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

JOINT EXECUTIVE COMMITTEE
Meeting Agenda
July 12, 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 (**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. **APPROVALS:**
   a) Today's Agenda
   b) 01/19/12 Joint Executive Retreat Meeting Minutes
   c) 5/17/12 Joint Executive Meeting Minutes
5. **HIV PLANNING COUNCIL & JOINT EXECUTIVE RETREATS -** Review Summary
6. **COMPREHENSIVE PLAN DISCUSSION**
7. **UNFINISHED BUSINESS**
   A. Parking Lot Items
      I. Part A /Part B Clarification
         a) Develop definitions for membership based on Part A vs. B
         b) Develop common process for committee member appointment and approval process
      II. Part B Processes and Procedures Clarification
         a) Committee Chair appointment and approval process
         b) Excused Absences at Joint Meetings (Example: Part A Co-Chair is absent – can Part B Co-Chair give an excused absence?)
         c) Part B Attendance Tracking
         d) Part B Warning Letters
         e) Part B Removals: Part B's: Removals due to non Attendance
8. **NEW BUSINESS**
   a) Consolidated Funding
   b) Cost Sharing with Eligibility
   c) AICP Policy Change Update
9. **GRANTEE REPORTS** (Part A, Part B, ADAP)
10. **PUBLIC COMMENT**
11. **REMINDER:** HRSA/HAB Request for Comments: 2013 Ryan White Reauthorization *(See Next Page)*
12. **REQUEST FOR DIRECTIVES** (from Staff)
13. **AGENDA ITEMS FOR NEXT MEETING:** Thursday, 09/20/12 at 12:30 p.m. Venue: BRHPC
14. **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.

FY 2012 HIVPC and Joint Executive Retreat Action Items Summary

Address Identified Comprehensive Plan Challenges — Potential Committee: Part A/Joint Executive

- Define Chair's Roles: 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
- Implement Mentoring by PC Chair/Vice Chair: New members can be intimidated and could benefit from having a mentor assigned. Identify a vehicle to address recommendations, details and tasks.
- Create Joint Executive and Part A Executive Work-Plan
- Identify Committee Work Products and Timeframes and Develop Recommendations
- Develop Comprehensive Plan Oversight and Evaluation Strategy: Need Ownership of the Comprehensive Plan from a functional standpoint to ensure consistent review and evaluation of how goals are being met. Joint Executive is possibly appropriate committee to monitor Plan by reviewing committees reports on the Plan's progress
- Identify how committees are interwoven through common themes
- Develop a parking lot item, on Executive Agenda to ensure issues have follow-up
- Ensure Comprehensive Plan Goals are woven into committees' work and work-plans
- Consider Committee Planning Cycles (Less meetings but more efficient and productive)
- Add work plans as a standing agenda item at the beginning of the agenda/meeting as opposed to the end
- Make work plan, including all Comp Plan activities, a priority. Reviewing work plan goals & activities are a core of the work plan not a list of checkbox items
- Comp Plan will be the ideal focus of each committee.
- Make Comprehensive Plan more modular, tailor aspects to each committee so that committee knows what part of Comp Plan intersects with their committee work, and a standing agenda item for that committee to reflect that part of the plan.

Health care reform; Insurance vs. Direct Care — Potential Committee: HIVPC

- Capacity Assessments: the "what if's" when "what happens" needs to be closely watched as the health care continuum changes.
- Are those identified groups/ASOs/CBOs prepared and able to provide services after changes to health care are implemented?
- Look at an "insurance program" vs. Ryan White.
- Add Standing **Healthcare Reform** Agenda Item at HIV Planning Council level
- HIVPC 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, and Private Insurance Enrollment –Need to get providers ready for a major transition
- Summarized info must be sent to committees to facilitate discussion regarding items relevant to each committee's work
- Educate community about **Healthcare Reform,** what it means, what changes to expect, how to get ready
- 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 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. HIVPC will have to determine the best method to address
- Review other EMA's: Which EMA's have already begun purchasing **insurance plans?** How is it being done?
- Ad Hoc or Standing Committee developed to address insurance.
- Need to review current cost utilizations, current existing **insurance plans** in Florida, cost avoidance, cost savings, provider networks for these insurance plans. An intense cost-benefit analysis by Grantee and staff or RFP conducted to determine which tier of clients would most likely save money for the system.

Funding Data — Potential Committee: PSRA

- Improve Utilization and Funding Data
- Design a "Grantee Data Request Form" indicating types of data is needed and how often.
- Quarterly data updates from Part C, D & F programs (including oral services)
- VA Baseline data needed. How many currently in RW system? VA data needed regarding utilization by HIV+ Broward County residents.
- Request County Commissioners invite all other funders to participate in HIV Planning.

Address Identified Comprehensive Plan Challenges — **Potential Committee: Planning**

- Recommend relevant work items for each Committee
- Look at Needs Assessment data and carefully select most important and useful data sets early in the calendar year. Preferably complete by April. May and June would be used to ensure the data are organized in "user-friendly" formats. Planning Committee's focus should be making sure HIVPC has best data possible for use in PSRA
- Formulate recommendations based on data findings and provide in user-friendly format for PSRA

Address Identified Comprehensive Plan Challenges — **Potential Committee: JCCR**

- Change structure of Joint Client/Community Relations (JCCR) Committee
- Communication → Consumers → Community events
- Rebuild trust in system by providing information (difference between Parts & ADAP etc.) to improve navigation
- Review legislation pertaining to disclosure of status
- Broaden committees' peer approach by using consumers' education & experience.

JCCR Committee – Special Population Related Activities (3/6/12)

- Discussed how JCCR could better tie into the EMA's Comp Plan and corresponding work-plan including NHAS & EIIHA.
- Develop/implement targeted strategies focusing on special pops to ensure PLWHA are informed about HIVPC and Part A services.
- Hold multiple Part A/B community meetings prior to PSRA (May/June) Identify populations to target at each community meeting.
- Identify and implement targeted recruitment and engagement strategies specific to each targeted population.
- Invite members of the EMA's special populations who were not currently represented by on JCCR.
- Gathering information regarding community events, resources, venues and activities to be utilized to develop targeted strategies.
- Recruitment of targeted special populations by JCCR Members (rather than staff) through social marketing including media campaigns, outreach at HIV community events and advertisement at non-traditional venues.

Marketing and Social Marketing Recommendations — **Potential Committee: JCCR**

- Identify better ways to market the system of care to ensure all consumers know what are resources are available to them.
- Complicated system could benefit from culturally competent marketing
- Recommendation to use some unspent direct services funds for social marketing.

Peers and Consumer Education — **Potential Committee: JCCR**

- All categories could be utilized by Peers.
- **Prevention**: Using linkage specialists, navigators and peers to find those who have fallen out of care (PE Data)
- Reach out to CBOs to promote HIV message (Boys & Girls Club, School Board & Senior Centers)
- True CBO/Non Governmental Organization (NGO) Involvement
- P & P Involvement – To get Peers involved into making system work.

Coordination and Linkage

- Coordination w/ Private Docs. HRSA working w/ 2 Broward health centers to coordinate Quality of Care & expanding to blood banks.
- Reinstate Outreach (EBIs/72 hours/ARTAS) – Some linkage was lost due loss of Outreach
- PE field for tracking all points of entry to track when and where clients first enter system. (Grantee/PE Field)
- The group would like for the providers to acknowledge that they are giving private information to individuals who are getting tested.
- Resource Information Accountability: providers in and out of Ryan White program.
- 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".

➲ Track and improve levels of screening; Apply for Medicaid at all access points
➲ Case Managers need to revisit client needs based on their care plans.
➲ Identify needs of clients and know which funders provide which services.

EIIHA **Potential Committee: Planning**

- Ensure HIVPC prevention seat is filled; have BCPP representation on HIVPC and vice versa
- Prevention and Testing Barriers (EIIHA Plan)
- Build a high risk negative data system –additional data needed on this subject.
- Need to ensure that medical screening occurs at all levels.
- Request ER's increase HIV testing – create a taskforce to work specifically on this issue.
- Increase communication between prevention & treatment related to EIIHA and overall 'quality of care. Research EMA models.
- Identify resources for those who test negative. Where do they go after getting n result? 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

Needs Assessment **Potential Committee: Planning**

- Resource list changes often. Part A has the most current list; there are several documents in circulation with partial information -creating a master list of resources.
- Create and maintain a resource matrix.
- Jail Release: issue with inmates being released prior to being notified of HIV+ test result. Inmate name often incorrect, making them difficult to find after release Group recommended taking a different approach to the traditional Focus Group by inviting the people involved in client care (*Contract Manager, Rapid Tester, and Surveillance*) who are aware of the problem.
- 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 data requested? What is the impact on the overall process?
- Conduct Client Needs Assessment Survey every 2 or 3 years (vs. annually) with annual data assessment reports. Also 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.
- Look at current system of information sharing and links.
- Identified four mandated large groups with several subgroups: noting a theme throughout all of the special populations that linked them together…

