Joint Executive Committee
Carpenter House
May 17, 2012 at 12:30 P.M.
Meeting Agenda

Samantha Kuryla, Part A Chair **Kim Saiswick, Part B Chair**

1. **Call to Order (**Please sign-in)
2. **Welcome and Introductions**
   a. Review Meeting Ground Rules, Sunshine and Public Comment (Sign-in at Front of Room)
   b. Committee Member and Guest Introductions
3. **Moment of Silence**
4. **Approve Today's Agenda**
5. **Approve 01/19/12 Joint Executive Meeting Minutes**
6. **HIV Planning Council Retreat & Joint Executive Retreat - Review Summary and Develop Next Steps**
7. **Comprehensive Plan Discussion**
8. **Unfinished Business**
   Parking Lot Items
   - ⇨ **Part A /Part B Clarification**
     - Develop definitions for membership based on Part A vs. B
     - Develop common process for committee member appointment and approval process
   - ⇨ **Part B Processes and Procedures Clarification**
     - Committee Chair appointment and approval process
     - Excused Absences at Joint Meetings (Example: Part A Co-Chair is absent – can Part B Co-Chair give an excused absence?)
     - Part B Attendance Tracking
     - Part B Warning Letters
     - Part B Removals: Part B's: Removals due to non Attendance
9. **New Business**
   - ❖ **Consolidated Funding**
   - ❖ **Cost Sharing with Eligibility**
   - ❖ **Effect of New AICP policy on Consumers/Notifications**
10. **Grantee Reports** (Part A, Part B, ADAP)
11. **Public Comment**
12. **Reminder:**
    - Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
    - Request for Comment on 2013 Ryan White Reauthorization *(See Next Pag)*
13. **Request for Information/Directives**
14. **Agenda Items for Next Meeting:** Thursday, 07/19/12 at 12:30 p.m. Venue: Carpenter House
15. **Adjournment**

Ryan White HIV/AIDS Program 2013 Reauthorization: Comments Requested

HRSA/HAB is requesting comments regarding reauthorization of the Ryan White legislation, which will take place in 2013. The Ryan White HIV/AIDS Program is the largest Federal program specifically dedicated to providing HIV care and treatment. It funds heavily impacted metropolitan areas, States, and local community-based organizations to provide medical care, medications, and support services to more than half a million people each year. Currently authorized by the Ryan White HIV/AIDS Treatment Extension Act of 2009, the program will be up for reauthorization by the U.S. Congress in 2013.

To inform that reauthorization, HRSA encourages stakeholders, including grantees, advocacy organizations, State and local administrators, and other members of the Ryan White and HIV/AIDS communities to provide comments on all aspects of the program. Comments should be organized under headings that clearly indicate which Part (Part A, B, C, D or F) the comment addresses. HRSA has established a web page with details on how to submit comments.

Comments are due July 31, 2012

HRSA will hold at least four webinar or teleconference listening sessions over the next few months, each focused on a different geographic region. Dates, times and other details will be available in near future.

In addition to the resources listed above, don't forget to check out these other HAB resources, which are updated regularly.

HAB Web site

TARGET Center, Central Source for Ryan White TA
(Not a US Government Web site)

Twitter, Sign up using "ryanwhitecare"
(Not a US Government Website)

The HAB Information E-mail is distributed biweekly by the HRSA/HAB Division of Training and Technical Assistance (DTTA). To subscribe or unsubscribe contact Paula Jones.

Joint Executive Committee Retreat
Meeting Minutes
January 19, 2012
Carpenter House
4414 N. Surf Road, Hollywood, 33019

#	Members	Present	Absent		Guests
	PART A				Roberson, Carl
1	Spencer, W. Part A Chair	X			
2	Kuryla, Part A Vice Chair	X			
3	Taylor-Bennett, C.	X			
4	Pryor, J.	X			
5	Creary	X			
6	Tomlinson , K.	X			**Grantee Staff**
7	Rajner, M.	X			Jones, L. (Part A)
8	Katz, H. B.	X			Mercer, A. (Part B)
	PART B				
9	Saiswick, K. Part B Chair	X			
10	Gammell, B. Part B Vice Chair	X			
11	Sabatino, D.		X		**HIVPC Support Staff**
12	Wynn, J.	X			Ariela Eshel
13	Cannon, K.	X			Faikah Hosein
14	Washington, L.		X		Michelle Rosiere
15	Agate, L.	X			Gladria De Sa
16	Carson, D.	X			
17	Moore, P.	X			
	Quorum = 9	**15**	**2**		

1. **Call to Order**
The Part A Co-Chair called the meeting to order at 10:06 a.m.

