be released later in 2026 and the EMA's Integrated Plan may be updated to reflect any identified changes to key areas.

Key Areas Identified in the 2022 SCSN:

- **HIV Prevalence:** Florida continues to have one of the highest rates of new HIV diagnoses in the United States.
- **Differences in Health Outcomes:** The epidemic continues to have a greater impact (poorer health outcomes) in Black/African American, Hispanic/Latino, and Haitian communities.
- **Barriers to Care:** Social determinants of health, including high rates of poverty, lack of transportation, food insecurity, housing instability, mental health issues, and substance use disorders add significant challenges to effective prevention and care efforts.
- **Service Gaps:** There is still a need for expanded access to pre-exposure prophylaxis (PrEP), mental health services, and means to address HIV-related population vulnerabilities.

For the past three years, the EMA has been guided by the 2022-2026 Integrated HIV Prevention and Care Plan (2022-2026 Plan) goals. The Miami-Dade HIV/AIDS Partnership (Partnership), the EMA's Ryan White Program Planning Council, has taken the lead on 2022-2026 Plan evaluation, monitoring, updating, and reporting. The Partnership's Strategic Planning and Prevention Committees have reviewed data and further evaluated and refined the activities. The committees meet independently and as a combined group, known as the Joint Integrated Plan Review Team (JIPRT).

Both qualitative and quantitative data were used in the 2027-2031 Integrated HIV Prevention and Care Plan (Plan) to describe the impact of HIV in the EMA; determine service gaps and barriers to care; identify prevention and treatment areas; as well as refine goals and objectives to ensure access to HIV prevention and care across the service delivery system, as detailed in **Section III: Contributing Data Sets and Assessments**, of this Plan (see below).

This Plan is structured around the overarching goals of the National HIV/AIDS Strategy (NHAS). It also incorporates the four pillars of the Ending the HIV Epidemic initiative (EHE), the key areas identified in the Statewide Coordinated Statement of Need (SCSN), and the Ryan White Program's 2030 goals and strategies. These elements are reflected throughout both the Plan's Goals and Objectives and the Situational Analysis sections. Although the NHAS is no longer included as required guidance for the 2027–2031 Plan, we remain committed to structuring this Plan around the national objectives supported by CDC and HRSA. Accordingly, our focus continues to include:

DRAFT

- Preventing the transmission of HIV.
- Strengthening health outcomes for people with HIV who are engaged in care.
- Addressing and reducing inequities in HIV-related outcomes.
- Promoting coordinated, collaborative efforts across partners to more effectively respond to the HIV epidemic.

The 2027-2031 Plan goals also evolved to align with the Four Pillars of Ending the HIV Epidemic (EHE) in the U.S.:

The Four Pillars of EHE

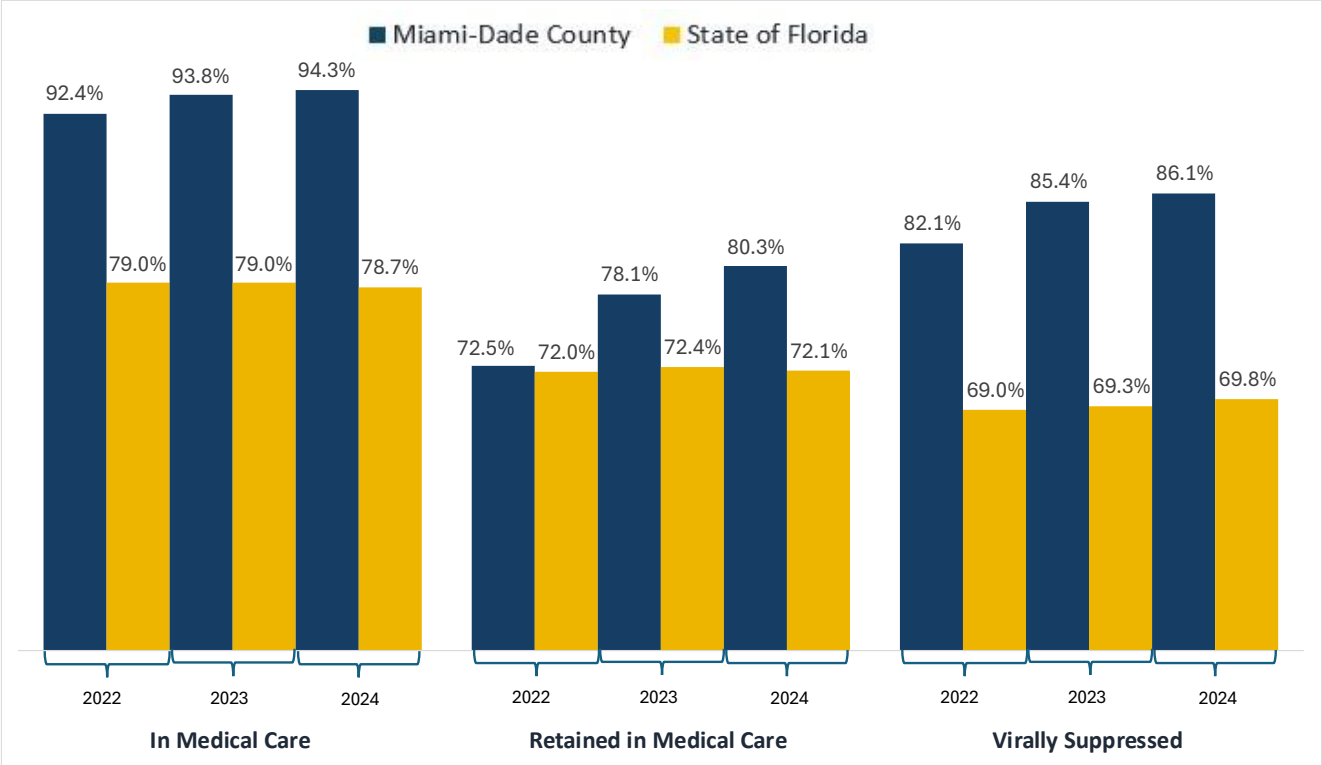
This Plan also incorporates the flexibilities of the EHE Initiative to advance the Ryan White Program 2030 goals. These goals emphasize continuing high-quality care for current Ryan White Program clients while expanding access to HIV care for people who are out of care or not virally suppressed, ensuring that no one is left behind in efforts to end the HIV epidemic. Continued progress depends on reaching people with HIV who are not engaged in care and supporting HRSA HAB's vision to strengthen partnerships, focus interventions, and engage the HIV community.

Key Ryan White Program 2030 goals and strategies reflected in this Plan include:

- Rapid initiation of HIV treatment;
- Community-based outreach;
- Treatment as prevention;
- Leveraging partnerships; and
- Using data-driven approaches to identify populations with the greatest unmet needs.

Additionally, HIV Care Continuum data are monitored and continue to show progress for RWHAP clients, particularly in comparison to state trends, as shown below.

HIV Care Continuum Comparison: Miami-Dade County and State of Florida (2021–2024)



Representatives from the Partnership and the Miami-Dade County Office of Management and Budget Grants Coordination/Ryan White Program – the Ryan White Program Part A/Minority AIDS Initiative and EHE Recipient (the Recipient), serve on the Florida Comprehensive Planning Network (FCPN); and Partnership staff served on the Statewide Integrated HIV Prevention and Care Plan (IPC) Workgroup and the Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC) Advisory Board. Regular reporting and feedback on statewide updates relevant to local planning and program administration were intended to be included in the 2027-2031 Plan development. However, FDOH's Statewide Integrated Planning group disbanded abruptly in March 2026 and there have been no further communications about the Statewide Plan. The FCPN meeting scheduled for May 2026 was also abruptly canceled and has not yet been rescheduled.

This Plan is truly a living document which will continue to be monitored for updates to meet changing legislative requirements, respond to local policy changes, and consider the implications of new data as they become available. Responsibility for monitoring and reporting on Plan progress will continue to be a collaboration between the Partnership, the Recipient, the Florida Department of Health in Miami-Dade County (FDOH-MDC), the local prevention funding grantee, and other stakeholders as identified in this Plan.

I.1.a. Approach to Preparing the Integrated Plan

This 2027-2031 Plan modifies and enhances the existing 2022-2026 Plan, with additional documents as needed. Contributors to the 2027-2031 Plan development, monitoring, and updating include Ryan White Program (RWHAP) clients, peer educators/navigators, and other community advocates with HIV; and representatives from RWHAP Parts A, B, C, and D; the AIDS Drug Assistance Program (ADAP); FDOH-MDC Community Mobilization Workgroups; the Florida Agency for Health Care Administration (Medicaid); the Recipient; FDOH-MDC; HIV prevention providers; the Partnership; and other collaborators as detailed in **Section II: Community Engagement and Planning Process**, of this Plan (see below). Throughout the development process, the 2027-2031 Plan was presented to the JIPRT and other Partnership committees at well-advertised, public meetings. All meeting documents, including meeting minutes, Plan drafts, supporting documents referenced in the Plan, and relevant presentations, are posted on the Partnership's website, www.PartnershipMiami.org. The Partnership approved the final draft of the 2027-2031 Plan in June 2026.

I.1.b. Documents Submitted to Meet Requirements

Data were drawn from the source documents listed below. Hyperlinks are provided for items available on www.PartnershipMiami.org or elsewhere online.

- 2022-2026 Integrated HIV Prevention and Care Plan for Miami-Dade County;
- 2022-2026 State of Florida Integrated HIV Prevention and Care Plan;
- 2024 Annual Report – HIV in Miami-Dade County, prepared by the Partnership;
- 2025 Annual Partnership Needs Assessment;
- 2025 State of Florida HIV Care Needs Survey for Area 11a; provided by The AIDS Institute (locally translated into Spanish and Haitian Creole);
- 2026 Survey on HIV Prevention in Miami-Dade County (in English and Spanish);
- CDC/HRSA 2027-2031 Integrated Plan Guidance (February 2025);
- Data on service gaps, provided by the FDOH-MDC and the RWHAP;
- FDOH Epidemiological data, CY 2024;
- Florida Community Health Assessment Resource Tool Set (CHARTS);
- HIV and STD testing data provided by the FDOH-MDC;
- Letter of Concurrence (see **Section VII** of this Plan, below);
- Results from listening sessions, interviews, community input sessions, and online surveys;
- RWHAP Client Satisfaction Survey, (administered in English, Spanish, and Haitian Creole), with data provided by BSR for 2022-2025;
- RWHAP utilization data provided by BSR, 2022-2025;
- The Health Council of South Florida District 11 Health Profile (January 2025); and
- Work Plan CDC-RFA-PS20–2010, Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States, FDOH-MDC.

