



**BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
MEETING AGENDA**

Thursday, April 24, 2014 at 12:30 p.m.
BRHPC Conference Rooms A, B, C, & D

Chair: Brad Gammell **Vice Chair:** Samantha Kuryla

Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

1. **CALL TO ORDER**
2. **WELCOME AND PUBLIC RECORD REQUIREMENTS**
 - a. Review Meeting Ground Rules, Public Comment and Public Record Requirements
 - b. Council Member and Guest Introductions
 - c. Moment of Silence
 - d. Excused Absences and Appointment of Alternates
 - e. Approval of 4/24/14 Meeting Agenda
 - f. Approval of 3/27/14 Meeting Minutes
3. **FEDERAL LEGISLATIVE REPORT** (Kareem Murphy) (Handout A)
4. **PUBLIC COMMENT** (Up to 10 minutes)
5. **PART A GRANTEE REPORT**
6. **DISCUSSION OF RFP CANCELLATION LETTER**
7. **ADAP REPORT**
8. **CONSENT ITEMS**

Consent #1: To add Vincent Foster to the HIVPC on the Social Services Provider seat
Justification: Mr. Foster qualifies for the mandated Social Services Provider seat.
Proposed by: Membership/Council Development Committee

Consent #2: To add Silvana Baner to the HIVPC on the Non-Elected Community Leader seat
Justification: Ms. Baner has shown a long standing commitment to the HIVPC.
Proposed by: Membership/Council Development Committee

Consent #3: To accept the amendments to the PSRA Policies and Procedures
Amendment: Funding Increase: In the event of a funding award greater than the amount received the previous year, service categories will be funded first at the most recent fiscal year's final expenditures, **if applicable**. The Grantee will exercise discretion in applying **any remaining increase up to \$500,000 to core services based on a pro-rata share** the ranking of service categories and service category needs **of the amount of the increase in proportion to the original grant application percentage (based on estimated need) for these services. If additional dollars still remain the same process will be applied for Support Services.**
Justification: To improve efficiency and prevent further delays to the funding process.
Proposed by: Priority Setting & Resource Allocation Committee

Consent #4: To add Will Spencer to the PSRA Committee
Justification: Mr. Spencer's commitment to and knowledge of the HIVPC will make him an asset to the committee.
Proposed by: Priority Setting & Resource Allocation Committee

Consent #5: To appoint Janelle Taveras to the Quality Management Committee
Justification: Ms. Taveras's quality expertise and work with Prevention will make her an asset to the committee.

Proposed by: Quality Management Committee

Consent #6: To approve the MAI Medical Case Management Service Delivery Model.

Justification: Providers currently working off of a draft service delivery model.

Proposed by: Quality Management Committee

Consent #7: To approve the AIDS Pharmaceutical Assistance (Local) Service Delivery Model.

Justification: The service delivery model has been updated.

Proposed by: Quality Management Committee

Consent #8: To approve the Ambulatory/Outpatient Medical Care Service Delivery Model.

Justification: The service delivery model has been updated.

Proposed by: Quality Management Committee

Consent #9: To approve the Substance Abuse Outpatient Care Services Service Delivery Model.

Justification: The service delivery model has been updated.

Proposed by: Quality Management Committee

Consent #10: To approve the Mental Health Services Service Delivery Model.

Justification: The service delivery model has been updated.

Proposed by: Quality Management Committee

Consent #11: To approve the Oral Health Care Service Delivery Model.

Justification: The service delivery model has been updated.

Proposed by: Quality Management Committee

Consent #12: To approve the Medical Case Management Service Delivery Model.

Justification: The service delivery model has been updated.

Proposed by: Quality Management Committee

9. DISCUSSION ITEMS (Handout B)

Discussion Item #1: To add Zostavax (Zoster vaccine) to the Ryan White Part A Formulary, Tier 3.

Justification: Accept Medical QI Network recommendation; Zoster is an issue for a number of older clients.

Use/Category: Helps reduce the risk of getting zoster (shingles) in individuals over the age of 50.

Estimate Cost: \$171.44 (based on FLDOH-BC cost)

Proposed By: Priority Setting & Resource Allocation Committee

10. NEW BUSINESS

11. MARCH COMMITTEE REPORTS

A. JOINT CLIENT COMMUNITY RELATIONS COMMITTEE (JCCR)

April 1, 2014

Part A Co-Chair: Y. Reed, Part B Co-Chair: L. Washington

A. Work Plan Item Update / Status Summary:

WP Item 1.1 – JCCR members discussed creating a Facebook page, administrated by PLWHA for PLWHA that would disseminate information to the community about HIV/AIDS, community events, scholarship opportunities for conferences, etc.

WP Item 4.2 – Members discussed accomplishments and challenges the committee faced over the past year. Members agreed that getting turnout for community events was a consistent issue.

WP Item 4.1 – JCCR reviewed their work plan and changed several work plan items to be ongoing items, rather than have a hard due date. JCCR will continue to review their work plan at the next meeting.

WP Item 1.2 – Laurie Yadoff from Legal Aid gave a Hot Topic presentation (*copy on file*) on Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

WP Item 2.1 – JCCR will have a community outreach event on May 6, 2014 at Latinos Salud instead of having their regularly scheduled meeting.

B. Rationale for Recommendations:

None.

C. Data Reports / Data Review Updates:

None.

D. Data Requests:

Staff to look into BRHPC social media policy and administrator privileges; Staff will confirm community outreach event with Latinos Salud.

E. Other Business Items:

Agenda Items for Next Meeting: Community outreach at Latinos Salud. *Next Meeting Date:* May 6, 2014

B. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

April 3, 2014

Chair: H.B. Katz, Vice Chair: T. Wilson

A. Work Plan Item Update / Status Summary:

WP Item 1.1 - The Committee reviewed the Council makeup to ensure it reflects the epidemic and 33% of members are unaffiliated PLWHA. Members were informed that there are currently 24 Council members, 38% of which are unaffiliated consumers. The Committee also reviewed several active applicants and moved two forward for HIVPC approval, including an applicant who will fill the Social Services Provider mandated seat.

WP Item 5.1 – The committee discussed creating a specified job description for alternates on the planning council. Members reiterated that the current alternates are continuously missing from PC meetings due to excused absences. The Grantee staff suggested that the alternate be a member on a standing committee, which will strengthen the position. He further recommended to reference that the alternate is required to fulfill the requirements of the affected community's job description.

WP Item 2.1- The MCDC Chair will ask for an extension of time for the Recruitment and Retention Plan Subcommittee for another 40 days. Their purpose is to determine the components of what is needed for the HIVPC and whether or not to solicit outside assistance from a consultant on how to execute the Recruitment Plan. Once the Subcommittee convenes, they will bring a list of objectives to the council. There was discussion regarding the Subcommittee identifying retention methods.

WP Item 1.11 – MCDC members were shown items that were purchased for client giveaways and as marketing tools to give to HIVPC members. Staff showed the committee examples of other Planning Councils that spotlight members on their websites to show appreciation.

WP Item 4.1 – This item was tabled until the next meeting.

WP Item 4.2 – The MCDC Chair plans to speak to the Executive Committee about having brief presentations at HIVPC meetings, with some HIVPC members presenting on pressing issues and topics. This will keep HIVPC members educated and informed.

B. Rationale for Recommendations:

None.

C. Data Reports / Data Review Updates:

The Committee reviewed the demographics of the Council as it reflects the epidemic of Broward County.

D. Data Requests:

The Committee requested a list of agencies that would be able to serve in the vacant seats on the HIVPC.

E. Other Business Items:

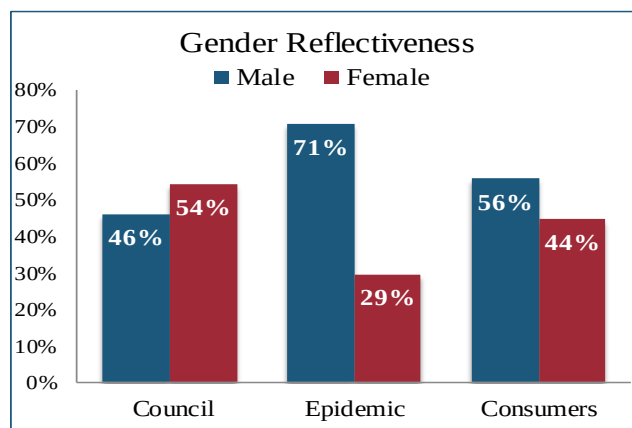
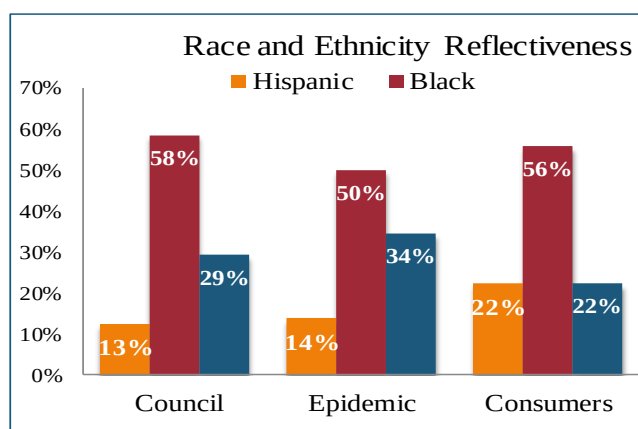
Agenda Items for Next Meeting: Review and Revise the Mentoring Program *Next Meeting Date:* May 1, 2014, 9:30 a.m., Rm A-335 at the Gov't Center.