Needs Assessment Follow-Up - Joint Planning Committee March 12, 2012

- It was suggested that the Client Survey be done every two to three years rather than annually as (i) there is no time to 'digest' the report and (ii) similar information is gathered during intake at Centralized Intake and Eligibility (CIED). CIED will not be doing the client survey for the county but that CIED captures valuable data. A member remarked that the survey is not a "convenience sample" and the results are a true picture of the population and can be generalized into what's happening in the county adding that qualitative information can be captured with focus groups to be statistically analyzed from any angle e.g. age group, gender, race/ethnicity, cultural background.. It was agreed that more specific questions e.g. "what was your special population at the time of diagnosis" and "where were you tested" ,"did you know this service was available", "were you eligible" and if so, "what prevented you from using the service (transportation, childcare etc)" will help Part A with the specific categories of special populations and data. It was noted that the survey does not capture the PSRA process.
- Grantee suggested that a PE profile report can be developed on a monthly/quarterly basis and proposed that a small workgroup be established to develop a general client profile to generate reports. The Part A grantee suggested that this group could participate in a PE 101(Provide Enterprise) WebEx with Groupware GTI. Two members along with the CIED manager will participate establishing a timeline, identifying, prioritizing and managing resources. The committee also reviewed the Ryan White Part A Planning Council Handout - Planning Process Evaluation document. What are the questions to ask and what is the plan for analyzing results? Member noted the resources needed to accomplish such a task from a "group of volunteer citizens". The committee agreed to obtain PSRA Committee's input on not doing a client survey this year, but to use last year's report along with current EPI utilization data. With lack of quorum, this could not be put into motion form but the Part A grantee suggested it be sent as a recommendation to PSRA Committee for data sets, data trends and data parameters at the next meeting It was requested from the BCHD representative for a three year EPI trend to give the committee a starting point to send recommendations to Priorities (PSRA) Committee.
- PSRA committee chairs will be informed of the direction the committee is headed with regards to (data sets, data trends)

3. HOW WILL WE GET THERE?

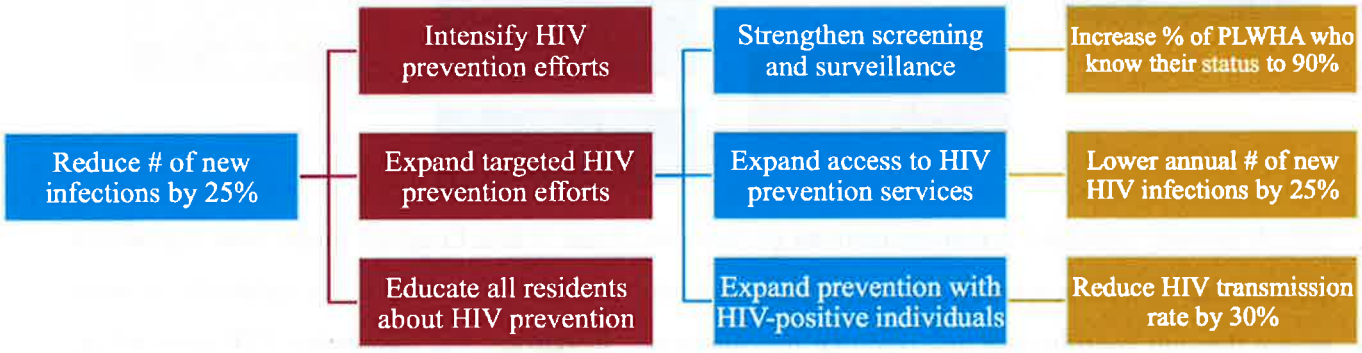
This section describes the specific strategy, plan, activities, and timeline associated with achieving specified goals and meeting identified challenges. The Comprehensive Plan is a living document and the Part A Grantee and HIVPC may revise, amend, and/or include additional goals, objectives, and activities throughout the implementation period to improve the health outcomes and quality of life for PLWHA in Broward County as needed. Implementation and oversight of this Plan are the responsibility of the Grantee, HIVPC, Committees, and QI Networks. Proper oversight will require the development of Committee work plans that incorporate the goals into their regular activities.

The NHAS goals are the foundation of the Broward County Comprehensive Plan and are listed below along with corresponding activities and anticipated outcomes. This section also illustrates how the Comprehensive Plan will address Healthy People 2020 objectives, plan for, and adapt to, changes resulting from the ACA, and reflect the SCSN.

The NHAS vision calls for collaboration and targeted funding so that: "New HIV infections will be rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination." Along with the three overarching goals, the NHAS lists measures to be met by 2015.

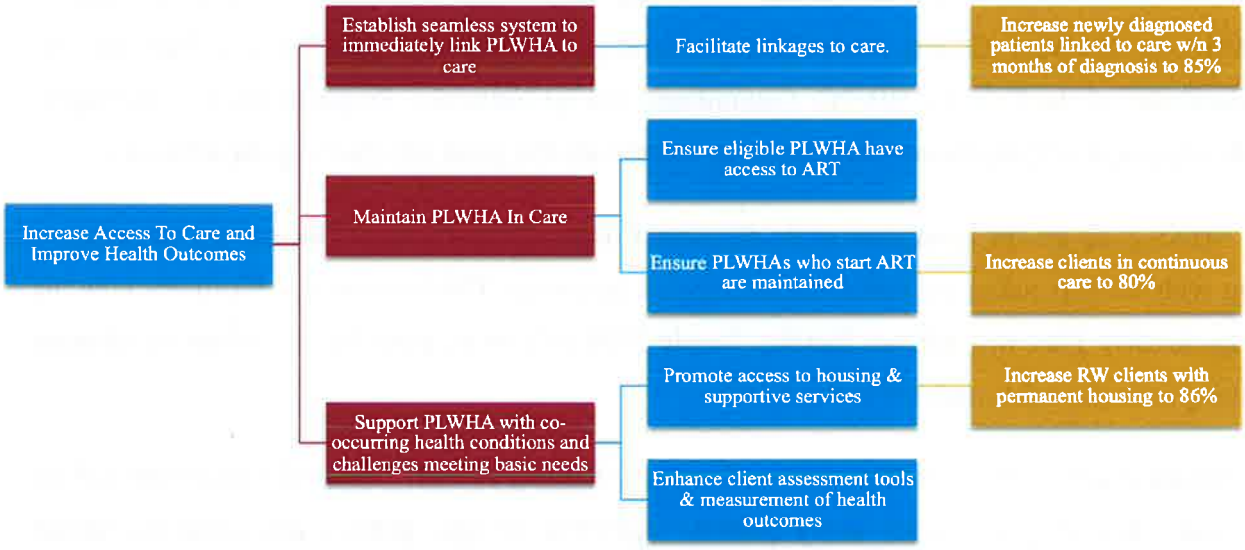
NHAS Goal #1 Reduce the number of people who become infected with HIV

- 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 from 79% to 90%



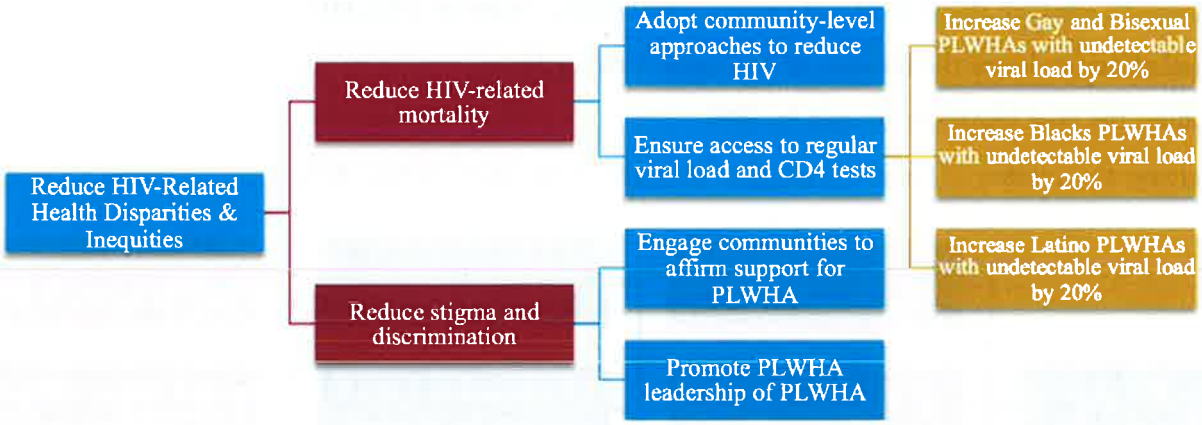
NHAS Goal #2 Increase access to care and improve health outcomes for PLWHA

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



NHAS Goal #3 Reduce HIV-related health disparities

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

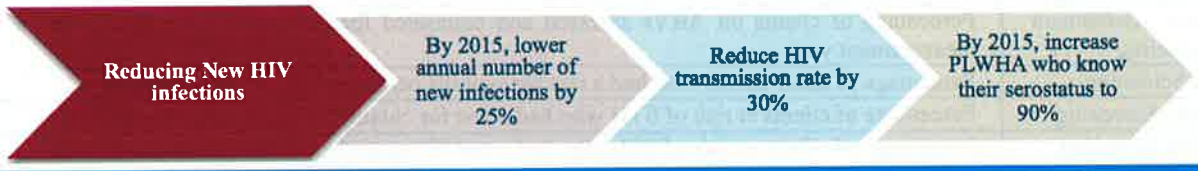


HRSA recently provided recommendations on how the Ryan White Program might best respond to achieve the NHAS outcomes. Those include concentrating resources where the epidemic is most severe through coordination and resource maximization; increasing and improving HIV prevention, care, and treatment strategies; utilizing the Needs Assessment process to tailor services to high-risk populations; collaborating with CDC-funded prevention programs; utilizing AETC for training and resources on all aspects of care and performance improvement.

