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.

MIAMI-DADE COUNTY

Ending the HIV Epidemic Together.

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Table of Contents

Acronyms and Terminology **1**

Section I: Introduction of Integrated Plan and SCSN **3**
I.1. Introduction 3
Table 1: The Four Strategies of EHE 4
Table 2: HIV Care Continuum 5
I.1.a. Approach to Preparing the Integrated Plan 6
I.1.b. Documents Submitted to Meet Requirements 6

Section II: Community Engagement and Planning Process **7**
II.1. Jurisdiction Planning Process 7
II.1.a. Entities involved in the process. 8
II.1.b. Role of the RWHAP Part A Planning Council – The Partnership 9
II.1.c. Role of Planning Bodies and Other Entities 10
II.1.d. Collaboration with RWHAP Parts – SCSN Requirement 11
II.1.e. Engagement of People with HIV – SCSN Requirement 11
II.1.f. Priorities 12
II.1.g. Updates to Other Strategic Plans Used to Meet Requirements 12

Section III: Contributing Data Sets and Assessments **13**
III.1. Data Sharing and Use 13
III.2. Epidemiologic Snapshot 13
III.2.a. Current Data 13
III.2.b. Key Descriptors 13
Table 3: New HIV and AIDS Diagnoses 14
Table 4: People with HIV 14
Table 5: FDOH-MDC and FOCUS HIV Testing 15
III.2.c. Types of Data 15
Table 6: Race/Ethnicity Comparison 15
Table 7: ZIP Code Map 17
Table 8: STIs 19
Table 9: Race/Ethnicity – Newly Diagnosed 20
Table 10: Sex – Newly Diagnosed 20
Table 11: Age – Newly Diagnosed 21
Table 12: HIV Care Continuum 22
Table 13: HIV Incidence 23
Table 14: HIV Prevalence 24
III.2.d. HIV Clusters 26
III.3. HIV Prevention, Care and Treatment Resource Inventory 26
III.3.a. Providers 28
III.3.b. Funding Sources 30
Table 15: Prevention Resource Inventory 30
Table 16: Core Medical Services Resource Inventory 31
Table 17: Support Services Resource Inventory 32

III.3.c. Assessment of Strengths and Gaps Across the Prevention and HIV Care Continuum 33
III.3.d. Approaches and Partnerships 36
III.4. Needs Assessment 36
III.4.a. Priorities 36
III.4.b. Actions Taken 37
III.4.c. Approach 37

Section IV: Situational Analysis 38
IV.1.1. Strengths 38
IV.1.2. Challenges 39
IV.1.3. Identified Needs 41
IV.1.4. Analysis of Structural and Systemic Issues Impacting People and Communities Disproportionately Impacted by HIV 42
IV.1.4.a. Diagnose 43
IV.1.4.b. Treat 43
IV.1.4.c. Prevent 43
IV.1.4.d. Respond 44
IV.1.a. People and Communities with Higher Rates of HIV and Related Challenges 45

Section V: Goals and Objectives 46
V.1. Goals and Objectives Description 46
Goal 1: Prevent New HIV Transmission 46
Goal 2: Improve HIV-Related Health Outcomes for People with HIV 50
Goal 3: Address HIV-Related Health Outcomes for Groups Experiencing Higher HIV Impact 58
Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Collaborators 63
Future Objectives and Activities 64
V.1.a. Updates to Other Strategic Plans Used to Meet Requirements 64

Section VI: 2027-2031 Integrated Plan Implementation, Monitoring, and Jurisdictional Follow Up 65
VI.1.a. Implementation 65
VI.1.b. Monitoring 65
Table 18: Sample IPMRS Database with Two Data Indicators 67
VI.1.c. Evaluation 68
VI.1.d. Improvement 68
VI.1.e. Reporting and Dissemination 69
VI.1.f. Updates to Other Strategic Plans Used to Meet Requirements 69

Section VII (Addendum 1): Letter of Concurrence 70

Acronyms and Terminology

These acronyms and terminology are used throughout this Plan and further defined within the text, as necessary.

Acronym or Term	Definition
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AHEAD Dashboard	America's HIV Epidemic Analysis Dashboard
AHF	AIDS Healthcare Foundation
ARV	Antiretroviral
ASO	AIDS Service Organization
BRTA	Business Responds to AIDS
BSR	Behavioral Science Research Corporation, contracted subrecipient for Planning Council Staff Support and CQM services
CBO	Community-Based Organizations
CHARTS	Florida Community Health Assessment Resource Tool Set
CHI	Community Health of South Florida
CQM	Clinical Quality Management Program, including CQM Steering Committee, managed through local Part A and Part B contracts with BSR
CQMSC	Clinical Quality Management Steering Committee
CTLS	Counseling Testing and Linkage System Database
CY	Calendar Year
DIS	Disease Intervention Specialist
EHE	Ending the HIV Epidemic, A Plan for America
EMA	Eligible Metropolitan Area, as designated by HRSA under the RWHAP; the local EMA is Miami-Dade County
FCPN	Florida Comprehensive Planning Network
FDOH	Florida Department of Health (State of Florida)
FDOH-MDC	Florida Department of Health in Miami-Dade County
FL Care Lookup Portal	Data portal used by FDOH-MDC
FOCUS	Gilead's FOCUS Program - Frontlines of Communities in the United States
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HIP	High Impact Prevention
HMN	HIV molecular networks
HOPWA	Housing Opportunities for Persons With AIDS
HRSA	Health Resources and Services Administration
IDEA Exchange	University of Miami Infectious Disease Elimination Act
IDU	Intravenous Drug Use
IHAP TAC	Integrated HIV/AIDS Planning Technical Assistance Center
IPMRS	Integrated Plan Monitoring and Reporting System developed by BSR
JIPRT	Joint Integrated Plan Review Team (Partnership Strategic Planning and Prevention Committees)
MAI	Minority AIDS Initiative, part of the RWHAP

Acronym or Term	Definition
MCM	RWHAP Medical Case Management or Medical Case Managers
MDC	Miami-Dade County
MMSC	Male-to-Male Sexual Contact (Refers to mode of transmission)
MOUs	Memoranda of Understanding
NHAS	National HIV/AIDS Strategy
nPEP	Non-occupational Post-Exposure Prophylaxis
OAHS	Outpatient/Ambulatory Health Services, provided by the RWHAP
OMB	MDC Office of Management and Budget, Grants Coordination
Part A/MAI	Part A and the Minority AIDS Initiative of the RWHAP
Partnership	Miami-Dade HIV/AIDS Partnership, local Ryan White Program Planning Council
PCN	HRSA Policy Clarification Notice
PE Miami	Provide® Enterprise Miami (data management system utilized by RWHAP Part A, Part B, and EHE)
PEP	Pre-exposure Prophylaxis
PESN	Peer Education and Support Network
Plan	Miami-Dade County Integrated HIV Prevention and Care Plan
Planning Council	Miami-Dade HIV/AIDS Partnership, Ryan White Program Planning Council
PrEP	Pre-Exposure Prophylaxis
QI	Quality Improvement
Recipient	Miami-Dade County Office of Management and Budget, Grants Coordination
RFP	Request for Proposal
RiMC	Retention in Medical Care
RWHAP	Miami-Dade County Ryan White Program Part A/MAI
SCSN	Statewide Coordinated Statement of Need
SMART Goals	Specific. Measurable. Achievable. Relevant. Time-bound.
SSP	Syringe Services Program
STARS	Surveillance Tools and Reporting Systems
STI	Sexually Transmitted Infection
Subrecipients	Organizations funded under the RWHAP (also called providers)
TTRA	Test and Treat / Rapid Access (local “rapid start” protocol)
U=U	Undetectable = Untransmittable Campaign
UDS	Uniform Data System
UM	University of Miami
VL	Viral Load
WICY	Women, Infants, Children, and Youth

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, 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 five 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).

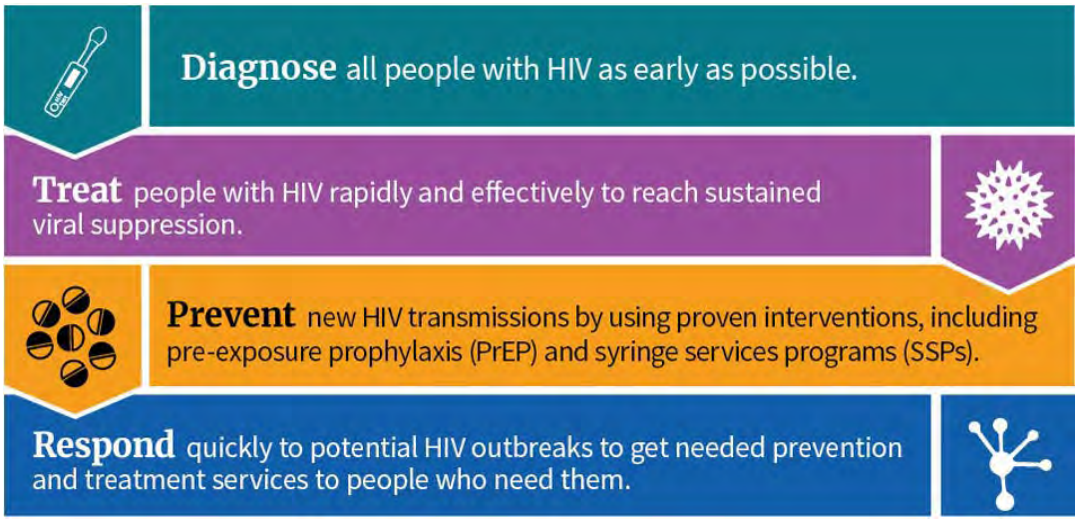
This Plan is structured around the overarching goals of the National HIV/AIDS Strategy (NHAS). It also incorporates the four strategies of the Ending the HIV Epidemic (EHE) Initiative, the key areas identified in the Statewide Coordinated Statement of Need (SCSN), and the Ryan White Program's 2030 goals 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, the EMA remains committed to structuring this Plan around the NHAS strategies for continuity along with the national objectives supported by CDC and HRSA as noted above.

