Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

# JOINT EXECUTIVE COMMITTEE
## Meeting Agenda
November 15, 2012 at 12:30 P.M.

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

***Reminder**: Meeting Attendance Confirmation Required 48 Hours Prior to Meeting Date*

1. **CALL TO ORDER**

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. **APPROVALS:**
   a. Today's Agenda, including addition of item A under New Business
   b. 9/20/12 Joint Executive Retreat Meeting Minutes

5. **NEW BUSINESS**
   a. Annual Viral Load Test as Eligibility Requirement for All Part A Services
   ACTION ITEM: Joint Planning Committee requests a discussion of whether to require annual viral load results for clients to be eligible for all Part A services. The goal is to collect data on additional clients to help develop a Community Viral Load.

6. **UNFINISHED BUSINESS**
   a. Joint Executive Committee 9/20/12 Retreat: Update (HANDOUT A)
   ACTION ITEM: Review each Committee's list of proposed actions that can be taken to advance the goals of the National HIV/AIDS Strategy. Approve a list for each Committee that can be used to build proposed 2013 work plans to present back to the Committees.
   b. Executive Committee Work Plan Update
   ACTION ITEM: Review updated Executive Committee work plan and make suggestions for items that should be added when drafting a proposed 2013 work plan.

7. **GRANTEE REPORTS:**
   a. Part A
   b. Part B and ADAP (HANDOUTS B-1, B-2)

8. **P.R.O.A.C.T. PRESENTATION:** Broward County Health Department (BLUE FOLDER)

9. **PUBLIC COMMENT**

10. **REQUEST FOR DIRECTIVES** (from Staff)

11. **AGENDA ITEMS FOR NEXT MEETING:** 01/17/13 at 12:30 p.m. Venue: BRHPC

12. **ADJOURNMENT**

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# JOINT EXECUTIVE COMMITTEE
## Retreat Meeting Minutes
September 20, 2012
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020

| # | Members | Present | Absent |
|---|---|---|---|
| **PART A** | | | |
| 1 | Kuryla, S. *Part A Chair* | **X** | |
| 2 | Taylor-Bennett, C. *Priorities* | **X** | |
| 3 | Creary K. *Membership* | | **A** |
| 4 | Gammell, B. *Part A Vice Chair* | **X** | |
| 5 | Katz, H. B. *JCCR* | **X** | |
| 6 | Tomlinson, K. *Planning* | **X** | |
| 7 | Spencer, W. *Ex oficio/By-Laws* | **X** | |
| | | | |
| **PART B** | | | |
| 8 | Saiswick, K. *Part B Chair/Planning* | **X** | |
| 9 | Agate, L. *Priorities* | **X** | |
| 10 | Washington, L. *JCCR* | **X** | |
| 11 | Wynn, J. *Consolidated Funding* | | **E** |
| | **Quorum = 7** | **9** | **2** |

| **Guests** |
|---|
| Grant, C. *Vice Chair QMC* |
| Hidalgo, Dr. J. *Facilitator* |
| Roberson, C. |
| Sabatino, D. |
| |
| **Grantee Staff** |
| Green, W. *Broward County* |
| Jones, L. *Part A* |
| Volpitta, R. *Part B/ADAP* |
| |
| **HIVPC Support Staff** |
| DeSa. G. |
| Eshel, A. |
| Hosein, F. |
| LaMendola, B. |
| Rosiere, M. |

**1. CALL TO ORDER**
The Part A Co Chair called the meeting to order at 12:15 p.m.

**2. WELCOME, STATEMENT OF SUNSHINE, PUBLIC COMMENT AND INTRODUCTIONS**
The Part A Co-Chair welcomed everyone. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Self introductions were made.

**3. MOMENT OF SILENCE**
A moment of silence was observed.

**4. APPROVALS:**

a) Joint Executive Meeting Agenda 9/20/12

| | |
|---|---|
| **Motion #1** | To approved Today's Meeting Agenda |
| **Proposed by** | H. Bradley Katz |
| **Seconded by** | Will Spencer |
| **Action:** | Passed Unanimously |

b) Joint Executive 7/12/12 Meeting Minutes

| | |
|---|---|
| **Motion #1** | To approve the 7/12/12 Meeting Minutes |
| **Proposed by** | H. Bradley Katz |
| **Seconded by** | Will Spencer |
| **Action:** | Passed Unanimously |

## 5. CO-CHAIRS' UPDATES

a. Part A Chair Update

The Part A Chair reported that two committee chairs changed Committee Chair assignments in order to comply with the By-Laws. H. B. Katz is now JCCR Part A Co-Chair and Karen Creary is now MCDC Chair.

b. Part B Chair Update

Brad Gammell has resigned as the South Florida AIDS Network (SFAN) Co-chair. Joey Wynn will temporarily fill the position until SFAN elections in December 2012. Chairs will possibly change for CY 2013.