HIV Planning Council Membership Report for March 24, 2014

Gender	Council	Epidemic	Consumers	Gender	Council	Epidemic	Consumers
Male	11	11,836	5	Male	46%	71%	56%
Female	13	4,944	4	Female	54%	29%	44%
	24	16,780	9		100%	100%	100%
Race	Council	Epidemic	Consumers	Race	Council	Epidemic	Consumers
Hispanic	3	2,290	2	Hispanic	13%	14%	22%
Black	14	8,361	5	Black	58%	50%	56%
White	7	5,772	2	White	29%	34%	22%
Other	0	357	0	Other	0	2%	0
	24	16,780	9		100%	100%	100%

Percent of Planning Council Members That Are Unaffiliated Consumers

38%



Current Members	24
Minimum Required Per County Ordinance	20
Maximum Allowed Per County Ordinance	35

Vacant Seats
Grantees of Other Fed HIV Programs - Prevention
Hospital/Health Care Planning Agencies
Local Public Health Agencies
Social Services Provider
Rep for Former Fed/State/Local Prisoners

Council cannot be comprised of more than 40% of Ryan White Part A Providers

No more than 3 members employed by one governmental agency or provider shall serve on the Planning Council at one time

C. RECRUITMENT & RETENTION SUBCOMMITTEE

April 3, 2014

Chair: V. Foster

A. Work Plan Item Update / Status Summary:

Review Planning Council Demographics and Vacancies – The committee reviewed the demographics and vacancies and brainstormed ideas for recruiting for vacant seats and PLWHAs. Committee members decided to focus on past HIVPC members of vacant seats for recruitment suggestions and to develop new print materials that are especially geared towards PLWHAs.

Review Part A Manual Recruitment and Retention Items – The committee reviewed excerpts from the Ryan White Part A Manual with suggestions about how to recruit new HIVPC members. The committee agreed with many of the suggestions, including having targeted print materials (posters, palm cards, and brochures), a video or PowerPoint presentation to play in agency waiting rooms, and developing a Leadership Institute program to transition PLWHA from interested community members into educated HIVPC leaders.

Review Current HIVPC Recruitment & Retention Plan – The current Recruitment & Retention plan was reviewed; committee members narrowed down the recruitment strategies to three main points: 1) Use current and previous HIVPC members to recruit new HIVPC members, 2) Develop two new sets of print materials, one set targeted to the general population and one set targeted to PLWHAs, and 3) Develop a leadership institute to transition interested community members into educated HIVPC leaders.

Review Current HIVPC Brochure – The current brochure has great information but is not aesthetically pleasing. Brochures from other EMAs were reviewed; the brochures from Boston and Houston were

deemed good examples to use to update the brochure. Staff will reach out to local college marketing and design programs to determine if a marketing or design student can help create new brochures and other print materials.
B. Rationale for Recommendations:
None.
C. Data Reports / Data Review Updates:
The Committee reviewed the HIVPC demographics and vacant seats to determine recruitment needs.
D. Data Requests:
Staff to create a list of appropriate agencies to recruit from for vacant seats; Staff to reach out to local colleges for help with marketing and print materials.
E. Other Business Items:
<i>Agenda Items for Next Meeting:</i> Review new marketing and print materials. <i>Next Meeting Date:</i> May 7, 2014- 9:00 a.m. - Room A-335 at the Governmental Center.

D. JOINT PLANNING COMMITTEE

No Meeting Scheduled *Part A Co-Chair: K. Tomlinson, Part B Co-Chair: K. Saiswick*

The Joint Planning Committee is in the process of restructuring.

E. QUALITY MANAGEMENT COMMITTEE (QMC)

April 21, 2014

Chair: C. Grant

A. Work Plan Item Update / Status Summary:
<u>WP Item 2.4</u> – The Committee reviewed the Minority AIDS Initiative Medical Case Management (MAI MCM) Service Delivery Model for HIVPC Approval on April 24, 2014.
<u>WP Item 2.3</u> – The Committee reviewed the Clinical Quality Management FY 2014-2015 Work Plan. Members of the Committee discussed reviewing the recommendations from the HIVPC Consultant Emily Gantz-McKay to streamline specific data to determine what to focus on to develop the upcoming 18 month Work Plan (to begin September 2014).
<u>WP Item 2.1</u> – The CQM Policies and Procedures were reviewed by the committee. The Committee requested researching the history of the “Assess Effectiveness of Services Offered in Meeting Needs” section to determine its relevance to the current Policies and Procedures and whether or not it was formerly used in the annual needs assessment procedure.
B. Rationale for Recommendations:
Members motioned to recommend Janelle Taveras as a member of the Quality Management Committee. Ms. Taveras will be representing HIV Prevention in an ongoing effort to collaborate and share resources between the Care and Prevention bodies in Broward County.
C. Data Reports / Data Review Updates:
NQC In+Care Retention Measures; Members were provided a copy of the revised HAB Measures for informational purposes and discussed differences in viral load reports from the South Florida AIDS Network (SFAN) and Part A. It was noted that SFAN receives reports from ADAP and Part B while Part A uses the CDC definition when reporting viral loads.
D. Data Requests:
Members requested feedback from all QI Networks regarding the advantages and challenges for requiring clients to provide Viral Load and CD4 Count data every 6 months for CIED; Staff to provide historical documentation in reference to the “Asses Effectiveness of Services Offered” section of the Quality Management Committee’s Policies and Procedures; Staff requested to pull numbers of clients from the FY 12-13 and FY 13-14 who were eligible for each measure of the NQC In+Care Retention Measures summary in order to further examine statistical trends.
E. Other Business Items:

Agenda Items for Next Meeting: Discuss 18 month QM Work Plan; Review CQM Policy and Procedures; Review findings from Needs Assessment and Client Surveys; Quarterly Data Review; Network Feedback on data requirements for eligibility, *Next Meeting Date:* May 19, 2014 from 12:30pm-2:30pm.

F. PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)

April 16, 2014

Part A Co-Chair: C. Taylor-Bennett, Part B Co-Chair: J. Wynn

A. Work Plan Item Update / Status Summary:

LPAC Update - The LPAC Chair brought forward a motion to add Zostavax to the Part A Formulary. The Committee will wait for the Grantee to finish research about the Gardasil vaccine, including a cost analysis and feasibility of a pilot project, before making a decision about adding Gardasil to the formulary.

ADAP Pilot Project Update - The Part B Co-Chair gave a brief presentation (*copy on file*) on ADAP programs and how they can be used most cost effectively in tandem with the Affordable Care Act.

MAI MCM Work Group Update - This item was tabled due to the work group Chair not being present.

Follow-up on Conflict of Interest Forms - The Part A Co-Chair and Staff reviewed the Conflict of Interest form, and reminded committee members that all members who have a conflict of interest need to fill out the form when voting, particularly when voting about financial allocations.

WP Item 4.1 - The Committee reviewed their work plan and policies & procedures. No changes were made to the work plan, but a change was made to the policies & procedures section on revised allocations to allow the Grantee more latitude in making time sensitive fiscal decisions.

WP Item 1.1 - The Committee reviewed the draft 2014 PSRA timeline; the community data presentation was removed, and the committee decided to complete the priority setting process immediately after the data presentations to the Committee, so everything will be fresh in member's minds. Some of the timeline dates may change based on the availability of consultant Emily Gantz-McKay, who will be giving a presentation on the Needs Assessment data.

Community Data Presentation - The Committee decided to forego a community presentation during this PSRA cycle. A different community presentation, or a town hall style meeting, may be held for consumers in January in order to gain valuable community input.

B. Rationale for Recommendations:

Zostavax to be added to the Part A Formulary, Tier 3 to cover those who are not eligible under the PAP; The PSRA Policies & Procedures were updated to improve efficiency and prevent further delays to the funding process.

C. Data Reports / Data Review Updates:

None

D. Data Requests:

Staff to ask for further clarification on filling out the Conflict of Interest form.

E. Other Business Items:

Agenda Items for Next Meeting: Review Updated Scorecards, *Next Meeting Date:* May 21, 2014, 12:30 p.m., Governmental Center Annex Room A-335.

G. AD-HOC BY-LAWS COMMITTEE

April 17, 2014

Chair: M. Schweizer

A. Work Plan Item Update / Status Summary:

Goals and Mission of the Committee – The Chair reviewed the committee's mission as a revisionary body, as is stated in the current By-Laws. The Chair reminded the committee that if anyone has concerns about anything in the By-Laws, now is a good time to bring it to the committee so that it can be reviewed and updated by the committee.

Meeting Dates and Timeline for Completion of Work – The Committee reviewed the timeline and aimed

to complete their review of the By-Laws Parking Lot Items by June 2014. The Committee decided to review the parking lot items in order of their importance and time sensitivities.

By-Laws Parking Lot Items - The Committee chose to focus on reviewing Parking Lot Items #1 and #2 during their first meeting. The Committee decided to remove the word ‘joint’ and replace it with the word ‘community stakeholder’, which was defined in the By-Laws definitions. The Committee also changed the leadership of the committees so each committee will now have a Chair and a Vice Chair.

B. Rationale for Recommendations:

The Committee felt that using the term ‘community stakeholder’ would allow more participation from other parties in the community who are not currently involved with the HIVPC. The change to the committee leadership was made to reflect the leadership positions of the Council and to keep things consistent.

C. Data Reports / Data Review Updates:

None.

D. Data Requests:

None.

E. Other Business Items:

Agenda Items for Next Meeting: Review By-Laws Parking Lot Items *Next Meeting Date:* May 15, 2014- 9:30 a.m. - Room A-335 at the Governmental Center.

H. PART A EXECUTIVE COMMITTEE

March 27, 2014 & April 17, 2014

Chair: B. Gammell, Vice Chair: S. Kuryla

A. Work Plan Item Update / Status Summary:

Wrap-Up from HIVPC Meeting - The Committee continued their discussion from the HIVPC meeting with consultant Emily Gantz-McKay about integrating with the HIV Prevention Planning Council as well as other HIV/AIDS community stakeholders.

Committee Work Plans – The Committee discussed work plans and creating a new committee to work on the Affordable Care Act (ACA) and the overall system of care. The committee agreed to keep the Joint Planning Committee and make a motion was to create an ad-Hoc System of Care Committee. The Committee’s recommendations are for Joint Planning to be responsible for the Comprehensive Plan and the Needs Assessment and the ad-Hoc System of Care Committee to oversee the impact of the ACA on the system of care in Broward County.

By-Laws – The Committee reviewed the list of By-Laws parking lot items and prioritized them in order of importance. A By-Laws Committee Chair has been identified, and the process of identifying committee members has been started.

B. Rationale for Recommendations:

The ad-Hoc System of Care will look at how the ACA will affect the work of each committee.

C. Data Reports /Data Review Updates:

None.