Accordingly, the focus of this Plan continues to include the following strategies:

- 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 Strategies of EHE Initiative in the U.S.:

Table 1: The Four Strategies of EHE



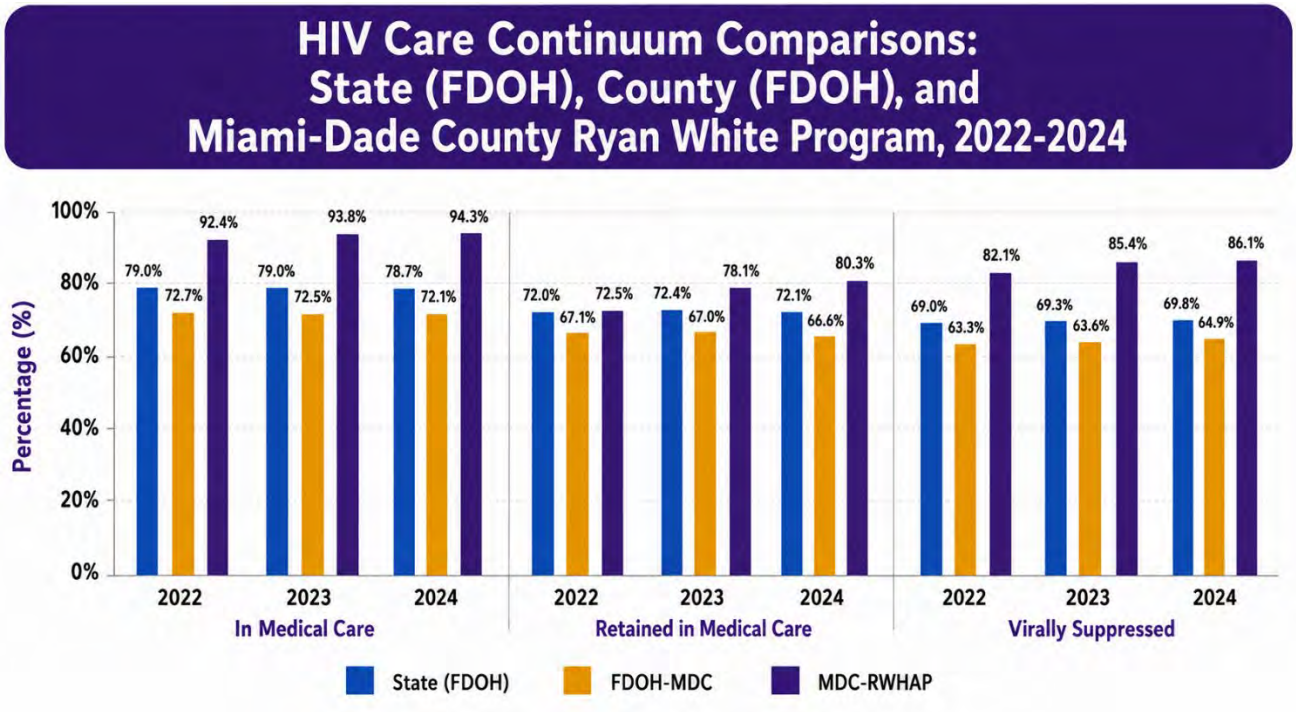
This Plan also incorporates the flexibilities of the EHE Initiative to advance the Ryan White Program 2030 goals. These goals emphasize continuing high-quality care for current Ryan White Program clients while expanding access to HIV care for people who are out of care or not virally suppressed, ensuring 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.

Table 2: HIV Care Continuum



Sources: PE Miami and 2024 FDOH State and Miami-Dade County Epi Profiles

Representatives from the Partnership, 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), and the FDOH-Miami Dade County, STD/HIV Prevention and Control Program serve on the Florida Comprehensive Planning Network (FCPN); and Partnership staff served on the Statewide Integrated HIV Prevention and Care Plan 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 abruptly discontinued the Statewide Integrated Planning Workgroup 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 by FDOH and has not yet been rescheduled.

Regardless, this Plan is a living document that the local jurisdiction will continually review and update to meet changing legislative requirements, respond to local policy shifts, and incorporate new data as it becomes 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 administered verbally in Haitian Creole, as needed);
- 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);
- NOFO PS24-0047;
- 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.

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, as noted above, 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 dialogue and collaborative problem-solving, the lack of open communication from the State has made it difficult to ensure this Plan's 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); HIV prevention providers; 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.

This Plan's 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 subrecipient contracted under Part A and Part B to provide staff support services to the Partnership, 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 people 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 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, JIPRT members 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;
- Local hospital representatives; and
- RWHAP subrecipients providing one or more of these services:
  - Medical Case Management,
  - Outpatient/Ambulatory Health Services,
  - Oral Health Care,
  - Mental Health Services,
  - Substance Abuse Services (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 the 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.

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 local jurisdictions can expect to have the updated SCSN. Nonetheless, locally, the survey is being promoted 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 meetings and the Care and Treatment Committee's Annual Needs Assessment include representatives from RWHAP Part A, Part B/ADAP, Part C, and Part D, EHE, Minority AIDS Initiative (MAI), who were provided feedback on Plan development. Members attending those meetings are also members of the Partnership and had a vote on this Plan prior to final submission. Additionally, though representatives of RWHAP Part A are not voting members on any committee, they participated as meeting guests and subject matter experts, and ensured the Plan was aligned with Executive Orders, legislative requirements, and program guidelines.

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 obstacles include the need to provide materials in English, Spanish, and Haitian Creole to ensure full understanding of information by participants. While some translations can be done using AI tools, the translations need to be vetted and there are no full-time, certified translators or interpreters on staff.

  The 2025 State of Florida HIV Care Needs Survey which was intended to gather feedback from across the state was only produced by FCPN and approved by FDOH in English, leaving jurisdictions responsible for developing their own translations, which may or may not use the same exact survey language in the translated versions. There were also no incentives for completing the survey. Despite being widely promoted, the survey response rate was low.

  The Partnership and FDOH-MDC Community Mobilization Workgroups continue to face challenges in recruiting new members, as employment and personal responsibilities often limit individuals' ability to participate in HIV community activities. Additionally, although FDOH-MDC Community Mobilization Workgroups can meet virtually, the Partnership is a County advisory board and must conduct all meetings in person only.

- **Successes.** Even considering 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 expected 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 survey response is consistent with the high levels of viral load suppression reported among RWHAP clients in Miami-Dade County and supports the EMA's 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 with the State Plan, as described in **Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up**, 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.

Section III: Contributing Data Sets and Assessments

III.1. Data Sharing and Use

Data for development of this Plan were gathered from the Florida State Department of Health (FDOH), the Florida Department of Health in Miami-Dade County (FDOH-MDC); Provide® Enterprise-Miami (PE Miami); 2025 Miami-Dade County Part A/MAI Needs Assessment; Florida Community Health Assessment Resource Tool Set (CHARTS) - www.flhealthcharts.gov/charts/; US Census Bureau; CDC HIV Supplemental Surveillance Report Volume 29; www.MiamiDadeMatters.org; community feedback; and additional sources as detailed in **Section I: Introduction** and SCSN, above.

Though the jurisdiction does not have formal data-sharing agreements, due to the close collaboration between the RWHAP Recipient, the RWHAP Partnership, and FDOH-MDC, necessary data are readily available.

III.2. Epidemiologic Snapshot

III.2.a. Current Data

Data used for this snapshot include the most recent five years of surveillance data from the Florida FDOH, 2020 through 2024; and the most recent five years RWHAP data, 2021 through 2025. All years are calendar years, January 1 through December 31, unless otherwise noted. Data from 2020 should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV prevention and testing.

III.2.b. Key Descriptors

Miami-Dade County has a high concentration of people with HIV and high rates of new HIV diagnoses, with both indicators among the highest in the United States. As of 2024, the FDOH reports 30,074 people with HIV in Miami-Dade County, accounting for more than 1% of the entire EMA population. Groups experiencing the highest HIV impact are the focus of Goal 3 as detailed in **Section V: Goals and Objectives**, below.

From 2021 through 2024, the EMA reported a total of 3,931 new HIV cases. This indicates a 9.4% decrease from the period of 2017-2020. For the same periods, 2021 through 2024, the EMA reported a total of 1,522 new AIDS cases. This indicates a 2.4% increase from 2017 to 2020.

Table 3: New HIV and AIDS Diagnoses

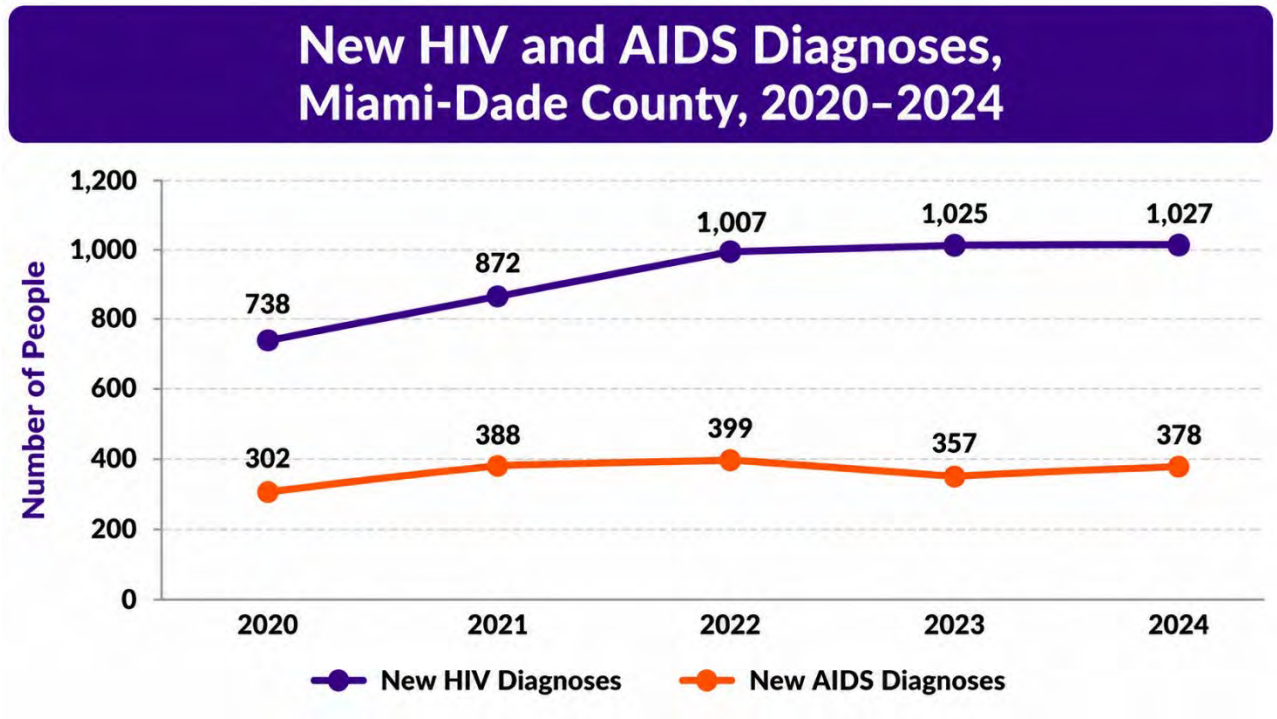
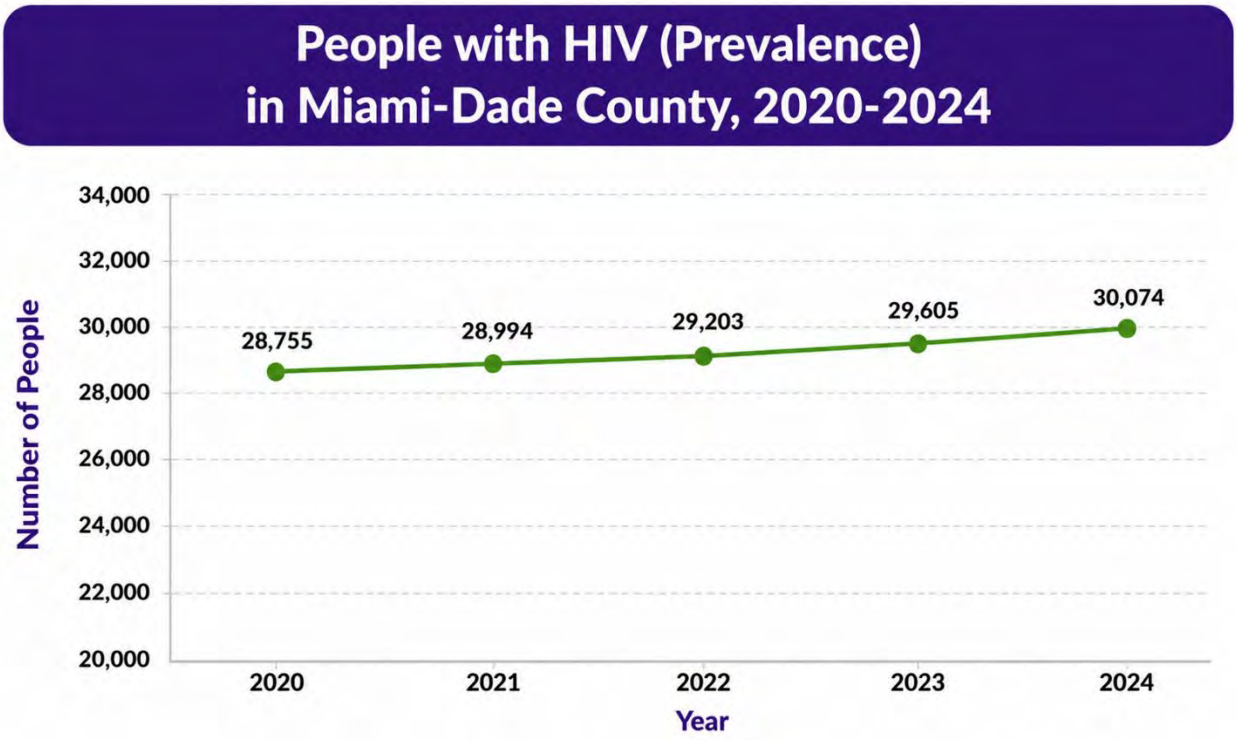


