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

BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

MEETING AGENDA
Thursday, March 27, 2014 at 9:00 a.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 3/27/14 Meeting Agenda
   f. Approval of 2/27/14 Meeting Minutes
3. **FEDERAL LEGISLATIVE REPORT** (Kareem Murphy) (Handout A)
4. **PUBLIC COMMENT** (Up to 10 minutes)
5. **CONSENT ITEMS**
6. **NEW BUSINESS – 9:15 a.m.**
   Consultant Emily Gantz- McKay
   - Findings and recommendations from the review of the Comprehensive Plan (Handouts B&C)
   - Outcome data – what does it mean and how does the HIVPC use it? (Handouts D, E, & F)
7. **DISCUSSION ITEMS – 11:30 a.m.**

Discussion #1	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.
Justification:	To remove the restrictions that may exist, and expand the roles, responsibilities, functions, and leadership structure to include all Ryan White Parts, Prevention, and other community stakeholders.
Proposed by:	Part A Executive Committee

8. **MARCH COMMITTEE REPORTS**
   a. **MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)**
   March 6, 2014 *Chair: H.B. Katz, Vice Chair: T. Wilson*

A. Work Plan Item Update / Status Summary:
Work Plan 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 25 Council members, 40% of which are unaffiliated consumers. The Committee also reviewed several active applicants but did not make a decision about moving them forward for HIVPC approval. Work Plan Item 5.1 - The Committee reviewed their work plan and made significant changes to the work plan for the upcoming 2014-2015 fiscal year. A review of the Policies & Procedures was tabled until the next meeting. Work Plan Item 2.1- This item was tabled for the next meeting. Work Plan Item 1.11- This item was tabled for the next meeting.
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 that they be informed about any community events being attended or hosted by other HIVPC committees.

E. Other Business Items:

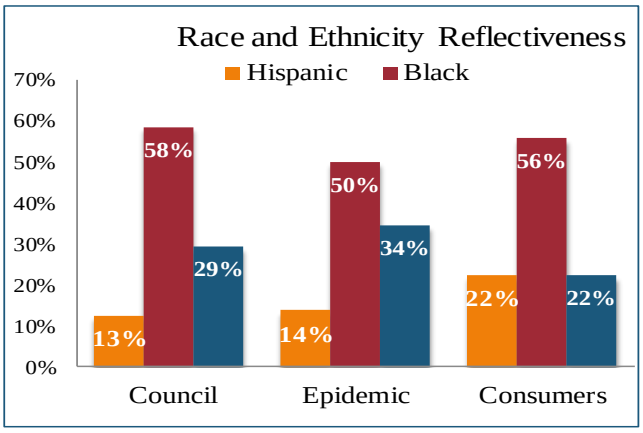
Agenda Items for Next Meeting: Discuss job descriptions for vacant seats and provide recommendations for appointment, Review Policies & Procedures, Update on the Recruitment & Retention Subcommittee, Council Member Appreciation, Review and Revise the Mentoring Program, Plan and Implement Trainings. *Next Meeting Date*: April 3, 2014- 9:30 a.m. - Room A-335 at the Governmental Center.

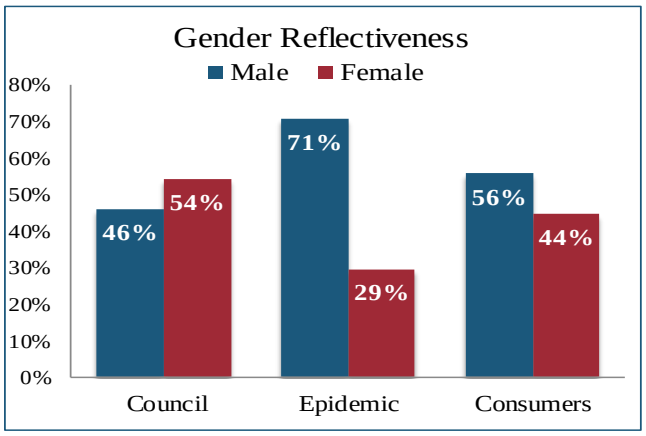
HIV Planning Council Membership Report for March 24, 2014

Gender	Council	Epidemic	Consumers		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**		**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

The following HIV Planning Council (HIVPC) seats are currently vacant:

- Grantees of Other Federal HIV Programs – Prevention
- Hospital/Healthcare Planning Agencies
- Local Public Health Agencies
- Social Services Provider
- Representative for Former Federal/State/Local Prisoners

b. **JOINT CLIENT COMMUNITY RELATIONS COMMITTEE (JCCR)**

March 4, 2014 *Part A Co-Chair: Y. Reed, Part B Co-Chair: L. Washington*

A. Work Plan Item Update / Status Summary:
Work Plan Item 2.3 – Members discussed ideas to increase client participation in JCCR meetings. A list of alternate meeting locations was created, with a focus on facilities located in areas beyond central Broward County. Work Plan Item 2.2 – In an effort to gain more participation from Hispanic and Latino clients, JCCR members decided to try to collaborate with two Hispanic and Latino community organizations for a May Cinco de Mayo event. Work Plan Item 1.2 – The committee heard a Hot Topic presentation by Mario DeSantis from HOPWA. Mr. DeSantis informed the members about the revisions being made to the HOPWA Policies and Procedures. Work Plan Item 1.1 – This item was tabled until the next meeting. Work Plan Item 4.2 – This item was tabled until the next meeting. Work Plan Item 4.1 – This item was tabled until the next meeting.
B. Rationale for Recommendations:
None.
C. Data Reports / Data Review Updates:
None.
D. Data Requests:
Staff was requested to communicate with Latino Salud and Hispanic Unity about collaborating for a May Cinco de Mayo event.
E. Other Business Items:
Agenda Items for Next Meeting: Hot Topic Presentation, Social Media Strategy, Annual Evaluation, Work Plan/Policies and Procedures, Plan for Next Community Meeting. *Next Meeting Date*: April 1, 2014.

c. **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.

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

March 17, 2014 *Chair: C. Grant*

A. Work Plan Item Update / Status Summary:
Work plan item 2.3 – The Committee reviewed the annual QM Work Plan and noted that the only item not achieved in FY13-14 was the proposed Mental Health chart review. Work plan item 2.5 – The Committee reviewed the annual Accomplishments and Challenges. Members discussed inviting private physicians to quarterly Medical QI Network meetings in order to open communication and provide shared trainings. The possibility of offering CME credits was discussed. Work plan item 2.4 – The Committee reviewed and approved the revised Oral Health Care Service Delivery Model. Work plan item 1.1 – The Committee reviewed the February NQC In+Care Retention Measures between December 2011 and February 2014 (the gap measure, medical visit frequency, patients newly enrolled in medical care, and viral load suppression). The Committee also reviewed the revised HAB Performance Measures and was informed that the measures will be programmed in PE.