The primary target population for the NHAS and EIIHA - individuals unaware of their status - is the same: "any individual who has not been tested for HIV in the past 12 months, or any individual who has not been informed of their HIV test result (HIV positive or HIV negative), or any HIV positive individual who has not been informed of their confirmatory HIV test result". Secondary target populations include individuals aware of HIV status but not in care, individuals receiving medical care but not HIV care, individuals lost to follow-up, and sporadic users of HIV care.

The desired outcomes for the activities described in the EMA's Comprehensive Plan are: improved access to and retention in HIV care for target populations, timely entry into HIV care, and prevention of vulnerable clients from dropping out of care. The activities will help the EMA identify PLWHA, link them to care, and retain them in treatment. It is the goal of the NHAS and the Broward EMA that these activities will help improve health, reduce HIV transmission, and reduce community viral load.

NHAS Goal 1: Reduce New HIV Infections by 25% by 2015



NHAS Objective 1.1 Intensify HIV prevention efforts in communities where HIV is most heavily concentrated

1.1.1.Target high-risk populations: gay/bisexual men; transgender; Blacks; Latinos; substance users

Responsible: Prevention Grantee, BCPPG, Broward AIDS Partnership **Timeframe:** Ongoing

Activities

1. Link couples where at least one partner tests positive or is currently living with HIV to appropriate counseling
2. Train HIV Counselors to conduct HIV Prevention counseling sessions and STI screening with couples.
3. Train Community Health Workers/Peers to work with the target populations
4. If serving HIV-negative MSM, promote routine testing every six months.

NHAS Objective 1.2 Expand targeted efforts to prevent HIV using effective evidence-based approaches

1.2.1 Strengthen HIV screening and surveillance to identify populations at greatest risk

Responsible: FL Bureau of HIV and AIDS **Timeframe:** Ongoing

Activities

1. Identify and address issues that impede ability of surveillance staff to track and report data regarding linkage
2. Design and implement performance measures to assess number receiving HIV testing, HIV+ individuals identified, and individuals receiving LTC services, engaged, receiving adherence counseling, and partner notification referrals to BCHD.

1.2.2 Expand access to prevention services for population-level impact for high-risk populations

Responsible: Prevention Grantee, BCPPG, BAP **Timeframe**: Ongoing

Activities

1. Target individuals at high risk
2. Select venues frequented by high-risk individuals and/or communities at greatest risk for HIV infection
3. Integrate CD program activities within other community-level intervention approaches to promote condom use and other risk reduction behaviors
4. Conduct community-wide mobilization efforts to support and encourage condom use aligned with Florida DOH Programs

1.2.3 Expand prevention with HIV+ individuals for avoidance of transmitting HIV to others

Responsible: Part A Grantee, Quality Management Committee, QI Networks **Timeframe:** FY12/13

Activities

1. Educate and counsel patients about reducing HIV transmission risk behaviors, such as risky sexual activities and sharing syringes, and encourage safer-sex practices among all patients
2. Become familiar with the evidence-based prevention interventions that are offered at community-based settings so that patients' referrals to these interventions are properly matched according to specific patient risks
3. Identify women who wish to become pregnant and provide preconception counseling; refer HIV-infected pregnant women for early prenatal care and antiretroviral therapy (ART)
4. Screen for, diagnose, and treat other STIs
5. Conduct substance abuse screening and make appropriate referrals for the management of substance use
6. Conduct mental health screening and make referrals for treatment
7. Promote adherence to ART treatment to ensure maximal viral suppression and t reduce transmission risk
8. Implement AETC Prevention with Positives trainings (Core Medical QI Networks)
9. MCM continue AETC Operation HOPEFUL pilot to assist risk and prevention assessmentswith patients
10. Identify available prevention with positives services and document in client services inventory

1.2.3 Evaluation Measures	HAB HIV Core Clinical Performance Measures
HIV Risk Counseling	Percentage of clients who received HIV risk counseling within the measurement year
Adherence: Assessment and Counseling	Percentage of clients on ARVs assessed and counseled for adherence 2 or more times in measurement year
Syphilis Screening	Percentage of adult clients who had a test for syphilis performed in the measurement year
Chlamydia Screening	Percentage of clients at risk of STIs who had a test for chlamydia in the measurement year
Gonorrhea Screening	Percentage of clients at risk of STIs who had a test for gonorrhea in the measurement year
Hepatitis/HIV Alcohol Counseling	Percentage of clients hepatitis B or C infection with alcohol counseling in measurement year
MAC Prophylaxis	Percentage of clients with CD4 <50 prescribed MAC prophylaxis in measurement year
Mental Health Screening	Percentage of new clients with HIV infection who have had a mental health screening
Substance Use Screening	Percentage of new clients screened for substance use (alcohol & drugs) in measurement year

1.3.1 Utilize evidence-based social marketing and targeted education campaigns

Responsible: Prevention Grantee, BCPPG, BAP, Part A EIIHA * **Timeframe:** Ongoing

Activities

1. Integrate CDC program activities within other community-level intervention approaches to promote condom use and other risk reduction behaviors
2. Conduct community-wide mobilization efforts to support and encourage condom use aligned with Florida DOH Programs
3. Social Marketing and Media in connection with a Counseling and Testing Program
4. Locally developed interventions (must have minimal data showing effectiveness evidence)
5. Peer Programs

1.3.2 Promote age-appropriate HIV and STI prevention education for all residents

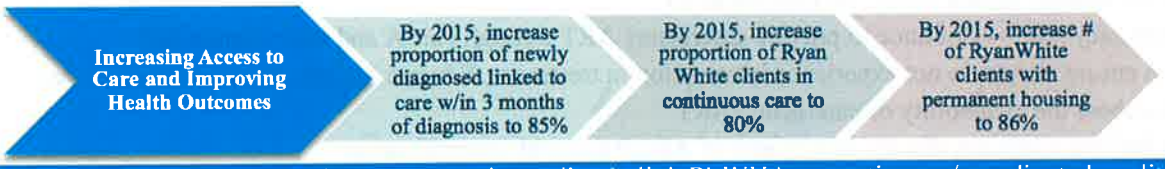
Responsible: Prevention Grantee, BCPPG, BAP, Part A EIIHA * **Timeframe:** Ongoing

Activities

Update EIIHA Plan utilizing Prevention, Testing Activities **Source**: Broward Jurisdictional Plan

1. Train HIV counselors to conduct HIV prevention counseling sessions and STI screening with couples.
2. Condom Distribution and sexual health, HIV/STI education
3. Behavioral/sexual risk screening and social service referrals (substance abuse, mental health, etc.)
4. Education about and linkage to Partner Services provided by BCHD's STI Program

NHAS Goal 2. Increase Access To Care and Improve Health Outcomes



Objective 2.1 Establish seamless system to immediately link PLWHA to continuous/coordinated quality care

2.1.1 Facilitate linkages to care (including coordination in health and social services setting for at-risk)

Responsible: RW Grantees, Prevention Grantee, Outreach, OAMC, CIED, QMC, QI Networks

FY 2012/2013 Activities

1. Implement Ryan White/Prevention Grantees Collaborative Work Group to Ensure Seamless Care System

a. Design client flow processes to ensure seamless system from test sites to Part A OAMC engagement

b. Define and provide training regarding linkage roles and responsibilities

c. Design and/or modify reporting and MIS to track HIV+ individuals receiving their diagnosis at confidential testing sites to LTC, and engagement and retention in OAMC

d. Develop aggregate reports regarding key processes, performance measures and outcomes

2. Ensure the following strategies are incorporated into Outreach through SDM revisions and training

a. Mobilize Part A-funded outreach workers to provide services at CDC and FDOH tests sites

b. Ensure application of motivational techniques to engage newly diagnosed and encourage immediate care

c. Ensure orientation about available services, and eligibility documentation assistance

d. Compute OAMC engagement rates three months or greater following HIV+ test and long-term retention

FY 2013/2014 Activities

1. Utilize engagement reports to identify areas of improvement. Reports include sub-analyses to assess EIIHA strategy impact on rates of racial, ethnic, and sexual minorities, and WICY