## 6. GRANTEE REPORTS

a. **Part A**

The Part A Grantee disclosed that a member of council had emailed a request to the county for a legal opinion on Council By-Laws:

(i) A potential membership seat violation of the Council by-laws. Grantee will ask MCDC to review.

(ii) Council having lack of consumer participation in the last year. Grantee noted that additional clarification is needed.

(iii) The HIVPC Chair being a conflicted provider.

The Part A Grantee stated that we need to look at our processes and strive to get where we need to be. Examples of issues are:

(i) The ability of HIVPC Chair to remove chairs, vice chairs or co-chairs: This authority to remove chairs is covered in Roberts Rules, but may need clarification in the By-laws, and

(ii) The HIVPC Chair's ability to sway or dissuade potential members

Discussions followed: A member asked "When members initiate legal proceedings, does the Council share costs for attorney?" Another member noted that the Part B processes are very strong and Part A needs to look at them. Another member stated that when we find we are not in compliance with the By-Laws, there is no need to point fingers, but simply take the necessary steps to become compliant.

b. **Part B/ADAP**

The Part B/ADAP update was provided by BCHD representative. Upon the retirement of Paul Moore, Ms. Volpitta will be attending meetings to report on ADAP until further notice. There **is** an emergency move of the entire ADAP program to the Operations Center building in Ft. Lauderdale. Providers are asked to take note of this change and all present were asked to communicate this to the community.

## 7. RETREAT ACTIVITIES

a. GOALS OF RETREAT

Part A/HIVPC Chair:

We have the largest epidemic of HIV/AIDS and the smallest system of care. We have had discussions and some distractions over the last few months and as the HIVPC Chair, I can tell you, this is what is important – this is the work we need to do. As a planning body we need to focus on the goal together and make strides to impact HIV in Broward County. In striving to do this we need to take the recommendations made at this meeting back to our respective committees, and integrate the recommendations into each committee work

plan and into the Executive work plan. It is also a good time to renew our partnership with Part B as we sit in joint committees and work toward the same goal(s).

Part B/SFAN Chair:
As much as we see things in black and white we do really have to follow the 'script' of where we need to get to and ask everybody to think about the goal(s), possibly remove the 'lenses' of how we do work day to day and try to 'work backward' so we would know where we need to be. Over the past year and a half we have been through a lot of challenges and crossed over many 'roadblocks'. We have realized that we need to do things differently and be more creative get to that desired end result. We need to take care of our community and as stakeholders at the table we need to figure out how to do that. We know what we have done has not been effective, otherwise we will not be the EMA with the #1 HIV rate of the nation. As we discuss things today, let us try to think outside the box in order to accomplish the work that we need to do.

b. **COMPREHENSIVE PLAN AND NATIONAL HIV/AIDS STRATEGY** – Julia Hidalgo, Positive Outcomes
The facilitator noted that committee chairs need to know where we are and how we are moving forward. This is an opportunity to reset and reinvigorate people's understanding to where we are with the HIV epidemic in this county and understand how your roles as committee chairs play in to what is now a very pivotal moment for addressing the epidemic here. We want to go through a process today that would help us reframe where you would be taking your committees over the upcoming months. Think about what you all need to do as committee chair representing your committees in terms of resources and understanding of where you need to take your roles, to move forward so you can get your jobs done. You will need to rethink how you relate to the Executive Committee, HIV Planning Council and SFAN in making this whole process move forward in terms of linkage to services and the entire care continuum.

c. **ACCOMPLISHMENTS SINCE LAST RETREAT** – Michele Rosiere, HIV Division Director
HIV Division Director presented a report on the accomplishments since the last two retreats (Joint Executive 1/19/12 and HIVPC 2/23/12) and is shown below:

## FY 2012 HIVPC AND JOINT EXECUTIVE RETREAT
### OUTSTANDING RECOMMENDATIONS SUMMARY

- Comprehensive Plan is ideal focus of each committee.
- Make work plans, including all Comprehensive Planning activities, a priority.
- Reviewing work plan goals & activities are a core of the work plan not a list of checkbox items.
- Add work plans as standing agenda item at the beginning of the agenda.

### JOINT EXECUTIVE AND PART A EXECUTIVE COMMITTEES

Review overall council functions, Committee Work Products and Timeframes and Develop Recommendations

Define Role of Chairs: Respectful collaborative relationship with support staff, articulate goals for meeting, contact staff prior to meetings to review minutes, agenda

Define Role of Members: Information sharing/reporting responsibilities based on membership categories

Consider Committee Planning Cycles (Less meetings but more efficient and productive)

Develop Comprehensive Plan Oversight and Evaluation Strategy: Need Ownership from functional standpoint to ensure consistent review/evaluation of how goals are achieved. Joint Executive monitor Plan by reviewing committee's reports on the Plan's progress.

Update Executive Committee Work-Plan

Appoint a committee to focus on *Healthcare Reform* HIV impact: Capacity Assessments: "the what if's when x happens" needs to be closely watched as the health care continuum changes. (Staff Note: Healthcare Reform is a standing HIVPC agenda item and a component of the legislative update item.)