B. Rationale for Recommendations:
Members approved the Oral Health Care SDM and requested that the definition of AAP (American Academy of Periodontology) be added. The OHC SDM will be sent to Planning Council for final approval.
C. Data Reports / Data Review Updates:
NQC In+Care Retention Measures
D. Data Requests:
Members requested that the SFAN definition of viral load suppression be provided to the Committee and documented in writing.
E. Other Business Items:
There was no other business.
F. Agenda Items for Next Meeting:
Standing Agenda Items, Approval of Annual QM Work Plan, Quarterly Network Update, and Follow-Up on Data Requests. *Next Meeting Date*: April 21, 2014 from 12:30pm-4:30pm.

G. PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)

March 19, 2014 *Part A Co-Chair: C. Taylor-Bennett, Part B Co-Chair: Vacant*

The March PSRA meeting was cancelled.

H. PART A EXECUTIVE COMMITTEE

March 20, 2014 *Chair: B. Gammell, Vice Chair: S. Kuryla*

A. Work Plan Item Update / Status Summary:
Committee Chair Reports – The Committee reviewed the Chair reports for the March HIVPC meeting and the HIVPC Chair reminded Chairs to move forward only with written reports for the meeting, if possible. The MCDC Chair requested an update about the 60-day sub-committee be added. Healthcare Reform Update on HIVPC Agenda – This item will be tabled until the April 2014 HIVPC meeting. Joint Part A & Part B – The Committee had a lengthy discussion on opening the language of the HIVPC By-Laws to better include all HIV/AIDS community stakeholders in Broward County. A motion was made to redefine or remove the word 'joint' from the By-Laws to remove the restrictions that exist in making the HIVPC more inclusive of all community stakeholders. By-Laws Parking Lot Items – The Committee discussed the By-Laws parking lot items and re-adjourning the ad-Hoc By-Laws committee. The HIVPC Chair hopes to find a chair for By-Laws soon so the committee can begin meeting. Discussion of Joint Executive Retreat – Due to consultant Emily Gantz-McKay being available for training, a motion was made to cancel the Joint Executive Retreat and to instead hold a Part A Executive Committee meeting to work on committee work plans and the comprehensive plan. HIVPC Meeting – A motion was made to change the time of the HIVPC meeting to 12:30 p.m., beginning with the April meeting.
B. Rationale for Recommendations:
The motion about the joint language was made to remove the restrictions that may exist, and expand the roles, responsibilities, functions, and leadership structure to include all Ryan White Parts, Prevention, and other community stakeholders. The motion to change the time of the HIVPC meeting was made to make it easier for attendees who use the bus system to get to the meetings.
C. Data Reports /Data Review Updates:
None.
D. Data Requests:

Staff was requested to do research on alternate meeting locations for the HIVPC meeting.
E. Other Business Items:
None. *Items for Next Meeting:* Review & Revise HIVPC Grievance Process, Review recommended changes to By-Laws. *Next Meeting Date*: April 17, 2014 at 12:30 p.m.

9. GRANTEE REPORTS

a) Part A

b) Part B (Handout G):

RYAN WHITE PART B REPORT	**ADAP Report thru February 2014**
Budget for year (April 2013 – March 2014): $1,101,929 Expenditures (April – February): $743,018 Balance: $358,911 Services Categories Funded /Amounts • Home Delivered Meals (serve 5-10 clients a year): $2479 • Medication Co Payment (serve approximate 121 clients a month): $310,000 • Medical Transportation (serve 1254 unduplicated clients to date): $134,330 • Non-Medical Case Management (Eligibility serves approximate 750-800 clients a month): $304,928 • Residential Substance Abuse (served 28 clients Nov 15-Feb 28): $240,000	Clients enrolled April 2013 **3646** – February 2014 **4073** # Medicare D Clients: 313 # AICP Transition Clients: 294 % Clients by Viral Load 0-75: 78% 76-500: 8% 501-5,000: 3% 5,001-30,000: 3% 30,001-55,000: 2% 55,001: 5% FPL 0-100%: 1822 101-150%: 982 151-200%: 448 201-250%: 362 251-300%: 197 301-350%: 137 351-400%: 57

c) Part C

d) Part D

e) Part F

f) HOPWA

g) Prevention

10. UNFINISHED BUSINESS

11. ANNOUNCEMENTS

Review revised County attendance policy (Handout H)

12. PUBLIC COMMENT (Up to 10 minutes)

13. REQUEST FOR DATA

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

15. ADJOURNMENT

PLEASE COMPLETE YOUR MEETING EVALUATIONS

HIV Planning Council and Committee Staff

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Welcome Brithney Johnson! Ms. Johnson is a training professional, formerly with the Broward County Supervisor of Elections office. She has been the driving force behind a renowned training program and cultivated relationships with public officials, community leaders, and over 10,000 Election Day Workers through outreach and training opportunities. Ms. Johnson earned her Bachelor of Arts in Business Administration from the University of Florida with a specialization in Health and Behavioral Sciences. She holds a Master of Science in Public Health from Nova Southeastern University. Ms. Johnson previously worked with the Broward County YMCA and BRHPC's TOUCH program. Ms. Johnson has experience in both the public and non-profit sector – creating and administering innovative training and educational programs, evaluating and presenting best practices research with community leaders, and honing her program evaluation skills throughout both her academic and professional career. She is committed to performing strategic client and project management functions and utilizing her ability to provide high-quality service to meet the needs of a diverse community. Ms. Johnson will provide support to the Planning Council and Committees.

Welcome Cady Sandler! Ms. Sandler is a two-time University of Florida graduate, and holds a Bachelor of Arts in Political Science and Master of Public Health degree with a concentration in Health Management and Policy. Ms. Sandler has a strong interest in community based health initiatives and health policy, and brings a strong knowledge of public health, policy development, implementation and analysis to her new position. Her previous experience in the public health world includes working on the nationally recognized Control Flu vaccination program, developing and implementing a healthy food policy for Southwest Advocacy Group in Gainesville, Florida, and analyzing Florida's Medicaid Reform measures as part of the Medicaid Reform Evaluation team at the University of Florida. Ms. Sandler will be providing support to the Planning Council and Committees.

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BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

MEETING MINUTES

Thursday, February 27, 2014 at 9:00 a.m.

