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

Committee Meeting Agenda: Executive Committee
Date/Time: Tuesday, May 19, 2015, 9:30 a.m.-11:30 a.m. **Location:** Governmental Center Annex A-337
Chair: Vacant **Vice Chair**: Reed, Y.

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 5/19/15 Executive Committee Agenda and 4/21/15 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
   a) Committee Chair Reports
   b) Discuss Healthcare Reform Update on HIVPC Agenda
   c) Approve 5/21/15 HIVPC Meeting Materials and Motions (Handouts A1 – A3)
   d) Review June HIVPC Calendar (Handout A-4)
4. **UNFINISHED BUSINESS:**
   a) PCS Quarterly Report (Handouts B1 – B2)
   ACTION ITEM: Review updates to the PCS Quarterly Report for the 3rd and 4th quarters of FY 2014-2015.
5. **MEETING ACTIVITIES/NEW BUSINESS**

Agenda Items (Work Plan Item #)	*Action to be taken, presentation, discussion, brainstorm etc.*
Meeting Evaluations (Handout C) (WP Item 3.5)	ACTION ITEM: Review meeting evaluations to assess effectiveness of Council and committee meetings, including meeting efficiency and effectiveness.
Training Schedule (Handout D) (WP Item 2.2)	ACTION ITEM: Determine a training schedule for MCDC & Executive quarterly trainings to avoid overlap. Ensure trainings focus on topics that inform on the 3 Guiding Principles.
Special Election Process (Handout E)	ACTION ITEM: Review the process for the special election that will take place at the May HIVPC meeting.
Evaluation Report (Handout F)	ACTION ITEM: Review the evaluation report and make recommendations for action based on analysis.

6. **GRANTEE REPORTS**
7. **PUBLIC COMMENT**
8. **AGENDA ITEMS / TASKS FOR NEXT MEETING:** June 16, 2015, 9:30 a.m. **VENUE:** A-337

Agenda Items for next Meeting	*Responsible Party*	*Action to be taken, presentation, discussion, etc.*
Attendance (WP Item 3.1)	*MCDC, Exec*	ACTION ITEM: Monitor adherence to attendance policy for Planning Council and committee members.
Priority Rankings & Allocations (WP Item 4.4)	*PSRA, Exec*	ACTION ITEM: Review recommended FY16/17 rankings allocations. Ensure allocations focus on efforts to provide effective and efficient services using the 3 Guiding Ideas.

9. **ANNOUNCEMENTS**
10. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS
THREE GUIDING PRINCIPLES OF THE HIV PLANNING COUNCIL
• Linkage to Care • Retention in Care • Viral Load Suppression •

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Meeting Minutes: Executive Committee
Date/Time: Tuesday, April 21, 2015, 9:30 a.m. **Location:** Governmental Center GC-302
Chair: Vacant **Vice-Chair**: Reed, Y.

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	Grant, C.	**X**			Myers-Culpepper, K.
2	Katz, H. B.	**X**			Runkle, D.
3	Lint, A.	**X**			
4	Reed, Y., *Vice Chair*	**X**			**Grantee Staff**
5	Sabatino, D.		**A**		Degraffenreidt, S.
6	Schweizer, M.	**X**			Green, W.E.
7	Siclari, R.		**A**		Jones, L.
8	Spencer, W.	**X**			Vargas, J.
9	Taylor-Bennett, C.	**X**			
10	Tomlinson, K.	**X**			**HIVPC Staff**
					Bente, A.
					Johnson, B.
	Quorum = 6	**8**			Sandler, C.

1. CALL TO ORDER

The Chair called the meeting to order at 9:45 a.m. and welcomed all present. 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. Chairs, committee members, guests, Grantee staff and HIV Planning Council (HIVPC) staff self-introductions were made. A moment of silence was observed.

2. APPROVALS

The following motions were made:

Motion #1: To approve today's meeting agenda
Proposed by: Tomlinson, K. **Seconded by:** Grant, C.
Action: Passed Unanimously

Motion #2: To approve meeting minutes of 3/17/15
Proposed by: Katz, H.B. **Seconded by:** Schweizer, M.
Action: Passed Unanimously

3. STANDARD COMMITTEE ITEMS

None.

4. UNFINISHED BUSINESS:

a) HIVPC Retreat (WP Item 2.3) (Handout A)

HIVPC staff stated that they had reached out to the Broward County HIV Prevention Planning Council (BCHPPC) Co-Chairs about participating in the annual HIVPC retreat in an effort to better integrate our comprehensive plan. The BCHPPC is very interested in participating, and will have more information about who from the BCHPPC will be attending after their May meeting. HIVPC staff suggested inviting the Houston Eligible Metropolitan Area (EMA) to speak about their recently integrated comprehensive plan. The Grantee explained the Houston EMA contains a workgroup consisting of Prevention and Care members. The Grantee stated that while other EMAs have completed comprehensive plan integration, the Houston EMA has been

considered a best practice. A member stated that he agrees the Houston EMA should be invited to share their ideas about integration, and that the Broward EMA can learn from the Houston EMA.

b) Annual Evaluation (WP Item 3.6) (Handout B)
HIVPC staff explained the HIVPC 2014 accomplishments and challenges. These accomplishments and challenges included a carryover for less than 1% of total grant funds for FY 2013-2014, implementing two new service categories, HICP and Medical Disease Case Management, in response to changes in the health care landscape, and increasing visibility in the community by holding multiple committee meetings and community events throughout Broward County. Challenges included planning for the unknowns of the ACA implementation, filling empty mandated seats on the HIVPC with numerous employment changes and restructuring of agencies that are responsible for carrying out programs affiliated with mandated seats, and developing marketing techniques and new ways to reach out to target audiences for HIVPC membership and outreach in the community. HIVPC staff asked that members can add to the list to highlight the work that has been made.

c) Committee Reflectiveness (Handout C)
HIVPC staff explained reflectiveness of each standing committee. HIVPC staff explained the Quality Management Committee (QMC) sent out letters to specific community agencies in an effort to recruit for the committee. A member asked about the efficacy of the letters. HIVPC staff explained the letters were successful in attaining new QMC members. A guest asked if recruiting can take place in nightclub parking lots. A member stated that venues must be appropriate. Grantee staff suggested that recruitment can place at the upcoming FLDOH Transgender symposium. A member stated the recruitment process can take up to 4 months for an interested party to become an HIVPC member, which can deter some from joining. Another member stated this process can be a daunting task for some interested parties. A member stated that there should an expedited process for new membership. The Vice Chair suggested the Community Empowerment Committee (CEC) take over some of the tasks completed by the Membership/Council Development Committee (MCDC). She suggested the CEC take over the Welcome Brunches that MCDC is currently tasked with completing.

d) Update Planning Documents (WP Item 5.2) (Handouts D-1 & D-2)
HIVPC staff explained that amended changes to the policies and procedures. The following motion was made:

Motion #3: To approve the Executive Committee Policies and Procedures
Proposed by: Taylor-Bennett, C. **Seconded by:** Spencer, W.
Action: Passed Unanimously

HIVPC staff explained the HIVPC mission and vision statements. HIVPC staff explained that research was completed regarding vision and mission statements among other EMAs that have completed integration. A member noted that inclusion of all populations is included in the Houston EMA mission statement. The Vice Chair asked that this item be tabled. HIVPC staff will provide further examples at the next meeting.

e) PCS Quarterly Report (Handout E-1 & E-2)
HIVPC staff explained the components of the quarterly reports and how they relate to the three guiding principles of the HIVPC. The Vice Chair asked where the Broward HIV resident data comes from, regarding a chart presented in the report. HIVPC staff explained that this data comes from the Florida Department of Health (FLDOH) and the Medical Monitoring Project (MMP). There was committee discussion regarding exclusions to the data of the Care Continuum. The Committee asked that a data exclusion disclaimer be added to the graph. A member asked that Broward HIV residents be removed from the graph. The Grantee stated that benchmarking data must be presented alongside with the Part A data. There was discussion regarding addition of other benchmarking data. The Grantee stated that this data be evaluated by the QMC, then presented to the committee with specific labels.

5. MEETING ACTIVITIES/NEW BUSINESS

a) HIVPC Chair

The Vice Chair announced the removal of the Chair and the HIVPC's next steps. HIVPC staff explained that because the former Chair was previously an unaffiliated consumer and now has accepted a job which affiliates him with a provider, he is automatically removed, pursuant to the Broward County Ordinance. There was discussion regarding By-Laws procedures and the process of electing a new Chair. The Vice Chair stated that a special election needs to take place for the Chair. The Grantee stated that legal opinion must be gathered before proceeding. A member stated that HIVPC By-Laws are not in sync with the Nominating Procedure. He stated that the nominating procedures manual was followed when the current Vice Chair was elected and now the By-Laws should be followed. He stated that in an effort to align the elections procedure between the Chair and Vice Chair, a special election for both Chair and Vice Chair must take place. The following motion was made:

Motion #3: To recommend to hold a special election for both HIVPC Chair & Vice Chair at the May HIVPC meeting.
Proposed by: Spencer, W. **Seconded by:** Tomlinson, K.
Action: Passed Unanimously

b) By-Laws Changes (Handout F)

The ad-Hoc By-Laws Committee Chair explained the proposed line of succession. HIVPC staff explained the reason(s) for the line of succession. The Grantee stated that if a seat becomes vacant then the line of succession would be implemented. There was justification included in the presented line of succession. The Vice Chair asked why the order was changed. HIVPC staff explained that because the Priority Setting Resource Allocation (PSRA) committee takes on many tasks that the role of the Chair of the PSRA would be moved further down the line of succession.

c) Monitor Comprehensive Plan (WP Item 1.2) (Handout G)

This item was tabled until the next meeting.

d) Evaluation Report (Handout H)

This item was tabled until the next meeting.

e) Meeting Evaluations (WP Item 3.5) (Handout I)

This item was tabled until the next meeting.

f) Training Schedule (Handout J) (WP Item 2.2)

This item was tabled until the next meeting.

g) Community Data Presentation

The PSRA Chair explained that the presentation explains the data process utilized in the PSRA process and asks consumers and community members for input. The PSRA Chair explained that partnering with the System of Care (SOC) event would be attract more attendees. The Grantee stated there appears to be disconnect from the topic of these community events, and further organization is required. A member offered his agency's space for the event.

6. GRANTEE REPORT

The Grantee now has a Twitter page, @GetCareBroward.

7. PUBLIC COMMENT

None.

8. AGENDA ITEMS / TASKS FOR NEXT MEETING: May 19, 2015, 12:30 p.m. VENUE: Room A-337

Agenda Items for next Meeting	*Responsible Party*	*Action to be taken, presentation, discussion, etc.*
SOC Recommendations for PSRA (WP Item 4.1)	*SOC, PSRA, Exec*	ACTION ITEM: Review the SOC recommendations about other funding sources for the PSRA process.

9. ANNOUNCEMENTS

None.

10. ADJOURNMENT

The meeting adjourned at 12:17 p.m.

Executive Committee Attendance 2015

Count	Meeting Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
	Meeting Date:	6	17	17	21									
			QNA											
	Gammell, B,	X	X	X	Z - 4/20									
1	Grant, C.	X	X	X	X									
2	Katz, H.B.	X	X	X	X									
3	Lint, A.	A	X	X	X									R - 1/15, N - 1/17
4	Reed, Y., *Vice Chair*	A	X	X	X									
5	Sabatino, D.	X	X	X	A									
6	Schweizer, M.	X	X	X	X									
7	Sicalari, R.	X	X	X	A									
8	Spencer, W.	X	X	X	X									
9	Taylor-Bennett, C.	X	X	X	X									
10	Tomlinson, K.	X	A	X	X									
	Wilson, T.	X	A	A	Z - 3/24									
	Quorum = 6	10	10	11	8									

Broward County HIV Health Services Planning Council
HIVPC MEMBERSHIP APPLICATION

Please be aware that this application and all of the information you provide becomes a public record under Florida's Government in the Sunshine Law, Florida Statute, Chapter 119.01.