DRAFT

Section II: Community Engagement and Planning Process

II.1. Jurisdiction Planning Process

Meetings to develop the 2027-2031 Integrated Plan (Plan) began in January 2025 during the Miami-Dade HIV/AIDS Partnership's (Partnership) Joint Integrated Plan Review Team (JIPRT) meeting. Members were provided with a copy of the guidance and expectations for draft review and completion dates were established. Partnership staff coordinated with the Recipient and the Florida Department of Health in Miami-Dade County (FDOH-MDC) to gather data and promote Plan development opportunities. JIPRT meetings were ongoing quarterly through May 2026 to establish SMART goals, review data, and give feedback on the narrative sections of the Plan. Each month, draft documents were publicly available, meetings were publicly noticed, progress was reported to the Partnership and JIPRT, and input gathered at meetings was incorporated into the Plan draft.

Webinars and other meetings related to Integrated Planning were widely advertised and attended by Partnership members and staff. Updates and relevant information were shared with the JIPRT throughout the Plan's development. Webinars included topics such as Plan development, the impacts of changing legislation on Plan development, gathering feedback from other jurisdictions and programs, and the development of the State of Florida Integrated Plan, as follows:

- HRSA/CDC Integrated HIV Prevention and Care Planning – April 30, 2025;
- Fast-Track Cities Town Halls – June 25, 2025, and October 29, 2025;
- Community Forum to Reduce HIV Infection in Miami-Dade County (in person meeting championed by Senator Rene Garcia, Miami-Dade County Commissioner) – August 5, 2025;
- Get on Board! The Partnership's Member Enrichment Training Series – Station 21: The Integrated Plan and You! – September 15, 2025;
- Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC) Advisory Board Meeting – September 15, 2025;
- University of Miami Support Group Presentation (in person) – October 7, 2025;
- IHAP TAC Integrated Planning 3.0 - Virtual Office Hours – October 21, 2025;
- IHAP TAC IP Development - Virtual Office Hours – December 10, 2025;
- IHAP TAC Advisory Board Meeting – February 23, 2026; and
- IHAP TAC Countdown to Integrated Plan Submission - Virtual Office Hours – February 24, 2026.

Partnership staff and Recipient representatives were invited to participate in the Statewide Integrated HIV Prevention and Care Plan Workgroup which met virtually via Zoom in 2025 on November 12 and 19, and December 3 and 17; and in 2026 on January 7 and 21, February 4 and 18, and March 4, 18, and 25. Unfortunately, this did not result in a meaningful collaboration. After 11 meetings, the group abruptly disbanded in March 2026, and there has been no further communication regarding the Statewide Plan. In addition, a high-level overview of the Statewide Plan was supposed to be presented to the Florida Comprehensive Planning Network (FCPN), whose members include the Partnership, prevention service providers, the Recipient, FDOH-MDC, and the other Part A and EHE jurisdictions across Florida. However, the FCPN meeting scheduled for May 2026 was also suddenly canceled a few days prior to the meeting, "due to unforeseen circumstances."

While planning and coordination between FDOH-MDC (prevention) and RWHAP (care) administrators and communication with the Planning Council remain consistently strong, active, and ongoing, with open

DRAFT

dialogue and collaborative problem-solving, the lack of open communication from the State has made it difficult to ensure our goals and objectives are in alignment.

Groups involved in Plan development, as noted in **Section I: Introduction**, of this Plan, above, included Ryan White HIV/AIDS Program (RWHAP) clients, peer educators/navigators, and other community advocates with HIV; and representatives from RWHAP Parts A, B, C, and D; the AIDS Drug Assistance Program (ADAP); FDOH-MDC Community Mobilization Workgroups; the Florida Agency for Health Care Administration (Medicaid); the Recipient; FDOH-MDC; the Partnership; and other collaborators. These contributors include Partnership and committee members as well as other community members who participated as meeting guests or subject-matter experts.

The primary goal-setting groups were the Partnership's Strategic Planning and Prevention Committees, meeting individually and collectively as the JIPRT. The JIPRT made concerted efforts to ensure all activities had a data source and a designated person responsible for providing the data. Where activities could not be tracked by a data source, those activities are included in other sections of this Plan as either future activities or aspirational goals.

A major part of Plan development was establishing a database for tracking progress on the Plan. Behavioral Science Research Corporation (BSR), the Partnership Part A staff support subrecipient, designed an Excel-based Integrated Plan Monitoring and Reporting System (IPMRS) as a functional tool to track progress for the next five years. The database was presented at local and statewide meetings to gather input on design, formatting, and what data should be captured. Details about the database are outlined in **Section VI: Situational Analysis**, of this Plan, below.

Aside from reference documents noted in **Section I: Introduction**, of this Plan, above, the key data sources available to the EMA include client-level data from Provide Enterprise® Miami (PE Miami), the Miami-Dade County Ryan White Program data management system; testing and community engagement data from the FDOH-MDC; and other surveys and community input sessions.

Community engagement activities are ongoing and include meetings, training, surveys, and promotion of Integrated Plan guides, documents, and resources intended to reach a broad range of community stakeholders and to gather information from persons both inside and outside the Partnership, RWHAP services system, and FDOH-MDC.

II.1.a. Entities involved in the process.

The primary planning team was comprised of staff from the Miami-Dade County Office of Management and Budget (OMB; the Part A/MAI/EHE Recipient), FDOH-MDC, and BSR. This core group determined the timeline for completion of each section, reviewed survey results and data, and posted, distributed, and/or presented Plan drafts and related reports at JIPRT and Partnership meetings. Throughout Plan development, meeting dates were widely advertised. All documents were available for review by Partnership members and the general public via the Partnership's website and promoted to the Partnership's email listserv of more than 1,300 people. Entities involved in the process are further detailed in sections **II.1.b**. and **II.1.c** of this Plan, below.

II.1.b. Role of the RWHAP Part A Planning Council – The Partnership

Partnership members were involved in every aspect of Plan development. The Integrated Plan Guidance was posted on the Partnership's website and distributed at Partnership and Committee meetings beginning in December 2024, with updates distributed in February 2025. Draft narrative sections were reviewed and

revised by the Strategic Planning and Prevention Committees in stand-alone meetings, and at JIPRT meetings. All drafts were publicly available on the Partnership's website. Members were regularly reminded of completion deadlines to keep on track for submission of the final Plan to HRSA in June 2026.

Review of data collection on the previous plan activities demonstrated that for many activities there was no measurable data and it was not always clear how the activities were connected to the plan goals. Members of the JIPRT met in October 2025, and at stand-alone Prevention Committee and Strategic Planning Committee meetings in March and April 2026 to make significant revisions to ensure inclusion of meaningful and measurable objectives and activities. Specifically, we reduced the number of objectives to align with the guidance recommendation to identify three objectives per goal. However, to ensure all important activities were captured, in some cases there may be more than three activities within the objectives. The review of 2022-2026 Plan goals also resulted in ensuring only SMART goals were included in the 2027-2031 Plan. The resulting goals, objectives, activities, and measurements are detailed in **Section V: Goals and Objectives**, of this Plan, below. JIPRT members also met in February 2026 to review and revise narrative sections of the Plan, with this activity ongoing in stand-alone meetings in March and April 2026.

All meetings where these deliberations took place were broadly advertised and open to the public. All Partnership meetings were conducted in person at centrally located meeting sites accessible by public transportation, with details on how to get to meetings included on the Partnership's website. Efforts were made throughout Plan development to gather feedback from representatives of the affected community; and these are primarily incorporated in **Section IV: Situational Analysis**, below, and in **Section V: Goals and Objectives**, below, where concerns could be tied to measurable activities.

As noted above, the Partnership's JIPRT was the primary group who reviewed and provided feedback and edits to Plan drafts. On May 19, 2026, the JIPRT conducted a read-through of Sections I, II, IV, VI, and the Letter of Concurrence, and voted to advance the Plan to the Partnership for final review with the allowance for Partnership and Recipient staff to make final edits. Included in the motion was the understanding that Sections III and V would be posted online with the opportunity to provide additional feedback prior to the Partnership meeting. The JIPRT presented their recommendations to the Partnership on June 1, 2026. The Partnership put forth several motions, including the approval of the Plan with the allowance for Partnership and Recipient staff to make final edits; the approval of the Miami-Dade County Letter of Concurrence for the 2027-2031 Maimi-Dade County Integrated HIV Prevention and Care Plan; and authorization for the letter to be co-signed by the named signatories. The Recipient received the approved Plan well in advance of the June 30, 2026, deadline for submission. The deliberations of the JIPRT and the Partnership are recorded in the approved minutes of each meeting. All minutes are part of the public record and approved minutes of the most recent ten meetings are posted on the Partnership's website. Records of prior meetings are archived.

The key stakeholders represented as voting members of the Partnership and its committees include:

- Persons with HIV, both RWHAP and non-RWHAP clients;
- Peer educators/navigators;
- RWHAP Parts A, B, C, D, and F (ADAP) representatives;
- FDOH-MDC representatives;
- FDOH and RWHAP Ending the HIV Epidemic (EHE) representatives and data managers;
- State of Florida General Revenue representative;
- Local private and university researchers;
- Prevention providers;
- Patient/client advocacy groups;
- Advocates for victims of sexual abuse and human trafficking;

DRAFT

- Local hospital representatives; and
- RWHAP subrecipients providing one or more of these services:
  - Medical Case Management,
  - Outpatient Ambulatory Health Care,
  - Oral Health Care,
  - Mental Health Services,
  - Substance Use Disorder Treatment (Outpatient and Residential),
  - Medical Transportation,
  - Outreach Services, and
  - Health Insurance Premium and Cost Sharing Assistance.

II.1.c. Role of Planning Bodies and Other Entities

In the EMA, the RWHAP Part B and HIV/STD Prevention programs are under the jurisdiction of the FDOH-MDC. EHE initiatives are funded through FDOH-MDC and the RWHAP Recipient. As noted above, both FDOH-MDC and the Recipient were involved in every part of creating this Plan, including scheduling and coordination of efforts, data collection, goals and activities development, and final draft submission.

EHE goals and activities have been incorporated into the Plan, with the funding source and responsible entities noted. The Plan was designed in this way to build on the strength of existing EHE activities, and to align with national EHE Initiative to diagnose, treat, prevent and respond. CDC's strategies and activities required to support high impact HIV prevention and the key Ryan White Program 2030 goals, as detailed in **Section I, Introduction**, above, are also incorporated to avoid duplication of efforts, and promote a more cohesive and collaborative approach to prevention and care planning and implementation.