Request County Commissioners invite all other funders to participate in HIV Planning.

Marketing and Social Marketing: Identify better ways to market system of care to ensure consumer awareness of available resources. Recommendation to use some unspent direct services funds for social marketing.

Implement Mentoring by PC Chair/Vice Chair: Identify a vehicle to address recommendations, details and tasks.

### PRIORITIES COMMITTEE

Develop VA, Medicaid, Medicare baseline utilization/funding data plan

Improve Utilization/Funding Data - Request from grantee detailed service utilization data for last 1-2 years. Quarterly Part C, D & F (including oral services) updates. Develop "Data Request Form" w/ data elements & frequency.

### JOINT PLANNING COMMITTEE

Assess Needs Assessment data and carefully select most important and useful data sets by April. Ensure data are organized in "user-friendly" formats in May. Formulate recommendations based on data and provide for PSRA

Assess current system of information sharing and linkages

Focus Group: Recommendation for different approach by inviting the people involved in client care (*Contract Manager, Rapid Tester, & Surveillance*) and aware of problem. Issue with release prior to being notice of + test.

Conduct a baseline Needs Assessment on everyone once they have gone through CIED. This would create a foundation that could identify gaps in the program from the beginning.

Develop PE field for tracking all points of entry to track when and where clients first enter system.

Create and maintain a resource matrix: Accountability: providers in and out of Ryan White program.

Reinstate Outreach (EBIs/72 hours/ARTAS) – Some linkage was lost due loss of Outreach

Identify and Remove barriers to all Special Populations.

Need for more 1:1 outreach which worked well in the past.

Need for on-going support for individuals as they deal with initial diagnosis.

Continue efforts of 1:1 interactions with clients. Increase Outreach efforts at "mainstream events"

d. **ACHIEVING FORT/LAUDERDALE/BROWARD EMA COMPREHENSIVE PLAN AND NHAS GOALS -** Developing a Path Forward: What Do We Do Next?

The facilitator's remarks: It has been a sobering year, and this is an overview of the Grant Application and Comprehensive Plan. The target is to make our goals as clear as ever in order to attain additional funds. The following data was presented and summarized below:

**SIZE AND SCOPE OF THE HIV EPIDEMIC**

- Broward EMA had the highest population adjusted HIV and AIDS case rates in the US in 2011.
- AIDS cases rose 7% between 2010 and 2011, and HIV+ cases rose 25%.
- 4.5 new HIV or AIDS cases were diagnosed on average per day in 2011.
- There are now 17,389 prevalent HIV/AIDS cases in Broward.
- This figure does not account for the in-migration of HIV+ cases from other Florida counties, states and countries.
- An average of 3.4 Broward HIV+ residents died per week.
- Among newly reported HIV+ cases in 2011, 8.4% were diagnosed with AIDS within one year of HIV case report and another 23% were diagnosed with HIV and AIDS at the time of case report.
- 7,314 HIV+ residents that are aware of their status but do not receive medical care.
- FL DOH estimates that unmet need among Broward residents with AIDS increased 103% from 2006 to 2011, 78% for residents with HIV (not AIDS), and 88% for all HIV+ residents.
- The HIV epidemic continues to grow unabated. Prevention activities have yet to make a significant impact on new HIV transmissions. While community HIV testing efforts have ramped up significantly, the actual number of newly identified HIV cases through these efforts has dropped. HIV testing in public health programs has dropped significantly in the last year.
- Community viral load has not been measured in Florida. The in-care rate of suppressed viral load is 62% among Part A-funded OAMC patients, while 35% do not have suppressed viral load.

**SERVICE DELIVERY SYSTEM**

- In large part due to inadequate HIV funding, Broward has one of the smallest HIV clinical and psychosocial support systems in the US for similarly sized HIV epidemics.
- Structural barriers including inadequate staffing and space severely limit the potential for growth among current HIV clinics.
- There was a 5% decrease in the number of Part A-funded HIV OAMC visits between FY 2010 and FY2011.
- Part D recently received a $200,000 cut in funds.

**FUNDING**

**ADAP**

| Difference In Annual Enrollment And Expenditure Figures | Per Year |
|---|---|
| Difference in Total ADAP Clients Between 2009 and 2011 | -743 |
| Difference in Total ADAP Expenditures Between 2009 and 2011 | -$10,581,344 |
| Difference in Average ADAP Expenditures Per Client Between 2009 and 2011 | -$1,917 |

**AICP**

- As of July 31, 2011, 535 HIV+ Broward residents are enrolled and an additional 98 are waitlisted.