D. Data Requests:

Staff was requested to put together a work plan for the new System of Care committee and revise the Joint Planning work plan.

E. Other Business Items:

None. *Items for Next Meeting:* Review recommended changes to By-Laws. *Next Meeting Date:* April 17, 2014 at 12:30 p.m.

A. Work Plan Item Update / Status Summary:

WP Item 4.1 – By Laws changes- The By-Laws Chair presented motions that were passed in the previous meeting. The Committee decided to remove the word “Joint” and to replace it with “Community Stakeholder.” They also approved removing Co-Chair member of HIVPC Committees to allow for Chair and Vice-Chair designations. The Committee plans to discuss the new System of Care Committee, the succession process of chairs, chair limits, alternates, etc. in future meetings.

Meeting Locations for HIVPC – Staff gave an overview of the locations that were contacted to conduct HIVPC meetings. The locations included Main Library, Broward Health, Central Broward Regional Park, ArtServ, and the Broward Center for the Arts. The Grantee suggested the Commissioners chambers for future meetings. The HIVPC meetings will continue to take place at 12:30 p.m. until a new location and time is finalized.

Attendance – The Chair advised that each committee Chair advertise the meeting time frame and inform members that they must be in attendance to the committee meetings at least 75% of the meeting time. The MCDC Chair will review the 75% rule with the Membership Committee and bring back recommendations and changes to the procedures to the Executive Committee.

Educational Component of HIVPC Meetings - MCDC will provide quarterly trainings for the planning council. There are four topics from which the committee will train. The educational trainings will be in 30 minute blocks. The first Membership quarterly training will take place in the May Planning Council meeting.

B. Rationale for Recommendations:

The Part A Executive Committee approved using the term ‘community stakeholder’ to allow more participation from other parties in the community who are not currently involved with the HIVPC. The By-Laws change to the committee leadership was made to reflect the leadership positions of the Council and to keep things consistent.

The Part A Executive Committee approved membership for two new individuals to join the HIV Planning Council; Vincent Foster and Silvana Baner. Each member has fulfilled the requirements of Planning Council membership. Vincent Foster will be added under the Social Services Seat and Silvana Baner will be added under the Non-Elected Community Leader seat.

C. Data Reports / Data Review Updates:

None.

D. Data Requests:

Staff to continue to find alternate locations for HIVPC Meetings.

E. Other Business Items:

Agenda Items for Next Meeting: Review Mentoring Plan Next Meeting Date: May 8, 2014- 12:30 p.m. - Room A-335 at the Governmental Center.

I. AD-HOC SYSTEM OF CARE COMMITTEE

No Meeting Scheduled

Chair: M. Schweizer

J. GRANTEE REPORTS

- a) Part A
- b) Part B
- c) Part C
- d) Part D
- e) Part F
- f) HOPWA
- g) Prevention

K. UNFINISHED BUSINESS

L. ANNOUNCEMENTS

M. PUBLIC COMMENT (Up to 10 minutes)

N. REQUEST FOR DATA

O. AGENDA ITEMS FOR NEXT MEETING: May 22, 2014 at 12:30 p.m. VENUE: BRHPC

P. ADJOURNMENT

PLEASE COMPLETE YOUR MEETING EVALUATIONS



BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
 March 27, 2014 Meeting Minutes

Attendance					
#	Members	Present	Absent	Guests	
1	Gammell, B. <i>Chair</i>	X		Majcher, B.	
2	Kuryla, S. <i>Vice-Chair</i>		Attended <75%	Agbodzakey, J.	
3	Wilkins, D.		X	Sabatino, D.	
4	DeSantis, M.		X	Washington, L.	
5	Grant, C.	X		Gantz-McKay, E.	
6	Hayes, M.		X	Bates, C.	
7	Bhrangger, R.	X		Buttimer, B.	
8	Holness, Comm. D. V.C.		Attended <75%	Hensley, G.	
9	Katz, H. B.	X		Rodriguez, J.	
10	Marcoviche, W.	X		Taveras, J.	
11	McBain, M.		X	Wynn, J.	King, J.
12	Moragne, Dr. T.		E	Lint, A.	Popper, D.
13	Proulx, D.		Attended <75%		
14	Schweizer, M.	X		Grantee Staff	
15	Siclari, R.		E	Vargas, J. (Part A)	
16	Spencer, W.	X		Copa, R. (Part A)	
17	Taylor-Bennett, C.	X		Jones, L. (Part A)	
18	Tomlinson, K.	X		Odusanya, S. (Part A)	
19	Wilson, T.	X		DeGraffenreidt, S (Part A)	
20	Parker-Maysonet, P.	X			
21	Reed, Y.		E	HIVPC Staff	
22	Creary, K.		Attended <75%	Rosiere, M.	
23	Burgess, D.	X		Eshel, A.	
24	Mercer, A.	X		Sandler, C.	
A1	Coscarelli, M. (Alt)		E	McEachrane, T.	
	Quorum=13	13		Newton, A.	

1. CALL TO ORDER. The Chair called the meeting to order at 9:10 a.m.

2. WELCOME AND PUBLIC RECORD REQUIREMENTS

The Chair welcomed everyone and self-introductions were made. Attendees were notified of Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. In addition, it was stated that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. A moment of silence was observed. The Chair reviewed excused absences. **The following motions were made:**

Motion #1: To approve today's meeting agenda. **Proposed by:** Creary **Seconded by:** Kuryla
Action: Passed Unanimously
Motion #2: To approve the 2/27/14 Meeting Minutes. **Proposed by:** Kuryla **Seconded by:** Creary
Action: Passed Unanimously

3. PUBLIC COMMENT (Up to 10 minutes). None.

4. FEDERAL LEGISLATIVE REPORT (Kareem Murphy – Handout A)

Kareem Murphy gave a brief legislative update on President Obama's Fiscal Year budget, Progress on Reauthorization, and the introduction of the new White House Czar. Housing Opportunities for Persons With AIDS (HOPWA) will see a \$2 million increase in funding for Fiscal Year 2015. There

is no expectation that Congress will make any progress on reauthorizing the Ryan White Program this year.

5. CONSENT ITEMS. None.

6. NEW BUSINESS.

Emily Gantz-McKay gave a presentation on her review of the Comprehensive Plan and her recommendations (*copy on file*). Her recommendations included:

- Adjusting the timetable to reflect the new due date of the next Comprehensive Plan (September 2016).
- Maximizing collaboration with Prevention in implementing the current Comprehensive Plan, and working towards an Integrated Prevention and Care Comprehensive Plan for 2016.
- Establishing priorities and eliminating Comprehensive Plan objectives/tasks if necessary.
- Agreeing on responsibilities related to the Affordable Care Act (ACA) and refining committee responsibilities to address ACA implementation and related changes in system of care.
- Increasing the priority to get clients into care as quickly as possible after they test positive for HIV; clients should be linked to care within 90 days of testing positive to ensure they are getting linked. This will ensure a smooth transition, use of services, and retention.
- Identifying and ranking the importance of eligible services.
- The importance of provider assistance; if a patient is not affiliated with any network; it is their responsibility to assist clients to enter into care. Providers can continue to provide services that are not covered by insurance. The two most important items are the formulary and the network.
- It's appropriate for providers to inform clients of the different insurance plans that are appropriate for HIV clients. If the client wants to keep their provider, they have an option to choose the appropriate plan to get the best service. November 15th through January 7th is the next ACA enrollment period. If a service is provided partly by a plan, Ryan White can fill in services not provided or add the components that are not provided.
- ACA Objectives on the Master Chart discuss assistance and support of PLWHAs who are eligible for ACA plans to ensure enrollment, use of services, retention in care, and viral suppression. Providers should make sure clients are aware of options and receive support.
- Meet HIV/AIDS Bureau (HAB) guidelines for outreach, ensure Ryan White capacity to provide post enrollment assistance to Part A clients, and refine the Ryan White system of care as needed to ensure retention in care.
- Utilize outcomes and performance data separated by populations that are considered most important and best used in decision-making. The priority populations drive the data.
- Communities of color and immigrants are not well informed in areas with Ryan White services in States where there is a Federal Marketplace and fewer navigators. It is critical that Planning Councils disseminate the most accurate information and dispel inaccuracies to calm peoples' fears of the changes.
- Planning Council responsibilities include: developing a Task Force or Committee focusing on System of Care; *Planning Committee*: data that give information on changes that are needed; *PSRA Committee*: allocations, *Joint Client Community Relations Committee*: regular community input from consumers on ACA plans; and *QM Committee*: having correct data.
- Two major things that will change current operations: ACA and the strong expectation from HRSA/CDC to collaborate on planning and integrate bodies to create a single plan so the process is not duplicated. Increasingly strong recommendation from HRSA that there are not separate plans.

There was a discussion regarding the how enrollment will affect funding including:

- HRSA policy states that ACA enrollment cannot be forced, but it can be made a part of eligibility and vigorously pursued. Plan cost and types of coverage will change in the coming year. ADAP identified plans without pharmacy deductibles and are in the process of determining coverage. Part A should develop a wraparound service when the primary payer has not decided what they will do. HRSA designates Part A as the responsible party for the primary Health Insurance Premium and

Cost Sharing Assistance piece. This will have an impact due consumers enrolling into private plans. Based on state averages (\$850/month), if an individual qualifies for free covered insurance premiums, those dollars are backed by Part A. These are clients covered by ADAP and Ryan White is covering the financial burden, without having the funds to do so.

The overview of the handouts provided by Emily Gantz-McKay is as follows:

- Handout D – The gap measure decreased over a period of several months before increasing slightly again. A suggestion was made to further delve into the data to identify changes that may have led to this trend. The key is to choose data to find out what consumers/providers are saying and work on it to make changes. Add attention to issues that are prevalent in your area. Quality Management can assist in the research and provide suggestions.
- Handout F– The percentage of clients with undetectable/suppressed viral load is increasing. There are disparities that still exist. Men have an advantage and youth have more are at a disadvantage. There has been a lot of education and outreach to help gay and lesbian individuals more informed and in care; this seems to be reflected in this population having better gap measure numbers.
 - If data is suggesting a negative trend, identify if it is something we are not doing, check the quality of data, determine if it is a reporting problem, a vast difference in populations, etc.
 - Work on providing data to the entire Planning Council to utilize on a decision making level to make sure there are less client difficulties when receiving care. Focus on priorities and be prepared to make changes.
- Some difficulties in utilizing the data include case managers not accurately inputting numbers. Data from ADAP is different from Ryan White data. Moving forward, it will be beneficial to identify how ADAP data can be incorporated into CIED data to gain a better understanding.
- Recommendations: acquire information from medical providers and medical companies. Identify data limitations and consistently analyze and triangulate assumptions to better develop the service delivery system.