Table 4: People with HIV



Source (Tables 3 and 4): 2024 FDOH Epi Profile

By the latest CDC estimate, in 2022, there were 2,412 individuals in the EMA who have HIV and are not aware of their status. Great strides have been made to improve access to testing with FDOH-MDC and Gilead's FOCUS Program - Frontlines of Communities in the United States (FOCUS), as shown in **Table 5**, below. Strategies to increase HIV testing opportunities are addressed in Goal 1, as detailed in **Section V: Goals and Objectives**, below.

Table 5: FDOH-MDC and FOCUS HIV Testing

Calendar Year	HIV Tests Conducted by FDOH-MDC	HIV Tests Conducted by FOCUS
2021	48,000	104,804
2022	54,857	146,410
2023	50,366	141,541
2024	63,625	225,582
2025	62,319	213,800

III.2.c. Types of Data

- **Demographics**

One of the defining characteristics of Miami-Dade County's population is the high proportion of Hispanic and Black/African American residents, accounting for almost 90% of the 30,074 people with HIV in 2024 in the EMA.

Latinos represent the largest demographic group, and therefore the high percentage of Hispanics among the newly-diagnosed is easily understood as correlated with the high numbers of Hispanics living in the EMA. By contrast, the incidence and prevalence of HIV/AIDS among Black/African Americans is grossly disproportionate, with prevalence rates historically more than double the percentage of the total population. A comparison of those two populations in 2024 is shown below. Historically, these percentages are on trend with the past five to ten years.

Table 6: Race/Ethnicity Comparison

Percentage of Black and Latino People with HIV or AIDS in the EMA, 2024				
Population Group	**% of Total EMA Population**	**% of People with HIV (Prevalence)**	**% of New HIV Diagnoses**	**% of New AIDS Diagnoses**
Black/African American	16.1%	36.8%	34.4%	40.2%
Latino	70.3%	52.8%	58.5%	52.6%

Sources: 2024 FDOH Epi Profile and US Census Bureau, Population Estimates, July 2024

In starker contrast, only 13.5% of the EMA's population are White/non-Hispanics and accounted for only 9.2% of the total number of people with HIV in 2024. Overall, between 2022-2024 there was a 3.2% decrease in HIV incidence and a 2.2% decrease in HIV prevalence among White/non-Hispanics.

Regarding sex, males are the predominate group leading the epidemic, with a total prevalence rate of 77.3% in 2024, consistent with the previous five years. Of those men, in 2024, 77.1% self-reported transmission from male-to-male sexual contact (MMSC), with an additional 2.6% indicating MMSC and intravenous drug use (IDU) as the transmission vector. Those percentages closely mirror the past five years.

The EMA continues to see a trend of people with HIV aging out of their 50s and living into their 60s and 70s, a trend which would not have been expected even 10 years ago. People 50 years of age and older accounted for 57% of people with HIV in the EMA in 2024, including a 16.4% increase from 2022 to 2024 among people aged 60 and older. Age "60+" is the highest age bracket reported in FDOH surveillance data.

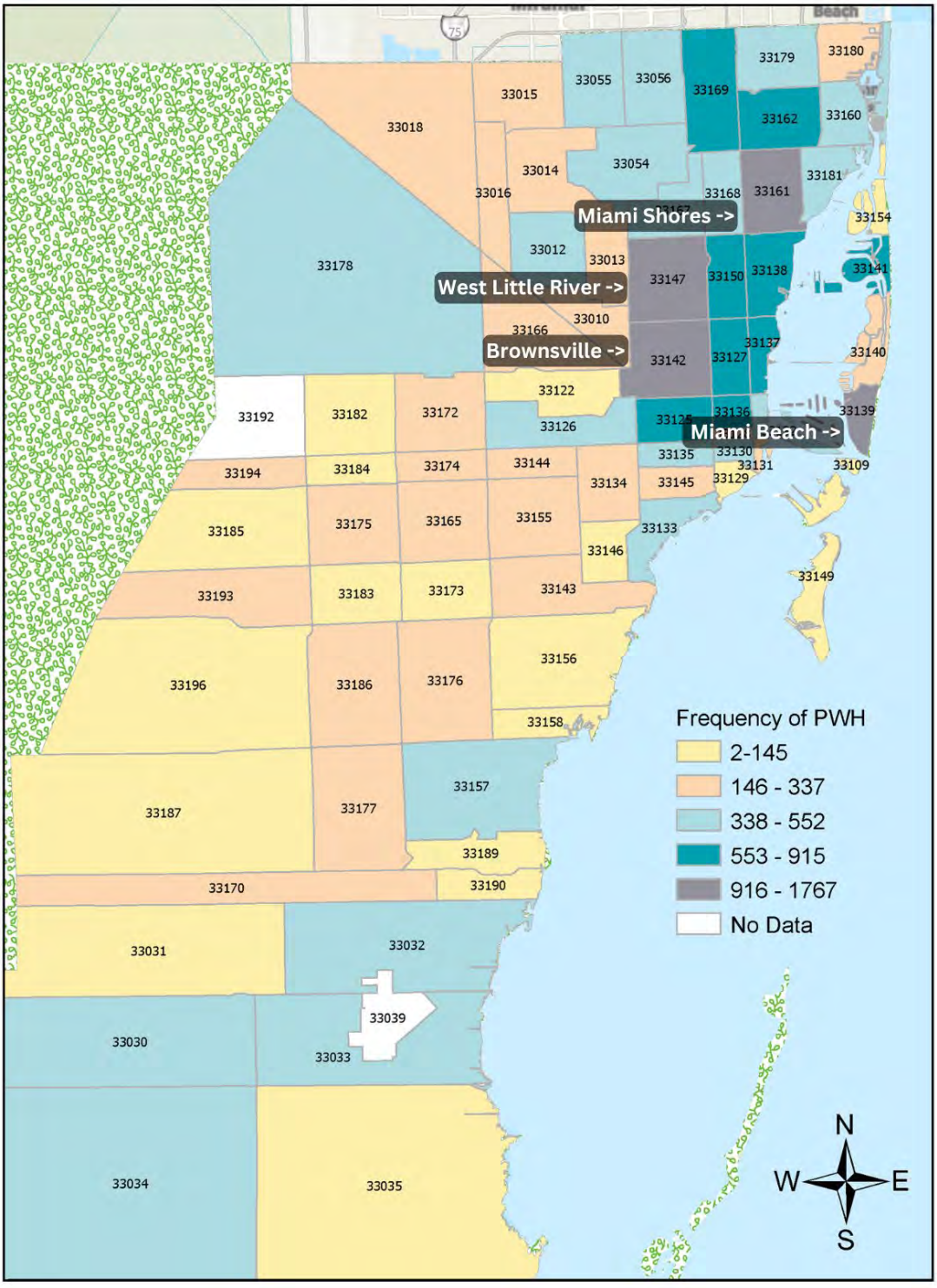
□ Geography

Miami-Dade County occupies 4% of the total area of the State of Florida and supports 12% of Florida's population, yet it accounts for almost 23% of the total number of people with HIV in the state. Of all people with HIV/AIDS in the state, the highest areas of concentration remain in the same four zip codes reported in the 2022-2026 Integrated Plan:

- 33161 – Miami Shores,
- 33147 – West Little River,
- 33142 – Brownsville, and
- 33139 – Miami Beach.

See **Table 7: Zip Code Map**, below, for reference.

Table 7: Zip Code Map



□ **Socioeconomic**

People with and people who are more likely to acquire HIV in the EMA are faced with a variety of socioeconomic obstacles and barriers, including language barriers, poverty, unstable housing, uninsured status, and food insecurity. These social determinants of health impede access to HIV testing, learning their status, and accessing care. Additional challenges are detailed in **Section IV: Situational Analysis**, below.

- **Language barriers.** Residents of the EMA include a high population of people from non-English-speaking countries. Having a lack of resources in one's native language can create a barrier to HIV testing and accessing services, as well as to accessing employment opportunities. In the EMA, 63.6% of newly-diagnosed persons were born outside of the United States, primarily in non-English speaking countries. From 2022-2024, two populations have significant case reporting:

  - Haitians: 87.7% increase in new HIV cases, and 32.6% increase in new AIDS cases; and
  - Venezuelans: 16.9% decrease in new HIV cases, and 27.3% increase in new AIDS cases.

- **Poverty.** According to the 2024 Small Area Income and Poverty Estimates (US Census, 2024) 14.2% of persons in the EMA live in poverty, a higher percentage than the overall state average of 12.1%.

- **Unstable housing.** Unstable housing and homelessness are indicators for increased likelihood of HIV transmission and falling out of care.

In Fiscal Year 2024, the EMA reported 671 Ryan White Part A/MAI Program clients (7.1%) reported experiencing homelessness or being unstably housed within the most recent 12 months. The lack of affordable housing and rising Fair Market Rents continue to hinder treatment adherence and threaten positive health outcomes.