Dear Interested Party,

Please be aware that this application and all of the information once provided and submitted becomes a public record under Florida's Government in the Sunshine Law, *Florida Statute, Chapter 119.01*. Any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested. In addition, anything said during a Planning Council or Committee meeting is recorded and becomes public record. This information can also be shared with the public.

If your information is requested by an outside source, you will be notified, however the information is a public record and it may become part of a response to a public records request.

Note: This application expires six (6) months from date of submission.
Mail, fax, or email your completed application to:

HIVPC Staff
Broward Regional Health Planning Council
200 Oakwood Lane, Suite 100
Hollywood, FL 33020
FAX: 954-561-9685
EMAIL: HIVPC@BRHPC.ORG

If you have any questions, please call: 954-561-9681

Contact and Demographic Information

This is the application for membership on the Broward County HIV Health Services Planning Council (HIVPC). If you wish to apply for membership on the HIVPC, please complete the application below:

First Name: _____ **Last Name**:_____

Home Address:_____ **Home Phone**:_____

City, State, Zip Code:_____ **Cell Phone**:_____

Employer (if applicable):_____ **Occupation/Title**:_____

Business Address:_____ **Business Phone**: _____

City, State, Zip Code: _____ **Fax**: _____

Home Email:_____ **Business Email**:_____

- **I prefer to receive phone calls and messages at:** ❑ Home ❑ Work ❑ Cell
- **I prefer to receive mail at:** ❑ Home ❑ Work
- **I prefer to receive email at:** ❑ Home ❑ Work
- **I prefer to receive HIVPC documents:** ❑ Electronically (via email) ❑ Hard copy (via mail)
- **What sex were you assigned at birth? (check one):**

  ❑ Male ❑ Female ❑ Decline to state

- **What is the current gender you identify with? (check all that apply):**

  ❑ Male ❑ Female ❑ Transgender (Male to Female) ❑ Transgender (Female to Male)

  ❑ Unknown ❑ Decline to state

- **Race (check all that apply):** ❑White ❑Black ❑Asian ❑Native Hawaiian/Pacific Islander

  ❑American Indian/Alaska Native ❑Other (Specify)_____

- **Ethnicity (check one):**

  ❑Hispanic/Latino ❑Non-Hispanic ❑Other (Specify)_____

- **Hispanic Subgroup (check one if any):**

  ❑Mexican ❑Puerto Rican ❑Cuban ❑Other (Specify)

- **Asian Subgroup (check one if any):**

  ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other (Specify)

- **Native Hawaiian/Pacific Islander Subgroup (check one):**

Commented [BRHPC1]: Gender is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111). The questions about sex and gender reflect the reporting methods used for the Ryan White Services Report (RSR).

Commented [BRHPC2]: Race/ethnicity is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111). The questions about race and ethnicity reflect the reporting methods used for the Ryan White Services Report (RSR).

Commented [HP3]: Subgroups are included in RSR client level data elements.

❑Native Hawaiian ❑Guamanian ❑Samoan ❑Other (Specify)

- **Are you an employee, consultant, or board member to any Ryan White Part A Program funded agency?** ❑Yes ❑No
- **Do you self-identify as HIV positive?*** ❑ Yes, and I am open about my status ❑ No ❑ I do not wish to disclose

**Disclosure of HIV status is not required for membership. Disclosure of HIV status in this application will become a part of the public record.*

- **If you self-identify as HIV positive, do you self-identify with any of the following risk factors?**

  ❑ Hemophilia ❑ Heterosexual (Straight) ❑ Intravenous Drug User (IDU) ❑ Blood Transfusion
  ❑ Perinatal Transmission (Mother to Child) ❑ Man who has sex with Men (MSM) ❑ I don't know/Unsure
  ❑ I do not wish to disclose

- **Do you receive Ryan White Part A services?** ❑ Yes ❑ No ❑ I do not wish to disclose
- **If you self-identify as HIV positive, how old were you when you were diagnosed?**

  ❑0-12 years old ❑13-19 years old ❑20-29 years old ❑30-39 years old
  ❑40-49 years old ❑50-59 years old ❑60 years old or older ❑I do not wish to disclose

Commented [BRHPC4]: Age at diagnosis is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111).

Categories of Membership (check all that apply)

- ❑ Health care providers, including federally qualified health centers
- ❑ Community-Based Organizations (CBOs) serving affected populations and AIDS Service Organizations (ASOs)
- ❑ Social service providers (including housing and homeless-services providers)
- ❑ Mental health providers
- ❑ Substance abuse providers
- ❑ Local public health agencies
- ❑ Hospital planning agencies or health care planning agencies
- ❑ Affected communities (people living with HIV/AIDS and underserved communities)
- ❑ PLWHA Recently Released from Jail or Prison or their representatives
- ❑ Non-elected community leaders
- ❑ Members of a Federally recognized Indian tribe
- ❑ Individuals co-infected with Hepatitis B or C
- ❑ State Medicaid agency
- ❑ Ryan White HIV/AIDS Program (RWHAP) Part B State agency
- ❑ RWHAP Part C grantees
- ❑ RWHAP Part D grantees
- ❑ RWHAP Part F grantees (including Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), and dental program grantees)
- ❑ Housing Opportunities for Persons with AIDS (HOPWA) grantees
- ❑ Federally funded HIV prevention program grantees
- ❑ Veterans Health Administration representative

Committee Assessment

All HIVPC members are required to serve on at least one standing committee. Please rank the committees below to indicate your interest.

_____ **Community Empowerment Committee (CEC):** Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting, and resource-allocation processes. Functions as the outreach and education arm of the HIV Planning Council.

_____ **Membership/Council Development Committee (MCDC):** Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

_____ **Needs Assessment/Evaluation Committee (NAE):** Develops and updates annual needs assessment and other planning activities to ensure quality core medical services are integrated into Broward County's system of care. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

_____ **Quality Management Committee (QMC):** Ensures highest quality HIV medical care and support services for PLWHA by developing client and system based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff and client training and education.

_____ **Priority Setting & Resource Allocation Committee (PSRA):** Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, and allocations.

_____ **System of Care Committee (SOC):** Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

General Information

Describe your interest in becoming a member of the HIV Planning Council.

Describe how HIV/AIDS has impacted your life, either personally or professionally.

Please list any experiences you have related to community decision making or planning bodies.

Please review and initial, indicating your acknowledgement of the following:

_____ I have received, read, and understand the HIV Health Services Planning Council Meeting Ground Rules and agree to abide by them at all Council and Committee meetings.

_____ I understand that to qualify for nomination to the Planning Council I must be a member of a standing committee and attend an Orientation.

_____ I understand that I must attend a post-appointment training within three (3) months of appointment to the Planning Council by the Broward County Board of County Commissioners. If I do not comply with this requirement, I could be removed from the Planning Council.

_____ I understand that serving on the Council and at least one of its Committees will require at least five hours per month, and that excessive absence will result in my removal from the Council and/or Committees. I acknowledge that I am aware of the Planning Council Attendance Policy: a member is automatically removed from the Council if he/she misses three (3) consecutive Planning Council meetings or four (4) Planning Council meetings in a year in accordance with the County Ordinance.

_____ If appointed, I would be willing and able to fulfill the responsibilities and functions of a member of the Broward County HIV Health Services Planning Council.

_____ I am not an appointed member of any other Council or Board appointed solely by the Broward County Board of County Commissioners.

_____ I understand any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested.

_____ _____

Signature Date

Broward County HIV Health Services Planning Council
COMMITTEE MEMBERSHIP APPLICATION

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Home Address:_____ **Home Phone**:_____

City, State, Zip Code:_____ **Cell Phone**:_____

Employer (if applicable):_____ **Occupation/Title**:_____

Business Address:_____ **Business Phone**: _____

City, State, Zip Code: _____ **Fax:** _____

Home Email:_____ **Business Email:**_____

- **I prefer to receive phone calls and messages at:** ❑ Home ❑ Work ❑ Cell
- **I prefer to receive mail at:** ❑ Home ❑ Work
- **I prefer to receive email at:** ❑ Home ❑ Work
- **What sex were you assigned at birth? (check one):**

  ❑ Male ❑ Female ❑ Decline to state

- **What is the current gender you identify with? (check all that apply):**

  ❑ Male ❑ Female ❑ Transgender (Male to Female) ❑ Transgender (Female to Male)

  ❑ Unknown ❑ Decline to state

- **Race (check all that apply):** ❑White ❑Black ❑Asian ❑Native Hawaiian/Pacific Islander

  ❑American Indian/Alaska Native ❑Other (Specify)_____

- **Ethnicity (check one):**

  ❑Hispanic/Latino ❑Non-Hispanic ❑Other (Specify)_____

- **Hispanic Subgroup (check one if any):**

  ❑Mexican ❑Puerto Rican ❑Cuban ❑Other (Specify)

- **Asian Subgroup (check one if any):**

  ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other (Specify)

- **Native Hawaiian/Pacific Islander Subgroup (check one):**

  ❑Native Hawaiian ❑Guamanian ❑Samoan ❑Other (Specify)

Commented [BRHPC1]: Gender is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111). The questions about sex and gender reflect the reporting methods used for the Ryan White Services Report (RSR).

Commented [BRHPC2]: Race/ethnicity is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111). The questions about race and ethnicity reflect the reporting methods used for the Ryan White Services Report (RSR).

Commented [HP3]: Subgroups are included in RSR client level data elements.

- **Are you an employee, consultant, or board member to any Ryan White Part A Program funded agency?** ❑Yes ❑No
- **Do you self-identify as HIV positive?*** ❑ Yes, and I am open about my status ❑ No ❑ I do not wish to disclose

  **Disclosure of HIV status is not required for membership. Disclosure of HIV status in this application will become a part of the public record.*
- **If you self-identify as HIV positive, do you self-identify with any of the following risk factors?**

  ❑ Hemophilia ❑ Heterosexual (Straight) ❑ Intravenous Drug User (IDU) ❑ Perinatal Transmission (Mother to Child) ❑ Man who has sex with Men (MSM) ❑ MSM/IDU ❑ Blood Transfusion ❑ I don't know/Unsure ❑ I do not wish to disclose
- **Do you receive Ryan White Part A services?** ❑ Yes ❑ No ❑ I do not wish to disclose
- **If you self-identify as HIV positive, how old were you when you were diagnosed?**

  ❑0-12 years old ❑13-19 years old ❑20-29 years old ❑30-39 years old

  ❑40-49 years old ❑50-59 years old ❑60 years old or older ❑I do not wish to disclose

Commented [BRHPC4]: Age at diagnosis is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111)

Committees of the Broward County HIV Health Services Planning Council:

Community Empowerment Committee (CEC)
Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes. Functions as the outreach and education arm of the HIV Planning Council.

Membership/Council Development Committee (MCDC)
Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

Needs Assessment/Evaluation Committee (NAE)
Develops and updates annual needs assessment and other planning activities to ensure quality core medical services are integrated into Broward County's system of care. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

Priority Setting & Resource Allocation Committee (PSRA)
Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on 'how best to meet the need.'

Quality Management Committee (QMC)
Ensures highest quality HIV medical care and support services for PLWHA by developing client and system based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff and client training and education.

System of Care Committee (SOC)
Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

Which committee(s) are you interested in serving on? (See previous page for an explanation of committee responsibilities)

❑Community Empowerment Committee (CEC)

❑Membership/Council Development Committee (MCDC)

❑Needs Assessment/Evaluation Committee (NAE)

❑Quality Management Committee (QMC)

❑Priority Setting & Resource Allocation Committee (PSRA)

❑System of Care Committee (SOC)

Provide a brief statement explaining your interest in the HIVPC and the HIV/AIDS planning process, including your background relative to HIV/AIDS (volunteer, professional, personal) and/or other relevant experience and expertise. You may also attach your resume or additional information.

_____

_____

_____

_____

Please review and initial, indicating your acknowledgement of the following:

_____ I have received, read, and understand the HIV Health Services Planning Council Meeting Ground Rules and agree to abide by them at all Committee meetings.