2. **Welcome and Introductions**
The Part A Co-Chair welcomed everyone and self-introductions were made. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. In addition, they were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

3. **Moment of Silence**
A moment of silence was observed.

4. **Approve Today's Meeting Agenda**

Motion	To "approve the 01/19/12 Meeting Agenda."
Proposed By	Kathleen Cannon
Seconded By	Karen Creary
Action	Passed

5. **Approve 11/08/11 Meeting Minutes**

Motion	To "approve the 11/08/11 Meeting Minutes."
Proposed By	Karen Creary
Seconded By	Michael Rajner
Action	Passed

6. **Review and Discussion: Existing Comprehensive Plan and Committee Workflow**
The following bullet points were reviewed and evaluated in detail noting Successes and Opportunities:

Evaluation Strategy, Oversight, and Estimated Impact of FY 2009-2011 HIV Service Implementation Plan		
Goal		**Evaluation Achievement/Strategy**
*1	Increase access to HIV o**utpatient/ambulatory medical care** and other **core** services in Broward County	• **Achieved** • **OAMC Cost Effectiveness Study** • **Implemented CIED and MOUs with Hospitals** Short to mid-term: Evaluate identification, engagement, and retention in medical care, evaluation of training, subgrantee reports, inter-agency collaborative workgroup, and MOUs with hospitals. Ongoing: Service outcomes evaluated using PE data.
2	Reduce the rate of secondary HIV infection in Broward County	• **Not Implemented** Short to mid-term: Complete the baseline assessment, number of MMP guidelines distributed, training and capacity development events arranged with the AIDS Education and Training Center (AETC), and randomized chart audit. Ongoing: Service-related outcomes to be evaluated using PCIS data.
3	Expand geographic availability of HIV outpatient/ambulatory medical care and other core services in Broward County	• **Expanded with AHF (including North Point)** • **Lost BCHD** Ongoing: Complete the initial and subsequent annual written analyses, request for proposals (RFP) language prepared by Grantee staff, and subgrantee reports.
4	Increase access and adherence to FDA-approved HIV-related pharmaceuticals.	• **Achieved (with cost savings due to LPAC)** Ongoing: Service-related outcomes evaluated using PE data.
*5	Ensure **retention** and engagement in HIV outpatient/ambulatory care by providing culturally and linguistically competent services in Broward County	• **Achieved** • **Implemented Cultural Competency Plan** • **Implemented NQC In Care/Retention Initiative** Ongoing: Subgrantee reports.
6	Increase access to, retention in, and adherence to high quality HIV **oral health care** in Broward County that is culturally and linguistically competent	• **Achieved** Ongoing: Service-related outcomes evaluated using PE data.
7	Increase access and reduce barriers to outpatient/ambulatory care, mental health, substance abuse, and oral health by providing **peer and/or near peer outreach services** that are culturally and linguistically competent.	• **Achieved and adding peers to MAI MCM** Ongoing: Service-related outcomes evaluated using PE.
8	Eliminate or decrease disparities related to racial or ethnic minorities	• **Achieved decreased disparities with MAI services** Short to mid-term: Training evaluation and subgrantees reports.
*9	Increase **access** to and **retention** in a high quality HIV continuum of care that is **culturally and linguistically competent**, consistent with PHS guidelines, and promotes parity	• **Implemented Cultural Competence Work-Plan** • **Implemented QM, HAB Performance Measures (PHS)** • **AETC Training, TA and Chart Reviews (PHS)** • **NQC Training and Retention Initiative** Ongoing: Service-related outcomes evaluated using PE data.
***Goals overlap and are repetitive.** **Red Items Not Accomplished		