The combination of high rates of poverty, as noted above, and high rental burden creates a situation where groups are more vulnerable to engaging in behaviors (sex without condoms, sex work, needle-sharing, etc.) which are vectors for HIV transmission.

- **Uninsured status.** In the EMA as a whole, the US Census reports 17.3% of residents under age 65 years of age have no health insurance. Within the RWHAP, 40.7% of clients in FY 2024 had no health insurance.

- **Food Insecurity.** In 2023, an estimated 15.1% of people in Miami-Dade County experienced food insecurity, according to the latest data available from www.MiamiDadeMatters.org. The local RWHAP funds Food Bank Services, with 9.8% of all RWHAP clients using the service at least once in FY 2024.

□ Behavioral

Behavioral factors influencing HIV in the EMA, include high rates of sexually transmitted infections, mental health needs, and substance abuse.

- **Sexually transmitted infections.** Sexually transmitted infections (STIs) serve as a vector for HIV acquisition. Miami-Dade County has a high incidence of STIs. Rates of gonorrhea have increased 15.9% from 2022 to 2024. Early syphilis rates saw an 8.5% decrease in the same period, although that accounts for more than 2,400 cases. Miami-Dade County data from 2020 through 2024 for gonorrhea, chlamydia, and early syphilis are shown in the table, below.

  Among RWHAP clients, 26% were co-infected with one or more of those STIs.

Table 8: STIs

Sexually Transmitted Infections, 2020–2024					
STI	2020	2021	2022	2023	2024
Chlamydia	14,692	15,867	14,238	14,117	12,426
Gonorrhea	7,428	7,596	6,401	6,289	5,135
Early Syphilis	2,413	2,614	2,640	2,548	2,152

Source: Florida CHARTS, 2024

- **Mental health care.** Engaging people in mental health care plays an important role in preventing HIV transmission and in retaining people in care. According to www.hivinfo.nih.gov, there are situations that can contribute to mental health conditions in people with HIV including, difficulty in telling others about your HIV diagnosis, stigma and discrimination associated with HIV, loss of social support and isolation, and difficulty in getting mental health services. Locally, about 5% of RWHAP clients received mental health services in FY 2024.

- **Substance use.** Another factor in HIV transmission and inability to remain in care is substance use. In 2024, among all people with HIV in the EMA, 1,200 self-reported IDU as a transmission vector, a total of only 4%; and 608 or 2% reported MMSC/IDU as a transmission vector. Locally, only nine (9) RWHAP clients received Substance Abuse Outpatient treatment, and 88 clients received Substance Abuse Residential treatment.

- Tables on the following pages depict demographics for the jurisdiction:

  - □ Table 9: Race/Ethnicity of People Newly Diagnosed with HIV;
  - □ Table 10: Sex of People Newly Diagnosed; and
  - □ Table 11: Age of People Newly Diagnosed.

Table 9: Race/Ethnicity – Newly Diagnosed

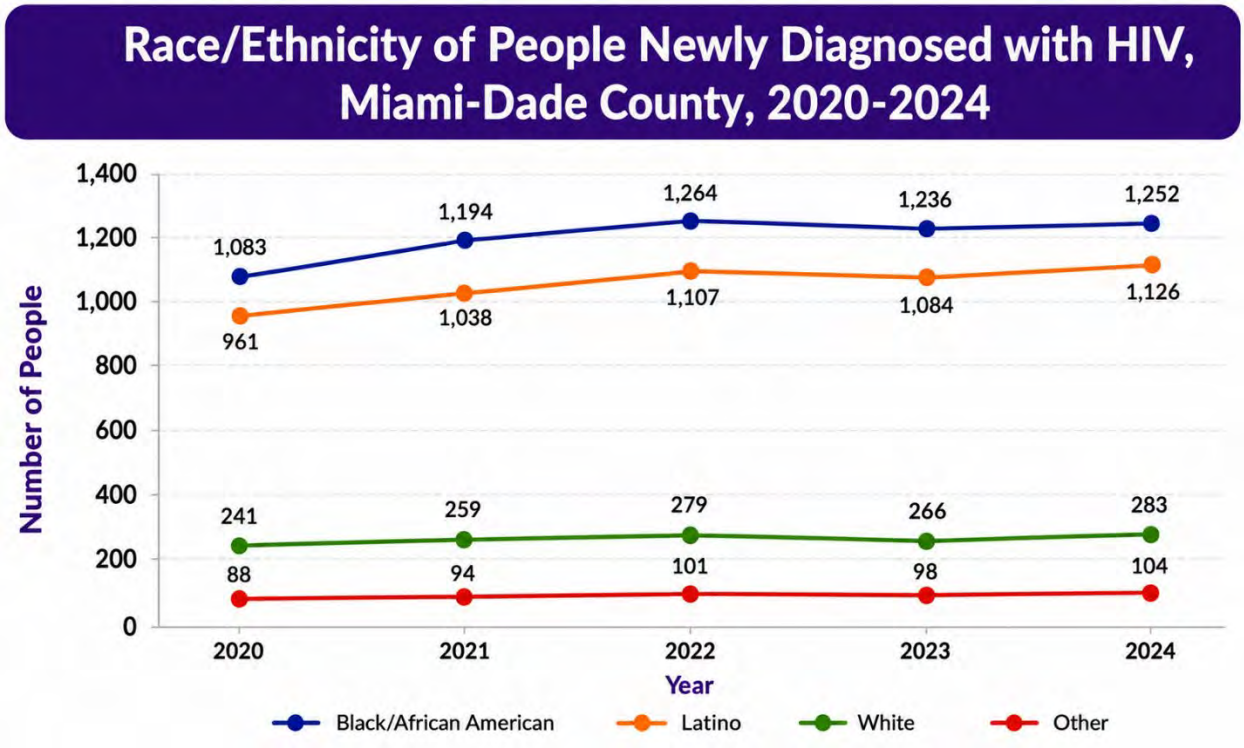
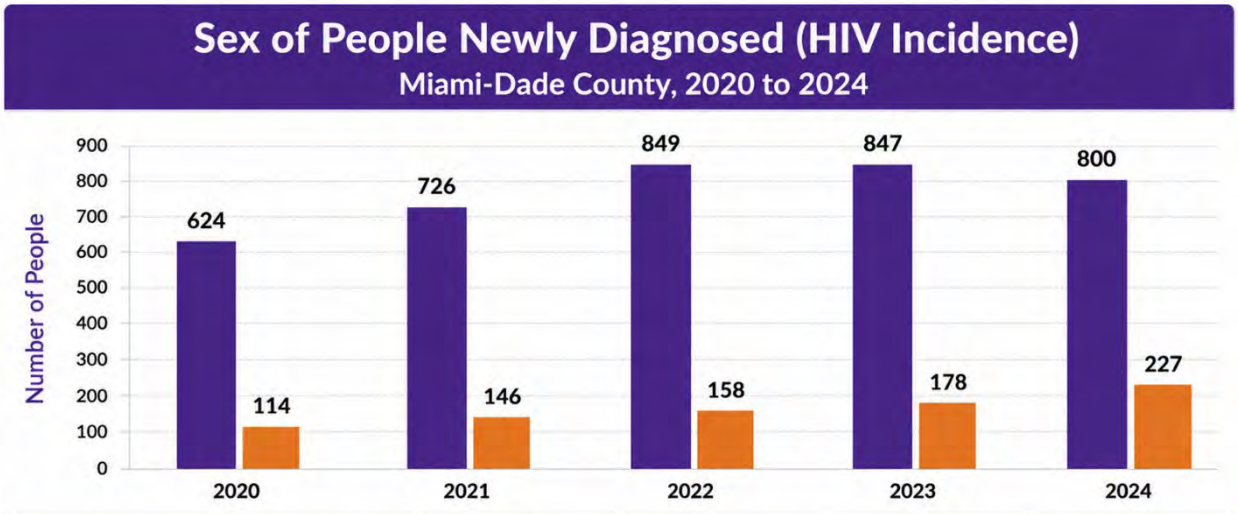