_____ I understand that serving on a Committee will require at least three hours per month, and that excessive absence will result in my removal from a Committee. I acknowledge that I am aware of the Planning Council Attendance Policy: a member is automatically removed from a Committee if he/she misses three (3) consecutive meetings or four (4) meetings in a year in accordance with the County Ordinance.

_____ I understand any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested.

_____ _____

Signature Date

Broward County HIV Health Services Planning Council
MEMBER UPDATE FORM

Please be aware that this application and all of the information you provide becomes a public record under Florida's Government in the Sunshine Law, Florida Statute, Chapter 119.01.

Dear Interested Party,

Please be aware that this application and all of the information once provided and submitted becomes a public record under Florida's Government in the Sunshine Law, *Florida Statute, Chapter 119.01*. Any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested. In addition, anything said during a Planning Council or Committee meeting is recorded and becomes public record. This information can also be shared with the public.

If your information is requested by an outside source, you will be notified, however the information is a public record and it may become part of a response to a public records request.

Contact and Demographic Information

This is the update form for all HIV Planning Council and committee members. Please note any changes since submission of your application or last update form.

First Name: _____ **Last Name**:_____

Home Address:_____ **Home Phone**:_____

City, State, Zip Code:_____ **Cell Phone**:_____

Employer (if applicable):_____ **Occupation/Title**:_____

Business Address:_____ **Business Phone**: _____

City, State, Zip Code: _____ **Fax**: _____

Home Email:_____ **Business Email**:_____

- **I prefer to receive phone calls and messages at:** ❑ Home ❑ Work ❑ Cell
- **I prefer to receive mail at:** ❑ Home ❑ Work
- **I prefer to receive email at:** ❑ Home ❑ Work
- **I prefer to receive HIVPC documents:** ❑ Electronically (via email) ❑ Hard copy (via mail)
- **What sex were you assigned at birth? (check one):**

  ❑ Male ❑ Female ❑ Decline to state

- **What is the current gender you identify with? (check all that apply):**

  ❑ Male ❑ Female ❑ Transgender (Male to Female) ❑ Transgender (Female to Male)

  ❑ Unknown ❑ Decline to state

- **Race (check all that apply):** ❑White ❑Black ❑Asian ❑Native Hawaiian/Pacific Islander

  ❑American Indian/Alaska Native ❑Other (Specify)_____

- **Ethnicity (check one):**

  ❑Hispanic/Latino ❑Non-Hispanic ❑Other (Specify)_____

- **Hispanic Subgroup (check one if any):**

  ❑Mexican ❑Puerto Rican ❑Cuban ❑Other (Specify)

- **Asian Subgroup (check one if any):**

  ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other (Specify)

- **Native Hawaiian/Pacific Islander Subgroup (check one):**

Commented [BRHPC1]: Gender is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111). The questions about sex and gender reflect the reporting methods used for the Ryan White Services Report (RSR).

Commented [BRHPC2]: Race/ethnicity is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111). The questions about race and ethnicity reflect the reporting methods used for the Ryan White Services Report (RSR).

Commented [HP3]: Subgroups are included in RSR client level data elements.

❑Native Hawaiian ❑Guamanian ❑Samoan ❑Other (Specify)

- **Are you an employee, consultant, or board member to any Ryan White Part A Program funded agency?** ❑Yes ❑No
- **Do you self-identify as HIV positive?*** ❑ Yes, and I am open about my status ❑ No ❑ I do not wish to disclose

**Disclosure of HIV status is not required for membership. Disclosure of HIV status in this application will become a part of the public record.*

- **If you self-identify as HIV positive, do you self-identify with any of the following risk factors?**

❑ Hemophilia ❑ Heterosexual (Straight) ❑ Intravenous Drug User (IDU) ❑ Perinatal Transmission (Mother to Child) ❑ Man who has sex with Men (MSM) ❑ MSM/IDU ❑ Blood Transfusion ❑ I don't know/Unsure ❑ I do not wish to disclose

- **Do you receive Ryan White Part A services?** ❑ Yes ❑ No ❑ I do not wish to disclose
- **If you self-identify as HIV positive, how old were you when you were diagnosed?**

❑0-12 years old ❑13-19 years old ❑20-29 years old ❑30-39 years old

❑40-49 years old ❑50-59 years old ❑60 years old or older ❑I do not wish to disclose

Commented [BRHPC4]: Age at diagnosis is one of the reflectiveness categories mandated by HRSA (Part A Manual p. 111)

Categories of Membership (check all that apply)

- ❑ Health care providers, including federally qualified health centers
- ❑ Community-Based Organizations (CBOs) serving affected populations and AIDS Service Organizations (ASOs)
- ❑ Social service providers (including housing and homeless-services providers)
- ❑ Mental health providers
- ❑ Substance abuse providers
- ❑ Local public health agencies
- ❑ Hospital planning agencies or health care planning agencies
- ❑ Affected communities (people living with HIV/AIDS and underserved communities)
- ❑ PLWHA Recently Released from Jail or Prison or their representatives
- ❑ Non-elected community leaders
- ❑ Members of a Federally recognized Indian tribe
- ❑ Individuals co-infected with Hepatitis B or C
- ❑ State Medicaid agency
- ❑ Ryan White HIV/AIDS Program (RWHAP) Part B State agency
- ❑ RWHAP Part C grantees
- ❑ RWHAP Part D grantees
- ❑ RWHAP Part F grantees (including Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), and dental program grantees)
- ❑ Housing Opportunities for Persons with AIDS (HOPWA) grantees
- ❑ Federally funded HIV prevention program grantees
- ❑ Veterans Health Administration representative

Please review and initial, indicating your acknowledgement of the following:

_____ I understand any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested.

_____ _____

Signature Date

June 2015
Broward County HIV Health Services Planning Council Calendar

HANDOUT A-4

Last Updated: 5/11/2015

Meeting dates & times are subject to change. Unless otherwise noted, meetings are held at: Governmental Center Annex, Ryan White Part A Program Office, 115 S. Andrews Ave.; Ft. Lauderdale, 33301. Please contact support staff at 954-561-9681 ext. 1250 or visit http://www.brhpc.org for updates.

Monday	Tuesday	Wednesday	Thursday	Friday
1	2	3	4 **Membership/Council Development Committee (MCDC)** 9:30 a.m., A-335^ **Community Forum** 6-8 p.m., Urban League#	5 **SFAN** 10:00 a.m.~
8 **Needs Assessment/ Evaluation Committee (NAE)** 1:00 p.m., A-335^	9 **ad-Hoc Food Services Eligibility Committee** 12:30 p.m., A-335^	10 **ad-Hoc By-Laws Committee** 9:30 a.m., A-337^ **HIVPC Coordination** 12:30 p.m., A-335^	11	12
15 **Quality Management Committee (QMC)** 12:30 p.m., A-335^	16 **Executive Committee** 9:30 a.m., A-337^	17 **Priority Setting and Resource Allocation Committee (PSRA)** 12:30 p.m., A-337^	18	19
22	23	24 **HIVPC Coordination** 12:30 p.m., A-335^	25 **HIV Planning Council (HIVPC)** 9:30 a.m., CDTC **MCDC Coordination** 12:30 p.m., A-335^	26 **System of Care Committee (SOC)** 9:30 a.m., GC-302^
29	30			

^Governmental Center —115 S Andrews Ave, Ft. Lauderdale, 33301
~Dorothy Mangurin Comp. Center—100 NE 56th St, Ft. Lauderdale, 33334
#Urban League of Broward—560 NW 27th Ave, Ft. Lauderdale, 33311

Meetings in ~~**Red**~~ are cancelled.
Meetings in **Blue** are for the HIV Planning Council Committees & QI Networks.
Meetings in Black are not associated with the HIV Planning Council.

June 2015

Broward County HIV Health Services Planning Council Calendar

HANDOUT A-4

Last Updated: 5/11/2015

Dates and times are subject to change. Visit http://www.brhpc.org/programs/hiv-planning-council/ for updates. For questions about the HIV Planning Council & Committees, please contact Cady Sandler at 603-689-8899. For questions about the QI Networks, please contact Brithney Johnson at 954-644-2774.

TODOS ESTAN BIENVENIDOS!

A menos que se anote de forma diferente en el calendario, todas las reuniones se realizarán en:

Governmental Center
115 S. Andrews Ave.
Ft. Lauderdale, FL 33301
(Acceso de Downtown Bus Terminal y Tri-Rail/Broward County Transit)

Para confirmar información acerca de la reunión de Consejo de Planeación VIH, o confirmar la reserva de servicios especiales tales como: Traducción Inglés a Español o a Criollo (Haitiano), servicios para discapacitados en visión o audición, por favor llame con 48 horas de antelación para que puedan hacerse los arreglos necesarios.

ALL ARE WELCOME!

Unless otherwise noted on the calendar, all meetings are held at:

Governmental Center
115 S. Andrews Ave.
Ft. Lauderdale, FL 33301
(Access from Downtown Bus Terminal and Tri-Rail/ Broward County Transit)

To confirm HIV Planning Council meeting information, or reserve special needs services such as: Translation from English to Spanish or Creole; or, are hearing or visually impaired, please call 48 hours in advance so that arrangements can be made for you.

BON VINI!

Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fèt:

Governmental Center
115 S. Andrews Ave.
Ft. Lauderdale, FL 33301
(Access from Downtown Bus Terminal and Tri-Rail/ Broward County Transit)

Pou konfime enfòmasyon ou resevwa sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyol; oswa, si ou gen pwoblèm wè oswa tande, rele 48 tè alavans pou yo ka fè aranjman pou ou.

HIVPC Committee Descriptions

Community Empowerment Committee (CEC) - Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes. Function as a primary level of appeal for unresolved grievances relative to the Council's decisions regarding Ryan White Part A funding.

Membership/Council Development Committee (MCDC) - Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

Needs Assessment/Evaluation (NAE) Committee - Develops and updates the annual Needs Assessment, including determining focuses for the client survey, provider survey, and client focus groups. Evaluates and updates the Comprehensive Plan to determine progress.

Quality Management Committee (QMC) - Ensures highest quality HIV medical care and support services for PLWHA by developing client and system based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff/client training/education.

Priority Setting Resource Allocation (PSRA) Committee - Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on 'how best to meet the need.

System of Care (SOC) Committee - Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

Executive Committee - Sets agenda for Council meetings. addresses conflict of interest issues, reviews attendance reports, oversees the planning activities established in the Comprehensive Plan, oversees committee work plans, reviews committee recommendations, ratifies recommendations for removal for cause, and addresses unresolved grievance issues.

HIV Health Services Planning Council (HIVPC) - Monitors, evaluates, and continuously improves systematically the quality and appropriateness of HIV care and services provided to all patients receiving Part A and MAI-funded services.

HANDOUT B-1

Quarterly Planning and Evaluation Report

FY 2014-2015 Third Quarter Report: September 1-November 30, 2014

Prepared by Broward Regional Health Planning Council

200 Oakwood Lane, Ste 100
Hollywood, FL 33020

p. 954-561-9681
f. 954-561-9685

hivpc@brhpc.org
www.brhpc.org

Summary: FY 2014-2015 Third Quarter

The fiscal year (FY) 2014-2015 third quarter ran from September 1, 2014 until November 30, 2014. In the third quarter, the HIV Planning Council (HIVPC) began using new work plans that were focused on three guiding principles. The three guiding principles were developed at the recommendation of a consultant who determined that the Broward Eligible Metropolitan Area (EMA) had so much data available to it, that it sometimes had difficulty focusing its activities.

What are the three guiding principles?

The three guiding principles of the HIVPC are:

1. Linkage to care
2. Retention in care
3. Viral load suppression

How were the three guiding principles developed?