Attendance					
#	**Members**	**Present**	**Absent**		**Guests**
1	Kuryla, S. Chair	**X**			Schiffer , K.
2	Gammell, B. Vice-Chair	**X**			Sullivan, G.
3	Wilkins, D.	**X**			Poon, K.
4	DeSantis, M.	**X**			Arnoux, J.
5	Dyer, L.		**A**		Sabatino D.
6	Grant, C.	**X**			Bates, C.
7	Hayes, M.	**X**			Rodriguez, J.
8	Bhrangger, R.	**X**			Agbodzakey, J.
9	Holness, Comm. D. V.C.	**X**			Popper, D.
10	Katz, H. B.	**X**			
11	Marcoviche, W.	**X**			**Grantee Staff**
12	McBain, M.	**X**			Vargas, J. (Part A)
13	Moragne, Dr. T.	**X**			Copa, R. (Part A)
14	Proulx, D.	**X**			Jones, L. (Part A)
15	Schweizer, M.		**A**		Green, W. (Part A)
16	Siclari, R.	**X**			DeGraffenreidt, S (Part A)
17	Spencer, W.*	**X**			
18	Taylor-Bennett, C.		**A**		
19	Tomlinson, K.	**X**			
20	Wilson, T.	**X**			
21	Wynn, J.		**A**		
22	Parker-Maysonet, P.		**E**		**HIVPC Support Staff**
23	Reed, Y.	**X**			Rosiere, M.
24	Creary, K.	**X**			Eshel, A.
25	Burgess, D.	**X**			Sandler, C.
26	Mercer, A.	**X**			McEachrane, T.
A1	Coscarelli, M. (Alt)		**E**		
	Quorum=14	**21**	**4**		***attended via phone**

1. CALL TO ORDER

The Chair called the meeting to order at 9:10 a.m. without Quorum. Quorum was achieved at 9:11 a.m.

2. MOMENT OF SILENCE

A moment of silence was observed.

3. WELCOME AND PUBLIC RECORD REQUIREMENTS

The Chair welcomed everyone and self-introductions were made. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements,

which includes the recording of minutes. In addition, it was stated that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. The Chair reviewed excused absences.

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

a. Approval of 1/23/14 Meeting Minutes

Motion #2	To approve the 1/23/14 Meeting Minutes		
Proposed by:	Creary, K.	**Seconded by:**	Tomlinson, K.
Action:	Passed Unanimously		

4. PUBLIC COMMENT (Up to 10 minutes)
None

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

Members reviewed the report (copy on file). The 2013-2014 fiscal year funding cycle will be coming to a close at the end of February followed by an early release of FY 2015 federal budget. Level funding is anticipated for all HIV/AIDS programs with possible slight increases for Ryan White and AIDS Drug Assistance Program (ADAP) titles.

Planning Council members are encouraged to participate in public testimonies held by the Senate Labor-Health and Human Services-Education Appropriations Committee. The deadline is May 23rd. For anyone who is interested in participating, Mr. Murphy and his team can provide instructions on coordinating with the Broward County Office of Intergovernmental Affairs.

In January President Obama signed an omnibus appropriations bill that will provide $2.3 billion to domestic health-related HIV/AIDS programs including $2.293 billion for the overall Ryan White title with $1.97 billion going to Ryan White Parts A and B. *Please note that there is a correction regarding the program highlights: ADAP will receive a $900 million increase.*

Unfortunately, Mr. Murphy was unable to announce in person that he has accepted a position as the Health and Human Services lobbyist for Hennepin County, Minnesota. Mr. Murphy will continue to remain engaged and supportive of the Planning Council's needs.

6. CONSENT ITEMS

The following four (4) consent items were presented for ratification by the Council. Consent #1 was pulled by a member to become Discussion item #1.

~~**Consent # 1**~~	~~**To remove Joey Wynn as a member of the Broward County HIV Health Services Planning Council** (representing Social Service Providers, including Providers of Housing and Homeless Services) due to a change in his professional responsibilities such that he no longer represents the constituency for which he was originally appointed. (originally appointed to represent Broward House)~~
~~**Justification**~~	~~**Membership Council/Development Committee Policies and Procedures** state that: The Committee will review the status of current members and alternates who: Fail to maintain the status to represent the membership category set forth in the Act Fail to maintain qualifications set forth in Broward County Resolution #94-1286 At such time as a member's professional responsibilities change such that he/she no longer represents the constituency for which he/she was originally appointed, that member shall immediately resign and his/her seat shall be filled in accordance with the provisions contained in the~~

	~~Membership policies and procedures. The member shall have the ability to reapply for membership to the Council.~~ ~~Social Service Providers, including Housing and Homeless Services Providers Job Description:~~ ~~a. Share information about how Council actions will affect social service agencies, providers and clients. b. When requested, provide data on funding sources and utilization by their HIV/AIDS clients.~~ ~~**HRSA Policy Notice 11-03: Residence of Planning Council Members and Consortia Members** states that: "to qualify for organizational representation on a Council, the representative from the organization listed below ***must provide services within the geographic boundaries of the EMA***/TGA" c. Social service providers, including providers of housing and homeless services.~~
~~**Proposed by:**~~	~~Executive Committee~~

Consent # 2	To request professional help with the Membership/Council Development Committee Recruitment Plan. A subcommittee to be set up for 60 days to report back to the Membership Committee what items should be included in the Recruitment Plan and to determine the appropriate professional help needed. Each Chair will be asked to appoint a member.
Justification	To have a feasible and realistic recruitment strategy that can be followed by the Membership/Council Development Committee as well as the HIV Planning Council.
Proposed by:	Executive Committee

Consent #3	To appoint Lakytia Clayton to the Joint Client/Community Relations Committee
Justification	Ms. Clayton has shown commitment to attending meetings and dedication to attending and helping with JCCR's community events.
Proposed by:	Joint Client/Community Relations Committee

Consent #4	To appoint Karen Creary to the Joint Client/Community Relations Committee
Justification	Ms. Creary has a longstanding commitment to the committee.
Proposed by:	Joint Client/Community Relations Committee

Motion #3	To approve Consent Items # 2,3 and 4.		
Proposed by:	Creary, K.	**Seconded by:**	Reed, Y.
Action:	Passed Unanimously		

7. DISCUSSION ITEMS

Discussion # 1	**To remove Joey Wynn as a member of the Broward County HIV Health Services Planning Council** (representing Social Service Providers, including Providers of Housing and Homeless Services) due to a change in his professional responsibilities such that he no longer represents the constituency for which he was originally appointed. (originally appointed to represent Broward House)
Justification	**Membership Council/Development Committee Policies and Procedures** state that: The Committee will review the status of current members and alternates who: -Fail to maintain the status to represent the membership category set forth in the Act -Fail to maintain qualifications set forth in Broward County Resolution #94-1286 At such time as a member's professional responsibilities change such that he/she no longer represents the constituency for which he/she was originally appointed, that member shall immediately resign and his/her seat shall be filled in accordance with the provisions contained in the Membership policies and procedures. The member shall have the ability to reapply for membership to the Council. Social Service Providers, including Housing and Homeless Services Providers Job Description: a. Share information about how Council actions will affect social service agencies, providers and

	clients. b. When requested, provide data on funding sources and utilization by their HIV/AIDS clients. **HRSA Policy Notice-11-03: Residence of Planning Council Members and Consortia Members** states that: "to qualify for organizational representation on a Council, the representative from the organization listed below ***must provide services within the geographic boundaries of the EMA***/TGA" - c. Social service providers, including providers of housing and homeless services.
Proposed by:	Executive Committee

Members discussed the removal of Joey Wynn from the Council. One member inquired about whether Mr. Wynn's violation of the mandated seat requirements jeopardized motions made in committee meetings. The Grantee stated that because Mr. Wynn was considered a full member of the Council at the time, the motions remain valid.