7. DISCUSSION ITEMS

Motion #3: Refer to the By-Laws Committee: to redefine or remove the word ‘joint’ as it is referenced in the HIV Planning Council By-Laws, in an effort to increase flexibility and collaboration, and to ensure a comprehensive continuum and planning process which encompasses the entire Broward County HIV/AIDS community.

Proposed by: Part A Executive Committee **Seconded by:** Katz, H. B.

Action: Passed Unanimously

The overall goal is to move forward and operate as a community. The ad-Hoc By-Laws Committee has been tasked with looking at the language in the By-Laws and how it speaks to A and B and decide how to change the language to better reflect integrating with Prevention, all Ryan White Parts, and other community stakeholders.

8. MARCH COMMITTEE REPORTS

a. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

The MCDC Chair gave a brief update on the subcommittee that has been tasked to work on Recruitment and Retention. The MCDC Chair would like to work with the HIVPC Chair to extend the scope of the committee for another 30 days. The MCDC Chair also noted that the committee will be moving forward with active applicants at their next committee meeting.

b. JOINT CLIENT COMMUNITY RELATIONS COMMITTEE (JCCR)

The JCCR Chair was not present.

c. JOINT PLANNING COMMITTEE

The Joint Planning Committee did not meet in March.

d. **QUALITY MANAGEMENT COMMITTEE (QMC)**

The QMC Chair divulged to the Planning Council that the Committee had identified committee accomplishments and looked at In+Care Campaign measures at the last meeting. The Committee will continue to look at that the In+Care Campaign measures in the coming years. The QMC Chair also thanked Staff member Ariela Eshel for all her support and dedication during her tenure. Ms. Eshel has taken accepted a position with another organization.

e. **PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)**

The PSRA Committee did not meet in March, but the PSRA Chair noted that the Committee will be starting the PSRA process in May.

f. **PART A EXECUTIVE COMMITTEE**

The Part A Executive Committee report stands as written.

9. **GRANTEE REPORTS** (up to 10 minutes)

- a) **Part A:** The Part A Grantee noted that they still have not received a final notice of grant award. The Grantee is in the processing of finalizing a time, date, and location for the MSM study being conducted by Dr. Marsha Martin. The presentation will likely take place in Mid-April at ArtServ. The Grantee may also try to do a community forum following Dr. Martin's presentation. Plans for the presentation will be finalized shortly.
- b) **Part B:** Under the ADAP program currently conducting a pilot for ACA. Many clients did not desire to go into ACA. Pilot might be smaller than originally anticipated. Still awaiting update. Will provide once all information is received.
- c) **Part C:** The Part C Grantee shared that they are also still awaiting their notice of grant award, and have no expectation of when they will receive notice. The Part C fiscal year begins in May.
- d) **Part D:** The Part D Grantee was not present.
- e) **HOPWA:** The HOPWA Grantee was not present.
- f) **Prevention:** The Prevention Grantee representative updated the Council on the Prevention program. The Prevention program will have a progress report with monitoring indicators available in June. The Grantee representative also updated Council members on their condom survey; 808 surveys have been collected and the data is still being analyzed. 70, 820 HIV tests were conducted in Broward in 2013; of those tested, 110 new positives were identified via tests conducted in a clinical setting, and 304 new positives were identified via tests conducted in non-clinical settings. The next Prevention Planning Council meeting will take place in June.
- g) **Part F:** A community dental partnership with Broward Community and Family Health Centers (BCFHC) is set to begin screening clients in mid-April and is expected to begin providing care in August. The Part F Grantee will provide a flyer at the next HIVPC meeting. The Grantee noted that the program is not restricted to just Nova clients.

10. **UNFINISHED BUSINESS.** None.

11. **ANNOUNCEMENTS**

The HIVPC Chair introduced new HIVPC Staff members, Brithney Johnson and Cady Sandler. The Chair also informed Council Members that the County attendance policy has been updated and sign-in sheets have been updated to reflect the new policy. Council members are encouraged to mark the attendance sheet if they already know they will be able to attend next month's meeting. Members did not remain for 75 percent of the HIVPC meeting will not be counted as present, even if they were present when the meeting began.

A guest informed the Council that next week is the combined statewide meeting. The guest also noted that the Florida Senate Health Policy Committee will hear SB1470 which concerns HIV testing on Tuesday, April 1st. He encouraged Council members to urge the Health Policy Committee members to support the bill.

The HIVPC Chair also informed the Council that beginning in April, HIVPC meetings will be at 12:30 p.m. The meetings will continue to be held at BRHPC.

12. PUBLIC COMMENT. None.

13. REQUEST FOR DATA. None.

14. AGENDA ITEMS FOR NEXT MEETING: April 24, 2014 at 12:30 p.m. **VENUE:** BRHPC

15. ADJOURNMENT. Without objection, the meeting was adjourned at 12:10 p.m.

CY14 Council Attendance	1/23	2/27	3/27	
Creary, Karen	X	X	A*	
Gammell, Bradford	X	X	X	
Grant Claudette	X	X	X	
Hayes, Marie	X	X	A	
Bhrangger, Ronald	X	X	X	
Holness, Dale V.C. (Comm)	X	X	A*	
Katz, Bradley	X	X	X	
Kuryla, Samantha	X	X	A*	
Marcoviche, William	X	X	X	
Moragne, Timothy	A	X	E	
Siclari, Rick	X	X	E	
Spencer, Will	X	X	X	
Taylor-Bennett, Carla	X	A	X	
Tomlinson, Karlene	A	X	X	
Wilson, Tara	A	X	X	
Proulx, Dionne	X	X	A*	
Parker-Maysonet, Patricia	X	E	X	
DeSantis, Mario	X	X	A	
McBain, Marsha	A	X	A	
Reed, Yolonda	A	X	E	
Schwiezer, Mark	X	A	X	
Wilkins, Debbie	X	X	A	
Quorum = 13	Yes	Yes	Yes	
Coscarelli, Monica (Alt 1)	A	E	E	
A* = Absence due to attending <75%				

Update for Broward County HIV Health Services Planning Council

From: Kareem Murphy

Date: April 24, 2014

Appropriations Update

Last month, President Obama released his Fiscal Year (FY) 2015 budget with a small increase of \$4 million for Ryan White Programs (\$2.323 billion). Part A grants were level funded.

Attention now shifts to Congress, which has spent most of the time with budget hearings. While the House's FY 2014 budget resolution calls for major cuts to health and human services program levels (top line), it does not target HIV/AIDS related programs in particular (most cuts would affect programs authorized under the Affordable Care Act).

Several Dear Colleague letters have been circulating in the House and Senate to petition for adequate funding for the Ryan White title. There was a Ryan White only letter in each chamber (led by Rep. Barbara Lee [D-CA] in the House and Sen. Tammy Baldwin [D-WI] in the Senate). Several members of the Congressional Black Caucus penned a Minority AIDS Initiative-specific letter, led by Rep. Maxine Waters (D-CA). Rep. Alcee Hastings was a co-lead on that.

No formal agreement is in place for the House and Senate to agree on a joint budget resolution, which would determine the top line amount of spending appropriators would have for FY 2015. We expect the House and Senate to write Health and Human Services appropriations bills with very different amounts of funding.

No Progress on Reauthorization

We continue to expect no meaningful work to take place this session of Congress toward the reauthorization of the Ryan White program. The President's budget argues for continuation of the program under its current methods for FY 2015, which is permissible under law. The bill that Rep. Renee Ellmers (R-NC) introduced, the "Ryan White Patient Equity and Choice Act of 2014," has not been scheduled for a hearing and there is no public commitment from the Energy and Commerce Health Subcommittee to hold a hearing on the bill or to formally mark it up.

RECOMMENDATION TO ADD ZOSTAVAX VACCINE TO THE PART A FORMULARY

November 2013

- The Medical Network noted that adding Zostavax would not create a large impact financially.
 - Estimated Cost (Based on FLDOH-BC Cost): \$171.44
- Medically Needed: Over 50 percent of Part A clients are over 50 years of age, and zoster is a big issue in older clients.
 - The Advisory Committee for Immunization Practices (ACIP) recommends a single dose of zoster (shingles) vaccine for clients over 60 years of age, whether or not the patient had a prior episode of shingles. Patients with chronic medical conditions may also be vaccinated as long as a contraindication does not exist for their condition.

Part A Medical Clients by Age During FY2013-2014 (current to 2/17/2014)

	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	Total
Total	14	437	735	1270	1166	239	8	2	3871

- PAP is available. Merck PAP Criteria: 19 years old or older; no health insurance or cannot afford the vaccines; maximum FPL 400%; reside in the U.S.; U.S. citizenship not required.
- The Committee requested insight from the F/C AETC.

January 2014

FC/AETC Presentation on Immunization in PLWHA

The group heard a presentation from Dr. Jose Castro, FC/AETC, on the efficacy of immunizations (specifically Zostavax and Gardasil) in PLWHA.

Goal is prevention

- Zoster vaccine is safe and immunogenic in adults CD4 > 200 and VL < 75 copies/mL
- Immunocompromised – higher risk of pneumonia, disseminated disease, visceral involvement
- Zostavax may be given at any stage of HIV infection
- Clinical Trial: Herpes Zoster live vaccine safe in HIV-infected patients on stable ART
- Following the presentation, the LPAC made a motion to add the Zoster and HPV vaccines to the Formulary.
 - The LPAC also requested that a Gardasil cost effectiveness study be prepared as a justification for the recommendation as the Gardasil vaccine is more expensive and requires 3 doses for completion.