Partnership staff developed a brief survey to gain community insights into HIV prevention needs, challenges, and successful strategies in Miami-Dade County. Those results contributed to development of **Section IV: Situational Analysis** and **Section V: Goals and Objectives**, of this Plan, below.

In order to gather input from other entities who may otherwise not be involved in integrated planning efforts, feedback from the Florida Comprehensive Planning Network's 2025 State of Florida HIV Care Needs Survey was considered. As of May 2026, a total of 402 surveys were collected, representing people with HIV in more than 65 ZIP Codes within the EMA. The survey collected feedback on service availability and the reasons for not accessing needed services. The survey was still open at the time this Plan was developed, and further results will be analyzed after the survey closes in August 2026. The final survey results are intended to be used to update the SCSN. However, communication with the State is troubled and there has not been an update on how they are using the survey results or when we can expect to have the updated SCSN. Nonetheless, we have continued to promote the survey at Ryan White Part A and Part B-funded subrecipient agencies and meetings, Partnership meetings and community engagement activities, and through the Partnership's social media, bi-weekly newsletter, website postings, and listserv.

II.1.d. Collaboration with RWHAP Parts – SCSN Requirement

The Partnership's JIPRT includes member representatives from RWHAP Part B, Part C, and Part D and Minority AIDS Initiative (MAI). The Partnership's Care and Treatment Committee, which conducts the Annual Needs Assessment, and whose members were solicited for feedback on Plan development, includes representatives from RWHAP Part C, and ADAP. All those members are also members of the Partnership and had a vote on this Plan prior to final submission. Additionally, though representatives of RWHAP Part

DRAFT

A are not voting members on any committee, they participated as meeting guests and subject matter experts, and ensured the Plan was aligned with legislative requirements.

II.1.e. Engagement of People with HIV – SCSN Requirement

Challenges: Efforts to gather feedback from a broad group of participants continues to be a challenge for the EMA. Some of the obstacles include the need to provide materials in English, Spanish, and Haitian Creole. While some translations can be done using AI tools, the translations need to be vetted and there are not full time interpreters on staff. Further, the 2025 State of Florida HIV Care Needs Survey which was intended to gather feedback from across the state was only produced in English, leaving jurisdictions responsible for making their own translations, which may or may not use the same exact survey language in the translated versions. Additionally, lack of funding for incentives for participation in surveys and in-person meetings was a challenge, particularly since the Partnership is a County advisory board and must conduct all meetings in person only and there are no funds to support transportation assistance. The Partnership and FDOH-MDC Community Mobilization Workgroups continue to face challenges in recruiting new members due to conflicts from employment and personal responsibilities, which leads to deprioritizing HIV community participation.

Successes: Even in light of the challenges, people with HIV were included in all stages of planning, through JIPRT and Partnership membership, participation in the annual Client Satisfaction Survey, and by completing the 2025 State of Florida HIV Care Needs Survey. As Partnership members and meeting guests, people with HIV were encouraged to contribute feedback and lived experiences at all meetings. It is our expectation that people with HIV and other community stakeholders will continue to be engaged as meaningful participants in all ongoing facets of Plan implementation, monitoring, evaluation, and improvement. People with HIV are encouraged to join meetings as voting members, if eligible, or as contributing guests. Reference materials are available to all interested parties at www.PartnershipMiami.org. Printed copies of materials are distributed at meetings and available by request.

Also, FDOH-MDC conducts meetings in person, virtually, or hybrid, and those may offer more opportunities for meaningful engagement, provided persons have access to virtual participation technology.

All told, the champions of this Plan are people with HIV who contribute at meetings, share their real-life experiences, and continue to promote opportunities to be involved in the process.

II.1.f. Priorities

On the 2025 State of Florida HIV Care Needs Survey, 92% (325 of 353 respondents to the question) said they “Always” take their HIV medication. This finding is consistent with the high levels of viral load suppression reported among RWHAP clients in Miami-Dade County and supports our overarching priorities to maintain high levels of VL suppression and retention in medical care, and to ensure access to life-saving HIV medications.

Strengths, challenges, and needs were identified and are outlined in detail in **Section IV: Situational Analysis**, of this Plan, below, based on the 2025 State of Florida HIV Care Needs Survey findings, the 2026 HIV Prevention Needs Survey, the 2025 Client Satisfaction Surveys, and community meeting input.. Where challenges can be quantified through an identified data source, these are incorporated into **Section V: Goals and Objectives**, of this Plan, below. Where concerns are not quantifiable or measurable, these are addressed elsewhere in the Plan. For all identified concerns, Plan monitoring will include reviewing measurable activities and reassessing other challenges on an ongoing basis and, as much as possible,

aligning our Plan with the State Plan, as described in **Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up**, of this Plan, below.

II.1.g. Updates to Other Strategic Plans Used to Meet Requirements

This Plan incorporates updated goals and objectives from the 2022-2026 Integrated Plan, the RWHAP EHE Plan, and the FDOH-MDC EHE plan.

1. The Partnership's Care and Treatment Committee conducts a complete annual Needs Assessment including prioritization of all RWHAP Part A/MAI services. Although the EMA does not fund all service categories available under HRSA Policy Clarification Notice (PCN) #16-02 through Part A/MAI, the entire roster of services was considered during the priority setting process. For each service category listed in HRSA PCN #16-02, members considered funding sources outside of RWHAP Part A/MAI. For instance, Home Health Care and non-Medical Case Management are also funded by the State of Florida General Revenue.

   There is no direct correlation between the funding and ranking of Part A/MAI services and Integrated Plan development in the EMA. However, both activities consider epidemiological data, comprehensive review of EMA HIV funding, utilization data, viral load suppression data, and unmet needs in decision making. Furthermore, several members of the JIPRT participate in the Needs Assessment process and share information between those two activities.

2. As previously noted, ongoing input from people with HIV and other stakeholders is gathered through broadly advertised public meetings, open access to all draft and final reference documents posted online, and active encouragement for members and guests to participate in all meetings. As the Plan is finalized and submitted to HRSA, the completed Plan – along with its implementation and ongoing monitoring – will be shared with the groups, including people with HIV, that contributed to its development to ensure continued community engagement.

3. Updates to the Plan are based on compliance with federal executive orders and incorporate community input as noted throughout this document.

4. The EMA used the same planning process as in previous years.

DRAFT

Section III: Contributing Data Sets and Assessments

This section is available as a separate document.

DRAFT

Section IV: Situational Analysis

Strengths, challenges and identified needs were drawn from the previous Plan, survey results, and community review at several meetings.

IV.1. Strengths

Miami-Dade County benefits from a long-standing, highly experienced HIV prevention and care infrastructure that has continuously evolved and strengthened over the past 36 years. Overseeing the "care" components of this infrastructure, the Miami-Dade County Office of Management and Budget Grants Coordination/Ryan White Program serves as the Ryan White Program Part A/Minority AIDS Initiative and Ending the HIV Epidemic (EHE) Recipient. The Florida Department of Health in Miami-Dade County (FDOH-MDC) functions as the local prevention funding administrators. Across this system of care, direct service providers bring sustained expertise in helping people with HIV achieve optimal health outcomes. Their work begins with effective prevention efforts and spans the full HIV Care Continuum, including diagnosis, linkage to care, retention in care, and viral suppression.

The EMA benefits from active involvement and dedication of various stakeholders engaged in needs assessment; client satisfaction surveys; prevention, care, and treatment planning; and priority setting and resource allocation activities. Recipients and subrecipients are in ongoing daily communication to help ensure quality services are provided to people with HIV.

Miami-Dade County has one of the most robust HIV testing programs in the state with upwards of nine hospitals routinizing HIV testing in their Emergency Departments; more than 100 testing sites conducting HIV tests in the community; and most of the Federally Qualified Health Centers (FQHC) in the EMA offering routinized HIV testing.

The ADAP and RWHAP prescription drug formularies provide a wide array of available antiretroviral therapy (ART) medications, including both oral medications and long-acting injectables, creating additional opportunities to improve treatment adherence, viral suppression, and treatment as prevention outcomes.

The Recipient, FDOH-MDC, and the Partnership maintain comprehensive websites and social media accounts which provide resources for people with HIV, service providers, and the general public:

- In 2026, the Recipient launched an expanded media campaign to better inform the community about available HIV treatment resources and related services. Information and resources are available on the County's website at www.miamidade.gov/global/initiatives/hiv-support/home.page. This site includes client eligibility information for service programs, information on available services and service providers, and links to the County's social media accounts. The information is subject to change following results of an upcoming competitive solicitation/procurement process, funding levels, and other programming changes.
- Local prevention resources are available through the Florida Health website at www.miamidade.floridahealth.gov/. This site includes an overview of FDOH programs and services, infectious disease services overview, HIV/AIDS resources, and links to FDOH-MDC social media accounts.
- The Partnership's website is www.PartnershipMiami.org, and includes Partnership meeting and membership information, resources for people with HIV, resources for RWHAP service providers, Clinical Quality Management Program resources, the Partnership's Community Newsletter, and links to the Partnership's social media accounts.

IV.2. Challenges

The ADAP Crisis: People with HIV in Florida are facing treatment uncertainty due to severe proposed funding cuts impacting ADAP, ACA insurance premium payments, and affordable access to HIV medications. In January 2026, the Florida ADAP program announced several drastic and unexpected changes to its service provision throughout the state. These changes were disruptive to program planning and service provision throughout the state, with the largest number of clients impacted in the Miami-Dade EMA. Changes included restricting access to ART medications to clients whose gross household income was at or below 130% of the Federal Poverty Level (FPL), removing Biktarvy® from the ADAP Direct Dispense Formulary, restricting Descovy® to clients with renal problems, and discontinuing insurance premium assistance for clients enrolled in the Affordable Care Act (ACA) through ADAP. Although the Florida legislature blunted the immediate impact of some of these changes such as delaying the decreased FPL requirement until June 30, 2026, planning for HIV care and treatment service delivery beyond that date has been enormously challenging.

The EMA has developed contingency plans in the event the most drastic changes take effect after June 30, 2026, with the understanding that these changes will severely impact the existing provision of RWHAP services and complicate integrated planning. If funds must be redirected to address the ongoing impacts of ADAP changes – likely higher demand on Outpatient/Ambulatory Health Services and Local Pharmaceutical Assistance Program services – the consequences would be severe. Critical services – such as Medical Case Management, Oral Health Care, Residential Substance Abuse Services, Food Bank Services, Medical Transportation, and Outreach Services – could face significant reductions. Due to Florida ADAP administrators' lack of transparency and community engagement in the planning process, clients and service providers have been forced to navigate an already complex service system with added uncertainty.