**PART A FUNDING**

- Part A funds increased at 1% or less between FY 2008 and 2010, there was a 2.5% decrease in 2011, and a 2.6% increase in 2012. The EMA's FY 2012 award was only 1.3% higher than its FY 2008 award. When inflation due to salary and other increases in the cost of delivering care are accounted for, there has been a net loss of Part A funds.
- In the EMA, average annual per capita funds dropped from $2,326 in FY 2008, to $2,300 in FY 2009, $2,186 in FY 2010, and $1,854 in FY 2011. This represents a 20% decrease between FY 2008 and FY 2011, or $472 loss per client served by Part A.
- Medicaid enrollment decreased by 13% among HIV+ beneficiaries between 2005 and 2010.

The facilitator continued: We are at an emergency level. Planning a meeting to plan something is not enough. Do not get caught up in having meetings. It is not enough to go to a meeting and plan something without true commitment for a meaningful outcome. Process issues (e.g. work plans) are needed but they are not the goal and the work is not completed when the process items are completed. There needs to be some triaging to address this situation, e.g. educating individuals in showing up to the doctor and not breaking appointments. Every broken appointment is a lost resource. There is good news: The turnover in clinical providers is not high as in other eligible metropolitan areas (EMAs).

Comments: Every state has to issue a waiver application for medication. Option of services can be limited, pharmaceuticals also. A member asked, will the effect of Affordable Care Act mean that Ryan White Part A is heading to fund only the Medical service category? The grantee added "not to minimize the discussion, but every EMA struggles with this (persons not in care) there are other factors (economic, social, family, stigma) attached for individuals not staying in care."

i. <u>How Will We Measure Our Progress?</u>

As committee chairs there is serious responsibility. You are the leaders or our group that meets once a month and it is important to understand the direction we are going in. It may be that you put responsibility to the HIVPC staff to drive you to that direction and to give you the road map and provide you with the resources to get you where you need to be. The Planning Council itself is not a neutral body that can do a lot of the important planning and other day to day activities that are needed. Therefore it is important that you all move forward as community dedicated to delivering HIV services. If you, the committee chairs, have not read the last section of the 2012-2015 Comprehensive Plan, I would urge that you read this section as it is relevant to where the committees are going. Look at the work plan as your road map. What are viewed as significant tasks are mundane tasks and are taking the focus off the goal. There are big-picture things that you need to cover. There appears to be some confusion as to the roles of the support staff and the committees – their work plans and your work plans. The minutia of planning activities is the staff's roles. Your role is seeing a much bigger picture. Pull back and look at the picture and ask 'what do we really need to know to set priorities and determine resources? What are the big-picture things do we need to know and when do we need to know it by and what sort of input do we need to have on the process?' If you are determining whether a question on your survey should be this way or that way, that is not a fabulous use of your time. If the outcome of a meeting is 'a meeting' we are not addressing the issue. The facilitator asked: Is it helpful to discuss where we all are in the process of planning the work for the next year?

Comments from some members were: "We need to take multiple steps back", "We need to see things visually rather than have a meeting", "From a Joint Planning process, I am unsure what is missing because we do what we are charged with.

**~~THERE WAS A~~ 15 MINUTE BREAK ~~AT THIS JUNCTURE~~**
**The meeting reconvened at 2:56 p.m.**

ii. Annual Evaluation and Monthly Committee Activities

Committee co-chairs were given twenty minutes to come up with specific ways their committees could advance the NHAS goals:

**Reduce the number of people who become infected with HIV.**

- Lead efforts to lower the number of new infections by 25%
- Reduce the HIV transmission rate by 30%
- Increase the number of people who know their serostatus to 90%

**Increase access to care and improve health outcomes for PLWHA.**

- Increase to 85% the number of people newly diagnosed with HIV receiving clinical care within 3 months of diagnosis.
- Increase to 80% the proportion of Ryan White clients in continuous care (2 HIV medical visits in 12 months, at least 3 months apart)
- Increase the number of PLWHA in permanent housing to 86%

**Reduce HIV-related health disparities.**

- Increase access to prevention and care services
- Increase the number of gay and bisexual men, Blacks, and Latinos with undetectable viral loads by 20%

iii. Annual Comprehensive Plan Update

This was not addressed.

iv. Incorporating Activities Included Under Each of the NHAS Goals 2013-14 Committee Work Plans

The following are the reports from the committee chairs:

**JOINT CLIENT/COMMUNITY RELATIONS COMMITTEE (JCCR):**

Reducing the Number of HIV Infections:

- Use peers for retention – identify issues to in care
- Develop a strategy to address redefining models
- Fund secondary prevention
- Treatment is prevention
- Integrated model: (i) prevention for positives (ii) outreach (iii) medical care, (iv) discordant couples

Increase access to Care:

- Capacity funding for all providers
- Explore incentives
- Look at funding private insurance

Reduce HIV Health Related Disparities:

- Integrate routine HIV care into primary family medicine

**MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC):**

- Slogan: Ryan White, Payer of last resort. RW's goals are to reduce the # of persons with HIV, yet, RW is the payer of last resort.
- Education needs to be developed in conjunction with a county wide health agency to get people into care
- There needs to be representation for RW in all health agencies Case loads are growing
- Other health provider hospitals can work within their group
- Membership should be at the educational meetings
- HIVPC/MCDC is not present at health fairs and testing sites

What are the Committees Going To Do? The facilitator: Consolidate the main points; Anticipate plan from prevention program; Discuss next steps with representatives from this program to avoid duplication of services. Members: Safe sex = no transmission; having personnel from the hospital district attend.