The three guiding principles were developed to reflect the National HIV/AIDS Strategy (NHAS) and the HIV Care Continuum. In 2010, the White House released NHAS. The four goals of NHAS were to reduce new infections, increase access to care and improve health outcomes for PLWHA, to decrease HIV-related health disparities and inequities, and to achieve a more coordinated response to the epidemic. The HIV Care Continuum was developed subsequently to NHAS, as a tool to be used to analyze the progress being made on NHAS goals. The HIV Care Continuum is most often shown as a bar graph made up of five bars (see Figure 1) showing the following percentages for people living in the United States: diagnosed with HIV, linked to care, retained in care, prescribed Antiretroviral Therapy (ART), and virally suppressed. Of the five bars, the HIVPC felt that the three bars the HIVPC could have the most impact on were linkage to care, retention in care, and viral load suppression. The work of local prevention programs is predominantly focused on diagnosing HIV, and once an individual enters care, being prescribed ART is largely automatic.

The HIV Care Continuum shown as Figure 1 below compares people living with HIV/AIDS (PLWHA) in Broward County overall to Part A clients. The Broward County overall graph is produced by the Florida Department of Health (FLDOH), and uses a mixture of real data and estimates to determine the percent of PLWHA at each stage. Real data are used for the first three bars and include eHars, CAREWare, and Medicaid data sets. The last two bars are estimated percentages based on a formula from the Center for Disease Control and Prevention's (CDC) 2011 Medical Monitoring Project (MMP). Since the last two bars are based on estimates, it is possible that actual numbers for prescribed ART and virally suppressed are higher than what is estimated. While not perfect, the Broward County continuum provides a starting point for comparison.

Since Part A is primarily responsible for HIV care and treatment, it does not collect significant data for diagnosed or linked to care. Data for Part A retained in care, prescribed ART, and virally suppressed are real data that come from the Part A management information system (MIS), Provide Enterprise (PE).

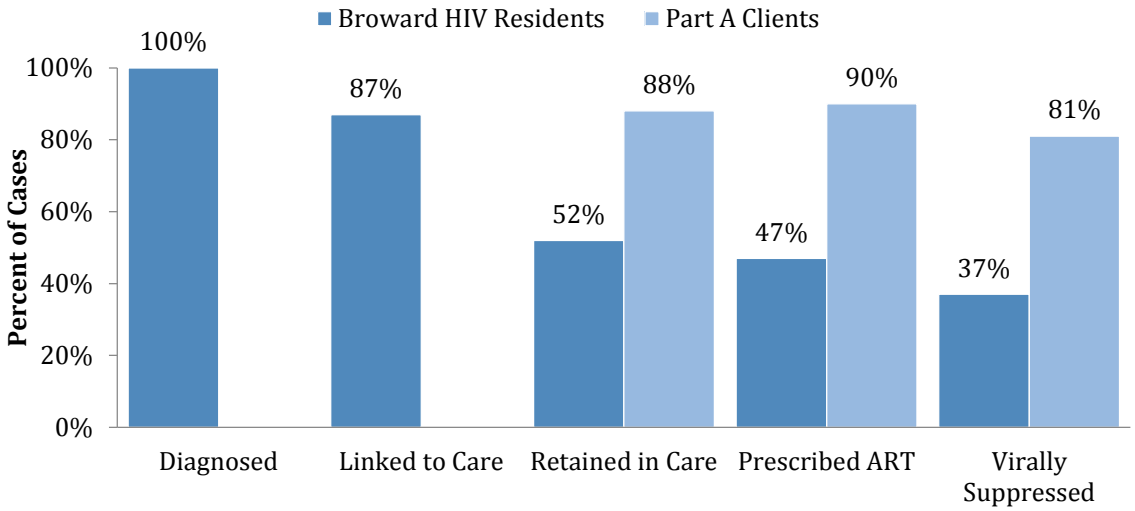

Figure 1. Outcomes along the HIV Care Continuum, Broward County Compared to the Broward EMA, FY 2013

Why are the three guiding principles important?

The Broward EMA's current Comprehensive Plan goals were developed to reflect the goals of NHAS and the HIV Care Continuum, and all of the committee work plans were developed using activities outlined in the Comprehensive Plan. The focusing HIVPC activities on the three guiding principles, the HIVPC can identify where gaps may exist in connecting individuals living with HIV to quality care and treatment. System improvements and service enhancements can be implemented to better support individuals as they move through the continuum of care. These efforts can help break the cycle of HIV transmission, reduce new infections, and improve the health of people living with HIV.

How are the three guiding principles being addressed?

The work plans are designed to relate activities of the HIVPC and committees to the three guiding principles and outcomes along the care continuum. For example, the Needs Assessment & Evaluation (NAE) Committee is tasked with developing questions for the annual client survey to identify barriers to being retained in care or virally suppressed. The System of Care (SOC) Committee works to determine gaps in the Broward continuum of HIV services for linking clients to care after their initial HIV diagnosis. The Quality Management (QM) Committee ensures high quality HIV medical care and support services by identifying and monitoring client and system-based performance measures for linkage, retention, and viral load suppression. The Quality Improvement (QI) Networks also examine the HIV care continuum to assess where improvements in services are needed and target them

accordingly. This report documents HIVPC activities that were conducted during the third quarter and how these activities help make progress on the HIVPC's goals and the three guiding principles.

Priority Setting & Resource Allocation (PSRA)

The reallocation of grant funds is conducted at least twice each fiscal year to ensure the effective and efficient use of grant funds and to meet priority needs. The first round of reallocations (hereafter referred to as sweeps) for FY 2014-2015 was conducted in November. During the sweeps process, providers are allowed to request additional funds or return funds that they anticipate will not be used. Requests for additional funding are reviewed by the Grantee to determine if requests are appropriate and will contribute to linking clients to care, retaining clients in care, or achieving viral load suppression.

The PSRA committee also reviews expenditure and utilization data, and takes into account emerging issues that may impact the reallocation of funds. In November, the PSRA committee had to take into account several issues that could impact the EMA. Historically, Outpatient Ambulatory Medical Care (OAMC) has been the largest funded, if not the most important service category. Funding OAMC appropriately so all clients have access to primary medical care is imperative to achieving outcomes related to retention in care and viral load suppression. As the EMA adjusts to a changing health care landscape and the impacts of implementing the Affordable Care Act (ACA), OAMC may cease to be the most important and largest funded service category. As clients move onto ACA Marketplace plans, services such as case management may become increasingly important to linking and retaining clients in care. Case managers are most often the personnel charged with enrolling clients in Marketplace plans, explaining to clients how a plan works, and following up with clients to make sure they are able to navigate the differences of having insurance compared to being a traditional Part A client.

The PSRA committee also had to account for dwindling funds for food services. Food services provides Part A clients with food in the form of a food box or food voucher. Ensuring the clients have adequate sources of food is important, since many clients on ART must take food when they take their medications. This could have an impact on viral load suppression for those clients. Clients who do not have access to food and therefore cannot take their medication would be less likely to be virally suppressed.

A total of $1,016,055 was redistributed among service categories in November. Service categories receiving additional funds included OAMC and Minority AIDS Initiative (MAI) OAMC, pharmacy, case management, mental health, substance abuse, and food services. Service categories that returned funds included dental, medical case (disease) management, Health Insurance Continuation Program (HICP), and legal services. A large amount of funds was swept from both disease management and HICP in order to provide funds for food

services. Both disease management and HICP had large sums of money available because they were newly funded service categories for FY 2014-2015 that had not been fully implemented. The Grantee also contributed $60,000 from available administrative funds to help provide funds for food services. Table 1 below shows all of the sweeps that were approved by the HIVPC in November:

SERVICE CATEGORY	Recommended TO	Recommended FROM
OAMC	$423,000	$321,315
MAI OAMC	$22,000	$0
Pharmaceuticals	$38,464	$8,000
Dental	$0	$38,464
Case Management	$78,445	$17,306
MAI Case Management	$0	$7,000
Disease Management	$0	$401,970
Mental Health	$18,590	$12,000
MAI Mental Health	$0	$15,000
Substance Abuse	$14,000	$0
Food Bank	$200,000	$0
Food Voucher	$221,556	$0
HICP	$0	$125,000
Legal Assistance	$0	$10,000
Unallocated Grant Funds		$60,000
Total Part A Funds	**$994,055**	**$994,055**
Total MAI Funds	**$22,000**	**$22,000**
Total Funds	**$1,016,055**	**$1,016,055**

Table 1. FY 2014-2015 Reallocations, Part 1

Outreach Report

The Community Empowerment Committee (CEC) strives to hold at least one meeting each quarter in the community in order to promote the HIVPC and provide outreach and education to community members. The CEC held its September meeting at Fusion in Wilton Manors. Fusion is an organization funded by FLDOH in Broward County (FLDOH-BC) that provides a safe space for gay and bisexual men to meet and learn. Fusion also works closely with the transgender population, which made the location a great choice for the meeting leading up to the CEC's *Transgender 101* event. When the CEC holds meetings in the community, interested parties from the venue are always invited to attend and participate in the meeting, and the committee always leaves HIVPC promotional materials for interested parties to spur interest in becoming involved with the HIVPC. Holding meetings in the community also allows the HIVPC to be more visible to community members who may be unfamiliar with the work of the Council, and also allows members the opportunity to educate community members about living with HIV and how and where to access services.

The two events sponsored by the HIVPC during the third quarter were the CEC's *Transgender 101* event and the Membership/Council Development Committee's (MCDC) Quarterly Welcome Brunch. The CEC's *Transgender 101* event was created to educate the community about the issues and challenges faced by the transgender community. Arianna Lint, the CEC Vice Chair and SunServe's Director of Transgender Services presented to attendees about various issues faced by the transgender population. Benjamin Di'Costa, the Youth and Transgender HIV/STD intervention and prevention specialist from Latinos Salud, presented to attendees on how HIV/AIDS affects the transgender community.

Event attendees also participated in an icebreaker titled 'Stand-Up, Sit-Down' which was adapted to have an emphasis on lesbian, gay, bisexual, and transgender (LGBT) issues. A CEC member acted as the facilitator for the icebreaker. All participants were asked to stand, and to sit only if the facilitator read a statement that they agreed with. The facilitator read several statements such as "You identify as a feminist" and "You are a man and you wear jewelry." The facilitator continued reading statements until most of the participants were sitting. The facilitator noted that all of the statements were actual reasons given by perpetrators who have targeted LGBT people. Attendees also had an opportunity to meet renowned photographer and HIV activist Duane Cramer. Mr. Cramer shared his story with attendees and took photographs of participants.

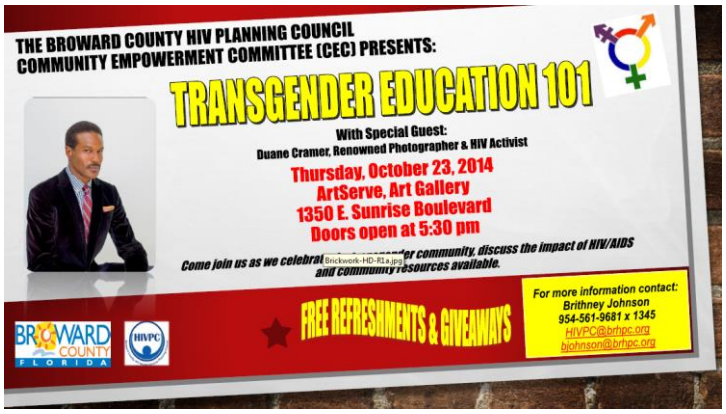

Figure 1. Transgender 101 flyer

The MCDC's Welcome Brunch is designed to promote the HIVPC and its committees to interested parties and community members. Attendees were educated about the importance of the HIVPC, as well as ensuring that their voice is heard when planning for Ryan White Part A services. The Welcome Brunch in November was well attended by the community, including five community agencies that provide HIV-related services throughout Broward County. The HIVPC received four applications from interested parties as a result of the Welcome Brunch. Future plans for the quarterly Welcome Brunch include holding the event at other community venues and targeting populations that are underrepresented on the HIVPC.