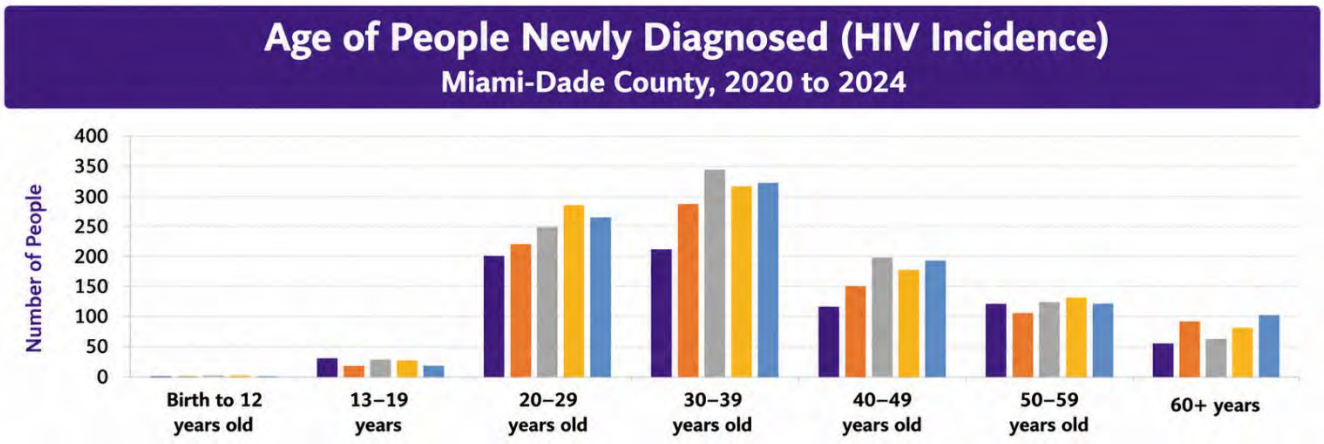
Table 10: Sex – Newly Diagnosed



Sex	2020	2021	2022	2023	2024
Male	624	726	849	847	800
Female	114	146	158	178	227

Source (Tables 9 and 10): 2024 FDOH Epi Profile

Table 11: Age – Newly Diagnosed



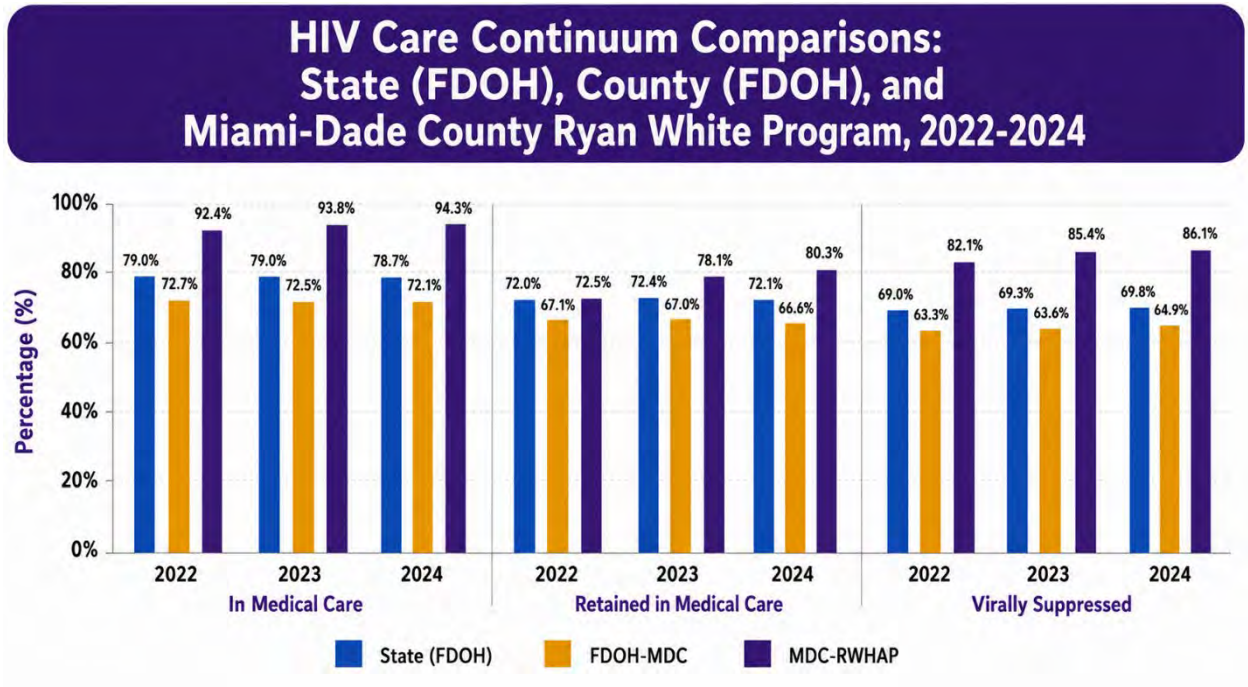
Age Group	2020	2021	2022	2023	2024
Birth to 12 years old	0	0	2	2	0
13–19 years	25	15	23	22	15
20–29 years old	203	222	248	286	265
30–39 years old	210	286	345	320	326
40–49 years old	119	151	198	181	195
50–59 years old	121	106	123	132	124
60+ years	60	92	68	82	102

Source: 2024 FDOH Epi Profile

□ HIV Care Continuum

Table 12, below, shows the HIV Care Continuum for all people with HIV in the state of Florida, compared to all people with HIV in Miami-Dade County, and to people receiving care through the EMA's RWHAP. The trends demonstrate both high levels of HIV burden in the EMA and high levels of RWHAP program success.

Table 12: HIV Care Continuum



Sources: PE Miami and 2024 FDOH State and Miami-Dade County Epi Profiles

Table 13: HIV Incidence

HIV Incidence People Newly Diagnosed with HIV Demographics and Transmission Categories Miami-Dade County, 2020 to 2024											
Demographic Groups and Transmission Categories	2020		2021		2022		2023		2024		% Change 2022-2024
	#	%	#	%	#	%	#	%	#	%	
Demographics: Race/Ethnicity											
White	67	9.1%	62	7.1%	62	6.2%	62	6.0%	60	5.8%	-3.2%
Black	196	26.6%	274	31.4%	284	28.2%	353	34.4%	353	34.4%	24.3%
Latino	467	63.3%	521	59.7%	653	64.8%	602	58.7%	601	58.5%	-8.0%
Asian	3	0.4%	9	1.0%	4	0.4%	4	0.4%	8	0.8%	100.0%
American Indian/Alaska Native	1	0.1%	3	0.3%	0	0.0%	0	0.0%	0	0.0%	-
Native Hawaiian/Pacific Islander	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-
Multi-race	3	0.4%	3	0.3%	4	0.4%	4	0.4%	5	0.5%	25.0%
Demographics: Age											
0–2 years	0	0.0%	0	0.0%	2	0.2%	0	0.0%	0	0.0%	-100.0%
3–12 years	0	0.0%	0	0.0%	0	0.0%	2	0.2%	0	0.0%	-
13–19 years	25	3.4%	15	1.7%	23	2.3%	22	2.1%	15	1.5%	-34.8%
20–24 years	72	9.8%	99	11.4%	106	10.5%	91	8.9%	85	8.3%	-19.8%
25–29 years	131	17.8%	123	14.1%	142	14.1%	195	19.0%	180	17.5%	26.8%
30–34 years	106	14.4%	165	18.9%	194	19.3%	168	16.4%	175	17.0%	-9.8%
35–39 years	104	14.1%	121	13.9%	151	15.0%	152	14.8%	151	14.7%	0.0%
40–44 years	69	9.3%	88	10.1%	116	11.5%	105	10.2%	120	11.7%	3.4%
45–49 years	50	6.8%	63	7.2%	82	8.1%	76	7.4%	75	7.3%	-8.5%
50–54 years	61	8.3%	54	6.2%	69	6.9%	77	7.5%	70	6.8%	1.4%
55–59 years	60	8.1%	52	6.0%	54	5.4%	55	5.4%	54	5.3%	0.0%
60+ years	60	8.1%	92	10.6%	68	6.8%	82	8.0%	102	9.9%	50.0%
Demographics/Transmission: Male Adults and Adolescents (ages 13 years and older)											
Male-to-Male Sexual Contact (MMSC)	526	84.3%	621	85.5%	715	84.2%	644	76.0%	606	75.8%	-15.2%
Heterosexual Contact	83	13.3%	98	13.5%	127	15.0%	196	23.1%	190	23.8%	49.6%
Injection Drug Use (IDU)	9	1.4%	5	0.7%	4	0.5%	3	0.4%	2	0.3%	-50.0%
MMSC/IDU	6	1.0%	2	0.3%	3	0.4%	3	0.4%	2	0.3%	-33.3%
Other Reason	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-
Demographics/Transmission: Female Adults and Adolescents (ages 13 years and older)											
Heterosexual Contact	109	95.6%	142	97.3%	154	98.7%	173	98.3%	227	100.0%	47.4%
IDU	5	4.4%	4	2.7%	2	1.3%	4	2.3%	0	0.0%	-100.0%
Other Reason	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-
Demographics/Transmission: Pediatric (ages 0-12 years old)											
Perinatal Exposure	0	-	0	-	2	100.0%	1	50.0%	0	-	-100.0%
Non-perinatal Exposure	0	-	0	-	0	0.0%	1	50.0%	0	-	-

Source: FDOH Epi Profile

Table 14: HIV Prevalence

HIV Prevalence People with HIV Demographics and Transmission Categories Miami-Dade County, 2020 to 2024											
Demographic Groups and Transmission Categories	2020		2021		2022		2023		2024		% Change 2022-2024
	#	%	#	%	#	%	#	%	#	%	
Demographics: Race/Ethnicity											
White	2,875	10.0%	2,865	9.9%	2,825	9.7%	2,769	9.4%	2,763	9.2%	-2.2%
Black	11,082	38.5%	11,054	38.1%	10,959	37.5%	10,971	37.1%	11,056	36.8%	0.9%
Latino	14,433	50.2%	14,710	50.7%	15,066	51.6%	15,506	52.4%	15,887	52.8%	5.4%
Asian	92	0.3%	97	0.3%	97	0.3%	99	0.3%	103	0.3%	6.2%
American Indian/Alaska Native	10	0.0%	13	0.0%	12	0.0%	12	0.0%	12	0.0%	0.0%
Native Hawaiian/ Pacific Islander	8	0.0%	7	0.0%	7	0.0%	8	0.0%	8	0.0%	14.3%
Multi-race	255	0.9%	248	0.9%	237	0.8%	240	0.8%	245	0.8%	3.4%
Demographics: Age											
0–2 years	0	0.0%	0	0.0%	2	0.0%	1	0.0%	1	0.0%	-50.0%
3–12 years	25	0.1%	21	0.1%	18	0.1%	18	0.1%	14	0.0%	-22.2%
13–19 years	81	0.3%	55	0.2%	53	0.2%	49	0.2%	49	0.2%	-7.5%
20–24 years	593	2.1%	560	1.9%	494	1.7%	416	1.4%	361	1.2%	-26.9%
25–29 years	1,618	5.6%	1,491	5.1%	1,391	4.8%	1,379	4.7%	1,296	4.3%	-6.8%
30–34 years	2,461	8.6%	2,527	8.7%	2,514	8.6%	2,427	8.2%	2,395	8.0%	-4.7%
35–39 years	2,515	8.7%	2,664	9.2%	2,774	9.5%	2,878	9.7%	3,030	10.1%	9.2%
40–44 years	2,662	9.3%	2,688	9.3%	2,707	9.3%	2,848	9.6%	2,844	9.5%	5.1%
45–49 years	3,020	10.5%	2,872	9.9%	2,793	9.6%	2,742	9.3%	2,806	9.3%	0.5%
50–54 years	3,901	13.6%	3,639	12.6%	3,486	11.9%	3,368	11.4%	3,228	10.7%	-7.4%
55–59 years	4,566	15.9%	4,556	15.7%	4,359	14.9%	4,204	14.2%	4,029	13.4%	-7.6%
60+ years	7,313	25.4%	7,921	27.3%	8,612	29.5%	9,275	31.3%	10,021	33.3%	16.4%

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Table 14: HIV Prevalence (continued)

HIV Prevalence
People with HIV
Demographics and Transmission Categories
Miami-Dade County, 2020 to 2024
– Continued –

Demographic Groups and Transmission Categories	2020		2021		2022		2023		2024		% Change 2022-2024
	#	%	#	%	#	%	#	%	#	%	
Demographics/Transmission: Male Adults and Adolescents (ages 13 years and older)											
MMSC	16,625	76.0%	17,002	76.6%	17,261	77.0%	17,581	77.2%	17,844	77.1%	3.4%
Heterosexual Contact	3,747	17.1%	3,732	16.8%	3,743	16.7%	3,835	16.8%	3,947	17.1%	5.5%
IDU	782	3.6%	782	3.5%	750	3.3%	725	3.2%	717	3.1%	-4.4%
MMSC/IDU	695	3.2%	664	3.0%	636	2.8%	618	2.7%	608	2.6%	-4.4%
Other Reason	11	0.1%	10	0.0%	10	0.0%	10	0.0%	10	0.0%	0.0%
Demographics/Transmission: Female Adults and Adolescents (ages 13 years and older)											
Heterosexual Contact	6,007	91.4%	5,950	91.6%	5,954	91.7%	6,022	92.2%	6,142	92.5%	3.2%
IDU	547	8.3%	525	8.1%	518	8.0%	490	7.5%	482	7.3%	-6.9%
Other Reason	12	0.2%	11	0.2%	11	0.2%	11	0.2%	10	0.2%	-9.1%
Demographics/Transmission: Pediatric (ages 0-12 years old)											
Perinatal Exposure	303	96.5%	292	96.7%	297	96.7%	287	96.3%	289	96.7%	-2.7%
Non-perinatal Exposure	11	3.5%	10	3.3%	10	3.3%	11	3.7%	10	3.3%	0.0%

Source: FDOH Epi Profile

III.2.d. HIV Clusters

As detailed in **Section IV: Situational Analysis**, below, at present, there are no identified HIV outbreaks within the EMA; however, three active molecular networks continue to be monitored and managed through ongoing surveillance and intervention activities.