**JOINT PLANNING COMMITTEE:**

Reduce the number of HIV infected

- Collaborate with County effort re condom use, distribution and also testing.
- Request geo-mapping to target areas for testing.
- Identify funding streams/community resources/activities
- Recruit Prevention Chair to be involved in Planning Process to increase knowledge to also periodically review at meetings: condom use, retention of care

Increasing Access to Care:

- Review data responses to HHS questions/elements and use these indicators to guide the system
- Conduct a survey of clients not in care – identify barriers to care.
- Better utilizing the experts on our committee; suggest reviewing data not be done in-committee
- Include education activities
- 6 month / annual review of adherence

Reducing HIV Health Related Disparities:

- Improve health outcomes
- Monitor viral loads (VL/CVL) as part of data collection

**JOINT PRIORITIES COMMITTEE:**

Reduce the number of HIV infected

- Redefining the current models to reduce the number of HIV infections
- Using peers for retention and also to identify issues of maintenance and retention of care
- To develop categories of scope within that service category to address those issues
- Treatment IS prevention.
- Discuss funding for secondary prevention/re-infection
- Integrated model to include prevention for positives, medical care, testing and outreach with a special emphasis on discordant couples. One model that would fund the treatment, prevention and outreach will be an ideal model.

Increasing Access to Care:

- Increase the capacity for accessing care in this community
- Providing funding through Joint Priorities for additional providers to give more choice, to give more range of services

- Address stigmas: stigmas reduce access to care, social stigmas are a barrier to accessing care
- Exploring ways to attract and retain additional providers; how do we get more providers come to the table. How do we incentivize providers?

How do we get people to participate in the process?

- Insurance: Looking into purchasing private insurance with Ryan White Part A funds; people may then be able to take their insurance cards and go anywhere for care, meds.

Reducing HIV Health Related Disparities:

- Integrate HIV medical care into family medicine
- Work with primary care physicians to integrate
- Only chronically ill persons will need to referrals to specialty care – this will free up funds
- Reduce clinic stigma – the more persons are integrated into primary medical care

Member noted the third point of Goal #2: Increasing the number of PLWHA in permanent housing to 86% and asked: What can your committee/the Council do to reach this goal?
The facilitator stated the HRSA Housing Policy: Ryan White Part A funds cannot purchase housing in any way, shape or form. A helper can be purchased to assist in finding housing,. The strategy that is being referred to was organized to address a multi focal set of activities at the federal, state and local levels and for housing entities to expand on housing resources.

**EXECUTIVE COMMITTEE:**

- Executive does not do the work of the committee but is the decider of what is significant
- Focusing on #1 will assist with #2 and #3 (stigma, disparities)
- System needs to be changed: we know where our best testing entities are. We may need to cut funding to testing for groups that are not finding positives. Testing does not link people into care
- CVL/VL is the key; education needs to be pushed on safe sex; secondary transmission needs to be addressed; mobilize providers.
- Being the link to the various hospital districts
- Celebrate positive behaviors
- Address access and disparities

**QUALITY MANAGEMENT COMMITTEE (QMC)**

- Celebrating positive behaviors – how do we celebrate these people who have practiced safe sex and have not transmitted HIV to their partner. (one HIV+ partner, one HIV- partner)
- Targeting the gonorrhea affected population and bring that transmission down, HIV transmission will be brought down

The Chairs were charged with going back to their respective committees and implementing the above three elements by integrating them into their work plan.

## 8. UNFINISHED BUSINESS

a. Review HIVPC By-Laws regarding Joint Sessions

This was not addressed at this meeting.

## 9. PUBLIC COMMENT

There was no public comment.

**10. REQUEST FOR DIRECTIVES** (Form for Staff)

Directives were finalized.

**11. NEXT MEETING DATE:**

- Part A Executive: October 18, 2012 at 12:30 p.m. Venue: BRHPC
- Joint Executive: November 15, 2012 at 12:30 p.m. Venue: BRHPC

**12. AGENDA ITEMS FOR NEXT MEETING**

- Continue the work at the November 15, 2012 meeting

**13. ADJOURNMENT**

Without objection the meeting was adjourned at 4:11 p.m.