Unless the Florida Legislature takes action to protect access to HIV medications for people with HIV who are at or below 400% of the Federal Poverty Level, health insurance premium assistance, and effective antiretroviral medications – including single-tablet regimens such as Biktarvy® and Descovy® – the drastic changes to Florida ADAP are expected to have severe negative effects on health outcomes for people with HIV in the EMA and across Florida. This situation represents both an urgent challenge and a growing crisis.

Other Funding Cuts: Significant concerns remain regarding pending and ongoing funding reductions including cuts affecting HIV direct client services; prevention activities, such as condom distribution, HIV testing availability, and PrEP access; HIV, mental health, and substance use disorder research; as well as workforce capacity, Ryan White Program services, and overall service sustainability.

Local and Statewide Legislation in Florida: It is difficult to plan effective HIV prevention strategies when the regulatory and funding landscape is constantly changing. FDOH-MDC distributes condoms at events and through mobile units with limited capacity to service providers or send condoms via mail. Providers must purchase condoms – often with 340B rebates – which may put additional strains on already destabilized or limited resources. Other legislation and policies restrict prevention activities in the public school system, specifically testing and sexual education. This lack of comprehensive sexual health education and limited opportunities to provide age-appropriate sexual health information, HIV prevention education, and HIV/STI testing in school settings limits the EMA's ability to address prevention needs among the youth.

Changes to the HRSA Funding Formula: Changes in RWHAP funding are being implemented under HRSA's new Formula Award calculation, which bases client counts on the most recent address rather than the address at diagnosis. The timing and method used to capture these updated addresses remain unclear,

DRAFT

creating uncertainty about how HRSA will determine future client counts. Even with this lack of clarity, Miami-Dade County has already been notified of funding losses to its Ryan White Part A Program exceeding $200,000 per year for the next five years.

Several key aspects of the new formula methodology which remain unclear include:

- **Documentation accepted:** It is not specified whether HRSA will rely solely on addresses recorded via lab reports (e.g., CD4 or viral load) or if alternative forms of verification are required.
- **Reporting mechanism:** The guidance does not clarify whether addresses must be reported through the CDC, HRSA directly, or another entity.
- **Timing:** There is no defined timeframe for when the address will be "snapshot" for reporting – whether at the start or end of a calendar year, or some other period.
- **Update frequency:** It remains undefined how often HRSA will recalculate the formula parameters (e.g., case counts and updated addresses) during the five-year phase-in from FY 2026-2030.

Additional Challenges identified through planning meetings and findings from surveys listed in **I: Introduction**, above, include:

- People aging with HIV continue to experience compounded challenges related to stigma, social isolation, chronic conditions, treatment fatigue, mobility limitations, and increased healthcare and insurance costs.
- Service delivery and administrative fatigue for service providers, subrecipients, recipients, and an aging workforce continue to threaten the long-term sustainability and effectiveness of HIV prevention and care systems.
- Preauthorization for PrEP continues to impair patients' ability to access PrEP medications including long-acting injectable medications, and scarce messaging about PrEP and nPEP may not effectively reach intended audiences.
- Inability to adequately measure or address stigma, combined with insufficient People First messaging and service delivery (i.e., people experiencing homelessness vs. homeless people), continues to create roadblocks for people who might otherwise seek testing and treatment.
- A better understanding of the challenges faced by people with HIV who are released from incarceration is needed in order to ensure positive health outcomes.
- Maintaining a focus on healthcare amid stigma issues, socio-economic factors, and social determinants of health, is especially challenging in underserved populations.

IV.3. Identified Needs

This Plan acknowledges difficulty in measuring activities to bring awareness to stigmatizing behavior throughout the service system. While reducing stigma remains an overarching priority in the EMA, activities specific to this goal are not tracked in the Provide® Enterprise Miami database.

Also, funding may not be sufficient to address all the needs identified in this Plan, and tracking retention in medical care (RiMC) and viral load (VL) suppression data outside the RWHAP represents a challenge due to not having access to client-level data funded under other programs.

During planning meetings and through surveys listed in **I: Introduction**, above, community members and respondents indicated the need for:

- Transitional housing, short-term housing, or emergency housing assistance to counter housing instability;

DRAFT

- Help to pay for private insurance costs, e.g., employer-sponsored or ACA premiums, copays, and deductibles;
- Oral health care beyond regular checkups, e.g., dentures, oral surgery, implants for edentulous clients, etc.;
- Limited, one-time, or short-term assistance to obtain medications not covered by AIDS Drug Assistance Program (ADAP), and for utilities, food, or transportation;
- Limited, one-time, or short-term assistance to pay for utilities and transportation;
- Reliable and consistent access to food through food bank services, grocery certificates, home-delivered meals, and nutritional supplements;
- Services directed to specific groups that may face barriers to care, including younger individuals and people aging into Medicare, particularly regarding issues such as stigma and access to services;
- In home services such as labs and medication delivery, consumable medical supplies, and durable medical equipment, particularly for the aging population and those with limited mobility;
- Access to informational resources in multiple languages; and
- Meaningful interventions to address stigma, specifically related to HIV testing and PrEP.

IV.4. Analysis of Structural and Systemic Issues Impacting People and Communities Disproportionately Impacted by HIV

Each of the four Ending the HIV Epidemic (EHE) Pillars are addressed below, including a brief analysis, further outlined throughout this Plan, and related strategies which are detailed in **Section V: 2027-2031 Goals and Objectives** of this Plan, below.

Regarding structural and systemic issues impacting populations disproportionately impacted by the HIV epidemic in the EMA, see **Section III: Contributing Data Sets and Assessments** of this Plan, below, which details uneven distribution of outcomes across communities, high rates of poverty, the difficulties for people experiencing homelessness or who are unstably housed, challenges of navigating a complex service system of core medical and support services, stigma and fear of disclosure of HIV status, and addressing implicit and explicit biases.

Because development of this Plan was an integrated process, key partners are consistent and redundant across all pillars, including:

- Partnership members, specifically members of the Prevention Committee and Strategic Planning Committee;
- FDOH-MDC and partners among FDOH-MDC Community Mobilization Workgroups;
- RWHAP Recipients, subrecipients, and front-line service providers;
- Partnership and CQM support staff; and
- Other community stakeholders, such as community activists, pharmaceutical representatives, and representatives of transitional housing programs.

The Partnership's Prevention Committee is guided by the activities of the FDOH-MDC; and the Strategic Planning Committee is guided by responsibilities for Part A Planning Councils in coordination with the Recipient. It is the intention of the two committees – working together as the Joint Integrated Plan Review Team (JIPRT) – to expand community stakeholders and continue to engage the broadest scope of partners throughout the implementation of this Plan. At the same time, this Plan is intended to integrate efforts without unnecessary duplication of effort.

DRAFT

IV.4.a. Diagnose

Testing is the key to diagnosing people and making them aware of their HIV status. For people with negative results, the goal is to develop a personalized prevention plan; and for people with a positive test result, the goal is to link them to care as soon as possible. According to Florida CHARTS, Miami-Dade County ranked as the Florida county with the most HIV diagnoses for each of the five years from 2020 to 2024. As noted in **Section III: Contributing Data Sets and Assessments** of this Plan, below, the EMA has the highest concentration of people with HIV in the state of Florida, and high rates of new HIV diagnoses.

This Plan's Prevention strategies related to diagnosing individuals who are unaware of their HIV status are intended to improve health outcomes for all people with HIV. The EMA historically had a robust and widely promoted HIV testing program which included on-site rapid testing, after-hours rapid testing, mobile unit rapid testing, opt-out testing in emergency rooms and clinics, and at-home testing. Marketing of testing availability was developed in English, Spanish, and Haitian Creole. However, as detailed above in **IV.2. Challenges,** above, recent prevention and care funding cuts are negatively impacting the availability and success of previously effective programs, services, and outreach strategies.

FDOH-MDC continues to review concerns about how "newly diagnosed" cases are counted. Individuals are classified as newly diagnosed when they receive HIV testing through FDOH, even if they were previously diagnosed outside the U.S. and only sought retesting to obtain documentation. Only people whose first U.S. diagnosis occurred within the EMA should be included in the EMA's newly diagnosed count. Cross-system record review is needed to verify the original diagnosis date and location, since misclassifying these cases inflates the EMA's new diagnosis numbers and affects the ability to demonstrate progress in prevention efforts.

IV.4.b. Treat

The local FDOH-MDC/RWHAP rapid start protocol, referred to as Test and Treat/Rapid Access (TTRA), is the basis for same-day access to medical care and ART medication, along with rapid linkage to ongoing care. The protocol has demonstrated success in linking newly diagnosed persons to care, with a linkage rate of 83% in 2024. Persons who enter the RWHAP service system through TTRA and those who are enrolled in RWHAP and ADAP can be monitored to ensure they are connected to and accessing available needed services.

IV.4.c. Prevent

Within the geographic boundaries of Miami-Dade County, a wide array of evidence-based HIV prevention strategies is available. These include access to PrEP and PEP, free condoms, routine HIV/STI screening, targeted testing in higher-incidence neighborhoods, Test and Treat rapid-start approaches, Undetectable=Untransmittable (U=U) treatment-as-prevention, and community-based prevention programs. Outreach initiatives and targeted prevention efforts in high-incidence communities continue to strengthen HIV prevention efforts and improve engagement throughout the EMA. Prevention initiatives are conducted via face-to-face and virtual interventions, mobile testing units, social media platforms, and print, radio and television advertising. The Florida Health website at www.miamidade.floridahealth.gov/ promotes PrEP, condom distribution, at-home HIV testing kits, and HIV testing sites, with links to locate prevention services throughout the EMA.

DRAFT

The initiative also leverages academic detailing to strengthen clinical practice. Through this approach, trained detailers offer clinicians information on routinized HIV testing, PrEP/PEP, and Test and Treat, as well as resources that support implementation.

Stakeholders and community members continue to demonstrate strong support for expanding affordable and accessible PrEP services, increasing HIV education efforts, improving prevention messaging, and strengthening prevention engagement opportunities across Miami-Dade County.

The IDEA Exchange Syringe Services Program (SSP) at the University of Miami Miller School of Medicine, launched in December 2016, is the innovative SSP established in Miami-Dade County and now serves as a statewide model for reducing HIV transmission associated with injection drug use. No federal funds are used to support SSP services.