The Committee identified the challenges needing to be addressed:

Comprehensive Plan Challenges That Need To Be Addressed

- Comprehensive Plan Goals aren't woven into committees' work and work-plans.
- No Comprehensive Plan Oversight or Evaluation– (Incomplete Pass Exec to Planning).
- Members are not required to provide information based on membership categories (including NECL).
- Planning and QM should formulate recommendations of their findings and provide for PSRA.
- Committees are not interwoven – operating separately – no common themes that come back together.
- Use HIVPC Retreat to celebrate things working well and acknowledge those that need improvement.

Recommendations from 2008 Comprehensive Plan Retreat

- New Comprehensive Plan provides an opportunity for us to examine many of our functions and how we operate.
- Several factors necessitate that we do this: (i) shrinking resources (ii) fragmentation of committee work and (iii) lack of focus on ultimate goals and big picture. Designing a comprehensive continuum of HIV care.
- Planning Councils are being called upon to make tough decisions, many are being asked to do more work with fewer resources. Therefore our weaknesses are consistent with what he sees among other planning councils across the country.
- Examine needs assessment and priority setting functions which are the two most important HIVPC functions. With needs assessment, (Planning Committee); look at the data and carefully select the most important and useful data sets early in the calendar year. Preferably complete this by April. May and June would be used to make sure the data get presented in "user-friendly" formats. This will ensure that the data can be understood by the widest variety of planning council members and hopefully encourage more consumer involvement.
- Making sure HIVPC has best data possible for use in PSRA would be the Planning Committee's focus.

Projected Retreat Outcomes

- Develop a plan to complete the 2012 Comprehensive Plan.
- Create Joint and Part A Executive Work-Plan.
- Identify Committee Work Products.
- Examine Committee Timeframes.
- Consider Committee Planning Cycles (Less meetings but more efficient and productive).
- Develop Recommendations.
- Other Challenges were also identified:
  - Complicated cases - where does a client start?
  - Eligibility for all services proves difficult.
  - Multifaceted processes for eligibility.
  - Constantly dealing with emergent crisis, making the real work.

7. Evaluate Success and Opportunities

Successes:

- The Joint Committees worked together and improved processes.
- Data Sharing with ADAP and working together with Provider Enterprise – the transition is starting to become easier.
- We are more data driven than ever and we need to become data driven with reference to Quality of Care.
- Clients are attending more meetings.

Opportunities:

- Providers enter data almost immediately so it is available to all Parts.
- Member noted that the Comprehensive Plan is a 'theoretical model' and the reality is based on the cycles as to when awards are granted, when funds are received, how applications get scored and how the funds are allocated.
- To make the Plan more modular, tailor aspects to each committee so that committee knows what part of the Plan intersects with the committee's work, and a standing agenda item for that committee will be to reflect of that part of the plan.

The Part A grantee remarked that someone has to own the Plan from a functional standpoint to ensure consistent review and evaluation of how goals are being met. The Part A Co Chair noted that Joint Planning is the appropriate committee

to monitor the Plan and make recommendations of relevant work items for each Committee; Committees would report progress back to the Joint Executive Committee. It was agreed that the Joint Planning Committee and BRHPC staff will modulate the plan. Thus the following motion was made:

Motion #3	To "recommend that Joint Planning be responsible to work with BRHPC staff to modulate the Comprehensive Plan and make recommendations to various committees. The committees will work on the modules to report to Joint Executive"
Proposed by:	Kim Saiswick
Seconded by:	Kathleen Cannon
Action:	Passed

The meeting structure of committees was discussed and it was agreed that all committees' work plans be a standing agenda item. Member noted that the meetings are quite long and work plan reviews are tabled more times than not. Members recommended that in order to empower committees to follow their work plans, work plans should be at the beginning of the agenda/meeting as opposed to the end. This should help make the work plan, including all Comprehensive Plan activities, a priority. The Part A grantee noted that reviewing work plan goals and activities are the core of the work plan not a list of checkbox items and will be the ideal focus of each committee.