III.3. HIV Prevention, Care and Treatment Resource Inventory

The organizations and agencies noted in this section provide care and treatment and prevention services throughout the EMA under various funding streams.

The Partnership, specifically the Prevention Committee which oversees Prevention activities (Goals 1 and 4), and the Strategic Planning Committee which oversees Care and Treatment activities (Goals 2 and 3), includes members who represent organizations covering all funding streams noted in the tables below. Management within each funding stream is based on the parameters of the funded programs. Additional efforts are ongoing to bring more collaborators to the table and gain broader understanding of the Ryan White Program 2030 Goals, the four strategies of Ending the HIV Epidemic (EHE), and the national HIV/AIDS strategy goals and objectives as detailed in **Section V: Goals and Objectives**, below.

Regarding substance use prevention, the EMA works in close coordination with the University of Miami Infectious Disease Elimination Act (IDEA Exchange) which is the first syringe exchange program in Florida, and whose Program Director is a member of the Partnership. This Plan includes a Prevention activity to promote and support the IDEA Exchange as well as activities to address the whole-person approach to HIV prevention services. Note: There are no Federal funds supporting this activity. As noted below, service providers throughout the county also receive SAMHSA and CDC funding for substance prevention and treatment.

Miami-Dade County and the Florida Department of Health in Miami-Dade County also receive EHE funding for innovative prevention and care initiatives to enhance and fill in gaps of RWHAP or other FDOH-MDC funding.

- **Miami-Dade County EHE**

  - **Quick Connect Services:** To 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; to expand EHE Quick Connect services across hospitals, clinics, and community settings to ensure rapid access to antiretroviral (ARV) medication and linkage to ongoing care; and use of the Positive Peers online app.

  - **HealthTec Services:** To 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.

  - **Housing Stability Services:** To 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.

- **Mobile GO Teams Services:** To 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.

- **Planned new service categories for EHE include the following, beginning March 1, 2027:**

  - Health Insurance Premiums and Cost Sharing Assistance;
  - Emergency Financial Assistance (grocery vouchers, utility assistance, etc.); and
  - Local Pharmaceutical Assistance Program.

- **FDOH-MDC EHE**

  - **HIV Testing:** To provide rapid HIV testing, routine HIV testing in emergency departments, and at-home HIV testing.

  - **Rapid Access to Care:** To ensure all persons who test positive for HIV will have medication to reach viral load suppression.

  - **Pre-Exposure Prophylaxis (PrEP):** To increase PrEP uptake and access points.

  - **Re-engagement in Care:** To get people who have fallen out of care back into care.

  - **Partner Services:** To provide confidential partners services to individuals exposed to HIV, including HIV testing, and linkage to HIV treatment or PrEP.

  - **Academic Detailing:** To educate hospitals and clinics on the benefits of routinized opt-out HIV testing.

  - **Establishing a Referral Network:** To connect people with HIV to care and services.

Overall, the EMA has a broad range of funding sources covering all RWHAP categories of services. Ryan White Part A services listed in **Table 16: Core Medical Services Resource Inventory,** and **Table 17: Support Services Resource Inventory**, below, are guided by HRSA Policy Clarification Notice (PCN) #16-02, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds.

It is the aim of this Plan to ensure all persons who have or are at risk of acquiring HIV are aware of and utilize all available services for which they qualify. Persons who enter the service system through the Test and Treat/Rapid Access protocol and those who are enrolled in RWHAP and ADAP care can be monitored to ensure they are maximizing available needed services. However, this Plan acknowledges some limitations in data collection for persons who are above 400% Federal Poverty Level (FPL), who have private medical coverage, and whose plans of care are not known.

III.3.a. Providers

The directory below lists local service providers and grantees by their identified funding sources. Several providers span multiple funding sources. The SAMHSA grantees listed are funded for one or more HIV-related grants, including research, capacity building, prevention, and direct services. The EMA receives funds for other CDC and SAMHSA grants which are not specific to HIV and are not included in this directory.

- □ **Ryan White Program Part A**
  - AIDS Healthcare Foundation (AHF)
  - Better Way of Miami
  - CAN Community Health
  - Citrus Health Network
  - Community Health of South Florida (CHI)
  - Food for Life Network
  - Jessie Trice Community Health System
  - Latinos Salud
  - Legal Services of Greater Miami
  - New Hope C.O.R.P.S.
  - Public Health Trust/Jackson Health System

- □ **Ryan White Program Part A and MAI**
  - Borinquen Health Care Center
  - Care 4 U Community Health Center
  - Care Resource Community Health Center
  - Empower U Community Health Center
  - Miami Beach Community Health Center
  - University of Miami (UM) Comprehensive AIDS Program

- □ **Ryan White Program Part B**
  - AIDS Healthcare Foundation (AHF)
  - Borinquen Health Care Center
  - CAN Community Health
  - Care 4 U Community Health Center
  - Care Resource Community Health Center
  - Community Health of South Florida (CHI)
  - Empower U Community Health Center

- □ **Ryan White Program Part C**
  - Borinquen Health Care Center
  - Empower U Community Health Center
  - Miami Beach Community Health Center
  - UM Comprehensive AIDS Program

- □ **Ryan White Program Part D**
  - UM Department of Pediatrics Division of Infectious Disease & Immunology

□ **Ryan White Part F**

- The EMA did not have a Part F Recipient at the time of this writing.

□ **2026 FDOH High Impact Prevention/EHE Providers**

- Care Resource Community Health Center
- Community Rightful Center
- South Florida AIDS Network contracted by the Public Health Trust of Miami Dade County (limited targeted HIV testing as part of Early Intervention Services outreach as defined in the HRSA PCN #16-02)
- CareFirst Foundation
- University of Miami Adolescent Medicine
- CAN Community Health (local EHE dollars)
- AIDS Healthcare Foundation (AHF) (local EHE dollars)
- Blessing Hands (local EHE dollars)

□ **CDC Prevention Providers**

- Borinquen Health Care Center
- Care Resource Community Health Center
- Community Health of South Florida
- Latinos Salud

□ **SAMHSA – HIV and Substance Abuse**

- Banyan Community Health Center
- Bethel Family Enrichment Center
- Borinquen Health Care Center
- Camillus House
- Care 4 U Community Health
- Carefirst Foundation
- Miami-Dade County
- Florida International University
- Gang Alternatives
- Jewish Community Services of South Florida
- Switchboard of Miami
- The Village South
- Westcare Foundation

□ **Ending the HIV Epidemic**

- Recipient: FDOH (funding earmarked for FDOH-MDC)
- Recipient: MDC OMB

□ **HOPWA**

- Recipient: City of Miami

□ **State**

- ADAP Recipient: FDOH
- General Revenue Provider: South Florida AIDS Network

III.3.b. Funding Sources

Although Miami-Dade County receives a broad range of state and federal funding for prevention and care, funding cuts and state and federal restrictions on use of funds have created challenges in the EMA, as detailed in **Section IV: Situational Analysis**, below.

Table 15: Prevention Resource Inventory

Prevention Resource Inventory									
Prevention Services	**FDOH-MDC EHE**	**FDOH-MDC Prevention**	**State HIP**	**State EHE**	**ADR (Linkage to Care)**	**General Revenue Prevention**	**HRSA/ EHE**	**CDC Direct Funding**	**SAMHSA**
Outreach	●	●	●	●				●	
HIV Testing	●	●	●	●		●	●	●	●
Linkage	●	●	●		●			●	
Education	●	●	●	●				●	
Integrated STI Screening	●	●						●	
PrEP/nPEP Screening, Referrals, and Linkage	●	●	●	●				●	
Condom Distribution	●	●	●	●				●	
Community Engagement	●	●	●	●				●	
Social Media Posts and Digital Advertising								●	
Treatment Referrals	●	●						●	

Table 16: Core Medical Services Resource Inventory

Core Medical Services Resource Inventory									
	Ryan White Program					Other Funding			
Core Medical Services	**A**	**B**	**C**	**D**	**EHE**	**SAMHSA**	**Federal**	**General Revenue (State)**	**Local***
AIDS Drug Assistance Program (ADAP)		●							
AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program) - prescription drugs	●								
Early Intervention Services (EIS)			●						
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	●	●**							
Home and Community-Based Health Services								●	
Home Health Care					●			●	
Hospice Care							●	●	
Medical Case Management, including Treatment Adherence Services	●	●	●	●	●			●	●
Medical Nutrition Therapy			●					●	●
Mental Health Services	●	●	●	●	●	●		●	●
Oral Health Care	●		●					●	●
Outpatient/Ambulatory Health Services	●		●	●	●			●	●
Prescription Drugs (Local AIDS Pharmaceutical Assistance)	●	●	●	●				●	
Substance Abuse Outpatient Care	●		●			●		●	

* Locally funded providers and organizations; exclusive of privately funded or for-profit organizations.
**ADAP assistance is limited.

Table 17: Support Services Resource Inventory

Support Services Resource Inventory										
	Ryan White Program				Other Funding					
Support Services	**A**	**B**	**C**	**D**	**EHE**	**SAMHSA**	**HOPWA (HUD)**	**Federal**	**General Revenue (State)**	**Local***
Emergency Financial Assistance	●	●	●						●	
Food Bank	●			●					●	●
Health Education/Risk Reduction			●	●						
Home Delivered-Meals										●
Hospital Services									●	
Legal Services - Limited (Civil legal assistance related to health care and benefits)	●									
Long-Term/ Short-Term Housing, Rental Assistance, Utility Assistance					●		●	●	●	
Linguistic Services				●						
Medical Transportation	●		●	●					●	
Non-Medical Case Management Services			●	●		●			●	
Nursing Home									●	
Outreach Services	●		●	●		●				
Psychosocial Support Services	●**			●		●			●	
Rehabilitation Services										●
Referral for Health Care and Supportive Services					●	●			●	●
Respite Care										●
Risk Reduction			●	●						
Special Patient Navigation			●							
Substance Abuse Services (Residential)	●					●			●	
Treatment Adherence Counseling		●	●	●	●	●				

* Locally funded providers and organizations; exclusive of privately funded or for-profit organizations.
** Pending an identified provider in the next RFP Cycle.

III.3.c. Assessment of Strengths and Gaps Across the Prevention and HIV Care Continuum

The ultimate strength of this jurisdiction is the active involvement and dedication of diverse partners, including funders who identify challenges and work jointly with others to address them, ideally coming together to improve the availability, accessibility, and quality of HIV services. Through the Partnership, collaborators are involved in a comprehensive **Annual Needs Assessment**, including priority setting, and resource allocation activities; prevention, care, and treatment planning; and community engagement. A comprehensive **RWHAP Client Satisfaction Survey** is conducted annually and shared amongst contracted providers to improve service delivery. Recipients and subrecipients are in ongoing, daily communication to help ensure quality services are provided to people with HIV.