Training and Development Summary

The HIVPC's Executive Committee and MCDC determine quarterly trainings for HIVPC members, so members are well educated and informed about emerging issues. Training topics are focused on strategies and information that will inform the HIVPC about making progress towards the three guiding principles. The third quarter training occurred at the November HIVPC meeting and focused on the System of Care Committee (SOC), the HIVPC's

newest standing committee. The SOC Chair presented the training, discussing the background of the committee and why it was formed and some of its roles and responsibilities.

The committee was formed after a recommendation from a consultant to have a committee whose responsibility would be to look at entire system in Broward County. Looking at the entire system will help identify any service gaps or needs in Broward, particularly linkage gaps, and the committee can make recommendations about how to address the gaps and needs. The committee will serve as a filter for data for several other committees, such as PSRA and the Quality Management Committee (QMC), and the committee will also receive information from other committees, such as the Needs Assessment/Evaluation Committee (NAE). Tasks assigned to the committee on the 18 month work plan include reviewing client health outcomes by payer and along the HIV Care Continuum, analyzing available funding in Broward County for all services, and developing language for How Best to Meet the Need (HBTMTN).

The SOC Chair encouraged interested parties to join the committee, noting that the committee could use more insight from consumers and experts in the HIV field. SOC committee meetings are held on the fourth Friday of every month at 9:30 a.m. at the Ryan White Part A Program Office.

Community Empowerment Committee (CEC) Survey Summary

The CEC's 18 month work plan includes the development of a survey to analyze the effectiveness of each community meeting or event. This survey will be distributed while the event is taking place in an effort to attain full participant feedback. Surveying attendees about the event venue, time, or topic will aid the CEC in planning future events that best suit the community. The committee is still in the development stage of the survey, which is included on CEC's January meeting agenda for final review and approval.

Meeting Evaluation Summary

Meeting evaluations are distributed at all committee meetings to collect feedback about the effectiveness and efficiency of meetings. Evaluation respondents have the opportunity to identify themselves, or to complete the evaluation anonymously. The meeting evaluation consists of the following nine questions:

1. The meeting place was a good working environment.
2. The agenda was clear and was supported by the necessary documents.
3. The Chair guided the meeting effectively.
4. All Council/committee members were prepared to participate in the agenda.
5. Reports were clear and contained needed information.

6. Next steps for future tasks were identified and responsibility was assigned.
7. The agenda was followed without spending too much time on non-agenda items.
8. It was possible to express my opinion if I wanted to.
9. Meeting participants conducted themselves appropriately.

Respondents can answer "Yes" or "Needs Improvement" and can also leave comments or suggestions for each statement. Historically, return rates for meeting evaluations have been low. Measures have been implemented to improve return rates, such as a verbal reminder at the end of meetings and a written reminder at the bottom of each agenda. Despite these efforts, meeting evaluation return rates remain low. From July to December 2014, the highest average rate of return for a standing committee was 57%. The rates of return for most other standing committees were much lower, ranging from 9% to 43%. As such, responses may not be truly representative of meeting attendees.

The majority of meeting evaluations received have "Yes" checked for all of the statements, but some evaluations do indicate "Needs Improvement." Statement four, "All Council/committee members were prepared to participate in the agenda" was the statement most frequently indicated as needing improvement, but had almost no comments about the issues that may have arisen or how to improve. Comments were most frequently left for statement nine, "Meeting participants conducted themselves appropriately" and statement three, "The Chair guided the meeting effectively." Comments for statement nine indicated that side conversations in meetings can be a distraction, and meeting participants may comment on topics that are irrelevant. Comments for statement three noted that while some chairs are able to guide the agenda and committee discussion effectively, other chairs are perceived as being overzealous and in control of the discussion, rather than guiding it.

Other comments suggest that meeting agendas need to be streamlined so the work is not overwhelming for the two hour time frame, and to take more care to clearly explain agenda items and discussion topics when guests or new members are present.

Epidemiology

Understanding epidemiology and analyzing data to determine its impact on a system has become increasingly important. The Broward EMA uses epidemiology and surveillance data provided by FLDOH to track trends and changes in Broward may impact the types of services needed or how services are delivered. Two basic data points are especially vital: prevalence and incidence. Prevalence and incidence both measure HIV, but have important differences:

- **Prevalence** (seen in Table 3 below) measures the *total* number of living cases of HIV and AIDS as of the date specified. Prevalence can be expressed as a number (for example, 8,362 living HIV cases through calendar year 2013) or as a proportion (for example, 475.4 living HIV cases per 100,000 population).

- **Incidence** (seen in Table 2 below) measures *new* cases of HIV and AIDS during a specific period of time. Incidence can also be expressed as a number (for example, 498 new AIDS cases during calendar year 2013) or as a proportion (for example, 28.3 AIDS cases per 100,000 population).

Measures of incidence and prevalence can also be broken down by subpopulations to track trends for target populations or MAI populations. Being able to see the data by subpopulation is important for making progress on Care Continuum outcomes; although 81% of Part A clients were virally suppressed in FY 2013, there may be certain subpopulations with lower rates of viral suppression. In order to increase the rate of viral suppression for all clients, improvements must be made in the viral load suppression rates for subpopulations. The most recent complete incidence and prevalence data for Broward are shown in the tables below.

Table 2. HIV and AIDS Incidence in Broward County, 2012-2014

	HIV				AIDS			
	2012	2013	2014	%Δ (2012-14)	2012	2013	2014	%Δ (2012-14)
White	214	298	175	**-18%**	72	119	99	**38%**
Black	326	453	418	**28%**	224	288	247	**10%**
Hispanic	116	178	381	**228%**	54	63	42	**-22%**
Other	11	10	19	**73%**	7	10	15	**114%**
Total	667	939	993	**49%**	357	480	403	**13%**

Table 3. HIV and AIDS Prevalence in Broward County, 2012-2013

	2012	% of total	2013	% of total
Race/Ethnicity				
White	5,677	34.1%	5,856	34.0%
Black	8,233	49.5%	8,521	49.4%
Hispanic	2,331	14.0%	2,476	14.4%
Other/Unknown	391	2.4%	398	2.2%
Gender				
Male	11,772	70.8%	12,275	71.2%
Female	4,860	29.2%	4,973	28.8%
Age				
<13 years	39	0.2%	34	0.2%
13 - 24 years	560	3.4%	552	3.2%
25 - 44 years	5,573	33.5%	5,562	32.3%
45 - 60 years	8,388	50.4%	8,745	50.7%
60+ years	2,072	12.5%	2,355	13.7%
Exposure Category				
Men who have sex with men (MSM)	8,030	48.3%	8,468	49.1%
Injection drug users (IDU)	1,225	7.4%	1,241	7.2%
MSM IDU	474	2.8%	474	2.7%
Heterosexuals	6,630	39.9%	6,794	
Other/Unknown	273	1.6%	271	
Total	**16,632**	**100%**	**17,248**	**100%**

HANDOUT B-2

Quarterly Planning and Evaluation Report

FY 2014-2015 Fourth Quarter Report: December 1, 2014-February 28, 2015

Prepared by Broward Regional Health Planning Council

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Summary: FY 2014-2015 Fourth Quarter

The fiscal year (FY) 2014-2015 fourth quarter ran from December 1, 2014 until February 28, 2015. In the fourth quarter, the HIV Planning Council (HIVPC) continued using new work plans that were focused on three guiding principles. The three guiding principles were developed at the recommendation of a consultant who determined that the Broward Eligible Metropolitan Area (EMA) had so much data available to it, that it sometimes had difficulty focusing its activities.

What are the three guiding principles?

The three guiding principles of the HIVPC are:

1. Linkage to care
2. Retention in care
3. Viral load suppression

How were the three guiding principles developed?

The three guiding principles were developed to reflect the National HIV/AIDS Strategy (NHAS) and the HIV Care Continuum. In 2010, the White House released NHAS. The four goals of NHAS were to reduce new infections, increase access to care and improve health outcomes for PLWHA, to decrease HIV-related health disparities and inequities, and to achieve a more coordinated response to the epidemic. The HIV Care Continuum was developed subsequently to NHAS, as a tool to be used to analyze the progress being made on NHAS goals. The HIV Care Continuum is most often shown as a bar graph made up of five bars (see Figure 1) showing the following percentages for people living in the United States: diagnosed with HIV, linked to care, retained in care, prescribed Antiretroviral Therapy (ART), and virally suppressed. Of the five bars, the HIVPC felt that the three bars the HIVPC could have the most impact on were linkage to care, retention in care, and viral load suppression. The work of local prevention programs is predominantly focused on diagnosing HIV, and once an individual enters care, being prescribed ART is largely automatic.

The HIV Care Continuum shown as Figure 1 below compares people living with HIV/AIDS (PLWHA) in Broward County overall to Part A clients. The Broward County overall graph is produced by the Florida Department of Health (FLDOH), and uses a mixture of real data and estimates to determine the percent of PLWHA at each stage. Real data are used for the first three bars and include eHars, CAREWare, and Medicaid data sets. The last two bars are estimated percentages based on a formula from the Center for Disease Control and Prevention's (CDC) 2011 Medical Monitoring Project (MMP). Since the last two bars are based on estimates, it is possible that actual numbers for prescribed ART and virally suppressed are higher than what is estimated. While not perfect, the Broward County continuum provides a starting point for comparison.

Since Part A is primarily responsible for HIV care and treatment, it does not collect significant data for diagnosed or linked to care. Data for Part A retained in care, prescribed ART, and virally suppressed are real data that come from the Part A management information system (MIS), Provide Enterprise (PE).

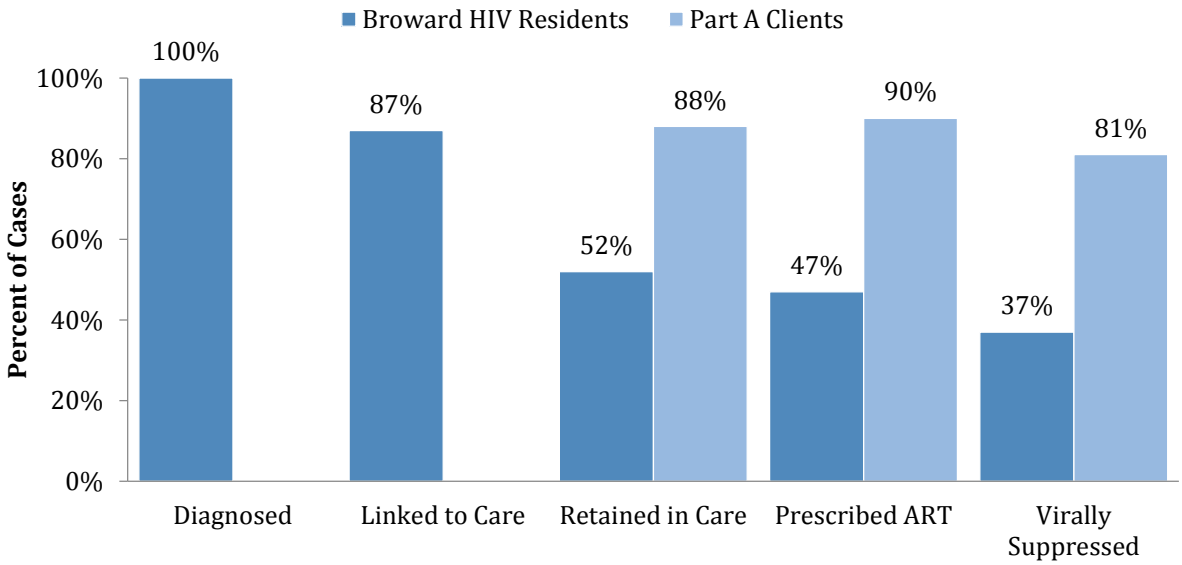

Figure 1. Outcomes along the HIV Care Continuum, Broward County Compared to the Broward EMA, FY 2013

Why are the three guiding principles important?