- B R E A K -

8. Morning Wrap Up – Identify 4 Key Issues for Afternoon Break Outs

The Committee identified four areas on which to work and members were divided into four groups: A, B, C and D:

- GROUP A: Healthcare Reform; Insurance vs. Direct Care
- GROUP B: Education; Communication; The Role of Chairs; Engagement in Care/Community Partners
- GROUP C: EIIHA; Data Collection
- GROUP D: CIED; Linkage to Care; Retention of Care; Health Disparities; Specialty Care

- L U N C H -

9. Break Out Groups

The break out groups went into session immediately following lunch. A reporting secretary was identified in each group who reported to the full workgroup body in summary form.

- B R E A K O U T G R O U P S S E S S I O N S -

10. Break Out Groups Report Back to Full Group and Identify Next Steps

GROUP A - Health care reform; Insurance vs. Direct Care

Healthcare Reform

- Standing Agenda Item at HIV Planning Council level.
- Point of Contact: HIV Planning Council to appoint a committee to focus on Healthcare Reform as it impacts HIV care and treatment.
- Regular updates to the HIVPC (similar to the monthly legislative report)
- Expectations of CARE Act providers: What is needed to be successful and looking forward to major transitions in 2014 including Medicare, Medicaid, Private Insurance Enrollment –getting providers ready for a major transition
- Information must be dispensed to all committees in summary form in order to facilitate discussion regarding those items relevant to each committee's work
- Educate the community about Healthcare Reform, what it means, what changes to expect, how to get ready for it.

Insurance

- Request from grantee detailed service utilization data for the last 1-2 years
- Determine whether a Standing Committee or an ad Hoc of a Standing Committee, should be created to address the possibility of Part A buying insurance plans for clients as a cost savings measure. This function will take a lot of time, detail and data analysis and HIVPC will have to determine the best method to address it
- Review other EMA's: Which EMA's have already begun purchasing insurance plans? How is it being done?
- The Ad Hoc or Standing Committee developed to address health insurance to review current cost utilizations, current existing insurance plans in Florida, cost avoidance, costs savings, provider networks for these insurance plans. An intense cost-benefit analysis by Grantee and staff or through an RFP will need to be conducted to determine which tier of clients would most likely save money for the system.

PROS & CONS

Pros:

- Access to more providers (i.e., more providers will be in the AvMed, BCBS than are in the existing Ryan White system)
- Already existing service category: HICP could be expanded to have us initiate insurance coverage instead of continuing coverage; we can build/tweak the process to what we need for our area; there would be a bigger formulary on the pharmacy side
- Consistent level of care
- Better access to existing specialty networks

Cons:

- No control over the quality of care as we will be contracted with an external care management organization
- Monitoring data would not be in our control – we will have to request data and ensure we obtain what we need
- Cost savings cards data: Will be a challenge to track cost savings/cost avoidance
- Health literacy barriers: Clients will need to learn to look at member enrollment books, benefits, prior authorizations, pre-existing conditions clauses, and provider networks benefits
- Enrollment periods could be a technical challenge especially in the beginning and politics and irregularities can occur as to what passes and what does not.

GROUP B - Education, Communication, The Role of Chairs, and Engagement in Care/Community partners

- Change structure of Joint Client/Community Relations (JCCR) Committee
- Target newly diagnosed to increase the probability of successful linkage to care
    - → In the first 24- linking client's immediately into care before the first stage of denial (referring to the three stages of newly diagnosed (i) denial, (ii) anger and (iii) acceptance) there is a better chance of getting them into care and saving money. (Refer to California's 'No Wrong Door')
- Target blood banks and doctors
- 24 hour on-call/peers specifically trained for supportive services for newly diagnosed
- Less time focusing on grievances
- Communication → Consumers → Community events
- Rebuild trust in the system by providing information e.g. the difference between Part A, B, ADAP etc. to improve system navigation
- Roles of chairs - to have a respectful collaborative relationship with support staff, articulate what they want to happen during a meeting, make contact with staff prior to meetings to go over minutes, agenda, etc.
- Mentoring by full Council Chair/Vice Chair: New members joining Council can be intimidated and could benefit from having a mentor assigned to them.
- Developing a 'parking lot' agenda item, to go on Executive Agenda: Many times things are discussed at length and are not followed up.
- Review legislation pertaining to disclosure of status