2. Apply quality management (QM) methods to identify areas of improvement and modify processes

3. Undertake QIPs to identify, test, and adopt effective methods for improving: Rapid LTC activities undertaken by outreach in collaboration with testing sites, hospitals and physician

a. Compute time from initial HIV+ test to the first OAMC visit with a physician; Engagement and retention in OAMC in the first year following initial HIV testing; Tailor Linkage and retention methods to unique needs of racial, ethnic, and sexual minority men and women

b. Develop QIPs by Outreach QI Network to design, test, and implement the new LTC model

Objective 2.2 Promote Collaboration Among Providers

Responsible: RW Grantees, Prevention, ADAP, Jail Linkage Staff, Re-Entry Coordinator

FY 2012/2013 Activities

1. Continue efforts to recruit Prevention Grantee to join the HIV Planning Council

2. Assess feasibility of combining HIV planning efforts required by prevention and care grants including: Client/Provider Needs (surveys, focus groups, community forums); Funding/Services Inventories/Directories

3. Increase linkage collaboration activities between Part A, testing, mental health, substance abuse and housing

4. Ensure MOUs between testing and Part A-funded outreach, CIED, and OAMC are implemented

5. Request quarterly linkage updates from all funders

6. Utilize data to evaluate effectiveness and program planning

2.3.1 Ensure that all eligible HIV-positive persons have access to antiretroviral therapy.

Responsible: Part B ADAP Grantee **Timeframe:** Ongoing

1. Decrease or eliminate the ADAP wait list

2. Create a system to obtain real time information for all ADAP clients

Responsible: Part A Grantee **Timeframe:** Ongoing

1. Ensure linkage to PAP – Educate MCMs, pharmacists, and Part A clinicians on changes to PAP requirements and eligibility guidelines to ensure that barrier to access to ART are addressed; Continue to monitor changing

PAP guidelines through the Medical Network ensure clinicians' recommendations for additions to Part A Formulary are brought before LPAC for consideration

2. LPAC Emergency ART – Continue to provide emergency ART through Part A and other community resources to ensure clients do not experience interruption in treatment; Educate MCMs, pharmacists, and Part A clinicians about the availability of emergency ART
3. Ensure MCMs and clinicians discuss importance of ADAP 6-month recertification

2.3.2 Ensure PLWHA who start therapy are maintained on regimen, per HHS guidelines

Responsible: Part A Grantee **Timeframe:** Ongoing

1. Increase the percentage of clients with a viral load less than 200 copies/mL by monitoring NQC viral load suppression and developing strategies to improve suppression rates

Evaluation Measures: HAB and NQC Viral Load suppression measures

Objective 2.4 Support PLWHA with co-occurring conditions and challenges to meet basic needs, such as housing

2.4.1 Enhance client assessment tools and measurement of health outcomes

Responsible: Part A Grantee, HIVPC, PSRA, QMC, QI Networks **Timeframe:** 2012 – 2015

1. Develop tools to measure the impact of all Core and Support Services on client level health outcomes
2. Program revised client level outcomes in PE MIS
3. Monitor the impact of non-medical services on retention in medical care
4. Integrate the two core group 1 viral load performance measures added 12/11 into PE system and SDMs

2.4.1.1 Provide case management and clinical services that contribute to improving health outcomes

1. Ensure Part A/MAI OAMC service category funding allocation is sufficient to serve all eligible PLWHA
2. Ensure Oral Health service category funding allocation is sufficient to serve all eligible PLWHA
3. Ensure AIDS Pharmaceutical Assistance service funding allocation is sufficient to serve eligible PLWHA
4. Ensure Mental Health funding allocation is sufficient to serve eligible PLWHA needing services
5. Ensure Substance Abuse funding allocation is sufficient to serve eligible PLWHA needing treatment
6. Ensure Medical Case Management service funding allocation is sufficient to serve all eligible PLWHA
7. Develop QIP's based on review of HAB Measures
8. Analyze client level data to develop strategies to improve retention
9. Develop a baseline measure of client Health Literacy levels

2.4.1.2 Increase access to non-medical services as critical elements of an effective HIV care continuum:

Including Centralized Intake and Eligibility Determination, Food bank/vouchers, Legal services and Outreach

Evaluation Measures

Medical Case Management Performance Measures focus on two key issues: care plans and medical visits. HAB encourages MCM programs to utilize core clinical performance measures as appropriate.

Indicator	How Measured
Dental and Medical History	Percentage patients with dental & medical history (initial or updated) at least once in year
Dental Treatment Plan	Percentage of patients with a treatment plan developed or updated at least once in year
Oral Health Education	Percentage of oral health patients who received oral health education at least once in year
Periodontal Screen Exam	Percentage of oral health patients with a periodontal screen or exam at least once in year
Phase 1 Treatment Plan	Percentage of oral health patients with a Phase 1 treatment plan completed within 12 months

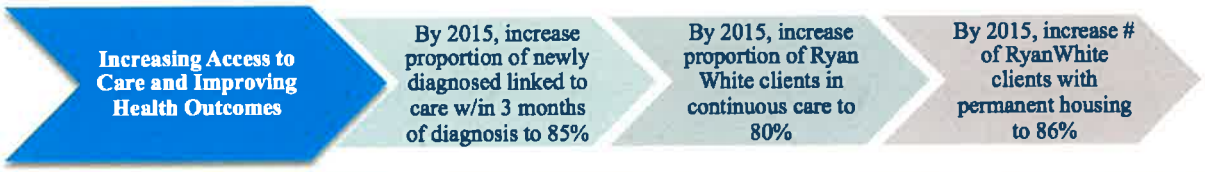
2.4.2 Address policies to promote access to housing and supportive services for PLWHA

2.Provide housing assistance and other services that enable PLWHA to obtain and adhere to HIV treatment

Responsible: A Grantee, HOPWA, PSRA **Timeframe:** 2012-2015

1. Continue to provide joint MCM trainings to Ryan White and HOPWA case managers
2. Review utilization of SOAR in assisting HOPWA clients acess benefits, thereby reducing the financial burden on HOPWA and opening housing slots for clients with no income
3. Identify barriers to care related to supportive services and develop QIP's to address barriers

NHAS Goal 3. Reduce HIV-related Health Disparities and Inequities by 2015



NHAS Objective 3.1 Reduce HIV-Related Mortality in Communities at High Risk for HIV Infection

3.1.1 Ensure high-risk groups have access to regular viral load and CD4 tests

FY 2012/2013 Activities **Responsible:** RW Grantee, QMC, QI Networks

1. Ensure access to high quality HIV-related OAMC services including access to regular VL and CD4 tests
2. Improve retention in HIV Primary Care
3. Ensure OAMC meets or exceed HHS guidelines as measured by HAB Performance Measures (Group 1)
4. Apply HAB performance measurement model to QI Network. Measures national benchmark; outcomes
5. Conduct PM quality assessment to ensure data are timely, complete, accurate and meet goals

FY 2013/2014 Activities **Responsible:** RW Grantees, QMC, QI Networks

1. Develop QIPs to address data reporting and data quality/reporting issues and/or performance deficiencies

FY 2014/2015 Activities **Responsible:** RW Grantees, QMC, QI

1. Review progress annually, identify remediation steps to achieve goals and key action steps for coming year.

Evaluation Measures: HAB HIV Core Clinical Performance Measures

Viral Load Monitoring: % of patients with a viral load test performed at least every six months

Viral Load Suppression: % of patients with viral load below limits of quantification at last test

NHAS Objective 3.2 Adopt community-level approaches to reduce HIV infection in high-risk communities

3.2.1 Establish pilot programs utilizing community models that reduce risk in high prevalence communities*

Timeframe: Ongoing **Responsible:** Prevention Grantee, BCPPG, BAP

3.2.2 Measure and utilize community viral load

FY 2012/2013 Activity **Responsible:** State ADAP

1. Assess comprehensiveness of viral load data contained in eHARS, ADAP, CAREWare and Provide Enterprise

FY 2012/2013 Activity **Responsible:** Grantees, Support Staff, Joint Planning

1. Assess reliability of estimate based on proportion of cases with known viral load
2. Ensure OAMC and MCM (regardless of funder) electronically document VL and CD4 at least every 6 months
3. Implement VL/CD4 lab documentation as a required recertification component those not in Part A OAMC

FY 2013/2014 Activity **Responsible:** Prevention Grantee, RW Grantees, Joint Planning

1. Assess viral load data for accuracy, completeness and quality
2. Develop a quality improvement plan for improving incomplete or inaccurate data
3. Develop undetectable community (Part A) VL baseline and subpopulations (gay/bisexual, Black, Latino)

NHAS Objective 3.3 Reduce stigma and discrimination against people living with HIV

3.3.1 Engage communities to affirm support for people living with HIV **Timeframe:** Ongoing

1. HIVPC planning efforts, materials and events will "Engage communities and affirm PLWHA support"

3.3.2 Promote public leadership of people living with HIV

1. Promote public leadership of PLWHA through actively recruiting PLWHA to serve as HIVPC members and council leadership positions; providing training; and disseminating national training opportunities

Institute of Medicine Releases Report on Monitoring HIV Care in the United States

HIV POLICY & PROGRAMS | March 16, 2012 1 Comment

By Gregorio Millett, M.P.H., CDC/HHS Liaison to the Office of National AIDS Policy

Listen:

Gregorio Millett

Yesterday, the Institute of Medicine (IOM) released a long-awaited report commissioned by the Office of National AIDS Policy back in 2010. IOM was tasked with recommending a list of essential indicators that can be standardized across various databases to provide a snapshot of the use of clinical services among people living with HIV/AIDS (PLWHAs). Recent scientific advances have placed a premium on the importance of clinical care for PLWHAs. The implementation of the Affordable Care Act (ACA) and the development of the National HIV/AIDS Strategy create a unique opportunity to dramatically improve the health outcomes of PLWHAs in the United States as well as opportunities to monitor and improve care provision.