To: Broward County HIV Health Services Planning Council
From: Ad Hoc By-Laws Committee
Date: April 24, 2014
Subject: **Proposal for Recommended By-Laws Changes**

A meeting of the Broward County HIV Health Services Planning Council is scheduled for:

Date: Thursday, May 22, 2014
Time: 12:30 P.M.
Place: Broward Regional Health Planning Council
200 Oakwood Lane, Suite 100
Hollywood, FL 33020

If you have special needs such as Translation from English to Creole or Spanish, or require other auxiliary aids or services because of a disability, please call at least 48 hours in advance.

To confirm meeting information, reserve special needs services or if you have questions, please call HIVPC Staff at 954-561-9681, Ext. 1295 or 1345.

Thank you.

Service Delivery Model Review Process

- ❖ In the Service Delivery Model Approval Process, it is the responsibility of the QI Networks to provide supportive documentation related to the creation and revision of their Service Delivery Models.
- ❖ To the extent that it is possible, all Service Delivery Models are developed and revised in accordance with the most recent research evidence and official guidelines available. Sources include (but are not limited to):
 - Florida AIDS Education Training Center (AETC) recommendations
 - Models from other Emerging Metropolitan Areas
 - HIV/AIDS Bureau (HAB) Performance Measures
 - HIV/AIDS Bureau (HAB) Programing Monitoring Standards
 - Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents
 - Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease
 - Florida Medicaid Behavioral Health Handbook
- ❖ Each delivery model ensures that services are to be conducted by culturally competent service providers.
- ❖ Each delivery model is brought to the QMC for review and approval prior to HIVPC
- ❖ Outcomes and Indicators were brought and approved by the Planning Council on December 13, 2012 and were updated accordingly in each SDM.
- ❖ All updates and/or changes to the SDM are indicated in bold.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

The QI Network is responsible for completing the *Service Delivery Model Request for Approval Form* prior to submitting a Service Delivery Model for approval by the Quality Management Committee. This form will provide the Quality Management Committee & the HIV Planning Council with the necessary information to effectively evaluate the Service Delivery Models submitted for approval.

***Please attach Service Delivery Model and cite sources used (where applicable).*

Date 4/24/14

Service Delivery Model MAI Medical Case Management

1. Please provide background/summary of original service delivery model and proposed changes.

2013

- The PSRA committee created a workgroup for MAI Medical Case Management in order to define the population and scope of services.

2014

- The MAI MCM workgroup has been reviewing and revising the draft Service Delivery Model.
- Providers of care have been operating off a draft SDM. This version needs approval so it can move from being a draft to an official document.
- The MAI MCM Workgroup under the PSRA Committee will continue to work on updating the draft to better reflect how providers target the population who should receive care.
- At its 4.21.14 meeting, the QM committee approved the draft MAI MCM Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: MAI Medical Case Management (MCM) services support the ability of clients to remain adherent to medical care. These services have a central role in providing treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS treatments. MAI MCM includes individual therapeutic support services facilitated or guided by an individual who may be the same age, gender, or HIV status as the client, and who has experienced and resolved the same type of problems as the client. Trained peers provide MAI MCM to optimize a client's strengths to ensure successful completion of established goals. MAI MCM draws upon the Antiretroviral Treatment Access Study-II (ARTAS-II) model. Components of MAI MCM services include: (1) treatment literacy; (2) emotional support; (3) adherence to care by attending appointments, monitoring test results, and following instructions; (4) adherence to medication regimens; and (5) encouragement of healthy behaviors and positive living enabling the achievement of healthy outcomes. MAI MCM is time-limited. MAI Medical Case Managers provide clients with information and practical solutions for systems-navigation and optimal use of program resources. This information is provided during an initial assessment visit and up to six individual sessions. This strengths-based counseling approach is used within a 90-day period. MAI Medical Case Managers serve as liaisons for maintaining regular communication between clients and their medical providers. MAI Medical Case Managers educate clients in HIV service delivery, disease progression and management, viral loads, CD4 values, and skills to achieve health literacy. MAI Medical Case Managers will provide other case management services including face-to-face visits with the client, telephone contacts, home visits, educating clients on the MAI MCM process and expectations; accompany clients to medical appointments, other support services, and any other forms of communication.

Strengths-based Counseling

MAI MCM services are based on a strengths-based counseling approach that establishes a partnering relationship between the client and MAI Medical Case Manager. The MAI Medical Case Manager shall assess the client to identify personal strengths, abilities, and skills that the client can use to access OAMC and accomplish other short-term goals. The strengths assessment focuses on the client's ability to accomplish a task, use a skill, or fulfill a goal in a significant life domain. The strengths assessment identifies and draws upon past successes experienced by the client. A Strengths Assessment Form is used to guide the MAI medical case manager in conducting sessions. Following completion of the strengths assessment, the MAI Medical Case Manager will help the client establish short-term goals, objectives, and activities aimed at linking the client to medical care and other short-term goals.

The MAI Medical Case Manager and the client will collaborate to assist the client in achieving goals that he or she identifies as valuable or important and emphasizes strengths as a way of achieving these goals. The strengths-based counseling approach must support the client's current medical case management plan of care. The counseling shall be conducted in no longer than a 90-day period using a maximum of six individual face-to-face client sessions that do not exceed 120 minutes per session:

- **Session 1** shall focus on assessing Client's individual needs and priorities utilizing potential strengths that the client can apply to help resolve problems or barriers.
- **Session 2** should focus on reinforcing and identifying resources needed to help carry out their Plan of Care based on the client's skills and abilities.
- **Session 3** shall help the Client to develop objectives that are specific, measureable, achievable, relevant and time-bound. Objectives shall identify and resolve barriers that interfere with the goal of adhering to their prescribed medical regimens.
- **Session 4** shall develop a Client specific implementation plan that focuses on achieving the objectives and ways to resolve previously identified barriers that interfere with the progression of achieving their goals.
- **Session 5** shall evaluate the Client's success of the transferred into the medical case management Plan of Care that will ensure the resolution of any barriers in the Strengths-Based Approach.
- **Session 6** is a collaborative staffing with the Client and the Medical Case Manager to ensure that the client has a seamless transition back into medical case management services.

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

Service delivery shall be conducted with cultural competency by culturally competent service providers. The medical case manager shall ensure client cultural needs are addressed. The MAI MCM services shall verify the client's eligibility by reviewing certification in Provide Enterprise (PE) System to ensure client's access to all services and the status of Ryan White as payer of last resort. MAI Medical Case Managers shall conduct chart reviews at least quarterly to ensure appropriate documentation of all services, including referrals, follow-up, and reassessment. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., HAB HIV Medical Case Management Performance Measures, etc.).

Activities of MAI medical case managers include, but are not limited to:

- Provide strengths-based treatment adherence counseling
- Complete Strengths Assessment
- Monitor service delivery and client adherence to medical care
- Promote readiness for and adherence to complex HIV/AIDS treatments
- Optimize client's strengths to ensure successful completion of goals
- Provide clients with information and practical solution for systems-navigation and optimal use of program resources
- Maintain regular communication between clients and their medical providers
- Educate clients in HIV service delivery, disease progression and management, viral loads, CD4 values, and skills to achieve health literacy

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

Each client will be assessed for barriers to access care, treatment adherence, adherence to medications, and culturally specific needs. An individual implementation plan will be developed in agreement with the client. The plan will be based on

optimizing the client's strengths and will address client's cultural needs. MAI Medical Case Managers will assist clients with treatment literacy; emotional support; adherence to care by attending appointments, monitoring test results, and following instructions; adherence to medication regimens; and encouragement of healthy behaviors and positive living enabling the achievement of healthy outcomes.

MAI medical case managers shall perform two follow-up assessments for each client to ensure scheduled OAMC appointments are kept and documented in PE. The MAI medical case manager shall follow up with the client and the Medical Case Manager to verify achievement of the implementation plan. The follow-up assessments shall be completed after the client's file has been closed. If appointments are missed, they are rescheduled until the sessions can be completed. If a client self-terminates from MAI MCM before completion, there will be a multidisciplinary staffing attended by the MAI Medical Case Manager and the client's assigned Medical Case Manager to assess the client's readiness for care, along with a referral to a more intensive treatment adherence program as applicable.

How does this service delivery model ensure integration of peers into treatment and care?

MAI Medical Case Management (MAI MCM) offers clients individual therapeutic support services facilitated or guided by an individual who may be the same age, gender, or HIV status as the client. This person will have experienced and resolved the same type of problems as the client. The trained peers provide MAI MCM to optimize a client's strengths to ensure successful completion of established goals. The peers provide other MCM services including face-to-face visits with the client, telephone contacts, home visits, educating clients on the MAI MCM process and expectations; accompany clients to medical appointments, other support services, and any other forms of communication.

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Decision

☐ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the Quality Management Committee and the respective QI Network (if necessary) for resubmission.

Fort Lauderdale/Broward County EMA

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***Please attach Service Delivery Model and cite sources used (where applicable).*

Date | 4/24/14

Service Delivery Model | AIDS Pharmaceutical Assistance (Local)

1. Please provide background/summary of original service delivery model and proposed changes.

2010

- At the 5.25.10 meeting, the Network made minor revisions to the Service Delivery Model.

2012

- At the 1.10.12 meeting, the Network reviewed client level outcomes and indicators and revised the Service Delivery Model.
- The QM Committee reviewed the outcomes and indicators and provided recommendations.
- At its 6.22.12 meeting, the Network made additional revisions based on the QM Committee recommendations.

2013

- The Service Delivery Model was sent to the AIDS Education and Training Center (AETC) for review.
- At its 4.15.13 meeting, the QM Committee approved the AIDS Pharmaceutical Assistance (Local) Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.

Standards for pharmaceutical services for persons living with HIV/AIDS (PLWHA) are defined by six major sources:

1. Florida Department of Professional Regulation, Board of Pharmacy
2. Florida Department of Health Comprehensive Pharmaceutical Services, Policies and Procedures Manual
3. State of Florida ADAP (AIDS Drug Assistance Program)
4. Broward County Health Department's Pharmacy and Therapeutics Committee
5. AIDS Education Training Curricula
6. Pharmacy QI Network
7. Local Pharmacy Advisory Committee

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

The delivery of AIDS Pharmaceutical Assistance services shall be conducted by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., HAB HIV Performance Measures, etc.). Clinic staff shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System to ensure client's access to all

services and the status of Ryan White as payer of last resort. Provider staff shall have a client grievance process that shall be discussed with clients during intake. Service provider shall conduct quarterly chart reviews to ensure all services have been provided to the patient based on the Treatment Plan, all referrals have been followed-up and documentation of all services is complete.