It was noted by the Grantee that the process for removal will be placed on an upcoming Broward County Board of Commissioners agenda. Members discussed the reassignment process for members who are no longer eligible to hold their current seat. Members are typically requested to change their seat by reapplying to the Council. The HIVPC Vice Chair stated that there were numerous attempts by support staff to contact Mr. Wynn with no response. The MCDC Chair announced that Mr. Wynn is working for an organization based in Miami and thus, does not meet the constituency requirement for mandated seats on the Planning Council. Discussion Item #1 was approved by Council consensus.

Discussion #2	To approve the Policies and Procedures as written on February 20, 2014, with the exception of the job description of alternate members.
Justificatio	Review of Policies and Procedures for any needed changes are part of the annual workplan.
Proposed	Membership/Council Development Committee

The following motion was made:

Motion #3	To approve the Policies and Procedures as written on February 20, 2014, with the exception of the job description of alternate members.		
Proposed by:	Katz, H.B	Seconded by:	Grant, C.
Action:	Passed Unanimously		

8. JANUARY COMMITTEE REPORTS

a. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

The report stands as written. At the next meeting a role description for alternates will be created to add to the policies and procedures. The MCDC Chair has requested that each committee chair select a member from their committee to join the ad-hoc subcommittee set to address the Council marketing and recruitment strategies. The HIVPC Vice Chair encouraged members to sign up as mentors for new committee members.

It was noted that MCDC will begin quarterly trainings starting in May. Clarification was given regarding the Representative for Former Federal/State/Local Prisoners seat requirements. The requirement currently states that the appointee must have been in *Federal, State, or local prison and released during the preceding three years at time of appointment.* Once an individual is appointed, they can remain in the seat for any length of time.

b. JOINT CLIENT COMMUNITY RELATIONS COMMITTEE (JCCR)

The report is as stands.

c. JOINT PLANNING COMMITTEE

d. **QUALITY MANAGEMENT COMMITTEE (QMC)**
The February Quality Management Committee meeting was cancelled.

e. **PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)**
The PSRA Part A Co-Chair was not present. The report is as stands.

f. **LOCAL PHARMACY ADVISORY COMMITTEE (LPAC)**
The report is as stands. The Committee is waiting for a cost analysis on how to implement the Gardasil vaccine from the Grantee.

g. **MAI MEDICAL CASE MANAGEMENT WORKGROUP (MAI MCM)**
The Committee is still in discussion regarding the implementation of the service model. Priorities heard a presentation from PROACT which touched upon linkage and reengagement of clients who have not been in care for a certain length of time. The PROACT discussion was continued at the workgroup meeting with a representative from PROACT. The committee has requested that a flow chart be created to see if there is more than one entry point into medical case management (MCM) for clients coming once they go through centralized intake and eligibility determination (CIED). Clients often come in with multiple needs that are identified immediately but the committee would like to see if there is another way for clients to receive MCM without going through the traditional channels of referral from a case manager or physician.

h. **PART A EXECUTIVE COMMITTEE**
The report is as stands.

i. **AD-HOC ADAP ELIGIBILITY COMMITTEE**
Although the meeting was cancelled, the chair recounted the discussion at the 64D-4 administrative rule workshop. The Chair announced the eligibility requirements for ADAP *(copy on file*). It was noted that next enrollment period is in October and that clients must utilize an ADAP contracted pharmacy to receive premium assistance, medication copayment or deductible assistance from Part A. Although CVS is the preferred pharmacy by the state, clients are allowed to stay with the pharmacy of their choice. The Chair announced that the Eligibility Committee is now disbanded.

9. GRANTEE REPORTS (up to 10 minutes)

a) **Part A:**
The Grantee announced to members Council that Mr. Murphy will continue to provide legislative reports to the Council. The Grantee recently held a conversation with the Part A project officer and there were no updates on when to expect the grant award. On Feb 18th there was a conversation among six Part A grantees regarding reduction in funding. It was confirmed by the project officer that Broward County will not receive a reduction. The West Palm Beach EMA may potentially receive $100,000 in reduced funding.

The Grantee recounted a Part A meeting in Tallahassee with HIV/AIDS Bureau and ADAP. The Bureau announced that it will not have infrastructure to expand the ADAP Premium Plus program before next enrollment period. They will expand for 500 clients, of which 1 or 2 were on PCIP and 1-2 who were kicked off their insurance for not meeting essential benefits. Will only accept marketplace plans for clients who meet specific criteria (i.e. high cost). Parts A will have to provide Health Insurance Continuation Program (HICP) until next enrollment period. It was noted that these costs are unanticipated and will be discussed in the upcoming PSRA process. The grantees have agreed to develop an implementation plan for HICP programs around the state in with minor variations.

The Grantee stated that there is concern with the lack of a coordinated process among Parts in response to the moving clients into the Marketplace. The Grantee is considering an outside consultant (TA) to help with the coordination of Parts regarding this issue. There will be ongoing discussions regarding cost-sharing of premiums between ADAP and Part A. The

Grantee stressed the importance of determining the best possible plan for coordination among Part A and B to have a seamless continuum of care within Broward County.

The Grantee announced that on April 22nd the Board of County Commissioners will sponsor Denim Day to bring awareness of the fight to end sexual violence.

There was brief discussion about Louisiana and part of the reason why insurance companies are on board with accepting third party payment due to the fact that because the client population is not what was anticipated. The Grantee suggested that a workgroup be created for evaluating Marketplace plans.

b) **Part B:**
The written Part B Grantee report was provided detailing expenditures up to January 2014. There were no home-delivered meals in January. Non-Medical Case Management conducted 790 eligibility interviews in January. Medication co-payment served 130 clients and 3 clients served for Mail Orders. Medical Transportation for January 2014: A total of 452 (31 day) passes distributed. The new Residential Service Category served 15 unduplicated clients.

There was brief discussion regarding the Residential Substance Abuse program. It was noted that allocations can change according to the needs.

10. OTHER REPORTS

a) **Part C:**
The Grantee announced that the program is still waiting for funding. The funding cycle begins in May. A notice was received that there will be partial funding in May with the remainder of funds received in August.

b) **Part D:**
The Grantee announced that the grant year will end in late July. In the next year, the fiscal year will end in early July. At the end of 2013 there were a116 pregnancies with 68 HIV negative births. To date there have been 25 pregnancies. It was noted has found an increase in women who are diagnosed and pregnant. The Grantee recounted a particularly difficult story of a client of a 13 year old, newly-diagnosed client with a much older partner.

c) **HOPWA:**
Funding for Housing at Minority Development and Empowerment, Inc. (MDEI) was pulled back by City Commission in January. The dollars have been split between Sunserve and Care Resource. It was noted that Sunserve has hired an individual who speaks Spanish and Creole and Care Resource is currently undergoing a recruitment process.

d) **Prevention:**
The FLDOH-BC Prevention representative announced the current social marketing anti-stigma campaigns both developed by the Pride Center. The anti-stigma campaign uses popular paintings on posted on city buses to promote acceptance for individuals living with HIV/AIDS. The social marketing campaign has been created to ensure that people know their status.