A parallel effort of identifying a core set of common indicators to monitor Federally-funded HIV prevention, treatment, and care services is also underway at the U.S. Department of Health and Human Services. (Review this recent presentation [PDF 344KB] to PACHA about the HHS efforts to implement common core indicators, streamline data collection, and reduce reporting burden for HHS-funded HIV programs.)

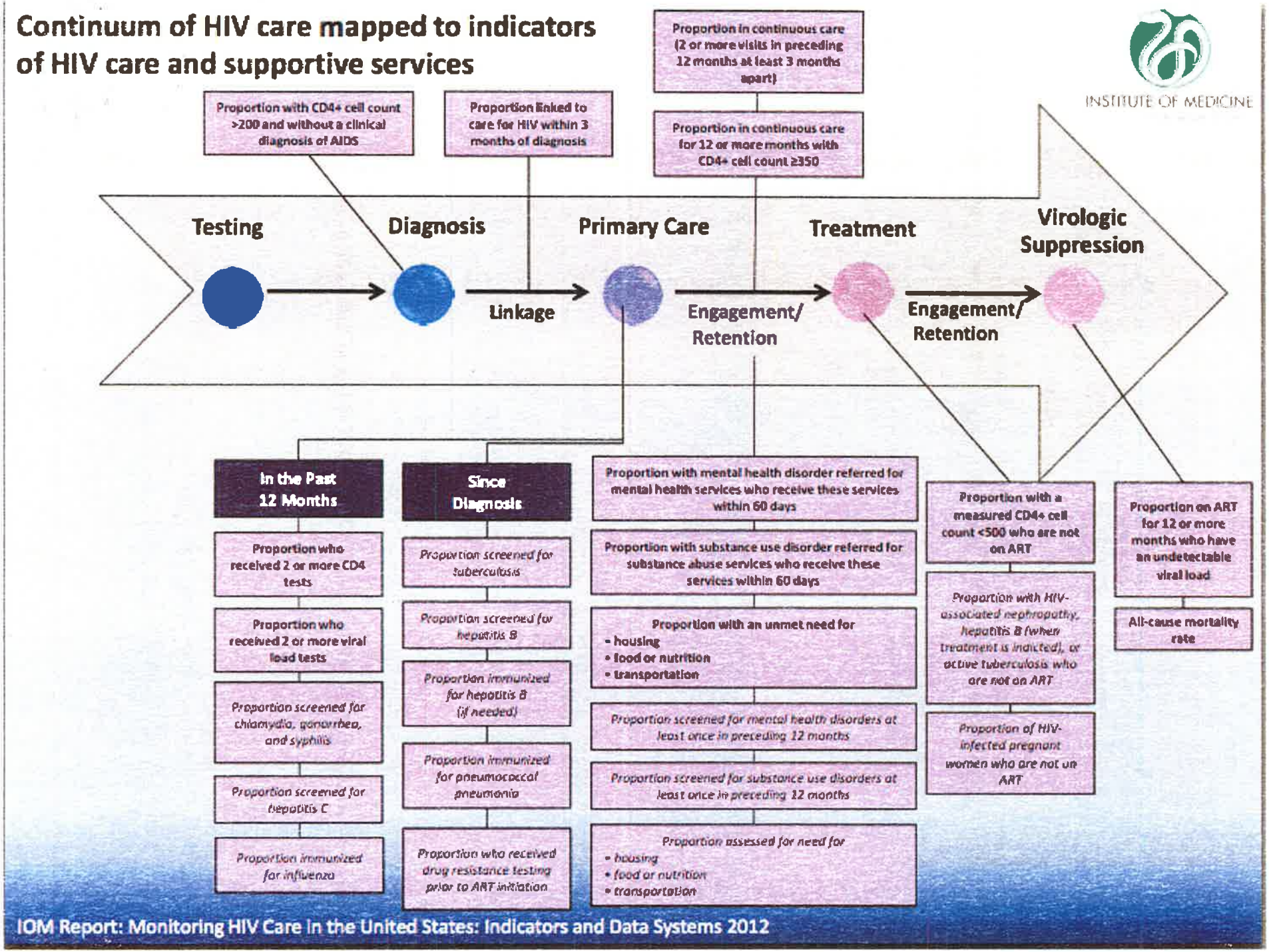
Working in collaboration, HHS's efforts and the new Institute of Medicine report move us further toward achieving the streamlining and standardization across data collection measures stipulated in the National HIV/AIDS Strategy and fulfilling the Strategy's vision to provide "unfettered access to high quality, life-extending care, free from stigma and discrimination."

More information on the IOM report, including a brief and the full report, can be found on their website.

Posted in: HIV Policy & Programs, National HIV/AIDS Strategy

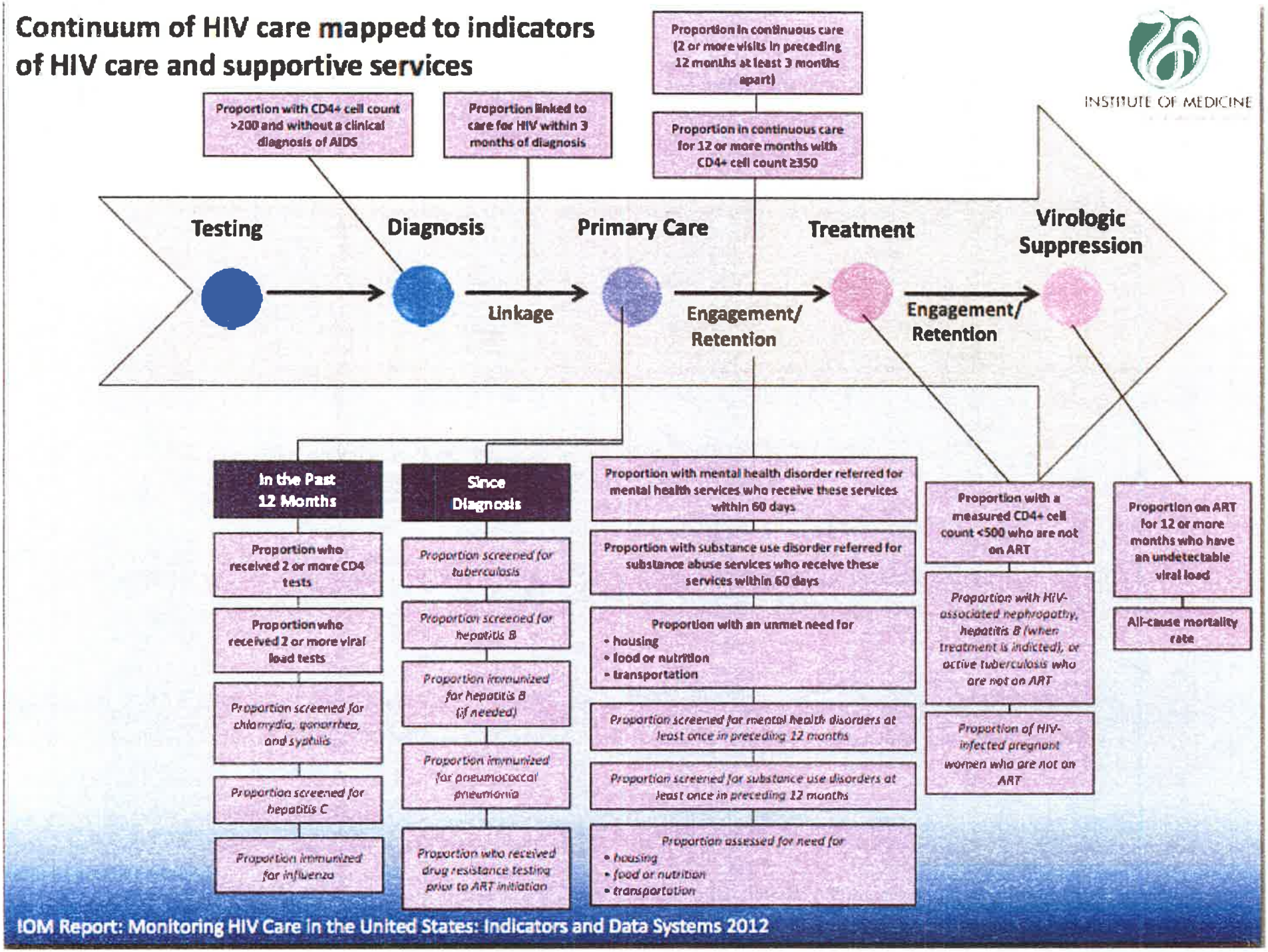
Ryan White Services Report (Health Resources and Services Administration)								
Design	**Population Covered**	**Source of Data**	**Number**	**How Representative**	**Strengths**	**Limitations**	**Potential Enhancements**	**ACA Implications**
• HRSA/HAB mandatory reporting for Ryan White grantees and contracted service providers	• HIV-infected individuals receiving at least one Ryan White service	• Ryan White grantees and contracted service providers • Grantee Report: summary of RW providers in the jurisdiction and services they offer • Service Provider Report: basic information about the organization; lists provider's service contracts reporting period • Client Report: client-level demographic information; HIV clinical information; HIV medical, health care, and support services received	• >500,000 HIV-positive individuals	• Representative of clients receiving Ryan White funded services • Not representative of national population of PLWHA in the United States	• Most indicators (or a proxy) can be calculated • Includes data on supportive services, such as need for and use of housing, food, transportation services for people served by Ryan White • Grantee data can be used to monitor changes at service system level	• Grantees/ providers are not required to report client service data for services not paid for by the Ryan White HIV/AIDS Program (may result in client-level data gaps) [Full clinical data are reported regardless of funding source] • Difficult to compare data across jurisdictions due to interstate variation in programs	• Report all client service data regardless of funding source	• Anticipated shift in clientele and services • Reduced dependency on program to meet health service needs • Redirection of funds to other vital services, e.g., housing, case management