GROUP C - EIIHA, Data Collection

- Three main groups were identified – Unaware of their status (who need to be tested), aware of their status but not linked to care (HIV+ not in care), tested negative (aware of their status and need resources to remain negative)
- Increase communication between the prevention side and the treatment side as it relates to EIIHA and overall 'quality of care' and research models in other EMA's
- Ensure the HIVPC prevention seat is filled; Have BCPP representation on the HIVPC and vice versa
- Identify resources for those persons who test negative: (i) where do they go after getting negative results (ii) how are they encouraged to stay negative?
- Locate those who tested positive and have not yet been linked to care including those tested at private clinics

Discussion

- Reduce the number of data sets
- Needs Assessment and Consumer Satisfaction:
    - → Surveyors – both the surveyor and the survey reflect the PIR (*Peri Inclusion Representation*) and that we pay attention to language, literacy and cultural sensitivity.
    - → How do we rise above a low level of satisfaction with regards to surveys/surveyors?
    - → How do we ensure that we look at our own collection? Being proactive/collecting more surveys.

→ How do we know that we really captured the data requested? What is the impact on the overall process?

GROUP D - CIED; Linkage to Care; Retention of Care; Health Disparities; Specialty Care

- Comprehensive CIED: Expand the CIED model to include all Ryan White Parts and ADAP. One system of care will prove more effective and efficient for consumers and will be more consumer-friendly. Before we can start pooling the dollars, there needs to be coordination of all the grantees. We can start with a co-location of services meaning, ADAP can come to a provider location while CIED is conducting intake/interviews. There can be a cost allocation percentage-wise on the majority e.g. Part A, ADAP etc.
- Prevention – Using linkage specialists, navigators and peers to find those who have fallen out of care (PE Data)
- Linkage and retention - reducing the community viral load. System is quite complicated and could benefit from culturally competent marketing efforts
- Regarding models it was recommended there be one entity for care coordination and that other EMA's be researched for resource sharing especially in terms of specialty care. More dollars will need to be allocated if we are to have a robust specialty network.
- Define HIV related health problems to ensure they are addressed as part of a continuum of care. Also, address prevention and treatment of non-HIV specific related health issues (e.g., undocumented clients with needs that cannot be addressed through Part A)
- Collecting good data- Letting data be your guide when looking at the survey-backed up by data and not assumptions
- Working with providers-using entities to make this work
- Social marketing: It was recommendation to the Part A Grantee to utilize any unspent direct services funds for this. Our system is complicated and consumers would benefit from marketing focusing on Medical care, Customer Service, Availability of Medical Care and Cultural Competency are very important. Model: United Way-DCF Prevention dollars have moved to United Way where 5% of providers' funding goes toward Community Intervention. The providers collectively come up with the most pressing issue and do a campaign surrounding the topic. (*e.g.: Last year Underage Drinking was the topic.)*
- Health Disparities in the Minority community. MAI dollars can go to specific intervention which can be studied.
- Faith based communities playing an important part of client well being.
- Medical based interventions. Health disparities have a lot to do with the medical provider: hours of operation, who is your provider, customer service, personalized service, the feeling of belonging.

11. Next Meeting Date

Thursday, March 15, 2012 at 12:30 p.m.

Staff will look into booking Carpenter House 4414 N. Surf Road for all Joint Executive committee meetings for 2012.
Subsequent to the meeting, Carpenter House has been reserved for this Committee's meetings for the remainder of 2012