Even with prevention initiatives designed for various communities and populations, along with broad public access to prevention messaging and resources, the latest update from CDC's Estimated HIV Incidence and Prevalence in the United States, 2018–2022, indicates that more than 2,400 individuals in the EMA in 2022 have HIV but are not aware of their status. This figure highlights the importance of the strategies and activities in this Plan aimed at identifying these individuals, encouraging testing to make people aware of their HIV status, and connecting them to ongoing resources – additional prevention, access to PrEP, or linkage to HIV care – depending on their status.

IV.4.d. Respond

To effectively implement the EHE Initiative's Respond Pillar, it is important to understand the following operational definitions:

- **Outbreak:** Rapid transmission of HIV in a well-defined geographic area.
- **Transmission Network (formerly Cluster Detection and Response):** Groups of molecularly linked people with HIV at the < 0.5% viral variance level.
- **Rapidly growing:** When there are five (5) or more people in a transmission network diagnosed within a rolling 12-month time frame.

FDOH RESPONSE – RAPIDLY GROWING TRANSMISSION NETWORKS

While the EMA currently has no identified or reported outbreaks of HIV, the local system of care has the capability and experience to quickly respond to such events. In prior years, FDOH-MDC and the RWHAP Recipient in the EMA collaboratively mobilized responses to Mpox, meningococcal disease, Hepatitis A, and COVID-19 outbreaks. Materials alerting the community to these outbreaks and available resources were produced in English, Spanish, and Haitian Creole, the top three languages of clients in the local HIV community. This information was widely distributed throughout the EMA, through printed flyers, social media campaigns, email messages to RWHAP Medical Case Management teams, and on various websites. HIV prevention and care resources are widely available throughout the EMA, and many of those partners were instrumental in disseminating information about other disease outbreaks. Strengthening and expanding community partnerships will further enhance our capacity to respond rapidly and effectively to future HIV outbreaks.

Police departments and first responders, domestic violence prevention organizations, Business Responds to AIDS (BRTA), and celebrity and social media personalities, are potential collaborators who will need to be identified to understand the importance of reporting potential outbreaks. Coordination across funding streams is also important to avoid delays in reacting to outbreaks.

The EHE Mobile GO Teams initiative uses mobile clinics to further support Miami-Dade County's ability to rapidly respond to HIV transmission clusters using the local Test and Treat/Rapid Access model. The EHE Recipient and subrecipients funded under this initiative collaborate with FDOH-MDC and are poised to respond to HIV clusters and hotspots.

IV.5. People and Communities with Higher Rates of HIV and Related Challenges

The designated populations in the EMA who are facing the greatest HIV burden and the lowest health outcomes as measured by RiMC and VL suppression are Blacks/African Americans and Haitians. Plan activities will focus on tracking and reporting RWHAP client RiMC and VL suppression rates for those subpopulations. Quality Improvement projects at the RWHAP subrecipient level may be designed to address low RiMC rates or low VL suppression rates. Additionally, health outcomes for people with HIV who are 50 years of age and older, and women with HIV, are areas of focus in this Plan.

DRAFT

Section V: Goals and Objectives

V.1. Goals and Objectives Description

Development of goals, objectives, activities, and measurements was a major focus of Plan development. This section includes goals, objectives, activities, measurements, key partners to accomplish each objective, the responsible party for providing data, data sources, and challenges, if any. This structure is in alignment with the Behavioral Science Research Corporation Integrated Plan Monitoring and Reporting System database (IPMRS). As detailed in **Section VI: 2027-20321 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up**, populating the IPMRS with baselines and targets will be the focus of the Partnership's Joint Integrated Plan Review Team (JIPRT) throughout the remainder of 2026 in order to begin implementation in 2027. Continuing to identify key partners will be ongoing throughout the life of the Plan.

We have also included social determinants of health and other concerns below. However, in accord with SMART goal-setting, those are not included in the IPMRS for data tracking since they have no identified data source. Therefore, we have not assigned measurable activities to those concerns. If a data source is identified throughout the life of the Plan, those concerns may be moved to the database for semi-annual data tracking. Regardless, we have included them here and in **Section IV: Situational Analysis** to ensure we do not lose sight of those needs, particularly since they were expressed as concerns in multiple community meetings and through survey findings.

Please see **Acronyms**, above, for guidance.

Goal 1: Prevent New HIV Transmission

- □ **Objective 1.1: Increase knowledge of HIV status to 95% by ensuring all people with HIV receive a diagnosis as early as possible.**

  - **Activity 1.1.1:** Implement HIV testing in health care settings, including routine opt-out HIV screenings. Promote and conduct routine opt-out HIV screening in health care settings (outpatient clinics, emergency departments, urgent care, inpatient hospitalization, county hospitals, correctional facilities, FDOH, and FQHC).

    - **Measurements:**

      1.1.1.1 Number of healthcare facilities educated on routine opt-out HIV testing in MDC.
      1.1.1.2 Number of healthcare facilities conducting routine opt-out HIV testing in MDC.
      1.1.1.3 Number of routine opt-out HIV tests in health care settings.
      1.1.1.4 Number of HIV positive people identified through routine opt-out testing in health care settings.

    - **Key Partners to Accomplish the Objective:** FDOH-MDC and organizations with an MOUs, private practices, FOCUS, FQHC, Quick Connect, and HCN.

    - **Responsible Party for Providing Data:** FDOH-MDC.

    - **Data Sources:** CTLS, FOCUS Reports, and UDS (FQHCs).

DRAFT

- **Activity 1.1.2:** Implement HIV testing, including HIV self-testing, in non-health care community settings.

  - **Measurements:**

    1.1.2.1 Number of non-healthcare community settings conducting HIV testing.
    1.1.2.2 Number of people tested for HIV at non-healthcare community settings.
    1.1.2.3 Number of HIV positive people identified at non-healthcare community settings via preliminary testing.
    1.1.2.4 Number of newly diagnosed HIV positive identified at non-healthcare community settings.
    1.1.2.5 Number of HIV self-test kits distributed; or Number of people who received a self-test kit.
    1.1.2.6 Number of preliminary HIV positive people identified through self-test kits.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC, CBOs, ASOs, mobile units, and contracted FDOH-MDC prevention providers.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** CTLS, FOCUS Reports, and UDS (FQHCs).

- **Activity 1.1.3:** Support integrated screening of HIV in conjunction with STIs, TB, viral hepatitis (HCV), and mpox for a syndemic and person-centered approach.

  - **Measurements:**

    1.1.3.1 Number of healthcare facilities conducting screening for HIV, STIs and HCV.
    1.1.3.2 Number of HIV tests conducted in conjunction with an HCV test within healthcare facilities.
    1.1.3.3 Number of people with a positive HCV identified through integrated screening at healthcare facilities.
    1.1.3.4 Number of HCV tests conducted at non-healthcare settings in conjunction with rapid or confirmatory HIV testing.
    1.1.3.5 Number of people with a positive HCV identified through integrated screening at non-healthcare facilities.
    1.1.3.6 Number of HIV tests conducted in conjunction with a Syphilis test within healthcare facilities.
    1.1.3.7 Number of people with a positive Syphilis identified through integrated screening at healthcare facilities.
    1.1.3.8 Number of Syphilis tests conducted at non-healthcare settings in conjunctions with HIV testing.
    1.1.3.9 Number of people with a positive Syphilis identified through integrated screening at non-healthcare facilities.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC, CBOs, ASOs, FQHCs, private providers, hospitals and urgent care centers, ObGYNs, and FOCUS /FQHC.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** FOCUS, CTLS, UDS, FLPortal, and HIP Reports.

DRAFT

□ **Objective 1.2: Prevent HIV transmission by increasing PrEP coverage to 50% of estimated people with indications for PrEP, increasing PEP services, and supporting HIV prevention, including condom distribution, prevention of perinatal transmission, harm reduction, and syringe services program (SSP) efforts.**

- **Activity 1.2.1:** Support and promote awareness and access to PrEP and PEP services.

  - **Measurements:**

    1.2.1.1 Number of PrEP educational sessions conducted for the community.
    1.2.1.2 Number of educational sessions conducted specifically to health care providers.
    1.2.1.3 Number of providers offering PrEP services.
    1.2.1.4 Number of clients with ongoing risk of HIV acquisition referred to PEP and PrEP services.
    1.2.1.5 Estimated percentage (or number) of people who are prescribed PrEP (PREP coverage).
    1.2.1.6 Estimated percentage (or number) of PrEP prescriptions written.
    1.2.1.7 PrEP to Need ratio in MDC.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC, CBOs, ASOs, FQHCs, and private sector.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** FDOH-MDC MOUs, Gilead, ViiV, CTLS, HIP reports, STARS, PrEP Referral Platform, University of California of San Diego, AIDSVu, and AHEAD Dashboard.

- **Activity 1.2.2:** Conduct condom distribution.

  - **Measurements:**

    1.2.2.1 Number of condoms distributed by Zip Code (report using Zip Code map).
    1.2.2.2 Number of Business Responds to AIDS (BRTA) sites.

  - **Key Partners to Accomplish the Objective:** CBOs, ASOs, FQHCs, private businesses, and BRTA sites.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Source:** HIP reports.

DRAFT

- **Activity 1.2.3:** Support harm reduction services, including the IDEA Exchange syringe services programs (SSPs), and whole-person approach to HIV prevention services. Note: There are no Federal funds supporting this activity.

  - **Measurements:** Under development.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC and Idea Exchange.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Source:** IDEA Exchange.

  - **Challenges:** Determining what data should be gathered to demonstrate meaningful progress toward the objective; maintaining the anonymity of IDEA Exchange clients.

- **Activity 1.2.4:** Conduct perinatal, maternal, and infant health prevention and surveillance activities and support maintaining the national goals of perinatal HIV incidence of < 1 per 100,000 live births and a perinatal transmission rate of < 1 %.

  - **Measurements:**

    1.2.4.1 Number of educational sessions conducted virtually and in person with providers and hospitals promoting routine HIV testing of all pregnant persons and diagnostic HIV testing for HIV-exposed infants.
    1.2.4.2 Number of educational sessions conducted virtually and in person with providers and hospitals to promote awareness and responsibility of utilizing the High-Risk Pregnancy Notification and Newborn Exposure Notification forms.
    1.2.4.3 Percent of birthing people with HIV who were linked to HIV care and prenatal care within 30 days of receiving the High-Risk Pregnancy Notification and Newborn Exposure Notification form.
    1.2.4.4 Percent of birthing people with HIV who received post-partum care which may include Family Planning Services.
    1.2.4.5 Percent of breastfeeding people with HIV who receive documented nursing-led lactation counseling within 24 hours of delivery.
    1.2.4.6 Percent of pregnant birthing people living with HIV who initiated breastfeeding and had continued at 6 months postpartum.
    1.2.4.7 Number of infants born to mothers who are HIV positive.
    1.2.4.8 Number of infants exposed to HIV from their HIV positive mother.
    1.2.4.9 Number of infants who contracted HIV from their HIV positive mother.