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

Practitioners are engaging PLWHAs by keeping clients informed about their health, encouraging them to adhere to medications, and stressing the importance of retention in care.

Patient Counseling

Upon receipt of a new or refill prescription, the pharmacist shall ensure that a verbal and printed offer to counsel is made to the patient or the patient's agent when present. If the delivery of the drugs to the patient or the patient's agent is not made at the pharmacy, the offer shall be in writing and shall provide for toll-free telephone access to the pharmacist. If the patient does not refuse such counseling, the pharmacist, or the pharmacy intern, acting under the direct and immediate personal supervision of a licensed pharmacist, shall review the patient's record and personally discuss matters which will enhance or optimize drug therapy with each patient or agent of such patient. Such discussion shall be in person, whenever practicable or by toll-free telephonic communication and shall include appropriate elements of patient counseling. Such elements may include, in the professional judgment of the pharmacist, the following:

- a) The name and description of the drug;
 - b) The dosage form, dose, route of administration, and duration of drug therapy;
 - c) Intended use of the drug and expected action (if indicated by the prescribing health care practitioner);
 - d) Special directions and precautions for preparation, administration, and use by the patient;
 - e) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
 - f) Techniques for self-monitoring drug therapy;
 - g) Proper storage;
 - h) Prescription refill information;
 - i) Action to be taken in the event of a missed dose; and
 - j) Pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug.
1. Patient counseling as described herein shall not be required for inpatients of a hospital or institution where other licensed health care practitioners are authorized to administer the drug(s).
 2. A pharmacist shall not be required to counsel a patient or a patient's agent when the patient or patient's agent refuses such consultation.

How does this service delivery model ensure integration of peers into treatment and care?

N/A. It is not mandated to use peers.

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Service Delivery Model Request for Approval Decision

☐ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the Quality Management Committee and the respective QI Network (if necessary) for resubmission.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

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***Please attach Service Delivery Model and cite sources used (where applicable).*

Date 4/24/14

Service Delivery Model Outpatient Ambulatory Medical Care

1. Please provide background/summary of original service delivery model and proposed changes.

2009

- The Network revised the Service Delivery Model using examples from Miami-Dade EMA and other service categories within Broward's EMA.
- The Service Delivery Model was sent to the AIDS Education and Training Center (AETC) for review.
- The Network discussed the AETC feedback.

2010

- Dr. Jeffery Beal of the FL/AETC provided a presentation to the Network on 6.23.10 to address comments and questions submitted by the medical providers in response to AETC feedback. Additional requests for clarification and data resulted from the discussion.
- Revisions were made to the Service Delivery Model over the course of several Network meetings.

2011

- The Service Delivery Model was approved by the Network at the 4.27.11 meeting.
- At its 6.20.11 meeting, the QM Committee recommended the Medical QI Network investigate standards of care for transgender consumers and review educational material to possibly include in their Service Delivery Model.
- At its 7.27.11 meeting, the Medical Network reviewed recommended language regarding transgender care. The language was revised and the SDM was formally approved as revised.

2013

- The Network reviewed the Service Delivery Model.
- The Service Delivery Model was sent to the AIDS Education and Training Center (AETC) for review and the Network discussed the AETC feedback.
- Revisions were made to the Service Delivery Model over the course of several Network meetings.
- At its 4.15.13 meeting, the QM Committee approved the Outpatient Ambulatory Medical Care Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: Outpatient/Ambulatory medical care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Diagnostic Testing: CD4 T-Cell Counts, HIV RNA, Resistance, HLA-B*5701, Tropism, Basic Chemistry [Serum Na, K, HCO₃, Cl, BUN, Creatinine, Glucose, Liver Function Tests, CBC with Differential, Fasting Lipid Profile, Urinalysis, Syphilis, N. Gonorrhea (GC), and C. Trachomatis (Chlamydia)]. Also refer to Appendix A of the Service Delivery Model for other labs to be ordered as

clinically needed and appropriate.

Early Intervention and Risk Assessment: Sexual health education, to include birth control method, discussion of condom use, and risk identification, shall be provided.

Preventive Care and Screening and Practitioner Examination: Hepatitis A Screening, Hepatitis B Screening, Hepatitis C Screening, Cytomegalovirus (CMV) Screening for patients with CD4 T-cell count <50mm³, Colon and Rectal Cancer Screening, Consenting female clients are given PAP test, Clients are offered immunizations (pneumococcal vaccine, influenza immunization, Hepatitis A and B vaccine, Tuberculosis testing, Mammograms (females), and practitioner shall assess and document co-morbidities and opportunistic infections.

Medical History Taking: All documentation is done in the client chart. Documentation of HIV infection, current medication list, signed written informed consent for vaccinations, a problem list, an allergy list, and immunization list are documented in the client chart.

Prescribing Managing Medication Therapy: Clients with CD4 T-cell counts below 200 are prescribed PCP prophylaxis, pregnant women are prescribed antiretroviral therapy, ART therapy shall be provided at the time of CD4 T-Cell count and HIV RNA monitoring, and practitioner will assess opportunistic infections and prophylaxis. Practitioner shall assess and document adherence to medication. Clients are educated about medication adherence.

Education and Counseling on Health Issues: Practitioner will provide nutritional health education, oral health education, mental health screening, drug/alcohol/screening/education, tobacco (including smokeless screening/education, and sexual health education.

Referral to and Provision of Specialty Care: Practitioner shall refer client to appropriate specialist based on the client clinical status.

Primary medical care for the treatment of HIV infection include the provision of care that is consistent with the following guidelines: Department of Health and Human Services (DHHS) Clinical Guidelines, American Cancer Society Guidelines for the Early Detection of Cancer, European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV, Lipid Disorders subset of the AIDS Education and Training Centers, CDC Recommended Adult Immunization Schedule, Incorporating HIV Prevention into the Medical Care of Persons Living with HIV.

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

The delivery of ambulatory/outpatient medical care shall be conducted by culturally competent service providers. Provider staff shall have a client grievance process that shall be discussed with clients during intake. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, HAB HIV Core Clinical Performance Measures for Adults Clients, etc.). Consumer satisfaction, identifying priority needs, and planning a responsive system of care are captured during the Needs Screening process with questions that specifically address medical care and providers. The screening results are used to drive improvement by the medical providers and their agencies.

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

Practitioners are engaging PLWHAs by keeping clients informed about their health, encouraging them to adhere to medications, and stressing the importance of retention in care.

If medical staff is unable to reach a client who has missed an appointment or when a client has missed 2 appointments in a row, the medical provider will contact the medical case management provider first (if client receives this service).

- If the client is not receiving medical case management services, the medical provider will refer the client to outreach providers by telephone call, fax, or through the PE system.
- If the client is receiving medical case management services and the client's medical case management provider cannot bring the client back to care, medical case managers will refer the client to outreach providers by telephone call, fax, or through the PE system.
- Within 2 weeks, outreach providers will fax the final progress notes as follow-up on the case to the medical provider.

How does this service delivery model ensure integration of peers into treatment and care?

N/A. It is not mandated to use peers.

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Service Delivery Model Request for Approval Decision

☐ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the Quality Management Committee and the respective QI Network (if necessary) for resubmission.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

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***Please attach Service Delivery Model and cite sources used (where applicable).*

Date | 4/24/14

Service Delivery Model | Substance Abuse

1. Please provide background/summary of original service delivery model and proposed changes.

2010

- The Network made revisions to language within the Service Delivery Model.

2011

- At its 11.18.11 meeting, the Network reviewed Client Level Outcomes and Indicators for Mental Health and Substance Abuse. The Network made several revisions.

2013

- At its 2.15.13 meeting, the Network reviewed the HIVPC discussion in response to the Mental Health and Substance Abuse outcomes and indicators' revisions.
- The Network revised and approved via consensus the Substance Abuse Service Delivery Model on 2.15.13.
- At its 4.15.13 meeting, the QM Committee approved the Substance Abuse Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: Substance abuse outpatient care services is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. Substance abuse treatment providers as defined in the State of Florida Mental Health Statutes are referred to as licensed or certified practitioners.

Treatment Plan (Individualized) The licensed or certified practitioner shall complete a Treatment Plan for each client based on the needs identified in the bio-psychosocial assessment. A formal review of active treatment plans must be conducted at least once every six (6) months. The electronic treatment plan may be reviewed more often than once every six months when significant changes occur with patients. Treatment plans and quarterly updates shall be completed with client participation as evidence by client signature. Objectives shall be reviewed and updated with necessary modifications reflecting any new agreements.

The treatment plan must contain all of the following components:

- The recipient's ICD-9-CM or DSM diagnosis code(s) consistent with assessment(s);
- Goals that are appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences and needs expressed by recipient(s);
- Measurable objectives and target dates;
- A list of the services to be provided (Treatment Plan Development, Treatment Plan Review, and Comprehensive Behavioral Health Assessment need not be listed);
- It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Signature of the recipient;
- Signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18);
- Signatures of the treatment team members who participated in development of the plan;
- A signed statement by the treating licensed practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs; and
- Transition or discontinuation of services.

Treatment Plan (*Group Therapy*) Clients are to participate in group therapy only as a result of an individualized treatment plan intervention. Group therapy documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan.

Expected Outcomes

The substance abuse shall assist the client to define outcomes for the needs addressed in the Treatment Plan. The strategies to achieve the outcomes shall be documented. The licensed or certified practitioner shall document the progress and specific assistance provided to the client in the progress notes. Notes must be entered into the PE system within 3 business days of interfacing with the recipient.

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

The delivery of Substance Abuse services shall be conducted by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, HAB HIV Performance Measures, etc.). Clinic staff shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System to ensure client's access to all services and the status of Ryan White as payer of last resort. Provider staff shall have a client grievance process that shall be discussed with clients during intake. Service provider shall conduct quarterly chart reviews to ensure all services have been provided to the patient based on the Treatment Plan, all referrals have been followed-up and documentation of all services is complete.