The Broward EMA's current Comprehensive Plan goals were developed to reflect the goals of NHAS and the HIV Care Continuum, and all of the committee work plans were developed using activities outlined in the Comprehensive Plan. The focusing HIVPC activities on the three guiding principles, the HIVPC can identify where gaps may exist in connecting individuals living with HIV to quality care and treatment. System improvements and service enhancements can be implemented to better support individuals as they move through the continuum of care. These efforts can help break the cycle of HIV transmission, reduce new infections, and improve the health of people living with HIV.

How are the three guiding principles being addressed?

The work plans are designed to relate activities of the HIVPC and committees to the three guiding principles and outcomes along the care continuum. For example, the Needs Assessment & Evaluation (NAE) Committee is tasked with developing questions for the annual client survey to identify barriers to being retained in care or virally suppressed. The System of Care (SOC) Committee works to determine gaps in the Broward continuum of HIV services for linking clients to care after their initial HIV diagnosis. The Quality Management (QM) Committee ensures high quality HIV medical care and support services by identifying and monitoring client and system-based performance measures for linkage, retention, and viral load suppression. The Quality Improvement (QI) Networks also examine the HIV care

continuum to assess where improvements in services are needed and target them accordingly. This report documents HIVPC activities that were conducted during the third quarter and how these activities help make progress on the HIVPC's goals and the three guiding principles.

Priority Setting & Resource Allocation (PSRA)

During the fourth quarter, several activities were completed that will have an impact on progress on the three guiding principles. In January, the second round of reallocations (also referred to as sweeps) for FY 2014-2015 was conducted. The reallocation of grant funds is conducted at least twice each fiscal year to ensure the effective and efficient use of grant funds and to meet priority needs. During the sweeps process, providers are allowed to request additional funds or return funds that they anticipate will not be used. Requests for additional funding are reviewed by the Grantee to determine if requests are appropriate and will contribute to linking clients to care, retaining clients in care, or achieving viral load suppression. The PSRA committee also reviews expenditure and utilization data, and takes into account emerging issues that may impact the reallocation of funds.

In January, the biggest issue affecting the reallocation of funds was the enrollment of Part A clients into Marketplace insurance plans. Based on recommendations from the Health Resources and Services Administration (HRSA), the Broward EMA strongly encouraged clients to enroll in Marketplace insurance plans. Enrolling eligible clients in insurance helps ensure that clients are retained in care by having access to primary medical care and antiretrovirals, as well as other supportive medical services and medications that make it easier for clients to stay in care. Enrolling clients in insurance plans that pay for a variety of health services costs less than the Part A program paying for those services directly. The savings from enrolling clients in insurance can be used to pay for other Part A support services not covered by insurance, such as food services or medical transportation, that can also help keep clients retained in care and adherent to their medication. Ultimately, access to medical care and support services that help with retention and adherence should help clients achieve viral load suppression. Additional funds were also swept to case management services, to account for the additional hours many case managers were spending with clients to enroll them in insurance.

Table 1 below shows all of the sweeps that were approved by the HIVPC in January:

SERVICE CATEGORY	Recommended TO	Recommended FROM	Variance
Outpatient Ambulatory Medical Care	$174,000	($324,800)	($150,800)
Pharmaceuticals	$14,700	$0	$14,700
Case Management	$119,060	($7,479)	$111,581
Mental Health	$0	($15,000)	($15,000)
Substance Abuse	$0	($5,350)	($5,350)

Food Bank	$20,000	$0	$20,000
Food Voucher	$0	($20,000)	($20,000)
Total Funds	**$327,760**	**($372,629)**	**($44,869)**

Table 1. FY 2014-2015 Reallocations, Part 2

Preparation for the FY 2016-2017 PSRA process also started in January. Changes were made to the way the PSRA process is being approached; previously a large amount of data would be presented and reviewed at one time, and the PSRA Committee would have the task of reviewing and analyzing the data, and making decisions based on the data over the span of one to two meetings. Conducting the PSRA process this way was somewhat overwhelming, and in January, the PSRA Committee decided to slow down the process by committing to a monthly review of utilization and expenditure data, service categories, and other important data elements, such as unmet need and the Early Identification of Individuals with HIV/AIDS (EIIHA). Service category scorecards are also being restructured to look at the clients who are not achieving health outcomes in each service, rather than the clients who are achieving. A narrative that further explains trends for each service category will accompany the scorecards.

Outreach Report

The HIVPC conducts outreach through the work of several committees, in particular the Community Empowerment Committee (CEC). The CEC strives to hold at least one meeting each quarter in the community in order to promote the HIVPC and provide outreach and education to community members. Beginning in April 2015, the committee will hold meetings at various Part A agencies; not only does the committee hope to bring in new participants by meeting clients where they are, the committee is also working to educate themselves on the services offered at each agency. All the meetings held at the Part A agencies will include a presentation by the agency's staff to inform the committee about the services offered there, and how clients can access those services. Keeping CEC members informed of available services is a key element of the CEC's role as the education arm of the HIVPC in the community.

In addition to meetings at Part A agencies, the CEC is also in the process of planning for a June event focused on educating the community about Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). PrEP and PEP are hot button topics in the community, and the CEC is committed to ensuring that the community has access to valuable, unbiased information about what PrEP and PEP are, who they can be used by, how they should be used, and when they should be used. Keeping the community informed about hot button issues can help ensure that clients are educated about the care that is available to them, and may help engage and retain them in care.

The Membership/Council Development Committee (MCDC) continues to hold Welcome Brunches. The MCDC's Welcome Brunch is designed to promote the HIVPC and its

committees to interested parties and community members. Attendees are educated about the roles and the responsibilities of the HIVPC, how to become involved with the HIVPC and its committees, and what the benefits of membership are. The committee has opted to hold them less frequently than quarterly, in order to give adequate preparation and planning time for each brunch. Welcome Brunches are now targeted to specific populations under represented on the HIVPC, or highly affected by the HIV/AIDS epidemic in Broward. The MCDC is reaching these populations, by holding brunches at community partnership organizations that target the populations, and in conjunction with a holiday or event that resonates with the target population. For example, the committee plans to hold a Cinco de Mayo themed event at a Hispanic/Latino-focused community organization in early May. By meeting clients and consumers where they are, the committee hopes to reach new people that are not currently involved in the HIVPC.

Training and Development Summary

The HIVPC's Executive Committee and MCDC determine quarterly trainings for HIVPC members, so members are well educated and informed about emerging issues. Training topics are focused on strategies and information that will inform the HIVPC about making progress towards the three guiding principles. The fourth quarter training occurred at the February HIVPC meeting and focused on How Best to Meet the Need (HBTMTN), an integral piece of the PSRA process.

HBTMTN are a set of directives to the Grantee from the HIVPC that are used to give direction to providers about where services should be located, who the services should be targeted to, and how services are to be delivered. HBTMTN is developed using data sources such as epidemiology, U.S. Census Data, and the needs assessment. These data sources provide information about the hardest hit populations (who services should be targeted to), where populations live (where to target services), and the barriers they face (how to deliver services). Although the HIVPC is ultimately responsible for developing priorities and allocations, which includes HBTMTN, the System of Care Committee (SOC) has been assigned the task of developing HBTMTN. In order for the HIVPC to approve the language for HBTMTN, it is imperative that its importance and the role it plays in service delivery in understood by all HIVPC members. The HBTMTN power point that was presented to the HIVPC is included at the end of this report.

Community Empowerment Committee (CEC) Survey Summary

The CEC's 18 month work plan includes the development of a survey to analyze the effectiveness of each community meeting or event. This survey will be distributed while the event is taking place in an effort to attain full participant feedback. The survey was developed in conjunction with the committee and staff, and was approved by the CEC at its February meeting. Rather than using the survey to gain feedback about the event itself, the committee

felt the survey should be used to gain information about who the people are that are attending events (clients, providers, community stakeholders), whether they are recipients of Part A services, and if they are in need of care that they are currently not receiving. Gaining this kind of feedback will give the HIVPC data about community members that come to events, but may not be involved in the HIVPC. Data about what kind of services are needed, and the kinds of marketing techniques that are successful in bringing clients to an event rather than providers to an event can be helpful to the HIVPC in planning for services, and developing HBTMTN.

Meeting Evaluation Summary

Meeting evaluations are distributed at all committee meetings to collect feedback about the effectiveness and efficiency of meetings. Evaluation respondents have the opportunity to identify themselves, or to complete the evaluation anonymously. The meeting evaluation consists of the following nine questions:

1. The meeting place was a good working environment.
2. The agenda was clear and was supported by the necessary documents.
3. The Chair guided the meeting effectively.
4. All Council/committee members were prepared to participate in the agenda.
5. Reports were clear and contained needed information.
6. Next steps for future tasks were identified and responsibility was assigned.
7. The agenda was followed without spending too much time on non-agenda items.
8. It was possible to express my opinion if I wanted to.
9. Meeting participants conducted themselves appropriately.

Respondents can answer "Yes" or "Needs Improvement" and can also leave comments or suggestions for each statement. Historically, return rates for meeting evaluations have been low. Measures have been implemented to improve return rates, such as a verbal reminder at the end of meetings and a written reminder at the bottom of each agenda. Despite these efforts, meeting evaluation return rates remain low. For the fourth quarter of the 2014-2015 fiscal year (December – February), From January to December 2014, the highest average rate of return for a standing committee was 80%. The rates of return for most other standing committees were much lower, ranging from 0% to 59%. As such, responses may not be truly representative of meeting attendees.

The majority of meeting evaluations received have "Yes" checked for all of the statements, but some evaluations do indicate "Needs Improvement." Statement five, "Reports were clear and contained needed information" was the statement most frequently indicated as needing improvement. Responses indicated that meeting materials could be improved to be better understood, and more time may need to be spent on reviewing materials to help committee members understand their purpose.

Epidemiology

Understanding epidemiology and analyzing data to determine its impact on a system has become increasingly important. The Broward EMA uses epidemiology and surveillance data provided by FLDOH to track trends and changes in Broward may impact the types of services needed or how services are delivered. Risk factors play an especially important role when measuring the HIV epidemic:

- **Risk factors** are the characteristics or exposures of an individual that increase the likelihood of contracting HIV.

Risk factors tracked by the FLDOH and the Part A program include hemophilia, heterosexual sex, injecting drug user (IDU), men who have sex with men (MSM), and perinatal infection. Risk factors are used to measure how people contract HIV, and can help target prevention programs, such as clean needle exchange programs. Understanding the risk factors associated with the epidemic in Broward can also help when planning for services. For example, knowing that a large number of Part A clients were most likely infected with HIV through the IDU risk factor may indicate the need for robust substance abuse services. The breakdown of Broward's HIV/AIDS epidemic by exposure category is shown in Table 2 below:

	2012	% of total	2013	% of total
Exposure Category				
Men who have sex with men (MSM)	8,030	48.3%	8,468	49.1%
Injection drug users (IDU)	1,225	7.4%	1,241	7.2%
MSM IDU	474	2.8%	474	2.7%
Heterosexuals	6,630	39.9%	6,794	39.4%
Other/Unknown	273	1.6%	271	1.6%
Total	**16,632**	**100%**	**17,248**	**100%**

Table 2. HIV and AIDS Prevalence in Broward County, 2012-2013

HIV Planning Council and committee meeting attendees (members and guests) are asked to complete a meeting evaluation following each meeting.

Participants can check **Yes** or **Needs Improvement** to the following Evaluation Statements:

1. The meeting place was a good working environment.
2. The agenda was clear and was supported by the necessary documents.
3. The chair guided the meeting effectively.
4. All Council/Committee members were prepared to participate in the agenda.
5. Reports were clear and contained needed information.
6. Next steps for future tasks were identified and responsibility was assigned.
7. The agenda was followed without spending too much time on non-agenda items.
8. It was possible to express my opinion if I wanted to.
9. Meeting participants conducted themselves appropriately.

Additional space is provided for comments.

Responses to statements are 100% "Yes" unless otherwise indicated. Needs Improvement = NI. No Response = NR.