  - **Key Partners to Accomplish the Objective:** UM-HIV Perinatal Services.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** DIS documentation and PeriApp Database.

DRAFT

Goal 2: Improve HIV-Related Health Outcomes for People with HIV

- **Objective 2.1: Increase the percentage of newly diagnosed and previously diagnosed people with HIV (i.e., new to local Ryan White HIV/AIDS Program (RWHAP) or lost to care) who are linked to comprehensive HIV care and treatment within 30 days of initiating or re-engaging in care from [baseline]% to 95%.**

  - **Activity 2.1.1:** Identify, standardize, and implement best practices to facilitate rapid access to antiretroviral therapy (ART) medication, including updating local protocols and training staff on related workflows to improve timely linkage to care.

    - **Measurement:**

      2.1.1.1 Training on current local TTRA protocol and process flowchart provided to front-line staff (medical case managers, peers, outreach workers).

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients and BSR.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

  - **Activity 2.1.2:** Implement and monitor local rapid access to antiretroviral therapy (ART) protocols (e.g., TTRA) to ensure newly diagnosed people with HIV initiate treatment within seven (7) days of diagnosis.

    - **Measurements:**

      2.1.2.1 Number of newly diagnosed people with HIV enrolled in local RWP through TTRA process only.
      2.1.2.2 Percentage of newly diagnosed people with HIV who complete a medical visit and receive an ART prescription on the same day as diagnosis through the TTRA process.
      2.1.2.3 Percentage of newly diagnosed people with HIV who complete a medical visit and receive an ARV prescription within 7 days of diagnosis through the TTRA process.
      2.1.2.4 Percentage of newly diagnosed people with HIV who received medical services through the TTRA process and are retained in HIV (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
      2.1.2.5 Percent of newly enrolled RWP clients enrolled in ADAP or other ARV payer source within 30 days of receipt of first ARV medication.

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

DRAFT

- **Activity 2.1.3:** Implement and monitor local rapid access to ARV protocols (e.g., TTRA) to ensure previously diagnosed people with HIV (i.e., new to local RWHAP and those who were lost to care) restart antiretroviral therapy (ARV) within seven (7) days of contact with a TTRA team.

  - **Measurements:**

    2.1.3.1 Number of previously diagnosed people with HIV enrolled in local RWP through TTRA process only.
    2.1.3.2 Percentage of previously diagnosed people with HIV who complete a medical visit and receive an ART prescription on the same day as re-linkage to care through the TTRA process.
    2.1.3.3 Percentage of previously diagnosed people with HIV who have a medical visit and ARV prescription within 7 days of re-linkage to care through TTRA process.
    2.1.3.4 Percentage of previously diagnosed people with HIV enrolled through the TTRA process who are retained in HIV care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.1.3.5 Percentage of previously diagnosed people with HIV enrolled through the TTRA process who are virally suppressed (≤ 200 copies/mL).

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.1.4:** Provide up to three encounters (days) of Medical Case Management (MCM) services, including treatment adherence counseling, to RWP clients served through the TTRA process to support linkage to ongoing HIV care (medical care and medications) within 30 days of ARV initiation or restart.

  - **Measurements:**

    2.1.4.1 Number of RWHAP clients who received MCM services within 30 days of initiating or re-engaging in care through the TTRA process.
    2.1.4.2 Percentage of RWHAP TTRA clients who received MCM assistance to enroll in ADAP or another ARV payer source within 14 days of ARV initiation or restart.
    2.1.4.3 Percentage of RWHAP TTRA clients who received MCM assistance to enroll in ADAP or another ARV payer source within 30 days of ARV initiation or restart.
    2.1.4.4 Percentage of RWHAP clients enrolled through the TTRA process who are retained in MCM at 60 days post enrollment.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 2.1.5:** Provide a Mental Health Services (MHS) counseling encounter within 30 days of ARV initiation or re-engagement in care for RWHAP clients served through the TTRA process. The encounter includes a behavioral health screening, assessment, and referral (if needed), to address mental health barriers that may affect retention in care.

  - **Measurements:**

    2.1.5.1 Number of RWHAP clients initiating or re-engaging in care through the TTRA process.
    2.1.5.2 Percentage of RWHAP clients who received a MHS encounter within 30 days of initiating or re-engaging in care through the TTRA process.
    2.1.5.3 Percentage of RWHAP clients who received a MHS encounter within 60 days of initiating or re-engaging in care through the TTRA process.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

□ **Objective 2.2: Increase the percentage of RWHAP clients receiving MCM, Outpatient/Ambulatory Health Services (OAHS), or Peer Education and Support Network (PESN) who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

- **Activity 2.2.1:** Implement standardized MCM to eligible clients, including development of a care plan, routine treatment adherence counseling, and monitoring of client needs and health outcomes.

  - **Measurements:**

    2.2.1.1 Number of RWHAP clients receiving MCM.
    2.2.1.2 Percentage of MCM clients with a documented adherence counseling encounter at each encounter.
    2.2.1.3 Percentage of MCM clients with documented viral load suppression.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 2.2.2:** Ensure medical case management (MCM) staff utilize available data, PE Miami 60-day no-contact alert system, and care coordination partners to identify and assist clients who are out of care or who are at risk of being out of care with staying connected to HIV care.

  - **Measurements:**

    2.2.2.1 Number of RWHAP MCM clients.
    2.2.2.2 Percentage of MCM clients with a 60-day no-contact flag.
    2.2.2.3 Percentage of MCM clients with no contact for 90 days.
    2.2.2.4 Percentage of MCM clients with no contact for 90 days who are re-engaged in care within 60 days.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.2.3:** Clinical staff and care coordinators implement proactive retention strategies for clients, including appointment reminders, outreach after missed visits, transportation support, and comprehensive care planning coordination.

  - **Measurements:**

    2.2.3.1 Number of RWHAP clients receiving MCM.
    2.2.3.2 Percentage of MCM clients retained in care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.2.3.3 Number of RWHAP clients receiving OAHS.
    2.2.3.4 Percentage of OAHS clients retained in care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 2.2.4:** Provide peer support services through peer support staff and certified peer specialists to improve retention in medical care and viral load suppression among RWHAP clients.

  - **Measurements:**

    2.2.4.1 Number of RWHAP clients receiving peer support services.
    2.2.4.2 Percentage of RWHAP clients served by peer support staff retained in medical care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.2.4.3 Percentage of RWHAP clients served by peer support staff who are virally suppressed (<200 copies/mL).
    2.2.4.4 Number of RWHAP subrecipient staff certified as peer specialists.
    2.2.4.5 Number of RWHAP clients receiving certified peer support services.
    2.2.4.6 Percentage of RWHAP clients served by certified peer specialists retained in medical care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.2.4.7 Percentage of RWHAP clients served by certified peer specialists who are virally suppressed (<200 copies/mL).

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.2.5:** The RWHAP Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among MCM and OAHS clients.

  - **Measurements:**

    2.2.5.1 QI projects developed addressing improving VL suppression among RWP MCM clients.
    2.2.5.2 QI projects developed addressing improving VL suppression among RWP OAHS clients.
    2.2.5.3 QI projects developed addressing improving retention in medical care among RWP MCM clients.
    2.2.5.4 QI projects developed addressing improving retention in medical care among RWP OAHS clients.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

DRAFT

- **Objective 2.3: Increase the percentage of people with HIV receiving Ending the HIV Epidemic (EHE) Initiative services who are linked to care within 30 days from [baseline]% to ≥90%, and achieve viral suppression from [baseline]% to ≥90%, through expanded use of Quick Connect Services (HIV education and rapid access to ARV), HealthTec Services (telehealth), Housing Stability Services (housing assistance), Mobile GO Teams Services (mobile health clinics).**

  - **Activity 2.3.1: Quick Connect Services:** Update and distribute clear, understandable HIV educational materials to non RWHAP funded clinics and testing sites to support access to HIV resources and services for newly diagnosed and re- engaging clients.

    - **Measurements:**

      2.3.1.1 Number of non-RWHAP-funded clinicians/clinics visited to provide academic detailing in HIV education and resources.
      2.3.1.2 Number of HIV education materials (packets) distributed to non-RWHAP-funded clinicians/clinics.

    - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

    - **Responsible Party for Providing Data:** EHE Recipient.

    - **Data Source:** PE-Miami.

  - **Activity 2.3.2: Quick Connect Services:** Expand EHE Quick Connect services across hospitals, clinics, and community settings to ensure rapid access to ARV and linkage to ongoing care.

    - **Measurements:**

      2.3.2.1 Number of people with HIV contacted by or initiating contact with an EHE Quick Connect team.
      2.3.2.2 Number of EHE Quick Connect clients linked to HIV medical care.
      2.3.2.3 Number of EHE Quick Connect clients retained in care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
      2.3.2.4 Number of EHE Quick Connect clients with viral load suppression at most recent VL test.

    - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

    - **Responsible Party for Providing Data:** EHE Recipient.

    - **Data Source:** PE-Miami.

DRAFT

- **Activity 2.3.3: HealthTec Services:** Provide access to telecommunication devices (smart phones or tablets) and internet services, along with basic instructions and connectivity support, to help people with HIV overcome barriers to care and engage in HIV services through telehealth.

  - **Measurements:**

    2.3.3.1 Number of clients enrolled in EHE HealthTec Services.
    2.3.3.2 Number of EHE HealthTec Services clients retained in care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.3.3.3 Number of EHE HealthTec Services clients with viral load suppression at most recent VL test.

  - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

- **Activity 2.3.4: Housing Stability Services:** Provide housing stability services, including short-term, transitional, emergency, and supportive housing assistance, along with housing navigation and supportive case management services, to help people with HIV remain in HIV care and overcome housing-related barriers.

  - **Measurements:**

    2.3.4.1 Number of clients enrolled in EHE Housing Stability Services.
    2.3.4.2 Number of EHE Housing Stability Services clients retained in care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.3.4.3 Number of EHE Housing Stability Services clients retained in HIV care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period) at 6 months following enrollment.
    2.3.4.4 Number of EHE Housing Stability Services clients with viral load suppression at most recent VL test.

  - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 2.3.5: Mobile Go Teams Services:** Deploy Mobile GO Teams Services using a mobile clinic to deliver healthcare services and provide access to ARV in high priority and underserved areas, reducing barriers to HIV care engagement and supporting improved health outcomes for people with HIV.

  - **Measurements:**

    2.3.5.1 Number of clients enrolled in EHE Mobile GO Teams Services.
    2.3.5.2 Number of EHE Mobile GO Teams clients retained in HIV care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.3.5.3 Number of EHE Mobile GO Teams clients with viral load suppression at most recent VL test.

  - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

DRAFT

Goal 3: Address HIV-Related Health Outcomes for Groups Experiencing Higher HIV Impact

- □ **Objective 3.1: Increase the percentage of women in RWHAP care receiving MCM and OAHS who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

  - **Activity 3.1.1:** Monitor viral load and retention in medical care rates among women in MCM and OAHS care to identify outcomes that fall behind established targets.

    - **Measurements:**

      3.1.1.1 Number of women in MCM care.
      3.1.1.2 VL Suppression among women in MCM care.
      3.1.1.3 Retention in Medical Care among women in MCM care.
      3.1.1.4 Number of women in OAHS care.
      3.1.1.5 VL Suppression among women in OAHS care.
      3.1.1.6 Retention in Medical Care among women in OAHS care.

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

  - **Activity 3.1.2:** The Ryan White Program Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among women.

    - **Measurements:**

      3.1.2.1 QI projects developed addressing improving VL suppression among women.
      3.1.2.2 QI projects developed addressing improving RiMC among women.

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

DRAFT

□ **Objective 3.2: Increase the percentage of adults aged 50+ in RWHAP care receiving MCM and OAHS who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

- **Activity 3.2.1:** Monitor viral load and retention in medical care rates among adults aged 50+ in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.2.1.1 Number of adults aged 50+ in MCM care.
    3.2.1.2 VL Suppression among adults aged 50+ in MCM care.
    3.2.1.3 Retention in Medical Care among adults aged 50+ in MCM care.
    3.2.1.4 Number of adults aged 50+ in OAHS care.
    3.2.1.5 VL Suppression among adults aged 50+ in OAHS care.
    3.2.1.6 Retention in Medical Care among adults aged 50+ in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.2.2:** The Ryan White Program Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among adults aged 50+.

  - **Measurements:**

    3.2.2.1 QI projects developed addressing improving VL suppression among adults aged 50+.
    3.2.2.2 QI projects developed addressing improving retention in medical care among adults aged 50+.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 3.2.3:** Ensure eligible clients aged 65+ are enrolled in Medicare.

  - **Measurements:**

    3.2.3.1 Number of RWP MCM clients over age 65.
    3.2.3.2 Percent of RWP MCM clients over age 65 with a Medicare marker in PE Miami.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

□ **Objective 3.3: Increase the percentage of RWHAP clients experiencing higher HIV impact (Black/African American males, Black/African American females, and Haitian males and females), receiving MCM and OAHS who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

- **Activity 3.3.1:** Monitor viral load and retention in medical care rates among Black/African American males in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.3.1.1 Number of Black/African American males in MCM care.
    3.3.1.2 VL Suppression among Black/African American males in MCM care.
    3.3.1.3 Retention in Medical Care among Black/African American males in MCM care.
    3.3.1.4 Number of Black/African American males in OAHS care.
    3.3.1.5 VL Suppression among Black/African American males in OAHS care.
    3.3.1.6 Retention in Medical Care among Black/African American males in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 3.3.2:** Monitor viral load and retention in medical care rates among Black/African American females in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.3.2.1 Number of Black/African American females in MCM care.
    3.3.2.2 VL Suppression among Black/African American females in MCM care.
    3.3.2.3 Retention in Medical Care among Black/African American females in MCM care.
    3.3.2.4 Number of Black/African American females in OAHS care.
    3.3.2.5 VL Suppression among Black/African American females in OAHS care.
    3.3.2.6 Retention in Medical Care among Black/African American females in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.3.3:** Monitor viral load and retention in medical care rates among Haitian males and females in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.3.3.1 Number of Haitian males and females in MCM care .
    3.3.3.2 VL Suppression among Haitian males and females in MCM care.
    3.3.3.3 Retention in Medical Care among Haitian males and females in MCM care.
    3.3.3.4 Number of Haitian males and females in OAHS care.
    3.3.3.5 VL Suppression among Haitian males and females in OAHS care.
    3.3.3.6 Retention in Medical Care among Haitian males and females in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

- **Activity 3.3.4:** The Ryan White Program Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among clients experiencing higher HIV impact.

  - **Measurements:**

    3.3.4.1 QI projects developed addressing improving VL suppression among Black/African American males.
    3.3.4.2 QI projects developed addressing improving retention in medical care among Black/African American males.
    3.3.4.3 QI projects developed addressing improving VL suppression among Black/African American females.
    3.3.4.4 QI projects developed addressing improving retention in medical care among Black/African American females.
    3.3.4.5 QI projects developed addressing improving VL suppression among Haitian males and females.
    3.3.4.6 QI projects developed addressing improving retention in medical care among Haitian males and females.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

DRAFT

Goal 4: Achieve Integrated, Coordinated Efforts the Address the HIV Epidemic Among All Partners and Collaborators

- **Objective 4.1: Respond quickly to HIV transmission networks and outbreaks to address gaps and inequities in services for communities who need them.**

  - **Activity 4.1.1:** Develop and maintain a cross-program Transmission Network Detection Response (TNDR) leadership and coordination group to oversee TNDR activities.

  - **Activity 4.1.2:** TNDR Group: Communicate and collaborate about TNDR.

  - **Activity 4.1.3:** TNDR Group: Detect and prioritize transmission networks.

    - **Key Partners to Accomplish the Objective:** FDOH-MDC and TNDR group.

    - **Responsible Party for Providing Data:** FDOH-MDC.

    - **Data Source:** FDOH surveillance data.

DRAFT

Future Objectives and Activities

These concerns and activities will be included in data tracking pending identifiable data sources.

□ **Increase access to services addressing key social determinants of health, including housing, food, transportation, and health insurance/benefits, among newly enrolled and re-engaged RWHAP clients, and improve retention in medical care from [baseline]% to ≥95.**

- Assess and address health insurance and benefits needs by providing navigation and enrollment support to newly enrolled and re-engaged RWHAP clients.
- Address treatment adherence barriers by providing transportation assistance to newly enrolled and re-engaged RWHAP clients to support access to HIV medical care and services.
- Assess and address food insecurity by connecting newly enrolled and re-engaged RWHAP clients to food and nutrition services (e.g., food banks, meal programs, nutrition support).
- Assess housing status and coordinate access to housing services (e.g., HOPWA, emergency housing, transitional housing) and related services (e.g., employment and life skills training) for newly enrolled and re-engaged RWHAP clients to support treatment adherence and housing stability.
- Develop guidelines and procedures for RWP MCMs to identify and address the impact of social determinants of health (e.g., childcare, housing, food insecurity, domestic violence, discrimination and other issues) on client clinical outcomes.
- Coordinate access to services addressing social determinants of health (e.g., housing, food, transportation, health insurance/benefits, and social support) for newly enrolled and re-engaged RWHAP clients to improve retention in care and viral load suppression.
- Address stigma and social support needs by connecting newly enrolled and re-engaged RWHAP clients to peer support, support groups, and related services.

V.1.a. Updates to Other Strategic Plans Used to Meet Requirements

This Plan incorporates updated goals and objectives from the 2022-2026 Integrated Plan, the RWHAP EHE Plan, and the FDOH-MDC EHE plan, as detailed in **Section II: Community Engagement and Planning Process**, above.

DRAFT

Section VI: 2027-2031 Integrated Plan Implementation, Monitoring, and Jurisdictional Follow Up

Implementation, monitoring, evaluation, and improvement will begin January 1, 2027, and continue through December 31, 2031, as outlined below. All processes will involve members of the affected community including Ryan White Program (RWHAP) clients and others, Partnership's Joint Integrated Plan Review Team (JIPRT) members, as well as RWHAP, Florida Department of Health in Miami-Dade County (FDOH-MDC), and EHE teams. Additional collaborators will participate in Partnership and Committee meetings and, as positions are available, will be invited to join as voting members.

The JIPRT has made significant effort to ensure the development of SMART goals and activities as detailed in the local Integrated Plan Monitoring and Reporting System (IPMRS), as designed by Behavioral Science Research Corporation, the contracted subrecipient for Planning Council Staff Support services. This effort includes specifying key individuals who will be accountable for implementing Plan activities and strategies, identifying data sources, as well as ensuring and establishing timelines for activity reporting and completion. Plan progress will be monitored quarterly to identify areas of the Plan that reflect optimal performance and that have challenges and lack progress. Status updates will be shared with the listed participants during the quarterly JIPRT meetings, where progress and issues will be reviewed, recommendations for improvement will be determined, and next steps will be identified.

VI.a. Implementation

Community stakeholders, specifically RWHAP-, FDOH-MDC-, and EHE-funded recipients and subrecipients have been instrumental in development of the Plan and are expected to take the lead on their assigned activities as detailed in the IPMRS. People with HIV are in leadership and supporting roles in the Partnership and its Committees and will continue to be active in the implementation of the Plan. No delays are expected in launching the 2027-2031 Plan on January 1, 2027. A smooth transition from the 2022–2026 Plan is anticipated.

However, recent funding cuts and new legislative restrictions have made it increasingly difficult to bring new partners into the integrated planning process. Even so, as key collaborators and subject matter experts are identified, they are encouraged to attend the appropriate meetings. All meetings are publicly noticed, and all related materials are available on the Partnership's website, www.PartnershipMiami.org.

VI.b. Monitoring

This Monitoring section outlines the structured processes we will use to assess program performance, ensure compliance with RWHAP requirements, and track progress toward improving health outcomes for people with HIV. Through routine data review, site visits, subrecipient monitoring, and continuous quality improvement activities, we aim to identify strengths, address gaps early, and support a responsive, equitable, and client-centered system of care.

The JIPRT is the primary forum for monitoring and reporting progress of the Plan, determining response strategies, and engaging collaborators. JIPRT meetings are held in person and publicly noticed through multiple channels. Members of the affected community participate as JIPRT members and as meeting guests.

The IPMRS is designed to support accountability by ensuring activities are SMART and organized under overarching Plan goals.