**Joint Executive Committee Attendance CY 2012**

| # | Members | Jan | Mar | May | Jul | Sep | Nov | Dec |
|---|---|---|---|---|---|---|---|---|
| 1 | Samantha Kuryla, **Chair** | P | No meeting | P | P | P | | |
| 2 | Brad Gammell, **Vice Chair** | P | | P | P | P | | |
| 3 | Carla Taylor-Bennett | P | | P | P | P | | |
| 4 | Karen Creary | P | | E | P | A | | |
| 5 | Karlene Tomlinson | P | | P | A | P | | |
| 6 | Gammell, B. | P | | P | P | P | | |
| 7 | H. Bradley Katz | P | | P | E | P | | |
| 8 | ***Will Spencer,*** *Ex Oficio* | P | | | | P | | |
| 9 | Saiswick, K. Part B Chair | P | | A | P | P | | |
| 10 | Agate, L. | P | | A | P | P | | |
| 11 | Washington, L. | A | | P | A | P | | |
| 12 | Wynn, J. | P | | P | P | E | | |
| | **Quorum Met** | Y | | No | Yes | Yes | | |

# MEETING THE GOALS OF THE NATIONAL HIV/AIDS STRATEGY

## IDEAS FROM THE HIVPC COMMITTEES, 11/15/12

During the retreat of September 20, 2012, the Executive Committee asked each Committee to come up with specific actions they can take to help the EMA meet the goals of the NHAS. These would be used by Executive to draft new 2013 Work Plans.

The NHAS goals are:

**Reduce the number of people who become infected with HIV**

→ Lead efforts to lower the number of new infections by 25%
→ Reduce the HIV transmission rate by 30%
→ Increase the number of people who know their serostatus to 90%

**Increase access to care and improve health outcomes for PLWHA**

→ Increase to 85% the number of people newly diagnosed with HIV receiving clinical care within 3 months of diagnosis
→ Increase to 80% the proportion of Ryan White clients in continuous care (2 HIV medical visits in 12 months, at least 3 months apart)
→ Increase the number of PLWHA in permanent housing to 86%

**Reduce HIV-related health disparities**

→ Increase access to prevention and care services
→ Increase the number of gay and bisexual men, Blacks, and Latinos with undetectable viral loads by 20%

Here are ideas offered by the Committees on how they can help the EMA. These were submitted to help the Executive Committee draft 2013 Work Plans.

### MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE

1. Make efforts to recruit more PLWHAs to be active on the Council and Committees. That will feed the Council information from the affected community, and the consumers on the board can carry back to the community information about prevention and the need to stay in care.

2. Train the Council members about the epidemic, prevention efforts and ways the community can slow the spread of HIV. That will help them make informed decisions and educate the public.

3. Make sure Council members are in the seats that match their background, so they can contribute their best to the Council. Recommend that Council members are on the Committee where their

skills and knowledge best serve the Council. MCDC has initiated a review of all mandated seats and is drafting job descriptions for each one.

## JOINT PLANNING COMMITTEE

1. Reduce the number of HIV infected
   - ❖ Collaborate with County effort on condom use, distribution and testing
   - ❖ Request geo-mapping to target areas of the county for testing
   - ❖ Identify funding streams/community resources/activities
   - ❖ Invited Prevention Chair to be involved in Planning Process to increase knowledge, and also to periodically review at meetings condom use and retention of clients in care
2. Increasing Access to Care
   - ❖ Review data responses to HHS 7 questions/elements and use these indicators to guide the system
   - ❖ Conduct a survey of clients not in care, and identify barriers to care
   - ❖ Better utilize the experts on our committee; suggest that data reviews not be done in-committee
   - ❖ Include education activities
   - ❖ 6 month or annual review of adherence
3. Reducing HIV Health Related Disparities:
   - ❖ Improve health outcomes
   - ❖ Monitor viral loads (VL/CVL) as part of data collection

## JOINT PRIORITIES COMMITTEE

**Chairs**:

1. Reduce the number of HIV infected
   - ❖ Redefine the current models to reduce the number of HIV infections
   - ❖ Use peers for retention and to identify issues of maintenance and retention of care
   - ❖ Develop categories of scope within a service category to address those issues
   - ❖ Treatment IS prevention. Keep in mind during funding decisions
   - ❖ Discuss funding for secondary prevention/re-infection
   - ❖ Integrated model to include prevention for positives, medical care, testing and outreach with a special emphasis on discordant couples. The ideal model would fund treatment, prevention and outreach
2. Increase Access to Care:
   - ❖ Increase the capacity for accessing care in this community
   - ❖ Provide funding through Joint Priorities for additional providers, to give more choice and more range of services
   - ❖ Address stigmas, which can reduce access to care and pose a barrier to receiving care
   - ❖ Explore ways to attract and retain additional providers; how do we get more providers to the table. How do we incentivize providers?
   - ❖ Look for ways to get more people to participate in the process

- Insurance: Look into purchasing private insurance with Ryan White Part A funds; people may be able to use coverage to go anywhere for medical care, meds.