The representative introduced a new employee who has been hired as director of the Men's Health Awareness Program. The Director will also be focusing on HIV and viral Hepatitis C among specific populations. The Director noted that the program will be working with the University of Miami physicians currently involved in Pre-Exposure Prophylaxis (PrEP). A town hall meeting addressing PrEP in the community. The program will be working with the Pride Center and physicians to determine dates good for all parties.

e) **Part F:**

The Grantee was not present.

11. UNFINISHED BUSINESS

None.

12. NEW BUSINESS

None.

13. ANNOUNCEMENTS

a. Marketplace Open Enrollment ends March 31, 2014.

A representative from the Community Access Center (CAC) announced that Black Treatment Advocates Network (BTAAN) will be hosting a Ladies Night to talk about prevention and issues among positive women on March 7, 2014 at 7:00 p.m. – 10:00 p.m. at the Main Conference Center at Memorial Hospital.

Commissioner Holness thanked the CAC and BTAAN for the Ladies Night event on March 7th as well as for the press conference awareness event on March 14th.

An announcement was made regarding HIV Crossroads. IT was noted as a resource to help providers navigate the Affordable Care Act (ACA) with clients.

The Part B Chair announced that that SFAN will be meeting at 6:00 p.m. at the women's complex on Thursday, March 6th.

The HIVPC Chair thanked the Council or their support and looks forward to remaining Council as Vice Chair.

14. PUBLIC COMMENT

None.

15. REQUEST FOR DATA

None.

16. AGENDA ITEMS FOR NEXT MEETING: March 27, 2014 at 9:00 a.m. **VENUE:** BRHPC

17. ADJOURNMENT

Without objection, the meeting was adjourned at 11:20 a.m.

HIV PLANNING COUNCIL ATTENDANCE CY 2014

Member	1/23/14	2/27/14
Creary, Karen	X	X
Dyer, Leroy	X	A
Gammell, Bradford	X	X
Grant Claudette	X	X
Hayes, Marie	X	X
Bhrangger, Ronald	X	X
Holness, Dale V.C. (Comm)	X	X
Katz, Bradley	X	X
Kuryla, Samantha	X	X
Marcoviche, William	X	X
Moragne, Timothy	A	X
Siclari, Rick	X	X
Spencer, Will	X	X
Taylor-Bennett, Carla	X	A
Tomlinson, Karlene	A	X
Wilson, Tara	A	X
Wynn, Joey	X	X
Proulx, Dionne	X	X
Parker-Maysonet, Patricia	X	E
DeSantis, Mario	X	X
McBain, Marsha	A	X
Reed, Yolonda	A	X
Schwiezer, Mark	X	A
Wilkins, Debbie	X	X
Quorum = 14	Yes	Yes
Coscarelli, Monica (Alt 1)	A	E

HANDOUT A

Update for Broward County
HIV Health Services Planning Council

From: Kareem Murphy
Date: March 25, 2014

President Obama's Fiscal Year 2015 Budget:

President Obama's Fiscal Year (FY) 2015 budget is largely good news for HIV/AIDS treatment and care providers. It includes a small increase of $4 million for Ryan White Programs ($2.323 billion). Part A grants are level funded. So the increase would support Part C grants. ADAP funding would continue to be funded through an inter-fund transfer from the Public Health and Emergencies fund, as has taken place over the past several years. HOPWA would receive a $2 million increase. Overall and in the context of the current budget and fiscal situation, this is a good budget. It does not represent the increases we know would bring the system closer to need, but it is better than many expected.

- $2.293+ billion for the overall Ryan White title
- $1.07+ billion for Ryan White Parts A and B
- $900 for ADAP, factoring in intra-agency transfers and "new" funding.
- $332 million for HOPWA, a $2 million decrease

The budget is only the first step in the funding process. Congress is scheduling oversight hearings on the budget now and that will take place over the next month. The first appropriations bills are not expected until May at the earliest. If custom follows this year, the Labor-HHS bill, funding Ryan White programs, will be the last. This is an election year and there is much speculation as to a potential turnover of control of the Senate. Completion of the appropriations bills before the election is questionable at this point.

Progress on Reauthorization Questionable

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.

Additionally, on March 14th, Rep. Renee Ellmers (R-NC) introduced the "Ryan White Patient Equity and Choice Act of 2014." Reps. Eddie Bernice Johnson (D-TX) and Bennie Thompson (D-MS) are co-sponsors. The bill would force clarity and the use of evidence-based methods in the Ryan White awards process, things the County and the Planning Council have sought for years. Stakeholders are concerned with certain new mandates in the bill including the provision of care through the medical home model and the imposition of a version of medical savings accounts for patients participating in a Ryan White system of treatment/care. Despite the lead

sponsor being a nurse in the Majority party and this being a bi-partisan bill, further progress is doubtful. There is no companion legislation in the Senate.

New White House AIDS Czar

The White House recently announced the appointment of a new director of the White House Office of National AIDS Policy. Stakeholders across the country have praised President Obama's appointment of 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 Douglas Brooks to the post. He was most recently the Senior Vice President for Community, Health, and Public Policy at the Justice Resource Institute. In addition to a lifetime career in community development he was also a member of the Presidential Advisory Council on HIV/AIDS (PACHA). He will be the first person of color to hold this post in the Obama Administration. The San Francisco AIDS Foundation called his selection "an inspired selection."

Broward County 2012-2015 Comprehensive Plan: Updated Work Plan based on UCHAPS "Crosswalk" PowerPoint[1] *Goals, Objectives, Tasks, and Activities – Updated 3/5/2014*					
Goals, Objectives, Tasks, and Activities	**Responsibility**	**Timeline**	**Performance/Outcome Measures**	**Progress as of 1-31-2014**	**Notes**
Broward EMA Goal: Improve health, reduce HIV transmission, and reduce community viral load • Improved access to and retention in HIV care for target populations[2] • Timely entry into HIV care • Prevention of vulnerable clients from dropping out of care					
BCHD Objectives, Tasks, and Activities					
NHAS Goal 1 - Reduce the number of people who become infected with HIV By 2015: 1. Lead efforts to lower the number of new infections by 25% 2. Reduce the HIV transmission rate by 30% 3. Increase the number of people who know their serostatus from 79% to 90%					Very difficult to measure/ estimate at a regional level
Objective 1.1 Lower number of annual	DOH-Broward	07/2014	Percent decrease of annual		

[1] This chart updates all Prevention-related content in the original comprehensive plan work plan, using the UCHAPS "Crosswalk" PowerPoint rather than the original comprehensive plan content. The care and treatment content is similar; the chart uses the Crosswalk content as a foundation, then includes content that was not in the Crosswalk but was in the original comprehensive plan work plan, highlighting it in yellow. Additional tasks listed in other parts of the comprehensive plan are not included. Content is presented in the order of the Crosswalk; outline numbering has been added since the Crosswalk does not include it. Responsibilities are included as stated in the Crosswalk, but additional entities specified in the comprehensive plan are also provided. Measures clearly stated in the comprehensive plan are included. Other measures will be added once the Goals, Objectives, Tasks, and Activities have been agreed upon.