Continuum of HIV care mapped to indicators of HIV care and supportive services



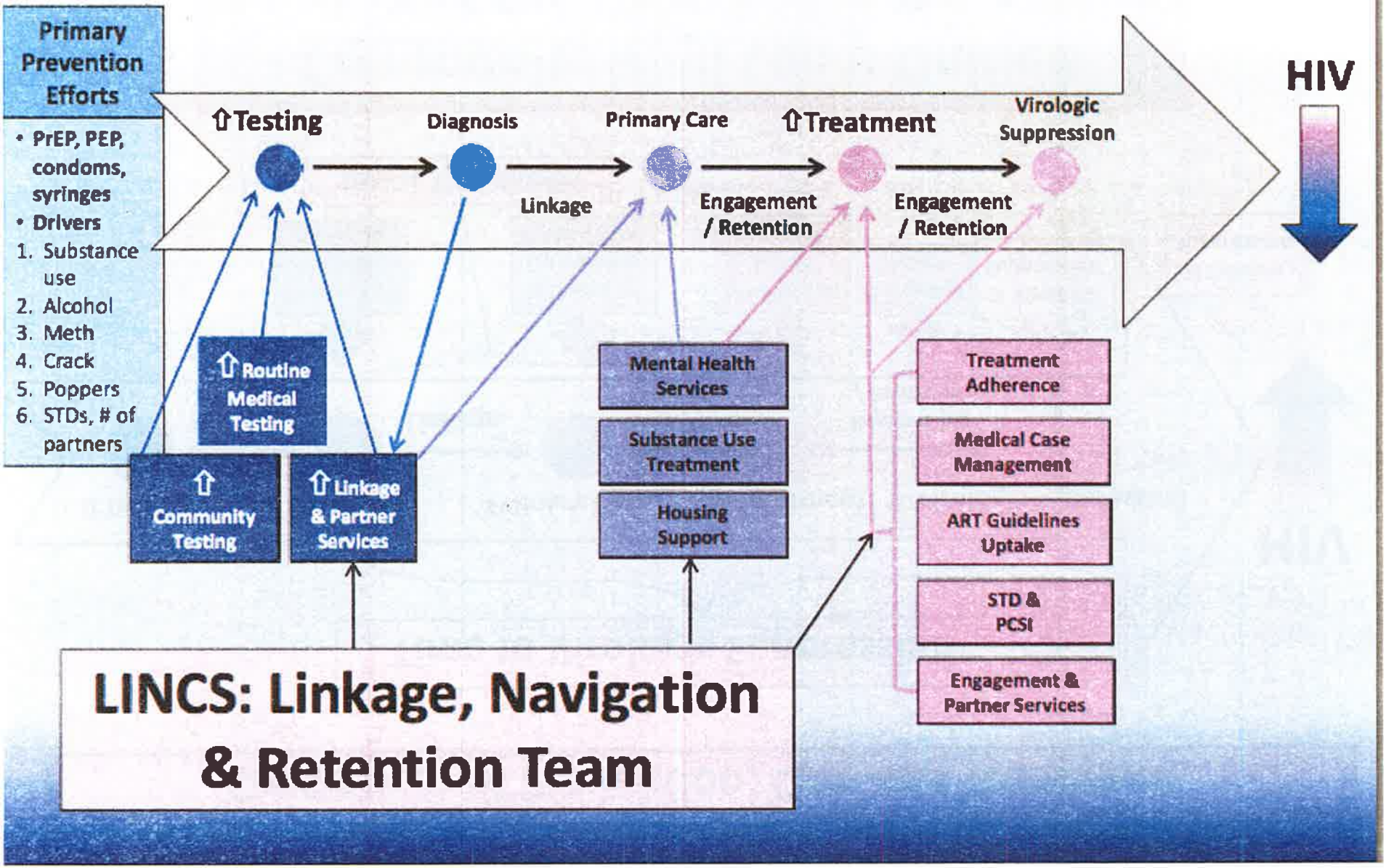
IOM Report: Monitoring HIV Care in the United States: Indicators and Data Systems 2012

Continuum of HIV care mapped to indicators of HIV care and supportive services

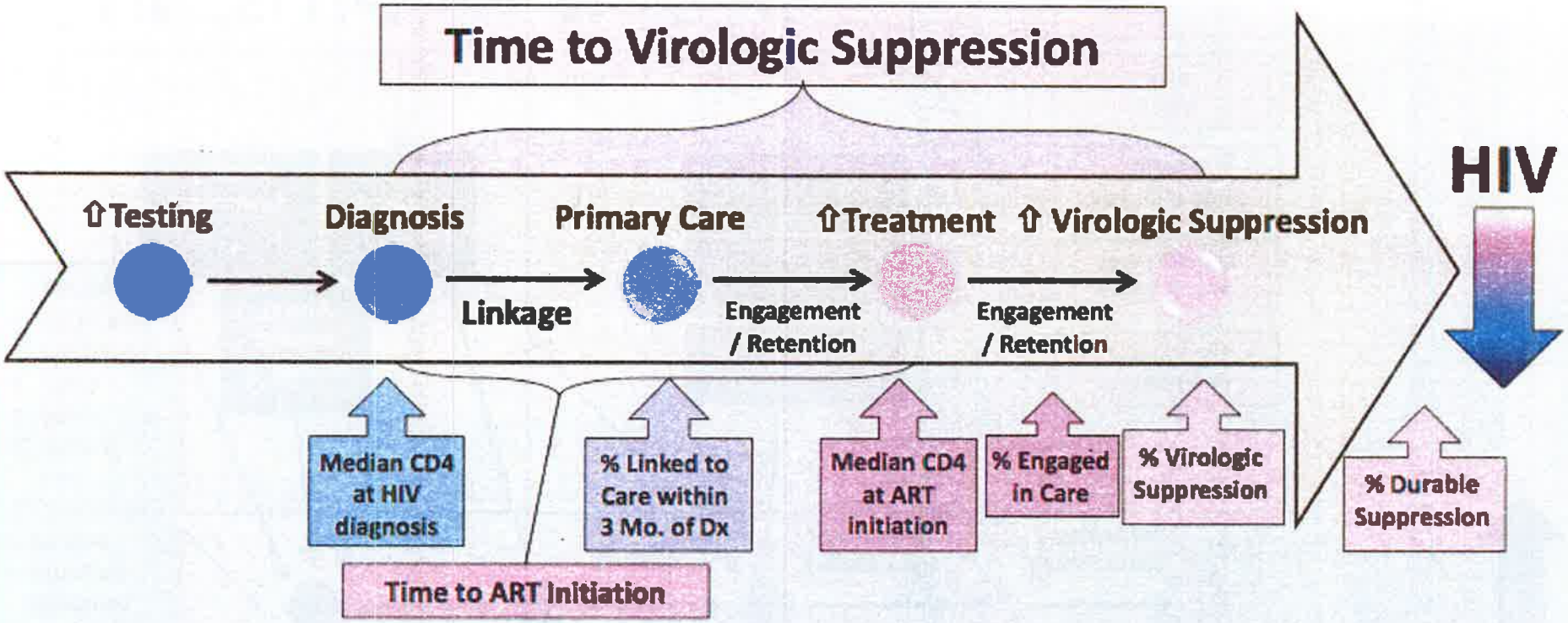


IOM Report: Monitoring HIV Care in the United States: Indicators and Data Systems 2012

San Francisco's Approach to Maximizing the Continuum of Prevention, Care and Treatment