3. Reduce HIV Health Related Disparities:
   - Integrate HIV medical care into family medicine
   - Work with primary care physicians to integrate HIV into their practices
   - Free up funds by requiring that only chronically ill persons need referrals to specialty care
   - Reduce clinic stigma, to bring more persons into primary medical care

**Joint Priorities Committee Members**

Offered at 10/17/12 meeting (More discussion planned 11/19/12):

1. **Pre-Exposure Prophylactic use of ARV drugs**: Reed says we should look at starting a program or encouraging it. Wynn says can't use Part A money for that. Grant says we can do some things to push PREP but not buying medications for it. Adding the service would create a cost to consider.
2. **Asking providers to educate clients**: Taylor-Bennett says we have to consider cost before asking them to do more.
3. **Keeping people in care**: Siclari says the key to reducing infections is to increase the number of people with undetectable viral loads, which means keeping people in care. We need to look at the system and make sure we are making it as easy as possible for clients to get in care and stay in care. Right now, it's not easy. The system is complicated. What are providers doing to reduce the paperwork and the appointments and the waiting times? Can eligibility do more to help? Sometimes we provider are blocked from enrolling clients. That is not helpful to them.
4. **Eligibility process**: Wynn says we may need to outstation the eligibility process to more locations, to make the process more accessible. Also, is there more that can be done electronically to speed it up?
5. **Reduce waiting times for appointments at clinics**: Wynn says we hear too many stories about long waits. A client recently went to the ER because it was better than waiting weeks to be seen at a clinic. Long waits chase people away. That's the No. 1 barrier. We lose some. Hayes agrees and says clinics are more complex than physician offices but it should not take so long to get appointments at clinics.
6. **Streamline electronic data share**: L. Jones says he would like to streamline our electronic data sharing, such as uploading documents to CIED.

**EXECUTIVE COMMITTEE**

- Executive does not do the work of the committee but is the decider of what is significant
- Focusing on #1 will assist with #2 and #3 (stigma, disparities)
- System needs to be changed: we know where our best testing entities are. We may need to cut funding to testing for groups that are not finding positives. Testing does not link people into care
- CVL/VL is the key; education needs to be pushed on safe sex; secondary transmission needs to be addressed; mobilize providers.
- Being the link to the various hospital districts

- Celebrate positive behaviors
- Address access and disparities

## QUALITY MANAGEMENT COMMITTEE (QMC)

- Celebrating positive behaviors – how do we celebrate these people who have practiced safe sex and have not transmitted HIV to their partner. (one HIV+ partner, one HIV- partner)
- Targeting the gonorrhea affected population and bring that transmission down, HIV transmission will be brought down

## JOINT CLIENT/COMMUNITY RELATIONS COMMITTEE (JCCR)

- Support group. Educating the public is a key. Start a group like AA, called "wellness club," where PLWHAs can go every week and get educated about the importance of staying on medication, living healthy, etc.
- Peer educators. Instead of just having them at agencies, send them into the community at events or locations to find those hiding from care. Start a hotline staffed by peer educators.
- Hold more JCCR seminars in the community with educational topics. Can we find videos that target our demographic groups? Have a certified HIV tester at each seminar so we can offer that service.
- Training. Train JCCR members to speak knowledgably about HIV so they can do presentations in the community. Can we attend Health Department classes? Can the Grantee pay for it?
- Produce HIV information kits for newly diagnosed people because case managers don't have time to explain everything.
- Case managers. Make them more responsible for telling clients which programs offer which services. Case managers should urge clients to practice safe sex.
- Grantees need to simplify the eligibility process across Part A, Part B and ADAP. Can't we do all at once? It's so complicated people may give up trying.
- Social media. Local Ryan White needs more of a presence on Facebook at Twitter.
- Bus passes. Need to loosen the rules so bus passes are more usable for accessing Ryan White services.

**Ryan White Part B**
**Expenditure Report**

HANDOUT B-1

| Service Category | Part B 2012-2013 Allocated | Part B 2012-2013 September / Encumbered | Part B 2012-2013 Monthly Average Left August | Part B 2012-2013 YTD Spent/ Encumbered | Part B 2012-2013 % Encumbered | Part B 2012-2013 (% Left) | Part B 2012-2013 (Balance) |
|---|---|---|---|---|---|---|---|
| **Home Delivered Meals** | $2,479 | $0 | $326 | $525 | 21.2% | 78.8% | $ 1,954 |
| **Medication Co-Pay** | $610,000 | $15,424 | $78,592 | $138,451 | 22.7% | 77.3% | $ 471,549 |
| **Case Management (non-medical)** | $228,287 | $15,096 | $22,659 | $92,333 | 40.4% | 59.6% | $ 135,954 |
| **Medical Transportation** | $150,971 | $49,909 | $16,844 | $49,909 | 33.1% | 66.9% | $ 101,062 |
| **Administration** | $110,192 | $7,755 | $9,827 | $51,232 | 46.5% | 53.5% | $ 58,960 |
| | | | | | | | |
| **TOTALS** | **$1,101,929** | **$88,183** | $128,247 | $332,450 | 30.2% | 69.8% | $ 769,479 |
| | | | | | 69.8% | | |