FDOH-MDC will continue to facilitate semi-annual **Speed Networking** sessions bringing HIV prevention providers, medical case managers, and other HIV care providers together with social services organizations to strengthen collaborations and foster a better understanding of available services, improve referral networks, and promote whole-person, status-neutral care.

Launched in January 2023, the **Florida Department of Health Capacity Development Academy** aims to bridge knowledge gaps in the rapidly evolving HIV field by equipping Miami-Dade County professionals with up-to-date information, terminology, and biomedical interventions. This initiative fosters a more informed and responsive public health workforce to meet the challenges of HIV prevention and care.

Launched in July 2024, the **Private Practice HIV Protocol Implementation Training** aims to provide a framework for clinical providers interested in implementing rapid HIV care and prevention, telehealth, and care coordination services based on relevant and measurable practices and protocols. During this hands-on training, private physicians and their representatives receive information on HIV, testing, prevention, and treatment, learn about national best practices and existing program flows, and work to develop a protocol that mobilizes resources, outlines essential steps, helps solve challenges within existing workflows, and meets the specific needs of their organization and communities served.

Feedback from and discussions with people with HIV and other collaborators in preparation for this Integrated Plan have also focused on social determinants of health and how the EMA must prioritize what is most important to identify, engage, and retain people with HIV in care. Needs assessments have not only identified the importance of continued prioritization of core medical services, but also the need to provide essential supportive services including, but not limited to, affordable and stable housing, transportation to get to medical and social services appointments, childcare, early intervention services, employment services, and mobile non-HIV specific clinic services to meet people with HIV where they live, work, or play. As noted in **Section V: Goals and Objectives**, below, activities related to social determinants of health may be hard to quantify and will need to be monitored throughout the life of the Plan.

- □ **HIV Prevention Services**

  Based on the Resource Inventory for HIV Prevention Services, above, it would appear there are no significant gaps in the community's ability to address demand and need for HIV/STI testing and counseling, partner prevention and notification, condom distribution, and PrEP, Non-occupational Post-Exposure Prophylaxis (nPEP), screening, referral, and linkages to services. However, the EMA has experienced severe cuts to prevention funding, which, along with legislative restrictions, have created challenges and threats to a robust prevention system. These challenges are detailed in **Section IV: Situational Analysis**, below. Nonetheless, HIV prevention resources are expected to

support the listed prevention services throughout the period of the Integrated Plan, 2027 through 2031, as long as the funding continues at least at current levels.

Gaps in the prevention process include underutilization of new HIV prevention tools such as long-acting injectables (Apretude® and Yeztugo®) and medication therapy for PrEP (Truvada® and Descovy®), medical mistrust, and provider reluctance to prescribe PrEP will need to be addressed over the course of this Integrated Plan.

Those who are on stable regimens may benefit from a change to Cabenuva®, once a month or every two months, rather than taking pills daily, to help maintain viral suppression and prevent HIV transmission. Further community education is needed regarding the benefits of Cabenuva® with the goal of getting people with HIV to viral suppression and using this HIV treatment as prevention, thus Treatment as Prevention.

There is also a need to further educate the community on the HIV Undetectable = Untransmittable (U=U) Campaign. Appropriately appealing messaging is necessary to inform the public of the overwhelming evidence that this concept works to improve the quality of life for people with HIV and can prevent HIV transmission.

When prevention activities are not enough, strong linkages to HIV care and treatment (e.g., core medical and support services) is needed. Related gaps in this area are presented in the section directly below.

□ **HIV Care and Treatment Services**

As reflected in the Core and Support Resource Inventories, above, as with prevention resources, it would appear that the EMA might have sufficient funding to cover the needs of the more than 30,000 people with HIV who reside here. However, as with prevention funding, changes to the HRSA Funding Formula represent a significant threat to the provision of RWHAP services, as detailed in **Section IV: Situational Analysis**, below.

□ **Gap Analysis in Reference to the Care and Support Services Resource Inventories**

- **ADAP.** Although some gaps may be interpreted from the EMA's Care and Treatment Resource Inventory where only one funding source is indicated for a service category, for instance ADAP, Early Intervention Services, and Legal Services, these are sometimes limited by legislation (e.g., FDOH is the sole pass-through agency overseeing ADAP funding throughout the state).

- **RWHAP Part D Program.** While having only one Recipient of these resources may be seen as a resource inventory gap, the University of Miami (UM) has unique expertise to serve the needs of women, infants, children, and youth (WICY) throughout the county – so much so that the County's Ryan White Part A Program has historically relied on UM's RWHAP Part D Program as its main resource for the WICY waiver. Also, for the past seven years in a row (2019-2025), no babies were born with HIV to mothers with HIV in Miami-Dade County, due in large part to initiatives funded by Ryan White Part D and the FDOH-MDC HIV perinatal program.

- **Transportation.** With a total area of 2,431 square miles, this jurisdiction must also address geographic disparities, including the issues of cost, distance, and time it takes some people to travel to appointments, especially for those who may not have their own reliable transportation.

Utilizing RWHAP Parts A, B, and C funding along with federal and state resources, there are means and well-developed procedures for clients to access public transportation (e.g., Metrobus and Metrorail). Unfortunately, due to the distances some clients need to travel for appointments, public transportation is not always the most effective or efficient mode of travel. Also, weather in the EMA affects the ability and willingness of some people to use public transportation: many bus stops simply have a bench with no shelter and other bus shelters are open on one side. During stormy weather, anyone waiting on public transportation in these areas would be exposed to the rain and possible thunder and lightning. While there has been success alleviating transportation issues through the use of ridesharing services, threats to RWHAP medical transportation funding, particularly in response to ADAP funding cuts, could be severe. The EMA must also continue to promote and fund telehealth initiatives, such as EHE HealthTec, as noted above.

- **Other Professional Services.** This service category has historically had only one funding source – RWHAP – and one subrecipient. Due to legislative restrictions and federal executive orders, allowable services under this category are much more limited than in previous years, and funds are generally underspent.

- **Linguistic Services.** As a distinct service category, linguistic services are only funded under the Ryan White Part D Program. However, all RWHAP-funded subrecipients are contractually required to offer services in English, Spanish, and Haitian Creole. Subrecipients offer access to language translation and interpretation services as needed and requested by their clients. Those services are covered through other resources. While this remains an important factor at the local level, multi-language resources are not supported by the State Department of Health.

- **Home Health Care.** As the EMA's local HIV population ages beyond 55 years old, an array of age-related illnesses and issues need to be considered. While three funding sources support Home Health Care at this time, this is an area that needs to be closely monitored to address emerging gaps. Similarly, access to durable medical equipment through the Outpatient/Ambulatory Health Services category will need to be considered for this aging population, especially for mobility and auditory issues that affect this aging population but may not be directly related to their HIV condition.

- **Housing Services.** Long-term housing assistance has one distinctly funded program, the Housing Opportunities for Persons With AIDS (HOPWA), whose Recipient is the City of Miami. New HOPWA funding and utilization limitations have significantly altered the availability of HOPWA resources. The Partnership is working with the City of Miami on future planning including maximizing existing resources, implementing cost-saving strategies, and, when necessary, ending housing assistance. In the meantime, the City maintains a waiting list for long-term housing, and the Partnership's Housing Committee holds an annual housing stakeholders meeting to engage non-HIV housing providers and identify additional resources. The overall impact of HOPWA funding cuts is largely unknown at this time.

  While the EHE Housing Stability Services initiative, noted above, is designed to help people with HIV remain in HIV care and overcome housing-related barriers, it is expected to be insufficient to cover the costs of long-term housing for people who may lose HOPWA funded housing.

III.3.d. Approaches and Partnerships

As part of the Annual Needs Assessment process, BSR directly contacted each agency and/or a representative of the noted funding stream to gather the data for the Core Medical and Support Services Resource Inventory. This data collection is an annual activity of the Partnership allowing the inventory to be updated regularly to highlight additional strengths and gaps.

Where their expertise is demonstrated by the ability to engage and retain clients who struggle with various socio-economic, medical, and/or behavioral health challenges, some organizations do not have sufficient staffing or understanding of the complexities of managing federal, state, or local service contracts. There is a need to build capacity of both large and small service provider organizations who over time have developed rapport with and earned the respect of people with HIV in their service area. Neighborhood organizations can be recruited and engaged through training and less complex procurement processes to help address issues of stigma, underutilization of services, and medical mistrust, especially if many of their staff come from communities they serve. By providing this administrative guidance and support, the EMA expects to see an increase in the number of new or returning organizations applying for funding who are capable and willing to accept federal resources to provide these services. Notably, OMB, where the MDC RWHAP Part A, MAI, and EHE are managed, is in the process of developing a capacity building component for non-profit organizations; this would not be specific to federal grants or HIV services, but rather would have a general and countywide reach, where information on federal grant requirements could be addressed.

FDOH-MDC compiled a resource inventory as part of their annual Florida Comprehensive Planning Network Coordination of Efforts reporting.

III.4. Needs Assessment

III.4.a. Priorities

Activities to assess community need, services that people with HIV need to stay in care and achieve viral suppression, and concerns which may act as barriers to achieve those ends are detailed in **Section II, Community Engagement and Planning Process**, above. Regarding access to HIV testing, the EMA has a robust and widely promoted HIV testing program which includes on-site rapid testing, after-hours rapid testing, mobile rapid testing, opt-out testing in emergency rooms and clinics, and at-home testing.

Further, the EMA's TTRA process is proficient in connecting newly diagnosed persons to care, including referrals to mental health, substance use, and medical care appointments. Persons at-risk who test negative are directed to PrEP services, also widely available throughout the EMA.

Activities specific to both testing and linkage to care are detailed within the goals of this Plan and will be evaluated and monitored throughout the life of the Plan to determine strengths, barriers, and areas of needed improvement.

III.4.b. Actions Taken

The breadth of goals and activities laid out in this Plan speak to the actions the EMA will take to improve all stages of the HIV Care Continuum.

III.4.c. Approach

The approach to assessing community needs is detailed in **Section II, Community Engagement and Planning Process**, above, including the data gathering processes, community partners, and resulting actions.

Section IV: Situational Analysis

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

IV.1.1. 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.

Miami-Dade County has a broad range of evidence-based HIV prevention strategies available, including PrEP, PEP, free condoms, routinized HIV/STI testing, priority testing in high-incidence neighborhoods, Test and Treat models, U=U treatment as prevention, and community-based prevention services.

Outreach initiatives, culturally tailored education, and targeted prevention efforts in high-incidence communities continue to strengthen HIV prevention efforts and improve engagement among disproportionately impacted populations.