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

The registered clinical intern or licensed practitioner shall assess the client's Biosychosocial needs using the Biopsychosocial Evaluation form. The Biosychosocial evaluation must be reviewed and signed by a licensed practitioner prior to providing treatment or intervention to client.

The licensed or certified practitioner shall assess the potential barriers to retention in treatment and shall strategize with the client to identify the necessary action steps to assist the client to remain in treatment

Access, Status, and Retention in Medical Care

Medical Care Status- The licensed or certified practitioner shall assess client's current participation in the health care system and shall document the status in the progress notes.

Access to Outpatient/Ambulatory Medical Care- The substance abuse licensed or certified practitioner shall assess any client barriers to access Outpatient/Ambulatory Medical care, including cultural issues and offer a referral to the Medical Case Manager to facilitate access. The substance abuse licensed or certified practitioner shall ensure that consenting clients are referred to get an appointment and coordination is secured to ensure continuity of services.

Retention in Outpatient/Ambulatory Medical Care- The licensed or certified practitioner shall assist client to remain in care. The licensed or certified practitioner shall discuss with the client the reasons the client had to access care in the first place and assess if those are still valid. The licensed or certified practitioner shall discuss what the client thinks needs to happen so

the client can remain in care.

The licensed or certified practitioner shall detail the assistance provided in the progress notes. The licensed or certified practitioner shall document any coordination conducted to assist client to remain in care.

Assessment of Medications Adherence

The licensed or certified practitioner shall assess client adherence to medications monthly and document in progress notes.

How does this service delivery model ensure integration of peers into treatment and care?

N/A. It is not mandated to use peers.

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Service Delivery Model Request for Approval Decision

☐ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the Quality Management Committee and the respective QI Network (if necessary) for resubmission.

Fort Lauderdale/Broward County EMA

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***Please attach Service Delivery Model and cite sources used (where applicable).*

Date 4/24/14

Service Delivery Model Mental Health

1. Please provide background/summary of original service delivery model and proposed changes.

2010

- At its 6.11.10 meeting, the Network made revisions to language within the Service Delivery Model.

2011

- At its 11.18.11 meeting, the Network reviewed Client Level Outcomes and Indicators for Mental Health and Substance Abuse. The Network made several revisions.

2013

- At its 2.15.13 meeting, the Network reviewed the HIVPC discussion in response to the Mental Health and Substance Abuse outcomes and indicators' revisions.
- The Network revised and approved via consensus the Mental Health Service Delivery Model on 2.15.13.
- At its 4.15.13 meeting, the QMC approved the Mental Health Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. Mental health professionals or authorized within the State of Florida are referred to as licensed practitioners in this document.

Treatment Plan (Individualized) The licensed or certified practitioner shall complete a Treatment Plan for each client based on the needs identified in the bio-psychosocial. A formal review of active treatment plans must be conducted at least once every six (6) months. The electronic treatment plan may be reviewed more often than once every six months when significant changes occur with patients. Treatment plans and quarterly updates shall be completed with client participation as evidence by client signature. Objectives shall be reviewed and updated with necessary modifications reflecting any new agreements.

The treatment plan must contain all of the following components:

- The recipient's ICD-9-CM or DSM diagnosis code(s) consistent with assessment(s);
- Goals that are appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences and needs expressed by recipient(s);
- Measurable objectives and target dates;
- A list of the services to be provided (Treatment Plan Development, Treatment Plan Review, and Comprehensive Behavioral Health Assessment need not be listed);
- It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Signature of the recipient;
- Signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18);
- Signatures of the treatment team members who participated in development of the plan;
- A signed statement by the treating licensed practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs; and
- Transition or discontinuation of services.

If the recipient's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided.

Treatment Plan (*Group Therapy*) Clients are to participate in group therapy only as a result of an individualized treatment plan intervention. Group therapy documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan.

Expected Outcomes The registered clinical intern or licensed practitioner shall assist the client to define outcomes for the needs addressed in the Treatment Plan. The strategies to achieve the outcomes shall be documented. The registered clinical intern or licensed practitioner shall document the progress and specific assistance provided to the client in the Progress Notes. Notes must be entered into the PE system within 3 business days of interfacing with the recipient.

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

The delivery of mental health services shall be conducted by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, HAB HIV Performance Measures, etc.). Clinic staff shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System to ensure client's access to all services and the status of Ryan White as payer of last resort. Provider staff shall have a client grievance process that shall be discussed with clients during intake. Service provider shall conduct quarterly chart reviews to ensure all services have been provided to the patient based on the Treatment Plan, all referrals have been followed-up and documentation of all services is complete.

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

The registered clinical intern or licensed practitioner shall assess the client's Biosychosocial needs using the Biopsychosocial Evaluation form. The Biosychosocial evaluation must be reviewed and signed by a licensed practitioner prior to providing treatment or intervention to client.

The registered clinical intern or licensed practitioner shall assess and record the potential barriers to retention in mental health treatment and shall strategize with the client to identify the necessary action steps to assist the client to remain in treatment. The registered clinical intern or licensed practitioner shall document all assistance given to the client in the Progress Notes.

Access, Status, and Retention in Medical Care

Outpatient/Ambulatory Medical care Status -The registered clinical intern or licensed practitioner shall assess client's current participation in Outpatient/Ambulatory Medical care and shall document the status in the Progress Notes.

Access to Outpatient/Ambulatory Medical care - The registered clinical intern or licensed practitioner shall assess any client barriers to access Outpatient/Ambulatory Medical care, including cultural issues and offer a referral to the medical case manager to facilitate access. The registered clinical intern or licensed practitioner shall ensure that consenting clients are referred to get an appointment and coordination is secured to ensure continuity of services.

Retention in Outpatient/Ambulatory Medical care - The registered clinical intern or licensed practitioner shall assist client to remain in Outpatient/Ambulatory Medical care. The registered clinical intern or licensed practitioner shall discuss with the client the reasons the client had to access care in the first place and assess if those are still valid. The registered clinical intern or licensed practitioner shall assess any client barriers to retention in Outpatient/Ambulatory Medical care, including cultural issues and refer to the medical case manager to facilitate retention.

The registered clinical intern or licensed practitioner shall detail the assistance provided in the Progress Notes. The registered clinical intern or licensed practitioner shall document any coordination conducted to assist client to remain in Outpatient/Ambulatory Medical care.

Assessment of Medications Adherence

The registered clinical intern or licensed practitioner shall re-assess psychotropic and HAART medications at least quarterly and document in Progress Notes.

How does this service delivery model ensure integration of peers into treatment and care?

N/A. It is not mandated to use peers.

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Service Delivery Model Request for Approval Decision

☐ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the Quality Management Committee and the respective QI Network (if necessary) for resubmission.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

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***Please attach Service Delivery Model and cite sources used (where applicable).*

Date 4/24/14

Service Delivery Model Oral Health Care

1. Please provide background/summary of original service delivery model and proposed changes.

2010

- The Network approved the Service Delivery Model on 9.28.11.
- The QM Committee approved the Service Delivery Model on 10.17.11.
- HIVPC approved the Service Delivery Model on 10.27.11.

2012-2013

- The Network revised the Oral Health outcomes and indicators.
- Revisions were made to the Service Delivery Model over the course of several Network meetings to ensure compliance with local and national guidelines and requirements.

2014

- At its 2.27.14 meeting, the Network reviewed and approved the Oral Health Service Delivery Model.
- At its 3.17.14 meeting, the QM Committee approved the Oral Health Care Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: Oral Health Care (Dental Services) will encompass dental screenings, prophylaxes, fillings, simple extractions as well as periodontal and other advanced treatments. Clinical interventions are based on treatment guidelines and recognized clinical protocols established legal and ethical standards. As such, Oral Health Care shall be provided based on the following priorities:

- Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
- Elimination of presenting symptoms
- Elimination of infection, preservation of dentition and restoration of functioning

Emergency, diagnostic, preventive, hygiene, basic restorative, limited oral surgical and limited endodontic services rendered by general dentists and dental hygienists.

Oral Health Care shall include a completed assessment; prioritized treatment plan which is tailored to the client's needs; dental treatment history; and an assessment of medical conditions that are appropriately monitored and updated as needed. The treatment plan will also include an appropriate recall/follow-up schedule every six months.

Intake

New clients shall receive a dental screening within 21 days of the initial referral to a dental provider. Client's initial non-emergency visits should include an oral evaluation with radiographs and treatments plan. Initial visits shall include:

- Comprehensive head and neck exam;
- Complete intraoral exam, including evaluation for HIV associated lesions
- Full medical status information from medical provider, including
- medication and stage of illness, as needed; and
- Dental risk assessment and prevention strategy including home care and other self-exam instructions.

Assessment of Patient Need

The oral health practitioner shall assess patient needs by conducting an oral exam to include: assessment of opportunistic infections, hard and soft tissue exam, including periodontal tissues and oral mucosa; gingival and periodontal structures,

other as needed. Need is documented in patient chart. The Assessment of Patient Need should include:

- Description of documented patient need, including relevant dental, medical and prescription information;
- Outline of service needs.

Treatment Plan

The purpose of the Treatment Plan is to guide the provider in delivering high quality care corresponding to the patient's level of need including determination of emergency versus non-emergency care, triage care and referral as indicated. The Treatment Plan is developed by a dental provider following the initial comprehensive dental exam and is kept within the patient's chart. The Treatment Plan may include services that are not covered by Ryan White Part A funds. Provider shall consult with the patient to discuss these services which may be available through other sources.

The client's primary reason for the visit, concerns and expectations should be considered by the Provider when developing the treatment plan. Treatment priority shall be given to the management of pain, infection, traumatic injury or the emergency condition. The Provider will manage the client's pain, anxiety and behavior during treatment to facilitate safety and efficiency. Emergency service(s) where there are severe, life threatening, or potentially disabling conditions shall be the first priority for service delivery. The provider must document the nature of the emergency, the dental site and the specific treatment involved.

Phase 1 of all oral health treatment plans must be completed within 6 months from the date of that the treatment plan has been agreed upon by the patient. Phase 1 treatment plan includes: Diagnostic, Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: basic restorative treatment including fillings; basic periodontal therapy (non-surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy.