COMMUNITY EMPOWERMENT COMMITTEE (CEC)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 6, 2015	14/15 (93%)	#1	NR (1)	Focus more on time than the committee members understanding
		#2	NR (1)	
		#3	NR (2)	
		#4	NI (1), NR(1)	Who order the pizza it bad? Bad veggies spoil! Nasty!
		#5	NR (2)	
		#6	NR (1)	
		#7	NR (1)	
		#8	NR (1)	
		#9	NR (1)	
February 3, 2015	0/14 (0%)	None.		None.
March 3, 2015	8/9 (89%)	#4	NI (1),	Started Late
April 7, 2015	11/24 (46%)	#3	NI (2)	"There is too much cross talk"
		#4	NI (1)	
		#7	NI (1)	

MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 8, 2015	5/5 (100%)	None.		None.
February 5, 2015	3/5 (60%)	None.		None.
March 5, 2015	0/5 (0 %)	None.		None.
April 2, 2015	5/6 (83%)	#2	NR (1)	I'm new so things are still a little bit blurry, but interesting.
		#5		New, but individual items clearer.

HANDOUT C

NEEDS ASSESSMENT/EVALUATION COMMITTEE (NAE)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 12, 2015	4/8 (50%)	None.	None.
No February Mtg.			
No March Mtg.			
April 13, 2015	4/10 (40%)	None.	None.

PRIORITY SETTING AND RESOURCE ALLOCATION COMMITTEE (PSRA)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 21, 2015	0/12 (0%)	None.	No comments.
February 18, 2015	0/10 (0%)	None.	No comments.
March 18, 2015	1/10 (1%)	None.	"Clamp down on cross talk!"
April 15, 2015	0/11 (0%)	None.	No comments.

QUALITY MANAGEMENT COMMITTEE (QMC)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 26, 2015	3/6 (50%)	None.		No comments.
February 23, 2015	4/6 (67%)	#5	NI (5)	Data tables could be made easier to read & understand.
			NI (5)	Statistics needed more clarification.
		#6	NI (6)	Break down info more in data.
March 16, 2015	11/11 (100%)	#3	NI (2)	Helpful if chair helped to guide "topic" or "input" a bit more "It seems the meeting got off track on several occasions"
		#7	NI (2)	Agenda appeared looser @ meeting—too much time on "off shoots" agenda items appeared to get lost at times. "Better Facilitation"
		#8	NI (2)	"Give members adequate time to make their points w/out cutting them off"
		#9	NI (1)	
April 20, 2015	3/7 (43%)	None.		No comments.

SYSTEM OF CARE COMMITTEE (SOC)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
This Committee did not meet Jan or Feb 2015			
March 27, 2015	2/15 (13%)		Training was very good. Cross talking.
April 24, 2015	1/12 (8.3%)		None.

EXECUTIVE COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 6, 2015	6/9 (66%)	#3	NI (1)	"Spent too much time on some items, very long meeting"
		#5	NR (1)	
		#6	NI (1)	"sometimes we procrastinate"
		#7	NI (1)	
February 17, 2015	0/10 (0%)	None.		No comments.
March 17, 2015	1/15 (7%)	None.		Training was very good.
April 21, 2015	4/10 (40%)	#3	NI (2)	
		#5	NI (1)	
		#6	NI (2)	
		#7	NI (1)	"Vice Chair had no idea how to end discussions"
		#8	NI (2)	
		#9	NI (2)	

HIV PLANNING COUNCIL

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 22, 2015	9/26 (35%)	#1	NR (1)	"Aesthetic & Spacious"
		#2	NR (1)	"Great visual board & audio as well"
		#3	NR (1)	"Reported well their plan & goal on committee's activities"
		#4	NR (1)	
		#5	NR (1)	
		#6	NR (1)	
		#7	NI (1)	
		#8	NR (1)	
		#9	NR (1)	"Very Professional"
February 26, 2015	0/28 (0%)	None.		No comments.
March 26, 2015	9/31 (29%)	None.		No comments.
April 23, 2015	4/23 (17%)	None.		No comments.

AD-HOC LOCAL PHARMACY ADVISORY COMMITTEE (LPAC)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
This Committee did not meet Jan or Feb 2015.				
March 12, 2015	3/3 (100%)	None.		No comments.
April 9, 2015	2/6 (33%)	#2	Yes	Prescriptions need more info on and completion
		#9	Yes	Very good one. I particularly enjoyed it!

EXPLORATORY SUB COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
This Committee did not meet Jan or Feb 2015			
March 18, 2015	3/7 (43%)	None.	No comments.
This Committee did not meet in April 2015.			

AD-HOC FOOD SERVICES ELIGIBILITY COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
This Committee did not meet Jan or Feb 2015				
March 10, 2015	2/4 (50%)	#9	NR (1)	No comments.
April 14, 2015	3/8 (38%)	#1	Yes (1)	Very productive meeting.

AD-HOC NOMINATING COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 8, 2015	3/4 (75%)	None.	No comments.
		This Committee did not meet Feb - May 2015	

AD-HOC BY-LAWS COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 14, 2015	2/4 (50%)	None.	No comments.
February 11, 2015	3/4 (75%)	None.	No comments.

FY 2014-16 HIVPC Trainings

Past

Comprehensive Plan (March 2014): (Ryan White legislation and implementation process)
Update of the 2012-2015 Comprehensive Plan for the Broward Part A program was developed by EGM Consulting, LLC (EGMC). The update was designed to provide a mid-term review and assessment of task completion and progress towards comprehensive plan goals and objectives, and to recommend updates in the work plan as needed.

Priority Setting and Resource Allocation (PSRA) Process (May 2014): (Specific skills related to particular planning and related tasks)
The Priority Setting and Resource Allocation (PSRA) Committee Chair conducted a brief presentation about the priority setting process. The process begins with the collection of data and a data presentation to the PSRA committee. The PSRA Chair reviewed the data presentation given by consultant Emily Gantz-McKay; Ms. Gantz-McKay was responsible for analyzing the data from the Needs Assessment, which included a client survey, a provider survey, and focus groups. Utilization and financial data from Part A, as well as other Ryan White parts and other community funders was used to create scorecards.

HIV Prevention Planning Council Presentation (May 2014): (Specific skills related to particular planning and related tasks)
Christopher Bates, a member of the Florida Department of Health in Broward County gave a presentation on the structure of Broward County's HIV Prevention Council. The council is broken into four teams and six advisory groups. The full council is comprised of approximately 15-21 members, with two appointed seats. One of the appointed seats belongs to the Broward County school district and the other is a research seat; the Council felt these were critical elements that needed to be a part of the Council.

System of Care Committee training (November 2014): (Service delivery system and provider profiles)
This training will allow the System of Care (SOC) committee Chair to discuss the main functions of the committee. This training will include: unmet need research, identifying gaps in care, and evaluation of community needs.

National Quality Center: Training of Consumers on Quality (TCQ) (January 2015): (Importance and sources of data)
This training will increase the number of consumers actively participating in local quality management committees or regional quality improvement activities. The rigorous TCQ Program includes extensive pre-work activities and a 2-day face-to-face TCQ session.

How Best to Meet the Need language and how it impacts services (February 2015): (Importance and sources of data)
The Ryan White legislation gives Planning Councils the responsibility not only to set priorities, but also to establish how best to meet those priorities. This training will highlight the legislative provision which includes establishing a role for the Planning Council in guiding the Grantee in identifying the types of organizations and service delivery mechanisms that best meet each service priority established by the Council (e.g.,

outpatient clinics, community-based organizations that serve affected populations and historically underserved communities).

HIVPC Reflectiveness and Mandated Seats (May 2015): (Specific skills related to particular planning and related tasks)
This training will focus on HIVPC membership requirements, reflectiveness, and mandated membership categories.

Future

Minority AIDS Initiative (MAI) Funds (June 2015): (Specific skills related to particular planning and related tasks)
This training will provide an overview of MAI funding, what it is, and how it works in the broader context of Ryan White Part A funding. It will also discuss the realities of MAI funding (it is less than 10% of total funds), the difficulties in developing specialized programming with the small amount of funds available, and how MAI funds work in Broward.

HIV Biomedical Interventions (June 2015): (Specific skills related to particular planning and related tasks)
This training will focus on current HIV biomedical medical interventions. This training will explore interventions such as Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), both utilized to prevent HIV infection.

Affordable Care Act Update (August 2015): (Ryan White legislation and implementation process)
Prior to the start of enrollment, this training will provide an update to the Affordable Care Act (ACA) and Health Insurance Marketplace. This training will include: an overview of the ACA marketplace, and Florida specific resources, and consumer feedback.

2016 Comprehensive Plan with Prevention (August 2015): (Ryan White legislation and implementation process)
Beginning in 2016, Ryan White Part A and Prevention will be responsible for a joint comprehensive plan. This training will include strategies to form an effective collaboration between the HIVPC and Broward County's HIV Prevention Council.

Self-Assessment Findings (February 2016): (Specific skills related to particular planning and related tasks)
Evaluation data from the HIVPC Self-Assessments will be presented. Self-Assessment findings will provide training opportunities that will benefit all committees as well as the HIVPC.

SPECIAL ELECTIONS PROCEDURES

Per the HIVPC By-Laws, the special election shall use a majority vote double election system. The By-Laws do not provide guidance for the nominations or ballot process, however. Since a process is not outlined, it is appropriate to follow the process outlined in Robert's Rules of Order.

Per Robert's Rules of Order, there are two usual types of elections. For the purposes of a special election, the second usual type of election makes sense. Voting for candidates for each office takes place for each office immediately following nominations from the floor for that office. If there are multiple candidates and no candidate receives a majority, a run-off vote will be held.

Special Election for HIVPC Chair

1. Call for nominations from the floor by the acting HIVPC Chair. These nominations are for candidates for Chair ONLY.
2. Once all nominations have been made, voting takes place by paper ballot, and voters write in the name of the candidate of their choice.
3. Votes are tallied, and a candidate must receive a majority of the votes to be elected. If there is more than one candidate, and no candidate receives the majority of votes, a second run-off election between the two candidates who received the most votes will take place.
4. A second vote between the two candidates who received the most votes will take place by paper ballot, and voters write in the name of the candidate of their choice.
5. Votes are tallied between the two run-off candidates, and the candidate who received the majority of votes is elected.

Special Election for HIVPC Vice Chair

1. Call for nominations from the floor by the acting HIVPC Chair. These nominations are for candidates for Vice Chair ONLY.
2. Once all nominations have been made, voting takes place by paper ballot, and voters write in the name of the candidate of their choice.
3. Votes are tallied, and a candidate must receive a majority of the votes to be elected. If there is more than one candidate, and no candidate receives the majority of votes, a second run-off election between the two candidates who received the most votes will take place.
4. A second vote between the two candidates who received the most votes will take place by paper ballot, and voters write in the name of the candidate of their choice.
5. Votes are tallied between the two run-off candidates, and the candidate who received the majority of votes is elected.

EVALUATION REPORT

In 2014, the HIVPC developed and implemented a number of surveys to evaluate processes and areas for improvement. Surveys included:

- Committee Chair Assessment
- PSRA Self-Assessment
- Community Event Surveys (Transgender 101, Welcome Brunch, Mini Retreat)
- HIVPC Self-Assessment Survey
- MCDC Barriers to HIVPC & Committee Participation

Committee Chair Assessment

The Committee Chair Assessment was developed after Vice Chairs were added to each committee. In addition to opening leadership opportunities on the HIVPC's committees to community stakeholders, Vice Chair positions presented an opportunity for leadership development, so that there are leaders ready and willing to take on more responsibility should a committee Chair resign. The Committee Chair Assessment was developed in the Executive Committee and was distributed via email to all committee members. The survey asked about member demographics (how long they had served on the committee, if the respondent was a Part A consumer), organizational matters (if the Chair follows the policies and procedures, or encourages open communication), leadership (if the Chair creates a culture of respect and high morale), and personal characteristics (if the Chair is respectful of other opinions, and if the Chair encourages individual member growth).