[2] A number of different but overlapping target populations are identified in the comprehensive plan. The primary target population for the NHAS and EIIHA is individuals unaware of their status, defined as: "any individual who has not been tested for HIV in the past 12 months, or any individual who has not been informed of their HIV test result (HIV positive or HIV negative), or any HIV positive individual who has not been informed of their confirmatory HIV test result," while "Secondary target populations include individuals aware of HIV status but not in care, individuals receiving medical care but not HIV care, individuals lost to follow-up, and sporadic users of HIV care" (p 91). HRSA identified the following target populations in the most recent Comprehensive Plan Guidance: Adolescents, Homeless, IDU, and Transgender. Task 1.1.1 of the work plan lists gay/bisexual men, transgenders, Blacks, Latinos, and substance users. The comprehensive plan also lists five emerging populations with special needs (p 94): Homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM.

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infections by 25%	Prevention		infection rates as of FY 2012.		
1.1.1 Increase the number of HIV tests conducted in healthcare settings by 5% each year 1. Collaborate with 6 hospitals to provide Emergency Department (ED) testing as part of routine medical care 2. Collaborate with 12 primary care providers to provide testing as routine care 3. Meet with hospital EDs, administrators and providers on importance of routine testing **4.** Provide TA and physician tool kits to enhance provider skills in implementation of HIV testing as part of routine medical care	DOH-Broward Prevention	12/31/2015 6/30/2014 6/30/2014 7/31/2014	Percent increase in annual number of HIV tests conducted in healthcare settings. Monitoring outputs 1.number of primary care physicians trained 2.symposiums held 3.grand rounds 4.face to face meetings 5.Tool kits provided	1. Two (2) hospitals currently provide E.D. testing: Memorial Regional and Broward Health2. Eleven (11) physicians have been identified and been trained for Hep C and HIV routine testing 3. Face to face meetings have been conducted with 8 birthing hospitals with (2) Grand Rounds conducted from July-December 2013 and a Perinatal symposium conducted on Nov. 1st, 2013. Three additional physician (3) Grand Rounds were conducted January-March 2014. Transgender Medical Symposium to be held April 10-11, 2014. Tentative Grand Rounds for physicians April 24th on PrEP. April 30th community forum on PrEP. Physician Medical Symposium for routine HIV testing to be held May 14, 2014. 4. Items/publications for inclusion in HIV Physician Tool Kit have been identified as	

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				well as billing information for HIV testing and counseling services.	
1.1.2 Increase number of tests conducted in non-healthcare settings by 5% each year 1. Fund 6 targeted HIV testing initiatives 2. Provide TA to enhance skills in implementing targeted testing and social network strategies 3. Provide training on HIV testing technologies **4.** Encourage contracted agencies to provide expanded hours and days for testing	DOH-Broward Prevention	07/01/2014 Ongoing Ongoing Ongoing	Percent increase in annual number of HIV tests conducted in non-healthcare settings. Monitoring outputs: 1.Technical Assistance 2. 500/501Trainings	1.DOH-Broward currently funds nine (9) testing providers 2. Finding Positives training completed. CDC contacted to provide SNS training. 3. Monthly Trainings are conducted as part of 500/501 training. 4. Testing hours/days are being reviewed during all contract monitoring site visits	
Objective 1.2 Decrease HIV transmission rate by 30%	DOH-Broward Prevention		Annual HIV transmission rate among newborns.	No new perinatal infections have been reported in 2013.	
1.2.1 Reduce to zero the number of pediatric HIV transmission cases 1. Educate OB/GYNs, labor/delivery hospitals & birthing centers to comply w/ FL Statutes & standards 2. Increase HIV testing awareness during 3rd trimester among pregnant women 3. Expand HIV Perinatal Provider Network capabilities with strategies	DOH-Broward Prevention	Ongoing Ongoing In progress	Number of pediatric HIV cases Monitoring outputs: 1.OBGYNs and Pediatricians educated 2.number of members of HIV Perinatal Provider Network 3. number of symposiums 4. number of materials provided	Completed 10/2013 Completed 02/2014 1 .Ninety-six (96) OBGYNs One Hundred- twenty six (126) pediatricians. All eight (8) labor/delivery hospitals have been reached. 2. Provided ACOG recommendations to all OBGYN and Protect Your Baby	

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to reduce transmissions 4. Conduct annual perinatal symposium in collaboration with FLAETC 5. Promote Walgreen's voucher program and other resources for HAART regimens 6. Distribute perinatal toolkits for OB/GYN providers **7.** Conduct HIV clinical/prevention grand rounds at two birthing hospitals each year		Completed Ongoing 07/2014 Completed for 2013, December 2014		cards to all the providers 3. Seven (7) priority areas for 2014 have been formulated. 4.November 1, 2013 4th Annual Perinatal HIV symposium – seventy-two (72) medical providers attended at Coral Springs MC 5.Information was provided to all OBGYN on Walgreens voucher program 6.The perinatal provider network of BCHPPC will work on toolkit to disseminate in 7/2014 7.Provided two (2) grand rounds at Holy Cross LD and Coral Spring LD	Main Priority Areas: 1.training/education, OBGYNs and L&D hospitals, pediatricians, Healthy Start Care Coordinators, Symposium and Grand Round, and Healthy Start Perinatal Classes, 2.Funding for testing 3. legislation & advocacy
1.2.2 Ensure 80% receiving positive result are linked to medical care w/in 90 days of receiving result [Refers to DOH registered test sites only] **1.** Assess local capacity to cross-match databases	DOH-Broward Prevention	In Progress June 2014	Percentage of clients receiving a positive test result linked to care within 90 days of receipt		MOU between Part A Grantee and DOH-Broward in Progress
1.2.3 Ensure 95% of People who received positive result are linked to partner services [Refers to DOH registered test sites only] **1.** Require HIP contracted agencies to	DOH-Broward Prevention	Ongoing	Percentage of newly identified positive test results returned to client Data from the Contract	2013- Total number HIV interviews-includes new (498) and previous positives (970) =1, 468 2013-Total numbers of	