12. Adjournment

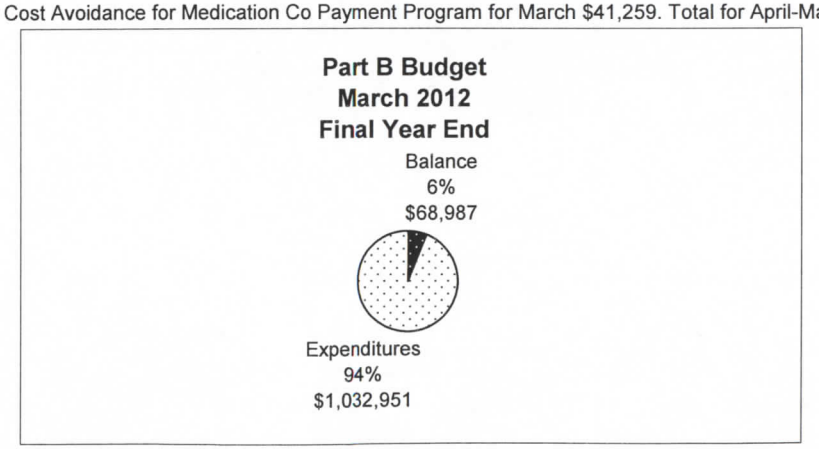
Meeting was adjourned at 3:29 p.m.

Ryan White Part B
Final Year End Report March 2012

Service Category	Part B 2011-2012 Allocated	Part B 2011-2012 (Final March Spent/ Encumbered)	Part B 2011-2012 Monthly Average Left	Part B 2011-2012 (YTD Spent/ Encumbered)	Part B 2011-2012 (% Left)	Part B 2011-2012 Final Year End (Balance)
Home Delivered Meals	$ 2,479	$ 315	N/A	$ 1,050	58%	$ 1,429
Home Health Care Services	$ 13,018	$ 3,360	N/A	$ 6,550	50%	$ 6,468
Medication Co Pay	$ 647,318	$ 116,396	N/A	$ 621,548	4%	$ 25,770
Case Management (non-medical)	$ 179,001	$ 23,309	N/A	$ 143,681	20%	$ 35,320
Medical Transportation	$ 149,930	$ -	N/A	$ 149,930	0%	$ -
Administration	$ 110,192	$ 6,455	N/A	$ 110,192	0%	$ -
TOTALS	**$ 1,101,938**	**$ 149,836**	**N/A**	**$ 1,032,951**	**6%**	**$ 68,987**
					94%	

Non-Medical Case Management conducted 521 interviews from March of which 130 were new.
Medication Co Payment served 340 clients in March in which 17 were new to the program.
333 Clients served in March Med Co Pay
7 Clients served in Mail Order

Cost Avoidance for Medication Co Payment Program for March $41,259. Total for April-March is $254,991.



This report reflects all invoices received and paid to close out fiscal year 2011-12.

Broward County Health Department ADAP Report as of 4/25/12

Total ADAP "Open" Enrollment		2,469
Total ADAP Clients Served in Last 30 Days*		1,526
Total ADAP Waitlist Enrollment**		111
	Category A	2
	Category B	51
	Category C	58
	Category D	0
Total ADAP/Medicare Part D Enrollment		187
Number of Appointments in April		606
Number of Missed Appointment in April		187
Percentage of April Appointments Missed		31%

*"Clients Served" defined as having at least one "pickup" in the period.

** Category Definitions:
CATEGORY A
Diagnosis of AIDS and/or CD4 < 200 cells/mm3 and/or CD4% < 14%
Diagnosis of active opportunistic infection
Diagnosis of HIV-associated nephropathy (HIVAN)

CATEGORY B
Persons who are currently on ARV therapy
Persons who were previously on ARV therapy but therapy was interrupted
Treatment naïve clients with CD4 cell count between 201-350 cells/ mm3

CATEGORY C
Treatment naïve clients with CD4 cell count > 350 cells/mm3

CATEGORY D
Unknown/Other

Clients are removed from the Wait List **by medical category** in the order they were placed on it. This serves as a reminder to people that if they are on the wait list they MUST recertify at 6 month they will loose their position on the Wait List.

Broward County HIV Health Services Planning Council

Approved Motions – January 26, 2012

Joint Executive: Motion of 1/19/12

To "recommend that Joint Planning be responsible to work with BRHPC staff to modulate the Comprehensive Plan and make recommendations to various committees. The committees will work on the modules to report to Joint Executive"