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

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.1.2. Challenges

The ADAP Crisis: People with HIV in Florida are facing treatment uncertainty due to severe proposed funding cuts, cost containment measures, and program eligibility changes 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, 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.
- The need to address barriers that limit access to HIV prevention services, PrEP, testing, care, and treatment, particularly for underserved and high-incidence communities.
- Insufficient funding for outreach and engagement efforts continue to impact the ability to effectively reach underserved populations, high-incidence neighborhoods, youth, hard-to-reach individuals, and communities experiencing significant social and structural barriers.
- The need to addresss bias, misinformation, and inconsistent knowledge regarding PrEP among some healthcare providers which may create barriers to PrEP education, prescribing practices, and prevention access.
- The urgent need to strengthen affordable and geographically accessible PrEP services, expand prevention services across multiple community locations, and improve access to prevention resources countywide.
- Lack of infrastructure to support PrEP persistence over time.
- Significant differences in the PrEP to Need ratio among priority populations.

IV.1.3. 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, such as Medicaid.

Miami-Dade County must continue leveraging the expertise of community stakeholders, consumers, providers, advocates, subject matter experts, and people with lived experience across the HIV prevention and care continuum to strengthen planning, implementation, and service delivery efforts.

Funding limitations may continue to impact the community's ability to fully address the breadth of prevention, care, treatment, housing, and supportive service needs identified throughout this Integrated Plan.

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

- Greater investments to address social determinants of health affecting HIV prevention and care outcomes, including housing instability, transportation barriers, food insecurity, unemployment, healthcare affordability, and limited access to supportive services.
- Limited, one-time, or short-term assistance to obtain medications not covered by AIDS Drug Assistance Program (ADAP), and for utilities, food, or transportation;
- Help to pay for private insurance costs, e.g., employer-sponsored or ACA premiums, copays, and deductibles.
- Addressing the unique and evolving needs of targeted populations, including youth, aging populations with Medicare, individuals with chronic conditions, and underserved communities.
- In home services such as labs and medication delivery, consumable medical supplies, and durable medical equipment, particularly for the aging population with HIV and those with limited mobility.

- Increased and sustained funding to support HIV prevention services, outreach activities, testing programs, PrEP access, workforce capacity, condom distribution, linkage services, and comprehensive HIV prevention infrastructure throughout Miami-Dade County, including support for and use of peer educators, peer navigators, and trusted community representatives, and additional provider education and training regarding PrEP to improve prevention access and quality of care.
- Easy-to-understand HIV prevention and PrEP educational materials and expanded access to affordable and accessible PrEP and PEP services, particularly for communities with a higher HIV burden.
- Expanded community and faith-based engagement initiatives to reduce stigma, normalize HIV prevention and testing, and strengthen trust within communities with a higher HIV burden.
- Expanded HIV education and awareness initiatives, including mobile services, outreach materials, and prevention resources specific to isolated communities and communities experiencing high HIV incidence across Miami-Dade County.
- Oral health services, including dental care, dentures, oral surgery, and other oral health support that directly impact overall health and treatment outcomes.
- Age-appropriate sexual health education and HIV prevention education in schools.

IV.1.4. Analysis of Structural and Systemic Issues Impacting People and Communities Disproportionately Impacted by HIV

Each of the four Ending the HIV Epidemic (EHE) Strategies 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, above, 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 strategies, 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 Clinical Quality Management (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.

IV.1.4.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, above, 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.1.4.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.1.4.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.

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.1.4.d. Respond

To effectively implement the EHE Initiative's Respond Strategy, 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.

The EMA response process uses surveillance and epidemiologic data to identify, assess, and respond to emerging or rapidly growing HIV molecular networks (HMN). Upon notification by the State Office of a new molecular network or the addition of a new member, the local FDOH-MDC HMN team is notified, and a multidisciplinary response is initiated involving surveillance staff, Disease Intervention Specialists, linkage-to-care personnel, prevention teams, and social services counselors. Data analysts conduct investigations to assess transmission patterns, viral suppression status, partner elicitation, barriers to care, and associated risk factors, with findings reviewed by the HIV Molecular Network Consulting Team to guide intervention strategies. High-risk geographic areas and populations identified through these investigations are prioritized for targeted outreach activities, including HIV testing, PrEP referrals, rapid linkage or re-linkage to care, treatment referrals, prevention education, and distribution of protective resources. The process also incorporates ongoing monitoring of viral suppression outcomes, follow-up investigations for individuals not engaged in care, coordination with community-based organizations (CBOs), and continuous staff training to ensure an effective, data-driven public health response aimed at reducing HIV transmission and improving continuity of care throughout the EMA.

The response process also includes close collaboration with neighboring counties and state partners to ensure a coordinated approach to multijurisdictional HMN. Quarterly statewide meetings support situational awareness across Florida and facilitate timely, unified public health responses. In addition, the RWHAP contracts with CBOs to strengthen network intervention efforts within the EMA. Based on information obtained through partner services interviews and network investigations, the FDOH-MDC and CBOs identify priority geographic areas and populations for targeted outreach activities, including deploying mobile units, HIV testing, linkage to care and PrEP referrals. Community collaboration and public health education also remain key components of the EMA's molecular network response strategy, with ongoing partnerships between FDOH-MDC, RWHAP-funded agencies, and CBOs supporting HIV prevention education, risk-reduction counseling, Test and Treat Rapid Access education, linkage to care, and increased awareness of available testing and PrEP services in high-priority communities.

At present, there are no identified HIV outbreaks within the EMA; however, three active molecular networks continue to be monitored and managed through ongoing surveillance and intervention activities. One local network (A) and two multijurisdictional networks (B & C) are currently under review. Network A is anticipated to close by June 2026, as no new members have been identified within the past year and all ten present members have achieved viral suppression. Network B spans 12 counties statewide and includes four members from the EMA, all of whom are currently virally suppressed. The most recent network, C, primarily involving Hillsborough and Polk Counties, recently added three additional members, including one residing within the EMA. This individual has already been linked to care through a RWHAP partner agency and is expected to achieve viral suppression within six months.

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.1.a. 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.

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**, below, 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.

Social determinants of health and other concerns are also included, 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, they are not designated as 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. Those concerns are included below and in **Section IV: Situational Analysis,** above, to ensure they are not overlooked, particularly since they were expressed as concerns in multiple community meetings and through survey findings.

Please see **Acronyms and Terminology**, 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 people with HIV 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 people with HIV identified at non-healthcare community settings via preliminary testing.
    1.1.2.4 Number of newly diagnosed people with HIV 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 people with a preliminary HIV positive test result 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.

□ 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 females 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 women 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 women with HIV who received post-partum care which may include Family Planning Services.
    1.2.4.5 Percent of breastfeeding mothers with HIV who receive documented nursing-led lactation counseling within 24 hours of delivery.
    1.2.4.6 Percent of pregnant females living with HIV who initiated breastfeeding and had continued at 6 months postpartum.
    1.2.4.7 Number of infants born to mothers with HIV.
    1.2.4.8 Number of infants exposed to HIV through their mother with HIV.
    1.2.4.9 Number of infants who contracted HIV from their mother with HIV.

  - 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 RWHAP 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 RWHAP 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.

- **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 RWHAP 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 RWHAP 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 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.

- **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.

- **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 RWHAP MCM clients.
    2.2.5.2 QI projects developed addressing improving VL suppression among RWHAP OAHS clients.
    2.2.5.3 QI projects developed addressing improving retention in medical care among RWHAP MCM clients.
    2.2.5.4 QI projects developed addressing improving retention in medical care among RWHAP 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.

- **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.

- **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.

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.

□ 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.

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

  - Measurements:

    3.2.3.1 Number of RWHAP MCM clients over age 65.
    3.2.3.2 Percent of RWHAP 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.

- **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.

- **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.

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

□ Objective 4.1: Respond rapidly to active HIV Molecular Network (HMN) reports to stop transmission in vulnerable communities, reducing gaps in access to prevention services, care and support services.

- **Activity 4.1.1: Develop and maintain a cross-program HMN leadership and coordination group to oversee HMN activities.**
  - Measurements:
    - 4.1.1.1 Number of instances where investigation findings are presented to local leadership within 10 days of new HMN or member added to active network.
    - 4.1.1.2 Percent of viral suppression rates on active HMN.
  - Key Partners to Accomplish the Objective: FDOH-MDC and CBOs.
  - Responsible Party for Providing Data: FDOH-MDC
  - Data Source: Tallahassee HMN Report, LTC Module, and Lab Report.
- **Activity 4.1.2: Implement outreach activities, led by FDOH-MDC, to stop HMN transmission in high impact areas to reduce gaps in preventative care services, treatment, and education.**
  - Measurement:
    - 4.1.2.1 Number of quarterly community outreach events for HMN response and intervention.
  - Key Partners to Accomplish the Objective: FDOH-MDC and CBOs.
  - Responsible Party for Providing Data: FDOH-MDC
  - Data Source: Outreach and Testing FDOH Access Database.
- **Activity 4.1.3: Promote community collaboration and education about HMN.**
  - Measurements:
    - 4.1.3.1 Number of community presentations for education and awareness.
    - 4.1.3.2 Number of intervention events conducted in collaboration with partners.
  - Key Partners to Accomplish the Objective: FDOH-MDC and CBOs.
  - Responsible Party for Providing Data: FDOH-MDC
  - Data Source: FDOH-MDC.

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 RWHAP 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.

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.1.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.1.b. Monitoring

This Monitoring section outlines the structured processes to be used 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, the collaborators on this Plan 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.

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 Strategy:**
  - 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 or other client identifying information is included in the IPMRS.

A sample of the IPMRS is presented directly below as **Table 18**. The image shows various public-facing fields and administrative fields, further described below.

Table 18: 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 strategies 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.
- **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 new collaborators and funding sources are identified.

VI.1.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, expanded collaborations are anticipated across the EMA to strengthen implementation and monitoring efforts.

VI.1.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, 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.1.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 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.1.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 comprehensive and 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 clearly defined to ensure they are measurable, outcomes can be accurately tracked, and that this Plan accounts for significant legislative and funding changes, as detailed in previous sections.

JIPRT members and other stakeholders will routinely review and update related strategic plans, including but not limited to annual EHE Workplans and other jurisdictional planning documents, to ensure alignment with the goals, progress, and challenges identified through implementation of the 2027-2031 Plan. Likewise, insights and updates from these companion plans will inform ongoing refinements to the 2027-2031 Plan, supporting a coordinated and responsive planning process across all HIV-related services and initiatives in Miami-Dade County.

This 2027–2031 Plan reflects strong collaboration among the Miami-Dade HIV/AIDS Partnership (planning council), the Part A/MAI/EHE Recipient, and FDOH MDC to ensure that all shared activities are fully captured and well-coordinated. Although statewide planning has presented challenges, as noted above in **Section I: Introduction**, and **Section II: Community Engagement and Planning Process**, the EMA remains committed to strengthening future collaborations, renewing the EMA's our shared vision and goals, and fostering greater transparency with the State FDOH throughout the duration of the 2027–2031 Plan.

Section VII (Addendum 1): Letter of Concurrence

MIAMI-DADE
HIV/AIDS PARTNERSHIP

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, Miami-Dade County

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

This document is available online at https://partnershipmiami.org/partnership/, or by contacting mdcpartnership@behavioralscience.com.