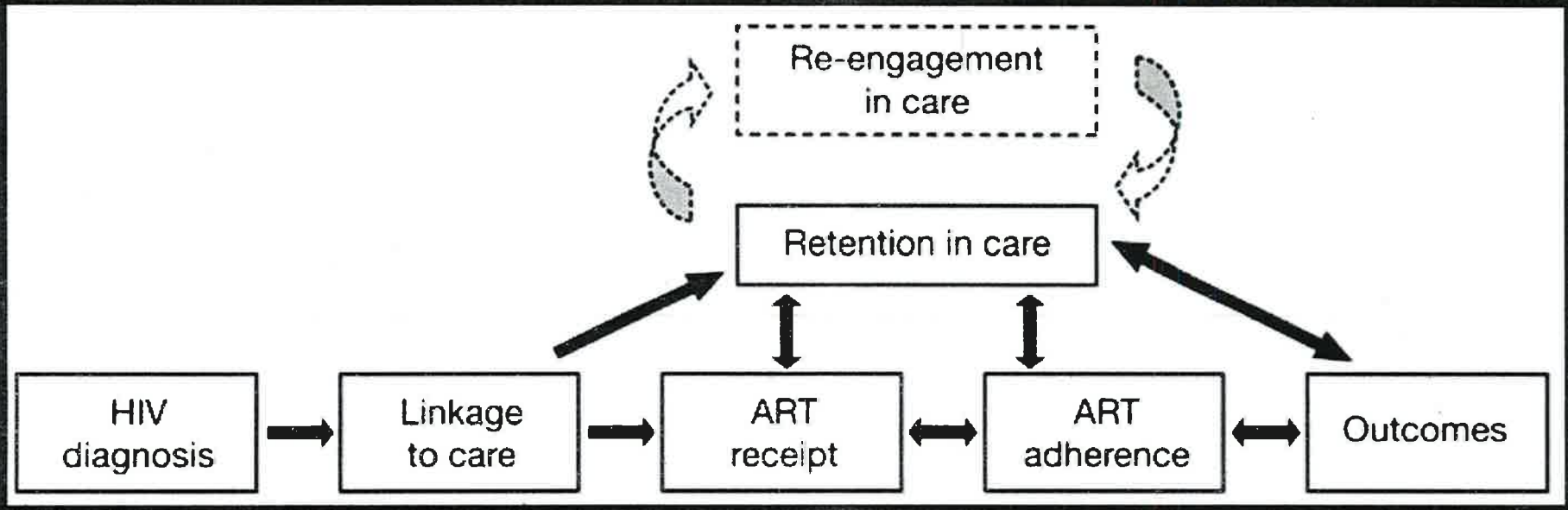
Using San Francisco's Surveillance Data to Evaluate Our Continuum of Prevention, Care and Treatment



Community Viral Load: Unified Marker of Prevention and Treatment

Das, et al. *CROI*, 2012.

Engagement in Care



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Monitoring HIV Care in the United States

Indicators and Data Systems

Table 1: Core Indicators for Clinical HIV Care

Proportion of people newly diagnosed with HIV with a CD4+ cell count >200 cells/mm³ and without a clinical diagnosis of AIDS **Rationale:** Improve health outcomes by reducing the number of people living with HIV/AIDS (PLWHA) with late diagnosis.
Proportion of people newly diagnosed with HIV who are linked to clinical care for HIV within three months of diagnosis **Rationale:** Timely linkage to care improves individual health outcomes and reduces transmission of the virus to others.
Proportion of people with diagnosed HIV infection who are in continuous care (two or more visits for routine HIV medical care in the preceding 12 months at least three months apart) **Rationale:** Continuous HIV care results in better outcomes, including decreased mortality, and reduced transmission of the virus to others.
Proportion of people with diagnosed HIV infection who received two or more CD4 tests in the preceding 12 months **Rationale:** Regular CD4 testing permits providers to monitor individuals' immune function, determine when to start antiretroviral therapy (ART), and assess the need for prophylaxis for opportunistic infections.
Proportion of people with diagnosed HIV infection who received two or more viral load tests in the preceding 12 months **Rationale:** Regular viral load (plasma HIV RNA) testing is important for monitoring clinical progression of the disease and therapeutic response in individuals on ART.
Proportion of people with diagnosed HIV infection in continuous care for 12 or more months and with a CD4+ cell count ≥ 350 cells/mm³ **Rationale:** Achieving and maintaining a CD4+ cell count ≥ 350 cells/mm³ reduces the risk of complicating opportunistic infections and cancers.
Proportion of people with diagnosed HIV infection and a measured CD4+ cell count <500 cells/mm³ who are not on ART **Rationale:** Appropriate initiation of ART improves individual health outcomes and reduces transmission of the virus to others.
Proportion of people with diagnosed HIV infection who have been on ART for 12 or more months and have a viral load below the level of detection **Rationale:** The goal of ART is durable virologic suppression, which improves health outcomes and reduces transmission of the virus.
All cause mortality rate among people diagnosed with HIV infection **Rationale:** Mortality rate is the ultimate outcome measure for people diagnosed with HIV infection. Mortality among PLWHA should be inversely related to the quality of overall care delivered.

Table 2: Core Indicators for Mental Health, Substance Abuse, and Supportive Services

Proportion of people with diagnosed HIV infection and mental health disorder who are referred for mental health services and receive these services within 60 days*

Rationale: Untreated mental health disorders can negatively affect maintenance in care, adherence to treatment, and health outcomes for PLWHA and may increase the risk of transmitting the virus to others.

Proportion of people with diagnosed HIV infection and substance use disorder who are referred for substance abuse services and receive these services within 60 days*

Rationale: Untreated substance abuse disorders can negatively affect maintenance in care, adherence to treatment, and health outcomes for PLWHA and may increase the risk of transmitting the virus to others.

Proportion of people with diagnosed HIV infection who were homeless or temporarily or unstably housed at least once in the preceding 12 months

Rationale: Homelessness and housing instability negatively affect maintenance in care, adherence to treatment, and health outcomes for PLWHA and may increase the risk of transmitting the virus to others.

Proportion of people with diagnosed HIV infection who experienced food or nutrition insecurity at least once in the preceding 12 months

Rationale: Food insecurity affects maintenance in care, adherence to treatment, and health outcomes for PLWHA and may increase the risk of transmitting the virus to others. Poor nutrition affects absorption of medications and can contribute to diet-sensitive comorbidities.

Proportion of people with diagnosed HIV infection who had an unmet need for transportation services to facilitate access to medical care and related services at least once in the preceding 12 months

Rationale: Unmet need for transportation to access HIV health care and related services negatively affects treatment access, service utilization, and health outcomes for PLWHA and may increase the risk of transmitting the virus to others.

* **NOTE:** Ideally, patients would receive care within 30 days. But given providers' limited ability to see new patients sooner, the committee acknowledges that a 60-day window is more realistic. Urgent cases should be seen as soon as possible.

Broward County HIV Tests 2009 - 2011

Tested/# Positive/% Positive

	Tested	Positive	% Positive
2009	43,955	817	1.9%
2010	49,499	643	1.3%
2011	62,262	630	1.0%

 # includes INDETERMINATE results

PositiveTests/Informed of Results/# Not Notified

	Pos HIV Tests	Pos. Post-Tested	POS % Posted	Pos Not Found
2009	817	797	97.6%	20
2010	643	625	97.2%	18
2011	630	620	98.4%	3

Negative Tests

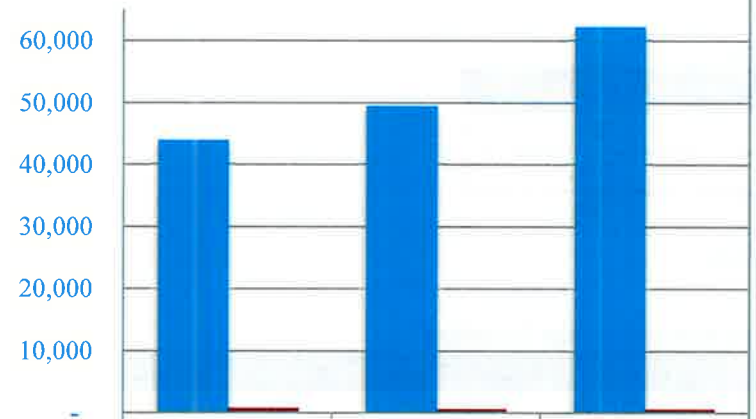
	Negative Tests	Neg Post-Tested	Neg % Posted
2009	43,117	33,500	77.7%
2010	48,824	38,029	77.9%
2011	60,732	49,874	82.1%

Positive Clients in Care

	Positive	First Appt	% in Care
2009	817	226	27.7%
2010	643	484	75.3%
2011	630	572	90.8%

