

## 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).

- **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.**

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- **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.

- **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.

- **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.

## 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 ( $\geq 2$  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.

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- **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 ( $\geq 2$  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 ( $\leq 200$  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.

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- **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.

- **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%.**

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- **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.

- **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 ( $\geq 2$  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 ( $\geq 2$  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.

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- **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 ( $\geq 2$  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 ( $\geq 2$  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.

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- **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.

- **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.

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- **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 ( $\geq 2$  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 ( $\geq 2$  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 ( $\geq 2$  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.

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- **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 ( $\geq 2$  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.

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### 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.

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- **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.

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- **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:**

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- 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.

- **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.

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- **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.

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## **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.

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## 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.