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refer all positives upon diagnosis to partner service **2.** DIS will locate partners, advise of their exposure, offer onsite testing and refer to PROACT		Ongoing	Management HIV Prevention monitoring tool to determine compliance. Monitoring client contact by Linkage Coordinator within 2 business days of STD referral date. Linkage appointment occurs within 5 business days following initial client contact.	partners linked to interviews were, 853. 16 contracts were monitored in 2013	PROACT M & E measures are kept in DOH-Broward Active Strategy Database System
Objective 1.3 Increase the number of PLWHA who know their status by 10%	DOH-Broward Prevention	Ongoing	Percent increase in identification of new positives		
1.3.1 Ensure >/=95% testing positive receive their results* **1.3.2 Ensure >/=75% testing negative receive results and offered counseling or referred to prevention services*** 1. Provide HIV prevention counseling, testing, referrals and linkage in high HIV prevalence community settings 2. Promote HIV testing in ED, correctional facilities, mental health/substance abuse treatment centers and CHCs 3. Review policies, procedures and QA protocols to make recommendations and streamline testing procedures	DOH-Broward Prevention	Ongoing Ongoing Ongoing Community Assessment	Monitoring client contact by Linkage Coordinator within 2 business days of STD referral date. Linkage appointment occurs within 5 business days following initial client contact. Monitoring outputs: HIV testing conducted in ED, mental health/substance abuse treatment centers and CHCs.		PROACT M & E measures are kept in DOH-Broward Active Strategy Database System DOH-Broward HIV testing is no longer conducted in correctional facilities as of 10/2013
Objective 1.4 Increase condoms distributed to PLWHA and those at highest risk by 15% each year	DOH-Broward Prevention	FY2012-2015	Percent increase in condoms distributed as of FY2013.		
1.4.1 Establish 10 condom distribution centers and 100 drop sites reaching	DOH-Broward Prevention		Number of new condom distribution sites established	As of 2014, utilization of surveillance data to evaluate	

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Goals, Objectives, Tasks, and Activities	**Responsibility**	**Timeline**	**Performance/Outcome Measures**	**Progress as of 1-31-2014**	**Notes**
>/=10,000 people annually at highest risk and PLWHA in high morbidity areas 1. Identify public & private condom distribution partners **2.** Increase accessibility, acceptability, and education of barrier methods in healthcare and non-healthcare settings **3.** Design/implement condom use Knowledge, Attitudes, Beliefs & Behaviors online assessment		Ongoing Ongoing Completed 12/2014	through recruitment efforts annually. Baseline values to be determined 04/2014	Condom Distribution Program. 808 assessments have been collected	
1.4.2 Distribute 16,000,000 condoms, 450,000 lubricants, and 96,000 female condoms 1. Conduct quarterly condom distribution to public and private partners 2. Monitor activities and provide technical assistance services 3. Integrate condom distribution with community interventions to promote risk reduction Support and participate in national HIV observance events, i.e. National Condom Week	DOH-Broward Prevention	Ongoing Ongoing Ongoing	Number of condoms, lubricants, and female condoms distributed as of January 1st, 2013. Monitoring of number of National HIV Observance Days that included condom distribution	Condom Distribution program monitored on a quarterly basis and evaluated bi-annually. In 2013, participated in World AIDS Day events.	
1.4.3 Include condom distribution center, drop sites and other info on Broward>AIDS web site 1. Design, launch and promote the	DOH-Broward Prevention	Completed in 2013 Ongoing updates		Completed in 2013	

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Broward>AIDS web site 2. Coordinate with HIP contracted agencies to serve areas 3. Design search engine capabilities for the public to find locations for free condoms			Condom Distribution Evaluation to be shared with HIP contracted providers		
Objective 1.5 Expand prevention with HIV- positive individuals	Ryan White Part A Quality Management and QI Networks				
1.5.1 Expand prevention with HIV+ individuals for avoidance of transmitting HIV to others 1. Educate and counsel patients about risk reduction and encourage safer-sex practices 2. Continue AETC Operation HOPEFUL pilot to assist risk and prevention assessments with patients 3. Implement AETC Prevention with Positives trainings (Core Medical QI Networks) 4. Identify available prevention with positives services and document in client services inventory 5. Become familiar with the prevention interventions that are offered at community-based organizations (CBOs) so that patients' referrals to these interventions are properly matched according to specific patient	Part A Grantee, Integrated Care and Prevention Coordination (ICPC) Work Group, Quality Management Committee, QI Networks	FY 2012-2013	• Percent of Part A clients who received HIV risk counseling within the measurement year • Percent of clients on ARVs assessed and counseled for adherence 2 or more times in measurement year • Documentation of training provided for MCM, Mental Health Provider Networks • Percent of MCM clients who receive treatment adherence counseling • Percent of adult clients who had a test for syphilis performed in the measurement year • Percent of clients at risk of STIs who had a test for	1-3: HOPEFUL (uses flash cards to provide points for discussion and contracting for change) • Successfully piloted with physicians and Medical Case Managers (MCMs); challenge for physicians identified: it is hard to do counseling in the 15 minutes allocated to each patient • Want to continue use of HOPEFUL, focusing on MCMs or non-physician clinical staff 3: Training: some providers attended CDC boot camp; AETC training has not yet occurred 4-5: Inventory to be prepared as first task of the new ICPC	•

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risks 6. Promote adherence to ART treatment to ensure maximal viral suppression and reduce transmission risk 7. Identify women who wish to become pregnant and provide preconception counseling 8. Refer HIV-infected pregnant women for early prenatal care and antiretroviral therapy (ART) 9. Screen for, diagnose, and treat other STIs 10. Ensure substance abuse screening and make appropriate referrals to treatment 11. Ensure mental health screening and make referrals to treatment			chlamydia in the measurement year • Number of women in Part A care who received family planning counseling in the measurement year • Number of women who indicated during the measurement year that they wished to become pregnant; percent of these women who received preconception counseling • Percent of HIV-infected pregnant women in care who were referred for and received early prenatal care and ART • Percent of clients at risk of STIs who had a test for gonorrhea in the measurement year • Percent of clients with Hepatitis B or C infection who received alcohol counseling in measurement year • Percent of new clients with HIV infection who have had a mental health screening • Percent of new clients	Work Group 6-11: QI networks working to ensure full implementation of these tasks/standards	

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			screened for substance abuse (alcohol & drugs) in measurement year		
NHAS Goal 2 - Increase access to care and improve health outcomes for PLWHA By 2015: 1. Increase to 85% the number of newly diagnosed receiving clinical care within 3 months of diagnosis 2. Increase to 80% the proportion of Ryan White clients in continuous care 3. Increase the number of PLWHA in permanent housing to 86%			• Percent of newly diagnosed [through public testing sites] receiving clinical care within 3 months following diagnosis • Percent of Part A clients in continuous care [defined as 2 routine HIV medical care visits a year, with one visit taking place during the first 6 months and one during the last 6 months of the year] • Percent of Part A clients in stable housing • Percent of Part A clients with viral suppression and with undetectable viral loads		HAB and HHS performance measures that are already being reported
Objective 2.1 Establish seamless system to immediately link PLWHA to continuous/ coordinated quality care					
2.1.1 Facilitate linkages to care (including coordination in health and social services settings)					
2.1.1.1 Implement Ryan	Grantee, Ryan	FY 2012/2013	• Documentation that	1-2: Not yet completed	