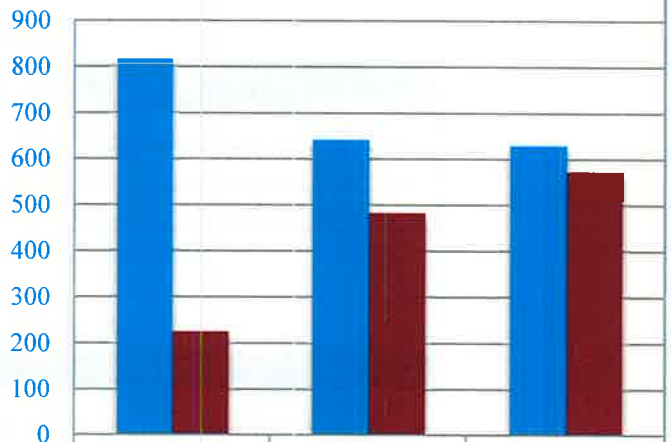
Source: FDOH Bureau of HIV/AIDS

HIV Tests and # Positive Tests



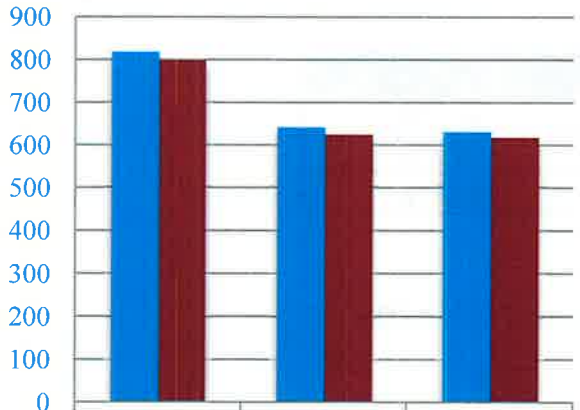
	2009	2010	2011
Tested	43,955	49,499	62,262
Positive	817	643	630

Newly Diagnosed & Linked to Medical



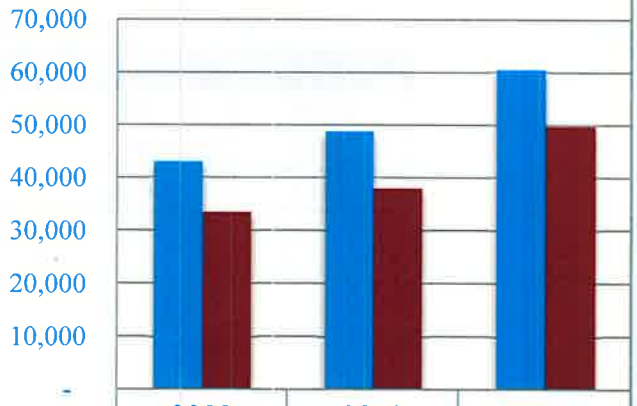
	2009	2010	2011
Positive	817	643	630
First Appt	226	484	572

Positive HIV Tests and # Post-Tested



	2009	2010	2011
Pos HIV Tests	817	643	630
Pos. Post-Tested	797	625	620

Negative HIV Tests and # Post-Tested



	2009	2010	2011
Negative Tests	43,117	48,824	60,732
Neg Post-Tested	33,500	38,029	49,874

Parking Lot Items

For Discussion at Executive Committee

1. **Attendance Policy** as stated in the Administrative Code
    a. *HIVPC motion* to Executive: Direction on restatement of Ordinance as it pertains to attendance.
    b. Methods of achieving Quorum (MS Outlook Calendar Appointments, Email, Survey)
2. **Part A and Joint Executive Committee Standing Meeting Time**
3. **Executive Committee Meeting Attendance**
    - When an Executive Committee member (Chair of a Committee) is non compliant with attendance and is in jeopardy of being removed – what is the protocol?
4. **Committee Vice-Chair Role**
    - Chairing committee when the Chair of that Committee is not present at said Committee

Added at April Executive Committee for Discussion at next Joint Meeting

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

Rick Scott
Governor

FLORIDA DEPARTMENT OF HEALTH

John H. Armstrong, MD
State Surgeon General

INTEROFFICE MEMORANDUM

DATE: June 8, 2012

TO: HIV/AIDS Program Coordinators
HIV/AIDS Contract Managers
Lead Agencies

THROUGH: Sherry Riley
Acting Chief, Bureau of HIV/AIDS

FROM: Joseph P. May
Patient Care Program Administrator

SUBJECT: AIDS Insurance Continuation Program (AICP) Waiver for Medicare Part B Eligible Clients

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The Policy Update "AICP Clients Possessing Medicaid, Medicare, or Medicare Supplemental Coverage," sent by AICP Director Robert Sandrock on March 22, 2012, states that new applicants with Medicare coverage (Part A, B, or D) are not qualified for enrollment in AICP and must access the Medicare Program for medical care and treatment; current clients with Medicare will be disenrolled from AICP by June 30, 2012.

Notwithstanding this policy, current clients who were previously eligible for Medicare Part B but chose not to sign up for Part B during their Initial Enrollment Period (IEP) may receive a temporary waiver into the AICP so that their health insurance will continue.

Medicare Part B (medical insurance) is a voluntary program that normally requires clients to pay a monthly premium. AICP clients who did not sign up for Part B during their IEP, must sign up during the next open enrollment period, between January 1–March 31, 2013. Their Medicare Part B coverage will begin July 1, 2013. These clients will continue to receive Ryan White assistance with monthly premiums, co-payments and deductibles **until June 30, 2013**.

AICP clients with questions should contact their local AICP case manager. Specific Medicare guidance is available by contacting Social Security at 1-800-772-1213. Visit www.medicare.gov to get detailed information about Medicare eligibility and enrollment options. If you have any additional questions, please contact your Community Programs representative.

cc: Ryan White Part A Grantees
Robert Sandrock, Health Council of South Florida
Community Programs Staff
Lorraine Wells, ADAP
Richard Power, Reporting Unit

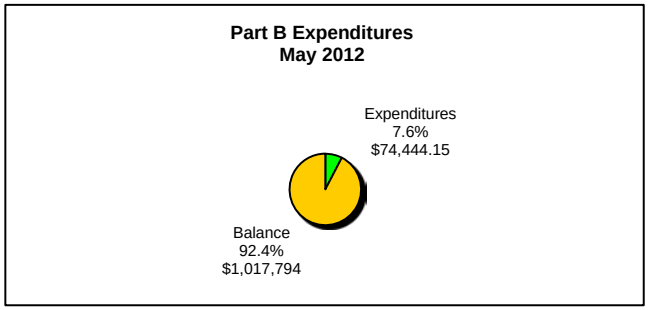
Ryan White Part B
Expenditure Report
MAY 2012

Service Category	Part B 2012-2013 Allocated	Part B 2012-2013 May / Encumbered	Part B 2012-2013 Monthly Average Left	Part B 2012-2013 YTD Spent / Encumbered	Part B 2012-2013 % Encumbered	Part B (% Left)	Part B 2012-2013 (Balance)
Home Delivered Meals	$2,479	$105	$237	$105	4.2%	95.8%	$ 2,374
Medication Co-Pay	$610,000	$34,054	$57,455	$35,447	5.8%	94.2%	$ 574,553
Case Management (non-medical)	$228,287	$24,373	$19,952	$28,767	12.6%	87.4%	$ 199,520
Medical Transportation	$150,971	$0	$15,097	$0	0.0%	100.0%	$ 150,971
Administration	$110,192	$15,911	$9,038	$19,814	18.0%	82.0%	$ 90,378
TOTALS	**$1,101,929**	**$74,444**	$101,780	$84,133	7.6%	92.4%	$ 1,017,796
					92.4%		

Non-Medical Case Management conducted 568 eligibility interviews in May of which 104 were new clients.
Medication Co Payment served 305 clients in May in which 11 were new to the program.
292 Clients served in May Medication Co Payment.
13 Clients served in May Mail Order
Medical Transportation Part B Bus Passes: 110 (31 day) and 43 (10 ride) were distributed in May.
Medical Transportation Part A Bus Passes: 153 (31 day) and 154 (10 ride) were distributed in May .
Total Passes distributed in May for Part A & B: 263 (31 day), 197 (10 ride).
The passes distributed is a partial number as not every agency pickups each month

Cost Avoidance for Medication Co-Payment Program for May is $35,397.58. Approximate savings as a result of using co-pay cards is $15,386 for April and May. This will vary each month due to deductibles and as new clients come into the program. This is computed against the $610,000 allocation.
Note: Cost Avoidance reflects the value of discount cards used in the reporting period. The projected Cost Avoidance was used to reduce the Medication Co-Pay Allocation and provide funding for Medical Transporttation and more eligibility clerks. Savings are the value of co-pay cards over and above the initial projection.

This report reflects all invoices received and paid as of 5/31/2012.



Broward County Health Department ADAP Report as of 6/27/2012

Total ADAP "Open" Enrollment		2,694
Total ADAP Clients Served in Last 30 Days*		1,716
Total ADAP Waitlist Enrollment**		75
	Category A	15
	Category B	28
	Category C	32
Total ADAP/Medicare Part D Enrollment		176
Number of Appointments in May		840
Number of Missed Appointment in May		239
Percentage of May Appointments Missed		28%

*"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.