Twenty eight committee members responded to the survey, and responses were overall positive, with 56% of respondents rating the performance of their Chair as excellent. Almost all Chairs were evaluated positively for organizational matters and personal characteristics, but some committee members did not agree with their Chair's leadership or communication style. Most respondents served on two committees and 40% of respondents had served on a committee for five or more years. There was strong feedback from consumers - 70% of respondents reported being a consumer of Part A services - and also strong feedback from HIVPC members. Of the twenty eight responses received, twenty five were also HIVPC members.

The largest number of evaluations were received for the CEC Chair, which is also the largest committee. This was followed by the PSRA Committee, and the QMC. The only committee Chair

not evaluated was the SOC Chair, since the SOC was a brand new committee, and members had not been to enough meetings to fairly evaluate the Chair. There were few differences in response by Chair; no respondents strongly disagreed with any of the survey statements, and there were very few that disagreed with a survey statement.

There were no responses received that indicated Chairs did not follow the HIVPC by-laws or committee's policies and procedures, but only 52% of respondents strongly agreed that their Chair follows the HIVPC by-laws and only 56% strongly agreed that the Chair follows the committee's Policies & Procedures. Communication between the Chairs and their committees was strong: 56% of respondents strongly agree that their Chair kept the committee up to date on important matters relating to the HIVPC, 52% strongly agreed that their Chair works effectively with committee members to complete work plan objectives, and 63% strongly agreed that their Chair encourages open communication among members.

Approximately half of respondents agreed that Chairs communicated a clear direction for their committees and encouraged an environment supportive of individual initiatives. Fifteen percent of respondents, however, reported being neutral or unsure that the Chair encouraged an environment that rewarded teamwork within the committee. Chairs were reported as creating a climate of respect and high morale for the committee, and for representing a positive image of the committee.

PSRA Self-Assessment

The PSRA Process Self-Assessment Survey was distributed to HIVPC and PSRA members in July 2014, following the completion of the PSRA process for FY 2015-2016. The survey was comprised of 10 questions and asked for member understanding of the purpose, process, and data sources. Respondents reported that they understood the purpose of the PSRA process, however, not all respondents understood the details of the PSRA process or data sources. Half of respondents reported being an HIVPC or PSRA member for 5-10 years, and 92% of respondents reported their knowledge of the PSRA process had increased a lot since becoming a member. Length of membership did not seem to have a large impact on responses, especially given the small number of respondents. Respondents who reported being an HIVPC or PSRA member for three to five years, however, were more likely to respond to a question with "I mostly understand" or "I understand some" in comparison to other lengths of membership.

While survey respondents overwhelmingly understood the purpose of the PSRA process (92%) only 75% reported completely understanding the process (Figure 1). Respondents were asked to answer questions about their understanding of important data sources, and responses were a little disheartening. As shown in Table 1, cost data was the data source least understood by respondents, with only 64% of respondents completely understanding the data. Additionally, only 75% of respondents reported completely understanding needs assessment and service utilization data.

		I COMPLETELY UNDERSTAND	I MOSTLY UNDERSTAND	I UNDERSTAND SOME
Needs assessment	n	9	2	1
	%	75.0%	16.7%	8.3%
Service utilization	n	9	2	1
	%	75.0%	16.7%	8.3%
Cost data	n	7	3	1
	%	63.6%	27.3%	9.1%
Priority setting	n	10	1	1
	%	83.3%	8.3%	8.3%
Resource allocation	n	10	1	1
	%	83.3%	8.3%	8.3%
Conflict of interest	n	8	2	1
	%	72.7%	18.2%	9.1%
Data used to create rankings	n	10	1	1
	%	83.3%	8.3%	8.3%

Table 1. Respondents were asked to indicate their understanding of the data sources

Only two-thirds of respondents reported completely understanding service category definitions, meaning a third of respondents either mostly understood or only understood some of the service category definitions. A quarter of respondents did not completely understand how each service category was ranked, nor did they understand why all of the service categories were ranked for FY 2015. Seventy five percent of respondents said they completely understood how allocations were made, which is surprising given that only 64% of respondents indicated understanding cost data.

Upon review of the survey findings, the PSRA committee decided to put measure in to place to improve understanding of the priority setting and resource allocation process. In 2015, the committee plans to spend a portion of each meeting reviewing a data source, which will include an explanation of where the data comes from, how it is used, and why it is important to the prioritization or allocation of funds. The Grantee's office will also provide the committee with a

monthly snapshot of expenditures and utilization for each service category, in order to help the committee better understand cost data, and to note expenditure trends before sweeps.

Transgender 101

The CEC held a community event at Art Serve in October 2014 titled Transgender 101, the purpose of which was to raise awareness of transgender issues, especially for transgender individuals who are HIV positive. A brief, nine question survey was distributed to participants to gain feedback about the event and what the community would like to see in the future. Responses were received by approximately 40% of attendees and were overwhelmingly positive. Ninety one percent of respondents rated the event as good or very good, noted that the event provided them with helpful resources, and would be willing to attend a similar event in the future.

Forty five percent of survey respondents were Part A clients, and respondents were mostly not affiliated with an agency (82% of respondents). Attendees largely heard about the event through word of mouth (90%), followed by seeing a flyer for the event (30%). All respondents agreed the event was held at a convenient location, but made suggestions that other events be held in Wilton Manors or at a Broward County library.

The CEC is in the process of developing a final survey to be used at all of its community events. The survey should be finalized in early 2015.

Welcome Brunch

The MCDC held two welcome brunches in 2014, one in July and one in November. Very few evaluations were received following the July welcome brunch, but close to half of attendees filled out an evaluation following the November brunch. Responses for completed evaluations were largely positive. Respondents felt that the event was easily accessible and well guided, and that the icebreaker and member testimonials were effective. Approximately 22% of respondents felt neutrally about whether HIVPC functions and duties were explained clearly and concisely; the MCDC may want to consider spending more time explaining the roles and responsibilities of the HIVPC in the future.

Mini Retreat

A brief, five question evaluation was sent to mini retreat attendees in the week following the retreat. Questions were asked about the event location, date and time, and the benefits of attending the mini retreat. A total of nine responses were received, although close to fifty people attended the event. Of the responses received, one respondent indicated that they were not able to attend the mini retreat due to a scheduling conflict. The remaining eight respondents were able to attend the retreat. Responses about the location were split, with half of respondents saying the location was excellent, and half rating the location average or good. Comments indicated that the location was difficult to find. A majority of respondents rated the time as good and said the mini retreat was beneficial to them. Based on the success of the mini retreat in December, the HIVPC plans to hold another mini retreat in the late summer of 2015.

HIVPC Self-Assessment

The HIVPC Self-Assessment was a three party survey distributed to HIVPC members over the course of three months in 2014. The parts were distributed to HIVPC members via email (part one in September, part two in October, and part three in November) and iPads were also available at HIVPC meetings to encourage additional responses. Of the three parts, part one had the most responses (about 57% of HIVPC members), part two had slightly less (43% of HIVPC members), and part three had very few responses (17% of HIVPC members).

Part one asked respondents questions about the HIVPC mission statement, work plans, and representation and diversity of HIVPC members. Respondents were tremendously aware that the HIVPC had a mission statement (92% of respondents reported knowing the HIVPC had a mission statement), but 30% of respondents were unaware of what the mission statement says. Some respondents knew where the mission statement could be found, identifying the training and orientation packet for new members (46%) and the HIVPC's written documents (39%) as the two most likely places to find the mission statement. Interestingly, although less than three quarters of respondents knew the text of the mission statement, 46% of respondents felt the mission statement influenced major decisions of the HIVPC a lot.

Respondents were much more aware of the work plans used to conduct activities. Ninety two percent of respondents were aware of the work plans, and 85% felt the work plans set adequate goals and objectives, provided specific activities for completion, and could be used to monitor

the HIVPC's effectiveness. Slightly over three quarters of respondents (77%) agreed that the work plans contained reasonable timelines and 92% agreed that work plans identified the responsible party of each activity. Respondents also largely understood the process for becoming an HIVPC member, and the procedures that are followed to approve an applicant for the HIVPC. Although respondents were well aware of the process and procedures for adding new members, respondents were not as aware of written policies for adding new HIVPC members. The HIVPC by-laws and policies and procedures were both cited by 69% of respondents as including the policy, but only 31% cited the Local Procedures Manual. Around three quarter (77%) knew of a written policy with criteria for HIVPC membership, but less than two thirds (62%) of respondents reported being aware of written job descriptions for members, and 15% of respondents indicated there were no written procedures at all for the application process.

Part two asked questions about the PSRA process and the needs assessment, and responses were similar to responses for the PSRA self-assessment. Less than three quarter of respondents (70%) identified that priorities are set annually, although all respondents were aware that allocations are set annually, with adjustments made as necessary throughout the fiscal year. Similar to the PSRA self-assessment responses, respondents to part two of the HIVPC self-assessment were aware of how and why the PSRA process was conducted; data sources used to make decisions were less familiar with respondents, particularly cost effectiveness data (only 70% of respondents identified that it was used as part of the PSRA process).

Both the needs assessment and Comprehensive Plan were less understood by respondents than the PSRA process. When asked which committee was responsible for the needs assessment, no committee emerged as a clear leader. Though it is true that all committees contributed to all HIVPC processes in some part, respondents clearly identified the PSRA committee as the lead committee for the PSRA process. Subsequent questions about the needs assessment indicate that respondents are not well aware of the methodology used in the needs assessment, or how the needs assessment is implemented. More clarity and education may be necessary about the methods used to conduct the needs assessment and the persons responsible for implementing the needs assessment. Respondents also had difficulty understanding the needs assessment report; only 50% of respondents agreed that it was easy to understand, and only 50% agreed that the report addressed the need for further study.

Part three was focused on the Comprehensive Plan and the continuum of services in Broward County. With only 17% of HIVPC members responding to part three of the self-assessment, it is difficult to say whether or not responses are significant and representative of HIVPC members as

a whole. Similarly to the needs assessment, confusion existed among respondents about which committee was responsible for the Comprehensive Plan. Half of respondents cited the Executive Committee as the responsible committee, and only 25% of respondents cited the NAE. This may be due in part to the changing of work plan activities over the past several years, which included the changing of most of the Comprehensive Plan responsibilities from the Executive Committee to the NAE. All respondents were are that the Comprehensive Plan contained goals and objectives, and respondents were familiar with the contents of the Plan, but 25% of respondents were unsure if the Plan is being implemented as intended and 25% of respondent were unaware if the Plan assigned responsibility for activities or if there was a mechanism to monitor the plan. Questions about the continuum of services in Broward indicated a good understanding among respondents about core services, the coordination of services, and the announcement of available services to the community.

Barriers to HIVPC & Committee Participation

The MCDC developed a survey to determine barriers that HIVPC and committee members face in participating. The survey was distributed throughout the month of March 2015. 36 responses were received, a third of which were from consumers. The majority of respondents were HIVPC and committee members (77%), and none of the respondents who reported only being committee members were consumers.

Overall, the greatest barrier to attending meetings was employment (cited by 34% of respondents). Of respondents indicating employment as a barrier, only 23% were consumers. The greatest barrier for consumers was transportation; this barrier was not cited by non-consumers. Half of respondents citing transportation as a barrier said reimbursement for transportation would help and 43% said a bus pass would help.

Suggested changes to help retain members focused largely on time and attendance or quorum requirements. 22% of respondents indicated changes to the times of meetings could help retain members, including shortening meetings, condensing or combining meetings, and keeping meetings focused on the agenda. 17% of respondents indicated changes were needed to attendance or quorum rules. Overall, time issues were mentioned in 16 comments, and location issues were mentioned in 5 comments; two of the comments about location were made by consumers. There were also several comments about increasing community involvement and reaching out to new community partners and interested parties.

The MCDC plans to revise the survey to be distributed at events and Welcome Brunches, to gain perspective about barriers from interested parties who may want to join, but have been unable to.