DRAFT

This structure brings forward continuously relevant themes from:

- The National HIV/AIDS Strategy
  - Preventing HIV transmission,
  - Strengthening health outcomes,
  - Addressing differences in health outcomes, and
  - Promoting coordinated and collaborative efforts to effectively respond to the epidemic;
- The EHE Pillars:
  - Diagnose,
  - Treat,
  - Prevent, and
  - Respond;
- The Statewide Coordinated Statement of Need;
- The HIV Care Continuum stages:
  - Diagnose,
  - Linkage to care,
  - Retention in care, and
  - Viral suppression; and
- Ryan White Program 2030 goals:
  - Rapid initiation of HIV treatment,
  - Community-based outreach,
  - Treatment as prevention,
  - Leveraging partnerships, and
  - Using data-driven approaches to identify populations with unmet needs.

The IPMRS database is the primary monitoring tool to track progress towards these goals based on related objectives, activities, and measurements. FDOH-MDC and RWHAP staff will work with subrecipient organizations and other stakeholders who have been assigned reporting tasks to confirm program progress. Data sources may include Provide Enterprise® Miami (PE Miami), FDOH-MDC local data, FDOH statewide data as available, and the HIV.org Americas HIV Epidemic Analysis Dashboard (AHEAD). A designated group of users will regularly enter information into the IPMRS as data become available. The IPMRS is maintained in a shared Microsoft OneDrive environment so users can collaborate in a single database concurrently. Client confidentiality is protected as no Protected Health Information (PHI) or other client identifying information is included in the IPMRS.

A sample of the IPMRS is presented directly below. The image includes various public-facing fields and administrative fields, as described below.

DRAFT

Sample IPMRS Database with Two Data Indicators

Goal

Objective 1.1	Sample											
Activity 1.1.1	Sample								See corresponding tabs for details			
Measurement #	Measurement	Baseline	Status	Summary Data	Target	Notes	Jan 1, 2027-Jun 30, 2027	Jul 1, 2027-Dec 31, 2027	Key Contact Person	Key Partners	Monitoring Data Source	Funding Sources
1.1.1.1	Sample	December 2026: 100	Activity Not Started	Cumulative Total: 37	December 2030: 500		12	25				
1.1.1.2	Sample		Activity In Progress	Average: 22.5			25	20				
1.1.1.3	Sample		Activity Suspended	Most Recent Measurement: 20			25	20				
1.1.1.4	Sample		Activity Complete	No Data								

Public-Facing Fields

- **Goal** – Four Goals built upon the National HIV/AIDS Strategy, then further evolved to align with the four pillars of EHE and the Ryan White Program 2030 goals.
- **Objective** – Each Objective corresponds to the Goal and has a unique number related to the Goal.
- **Activity** – Each Activity corresponds to the Objective and has a unique number related to the Objective.
- **Measurement #** – Each Measurement corresponds the Activity and has a unique number related to the Activity.
- **Measurement** – Indicates a quantifiable amount for which there is a known data source.
- **Baseline** – Indicates the most recent data available before January 1, 2027, with referenced date and value (i.e., December 2026: 100).
- **Status** – Programmed to provide quick visual clues as to the progress of Activities for reference during monitoring. Progress colors are:
  - **Blue: Activity Not Started** (Activity and/or data collection has not begun);
  - **Yellow: Activity in Progress** (Activity and data collection has begun and is ongoing);
  - **Red: Activity Suspended** (Activity began and was suspended; reason for the suspension would be in the Administrative Field "Notes" section, see below); or
  - **Green: Activity Complete** (Activity complete and no further action needed).
- **Summary Data** – This field is calculated to capture data as either:
  - Cumulative Total;
  - Average;
  - Most Recent Measurement; or
  - No Data.
- **Target** – Indicates the end date for completing the Activity and the Target Measurement (i.e., December 2030: 100).
- **Dashboard** of graphs, tables, and charts to demonstrate progress in a user-friendly format.

Administrative Fields

- **Notes** – User notes to track any peculiarities (e.g., reason for suspension, clarifications, etc.) of the related Activity.
- **Measurement Periods** – There are ten 6-month measurement periods – January through June, and July through December – for each of the Plan years.

DRAFT

- **Key Contact Person** – The go-to person for data; this field corresponds to a tab to collect the Key Person's contact information, including title, in case of changes in staffing.
- **Key Partners** – Community organizations related to the Activity (e.g., RHWAP subrecipients); this field corresponds to a tab to collect organization names and contacts, including URLs.
- **Monitoring Data Source** – The database from which data are drawn to quantify the Activity; this field corresponds to a tab to collect the database name, related key contacts, and URLs.
- **Funding Source** – Funding stream(s) related to the Activity; this field corresponds to a tab which indicates the source of funds, years of funding, and related URLs.
- **All administrative sections** will be continually updated as we identify new collaborators and funding sources.

VI.c. Evaluation

A robust evaluation process is essential to ensuring that the Integrated Plan remains effective, accountable, and responsive to emerging needs. To support this, the IPMRS is designed to collect performance data in six-month measurement periods, providing a structured foundation for ongoing assessment. The JIPRT convenes quarterly to review progress, identify areas where measurements are not on track, and recommend corrective actions. Over the life of the Plan, the JIPRT is expected to meet approximately 20 times, ensuring consistent opportunities for evaluation, refinement, and accountability. While the Plan will continue to evolve as needed, every effort has been made to develop SMART goals, objectives, and activities that support meaningful measurement and analysis of progress.

Beginning in July 2026, JIPRT meetings will focus on establishing performance Targets; completing the Key Contact Person, Key Partners, Monitoring Data Source, and Funding Source fields; and determining Baselines. As additional Key Partners are identified, we anticipate expanded collaboration across the EMA to strengthen implementation and monitoring efforts.

VI.d. Improvement

A strong improvement process is vital to ensuring that evaluation results translate into meaningful action. Throughout implementation of the Integrated Plan, the JIPRT will serve as the primary forum for reviewing data and results, recommending modifications, and elevating improvement strategies to the Partnership and stakeholders. The JIPRT will be responsible for identifying weaknesses in implementation, measurement, and operational processes; flagging activities that fall behind established targets; and requesting technical assistance when needed. In alignment with the JIPRT schedule, meetings will alternate between data review and follow-up on the Challenges and Identified Needs outlined in **Section IV: Situational Analysis** of this Plan, see above.

Although many of the Challenges and Identified Needs in **Section IV: Situational Analysis** cannot be linked to measurable outcomes and therefore are not included in the IPMRS, they remain important to the overall health of the system. The Partnership will continue to identify resources, gather stakeholder feedback, and elevate these issues to ensure they remain visible and are addressed through community collaboration and problem-solving.

VI.e. Reporting and Dissemination

Transparent and consistent reporting is essential to maintaining accountability, strengthening stakeholder engagement, and ensuring shared ownership of the Plan's progress. To support this, updates on the implementation and execution of the Integrated Plan will be presented at quarterly JIPRT meetings, incorporated into the regular Partnership committee reporting process, and shared with other Partnership

DRAFT

committees and subrecipients as appropriate. FDOH-MDC workgroups, community collaborators, and other stakeholders will also receive updates and will be encouraged to contribute to ongoing planning, implementation, and evaluation efforts. Special presentations may be provided to community partners when appropriate or upon request.

The Partnership's website includes dedicated pages for both the JIPRT and the Integrated Plan, where all meeting materials – including progress reports – are posted for public access. Printed copies of reports are distributed to JIPRT members during regular meetings and are available to others upon request. Evaluation results will also be integrated into the Annual State of HIV Report, produced by the Partnership's Strategic Planning Committee in collaboration with FDOH-MDC and the RWHAP Recipient, and provided to the Miami-Dade County Mayor, Board of County Commissioners, and Partnership members.

VI.f Updates to Other Strategic Plans Used to Meet Requirements

The 2027-2031 Plan is largely drawn from the 2022-2026 Plan since the latter was well-received and comprehensive. This Plan varies most markedly from the earlier version in that the activities for 2027-2031 are much more complete, and this Plan accounts for significant legislative and funding changes, as detailed in previous sections.

This 2027-2031 Plan represents a strong collaboration between the RWHAP Planning Council and Recipient, and FDOH-MDC to ensure our mutual activities are captured and coordinated, and we look forward to future collaborations with the State FDOH.

DRAFT

[LETTERHEAD]

Addendum 1

June 1, 2026

Ms. Jenifer Gray
HRSA Project Officer
Division of Metropolitan HIV/AIDS Programs - HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Gray:

The Miami-Dade HIV/AIDS Partnership (Partnership), the local Ryan White Program Planning Council, concurs with the submission of the *2027-2031 Integrated HIV Prevention and Care Plan for Miami-Dade County, Florida (Integrated Plan)*. This submission is in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention and HRSA's HIV/AIDS Bureau for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, for calendar years 2027 through 2031. This concurrence is specific to the local Integrated Plan only and does not provide concurrence with the statewide Integrated HIV Prevention and Care Plan.

The Partnership's Strategic Planning and Prevention Committees met jointly and as stand-alone committees in publicly noticed meetings on November 18, 2025, and January 22, February 17, March 10, March 26, April 14, April 30, and May 19 in 2026, to review Integrated Plan drafts and supporting data, and to recommend revisions. The final draft in its substantially complete form – subject to final minor administrative edits – was presented to the Partnership for ratification on June 1, 2026.

Following discussions and recommendations from these meetings and other feedback opportunities, draft Integrated Plan documents were produced. The Florida Department of Health in Miami-Dade County (FDOH-MDC) and Miami-Dade County Office of Management and Budget Ending the HIV Epidemic initiatives were also incorporated in the Integrated Plan goals and objectives. Drafts were posted for public access and comment throughout this process. Development of this updated Integrated Plan has been an intensive and collaborative effort between the Partnership; FDOH-MDC; OMB - the Ryan White Part A/MAI/EHE Program Recipient; and the local HIV community.

Partnership members, including representatives of the affected community, service providers, and FDOH-MDC representatives, along with OMB representatives have reviewed this *2027-2031 Integrated Plan* prior to its submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being directed to the populations and geographic areas with the highest HIV burden and differences in health outcomes.

Partnership members concur that this *2027-2031 Integrated Plan* submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV/AIDS Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The signatures below confirm concurrence with the submission of the *2027-2031 Integrated HIV Prevention and Care Plan for Miami-Dade County*.

Harold McIntyre Chair, Miami-Dade HIV/AIDs Partnership	**Daniel T. Wall** Assistant Director, OMB / Ryan White Program Director, MDC	**Kira Villamizar** Public Health Services Manager, FDOH-MDC

DRAFT

c: Matthew James, HRSA EHE Project Officer
Miami-Dade HIV/AIDS Partnership Members

DRAFT