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

The delivery of Oral Health Care shall be conducted by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, HAB HIV Performance Measures, etc.). The provider shall give access to routine and emergency dental care for persons living with HIV/AIDS residents of the Broward County EMA, who either have no dental third party payment source, have limited third party coverage, or have been denied coverage by a third party payer. Clinic staff shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System. Provider staff shall have a client grievance process that shall be discussed with clients during intake. Service provider shall conduct quarterly chart reviews to ensure all services have been provided to the patient based on the Treatment Plan, all referrals have been followed-up and documentation of all services is complete.

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

Providers shall assist patient to adhere to oral health treatment plan and shall refer to a Ryan White Part A medical case manager any patients presenting other needs that could potentially impair adherence to the oral health treatment plan. Oral Health Care shall strive to retain clients in oral health treatment services. Providers shall have a coordinated Retention and Client Recall system with policies and procedures for non-compliance, missed appointments, appointment reminders.

The retention policy shall include coordination of treatment with primary medical care provider, treatment adherence, case manager and Ryan White Part A outreach services as required ensuring continuity of care and retention of clients in dental and or medical care.

Case conferencing shall be conducted when Client's dental treatment has been interrupted due to a condition or behavior that threatens his/her ability to access care, missed appointments, remain in care or adhere to care and/or medications. Case conferencing shall include written documentation of collaboration with Client's primary medical provider, Case Manager and/or appropriate retention and adherence staff.

Providers shall assess if patients are receiving primary medical care. Patients not in primary medical care shall be offered a referral to Ryan White Part A Outpatient Ambulatory Medical care.

How does this service delivery model ensure integration of peers into treatment and care?

N/A. It is not mandated to use peers.

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Service Delivery Model Request for Approval Decision

☐ Approved

☐ Denied

Reason(s) for denial:

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Fort Lauderdale/Broward County EMA

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***Please attach Service Delivery Model and cite sources used (where applicable).*

Date 4/24/14

Service Delivery Model Medical Case Management

1. Please provide background/summary of original service delivery model and proposed changes.

2010-2011

- Part A launched a new service in August 2010, Centralized Intake and Eligibility Determination (CIED).
- With the implementation of this new program, the Medical Case Management service delivery model was revised to reflect the changes in responsibility.
- Clients newly diagnosed are linked to CIED.
- Peer Education Counseling was integrated into the service delivery model.
- The Needs Assessment was uploaded into Provide Enterprise and to be completed electronically.
- The Service Delivery Model was approved by the Network on 4.5.11.
- The Service Delivery Model was approved by the QM Committee on 4.18.11
- The Service Delivery Model was approved by the HIVPC on 4.28.11

2012

- The Network developed medically focused outcomes and indicators.
- AETC provided input on the development of medically focused POC goals.
- The QM Committee reviewed the client level outcomes and indicators and provided recommendations.

2013

- The Service Delivery Model was revised and approved by the Network at the 2.5.13 meeting.
- At the 4.15.13 meeting, the QM committee approved the Medical Case Management Service Delivery Model.

2. Please discuss the ways in which the standards proposed in this Service Delivery Model relate to the Model's Service Definition.

Service Definition: A range of client-centered services that link clients with health care, psychosocial, and other services including benefits/ entitlement, counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. In addition, Peer Education Counseling is coupled with medical case management to offer clients individual therapeutic support services by an individual who may be the same age, gender, and HIV status as the client. This person will have had experienced and resolved the same type of problems as the client. The peer counselor will assist the client with the implementation of the case plan goals and objectives, which may include a recommended therapeutic regimen, medication adherence, compliance with medical procedures and self-care. The Peer Education Counselor will also conduct medical case management services including face-to-face, phone contact, home visits, medical eligibility screenings, educating new client regarding HIV and accompanying client(s) to initial appointments for medical care and other support services.

Coordination and follow-up of medical treatments:

- Assist the client to get primary medical care, if he/she is not in care, using information provided in the Needs Assessment.
- Discuss with the client the reasons for not accessing primary medical care and with client participation determine how the medical case manager can help him/her access primary medical care.
- Discuss with the client what needs to happen so he/she can start primary medical care.
- Coordinate a primary medical care appointment for consenting client within 2 weeks of client contact with medical case manager.
- Assist client to remain in primary medical care.
- Assess possible barriers to continue in primary medical care and assist in their removal.
- Assist the client to adhere to treatment using information provided in the discussion of retention in primary medical care. Discuss with the client strategies to improve adherence to treatment.
- Access outreach services if client remains unreachable after 6 months of not showing for outpatient/ambulatory medical care or medical case management appointments.

(1) Initial assessment of service needs:

The medical case manager shall assess client needs by completing all sections of the Needs Assessment. The medical case manager shall complete the Needs Assessment within three (3) sessions from the time of initial visit.

(2) Development of a comprehensive, individualized service plan: The medical case manager in conjunction with the client shall complete an individualized Action Plan that incorporates the specific needs of the client. Action Plan includes the needs that can be met in the time frame agreed with the client. The medical case manager completes the Action Plan the same day the Needs Assessment is completed. The medical case manager shall assist the client to define medical and social service goals for the needs identified in the Action Plan. The expected results/benefits shall be documented in the Action Plan.

(3) Coordination of services required to implement the plan: The analysis of the Needs Assessment shall assist the medical case manager in determining the referrals needed. Referring medical case manager shall provide client with information of available services. Referring medical case manager shall follow-up and document the results of the referral. Referring medical case manager and provider that receives the referral shall communicate to update each other on the status of the referral.

(4) Client monitoring to assess the efficacy of the plan: The medical case manager shall provide follow-up based on the client Action Plan. The medical case manager shall follow-up the progress of the Action Plan and adherence to treatment and medications. Checking lab reports and medication pick-ups at the pharmacy constitute follow-up. The medical case manager shall take every possible interaction with the client as a window of opportunity to assess and/or reinforce access, retention and adherence to treatment. The medical case manager will collect, plot, analyze and monitor and review with client his/her CD4 and viral loads at a minimum biannually. Each client will be assessed to determine whether multidisciplinary case staffing is warranted upon receipt and analysis of lab results.

(5) Periodic re-evaluation and adaptation of the plan as necessary over the life of the client: The medical case manager shall conduct: a) continuous client monitoring to assess the efficacy of the Action Plan and b) Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary. The medical case manager shall document the reassessment in the Progress Notes. The medical case manager shall revise and update the Action Plan at reassessment.

Forms of communication: This includes all types of case management including face-to-face, phone contact, and any other forms of communication. The medical case manager shall document the follow-up in the Progress Notes, including phone calls, mail, face-to-face and/or electronic communication.

3. How do the standards proposed in this Service Delivery Model address the vision, mission, goals, and objectives of the Broward EMA's Comprehensive Plan? Currently, these are:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction,

identifying priority needs, and planning a responsive system of care.

- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

Service delivery shall be conducted with cultural competency by culturally competent service providers. The medical case manager shall ensure client cultural needs are addressed in Action Plan. Upon a face-to-face discharge medical case managers will review community resources with client. The medical case manager shall verify client's eligibility is established by reviewing the certification in the designated HIV MIS System to ensure client's access to all services and the status of Ryan White as payer of last resort. Medical case management shall conduct chart reviews at least quarterly to ensure appropriate documentation of all services, including referrals, follow-up and reassessment. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, HAB HIV Medical Case Management Performance Measures, etc.).

Activities of medical case managers include, but are not limited to:

- Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
- Complete Needs Assessment
- Complete Plan of Care (POC)
- Monitor service delivery and client adherence to POC
- Follow-up POC
- Re-assess Needs Assessment and POC
- Promote medical adherence, including medication
- Facilitate access to primary medical care, medications, home health care, specialty care
- Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
- Coordinate medical referrals
- Monitor referral status
- Coordinate medical care needs
- Ensure all non-Ryan White Part A medical clients' verified Viral Loads, CD4 counts are available and entered into designated HIV MIS system
- Refer to disease management programs non-adherent clients
- Identify, refer, follow-up social support service needs identified in the POC
- Coordinate client care with all appropriate parties
- Document all interventions
- Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)

4. How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services? How does this service delivery model ensure integration of peers into treatment and care?

How does this service delivery model address identifying, engaging, and retaining PLWHA in HIV core services?

Each client will be assessed for barriers to access care, treatment adherence, adherence to medications, and culturally specific needs. An individual Action Plan will be developed in agreement with the client. The Action Plan will be based on identified needs and will address client's cultural needs. Medical Case Managers will facilitate access to primary medical care, medications, home health care, specialty care and facilitate referrals to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies). Each client will be assisted to remain in or return to primary medical care and adhere to treatment.

How does this service delivery model ensure integration of peers into treatment and care?

Peer Education Counseling is coupled with Medical Case Management to offer clients individual therapeutic support services by an individual who may be the same age, gender, and HIV status as the client. This person will have had experienced and resolved the same type of problems as the client. The peer counselor will assist the client with the implementation of the case plan goals and objectives, which may include a recommended therapeutic regimen, medication adherence, compliance with medical procedures and self-care. The peer counselor will also conduct medical case management services including face-to-face, phone contact, home visits, medical eligibility screenings, educating new client regarding HIV and accompanying client(s) to initial appointments for medical care and other support services.

Responsibilities of Peer Counselors

- Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
- Monitor service delivery and client adherence to POC
- Follow-up POC
- Promote medical adherence, including medication
- Facilitate access to primary medical care, medications, home health care, specialty care
- Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
- Coordinate medical referrals
- Monitor referral status
- Coordinate medical care needs
- Refer to disease management programs non-adherent clients
- Identify, refer, follow-up social support service needs identified in the POC
- Coordinate client care with all appropriate parties
- Document all interventions
- Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)
- Assist Medical Case Manager in care coordination

To be completed by the Quality Management Committee only:

Service Delivery Model Request for Approval Decision

☒ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the respective QI Network for review and resubmission.

To be completed by the HIV Planning Council only:

Decision

☐ Approved

☐ Denied

Reason(s) for denial:

If denied, this form will be sent to the Quality Management Committee and the respective QI Network (if necessary) for resubmission.