**Home Delivered Meals Served 0 client**

**Medication Co Payment** served 255 clients in which 5 were new to the program.
246 Clients served in September Medication Co Payment.
9 Clients served in September Mail Order
**Cost Avoidance for Medication Co-Payment Program for September is $33,642.63**
**Savings as a result of using co-pay cards April- September is approximately $107,177.**

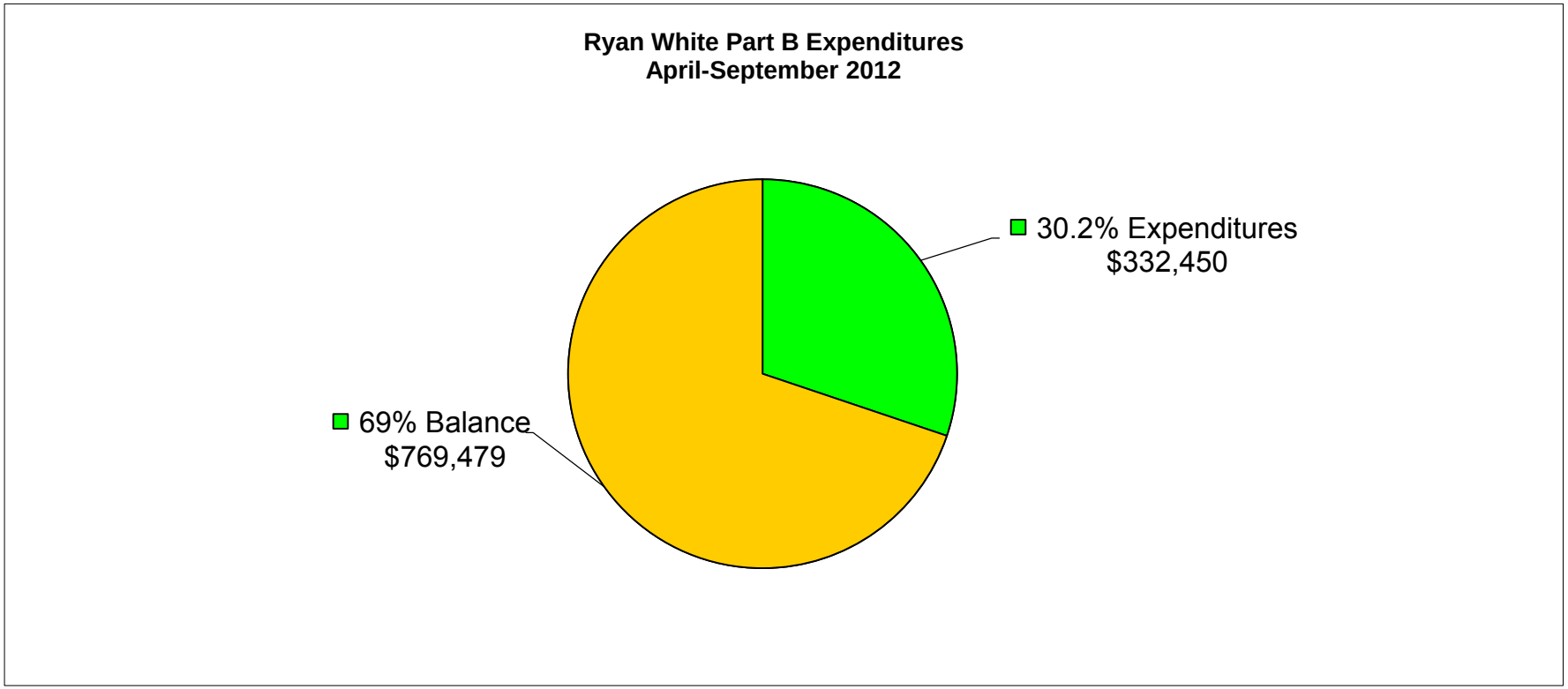
**Non-Medical Case Management** conducted 697 eligibility interviews in September.

**Medical Transportation Part B Bus Passes**: 366 (31 day) and 189 (10 ride) were issued to agencies in September.
**Medical Transportation Part A Bus Passes**: 0 (31 day) and 266 (10 ride) were distributed to agencies in September.
The passes distributed is a partial number as not every agency pickups each month.

This report reflects all invoices received and paid as of 9/30/2012.

**Ryan White Part B**
**Expenditure Report**

HANDOUT B-1




Report for Fiscal Year April 2012 thru March 2013

HANDOUT B-2

Broward County Health Department ADAP Report as of 10/25/2012

| | | |
|---|---|---|
| Total ADAP "Open" Enrollment | | 2,815 |
| Total ADAP Clients Served in Last 30 Days* | | 774 |
| Total ADAP Waitlist Enrollment** | | 52 |
| | Category A | 8 |
| | Category B | 7 |
| | Category C | 37 |
| Total ADAP/Medicare Part D Enrollment | | 176 |
| Number of Appointments in October | | 774 |
| Number of Missed Appointment in October | | 242 |
| Percentage of October 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 months or they will loose their position on the Wait List.