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White/Prevention Grantees Collaborative Work Group to Ensure Seamless Care System 1. Design client flow processes to ensure seamless system from test sites to Part A OAMC engagement 2. Define and provide training regarding linkage roles and responsibilities 3. Design and/or modify reporting and MIS to track HIV+ individuals receiving their diagnosis at confidential testing sites to linkage to care (LTC), and engagement and retention in OAMC 4. Develop aggregate reports regarding key processes, performance measures and outcomes	White Quality Management Committee, QI Networks, ICPC, Central Intake and Eligibility Determination (CIED)		processes and system were developed • Documentation that all appropriate staff received training on linkage roles and responsibilities • Data system able to track HIV+ individuals as specified • Format for aggregate reporting developed and reporting implemented	3-4: QM can track data for Part A; CIED obtains self-reports from clients; more complete data requires data sharing with area and State Part B and Prevention	
2.1.1.2 Ensure the following strategies are incorporated into Outreach through Service Delivery Model (SDM) revisions and training 1. Mobilize Part A-funded CIED personnel including peer community health workers (CHWs) to provide services at CDC and FDOH test sites and to facilitate linkage to care 2. Ensure motivational techniques to engage newly diagnosed and encourage immediate care 3. Ensure orientation about available services, and eligibility documentation assistance	Ryan White Quality Management Committee, QI Networks		• Documentation that outreach workers are providing services at CDC and FDOH test sites • Documentation of use of motivational techniques to encourage immediate LTC for newly diagnosed clients • Percent of newly diagnosed who received orientation about available services and/or eligibility documentation assistance within X months after diagnosis	1: Funding for Outreach has been eliminated but every provider expected to bring clients into the system; linkage responsibility now shared by CIED and other service providers, using peer CHWs and the ARTAS and PROACT models 2: Such techniques in use by MAI Case Managers using CDC's ARTAS model; focus more on retention than initial engagement in care 3: Done by CIED and by	Continuous care definition different from and more demanding than HRSA/HAB in-care definition (one VL test or one CD4 count or prescription for ART)

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4. Compute OAMC engagement >/= 3 month rates following HIV+ test and long-term retention			• Percent of newly diagnosed from public testing sites who are linked to Ryan White Part A care within 3 months • Percent of individuals who remain in care [2 routine HIV medical care visits a year, with one visit taking place during the first 6 months and one during the last 6 months of the year]	prevention and counseling & testing personnel 4: Data collected for individuals tested at public sites and linked to Ryan White services; most HAB performance measures being tracked; new or revised measures added at the beginning of each program year	
2.1.1.3 Utilize engagement reports to identify areas of improvement [Reports include sub-analyses to assess EIIHA strategy impact on rates of racial, ethnic, and sexual minorities, and WICY] 1. Compute time from initial HIV+ test to the first OAMC visit with a physician; engagement and retention in OAMC in the first year following initial HIV testing 2. Apply quality management (QM) methods to identify areas of improvement and modify processes 3. Tailor linkage and retention methods to unique needs of racial, ethnic, and sexual minority men and women **4.** Develop Quality Improvement Plans (QIPs) by Outreach QI Network to	Quality Management Committee; QI Networks	FY 2013/2014	• Areas of improvement identified and made a part of QIPs • Percent of newly diagnosed who have their first OAMC appointment with a physician within 3 months following diagnosis • Percent of newly diagnosed who have 2 VL and CD4 tests annually and at least 3 medical visits with the first year following initial HIV testing, overall and by racial/ethnic group and sexual orientation • Documentation that QIPs developed by the Outreach QI Network call for design,	1: Performance measures specified collected on Ryan White Part A clients and can be reported by demographics, including risk factors 2: QI Networks and QM Committee are reviewing data and determining needed service refinements 3: Providers can run their own data by demographics and service category in order to identify and address areas for improvement 4: LTC model???	• CIED ensures an appointment is made with a physician within 48 hours of intake. Linkage to care is defined as an appointment within 3 months of diagnosis. We may want to refine our

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design, test, and implement the new Linkage to Care (LTC) model			testing, and implementation of the new LTC model • Documentation that model has been designed, tested, and implemented		definitions further.
Objective 2.2 Support PLWHA with co-occurring conditions and challenges to meet basic needs, such as housing					
2.2.1 Enhance client assessment tools and measurement of health outcomes 1. Develop tools to measure impact of all Part A Services on client level health outcomes 2. Program revised client level outcomes in Provider Enterprise (PE) MIS 3. Monitor the impact of non-medical services on retention in medical care 4. Integrate the 2 HAB core group 1 VL performance measures into PE system and SDMs	Ryan White Quality Management Committee, QI Networks		• Documentation that tools have been developed • Revised client-level outcomes programmed into PE MIS • Plan in place for monitoring impact of non-medical services on retention in care • Network reports include measures of impact of non-medical services on retention in care • Specified performance measures integrated into PE system and SDMs	Tools to measure clinical outcomes have been developed as part of the PE MIS and are revised to include new/updated performance measures • Data reports are broken down by service categories and used to produced category-specific scorecards • Part A providers can generate data reports on their own clients by service category • PE to be updated to include all 2013 HAB performance measures for the 2014-15 program year • Requirement to use revised Broward client-Level outcomes and indicators, which are to be included in provider contracts as of June	

Broward County 2012-2015 Comprehensive Plan: Updated Work Plan based on UCHAPS "Crosswalk" PowerPoint[1] *Goals, Objectives, Tasks, and Activities – Updated 3/5/2014*					
Goals, Objectives, Tasks, and Activities	**Responsibility**	**Timeline**	**Performance/Outcome Measures**	**Progress as of 1-31-2014**	**Notes**
				2014 • Measures of impact on retention and care developed for all service categories as of end of 2013 and will be collected and analyzed along with other performance and outcomes data • Impact data reported by QI Networks • QM staff and QI networks reviewing data to determine the extent to which participation in non-medical services contributes to retention in medical care	
2.2.2 Provide MCM and clinical services that contribute to improving health outcomes 1. Ensure Part A/MAI service allocations are sufficient to serve all eligible PLWH 2. Ensure core services allocations for Oral Health, AIDS Pharmaceutical Assistance Program, Mental Health, Substance Abuse, and Medical Case Management (MCM) are sufficient to serve all eligible PLWHA 3. Develop QIPs based on review of HAB	Ryan White HIVPC, PSRA, Quality Management Committee, QI Networks		• Documentation of existence of waiting lists and average wait times for Part A/MAI-funded services • Documentation of existence of waiting lists and wait times of less than 2 weeks, 4 weeks, and 6 weeks or more for Part A funded core medical-related services • Documentation that allocations for Part A/MAI and specified Part A services	1-4: Data on service access obtained, analyzed, and used in allocations and re-allocations where needed • Baseline data on service access and gaps obtained from 2011 and prior PLWHA surveys • Provider reports on waiting lists and wait times for specific services and populations (e.g., language minorities) obtained via	

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Measures 4. Analyze client level data to develop strategies to improve retention **5.** Develop a baseline measure of client Health Literacy levels			consider number of clients served through other funding streams and through Part A during previous year and projected number of new clients needing each service in the upcoming year • QIPs developed • Regular analysis of client-level data • Evidence of use of analysis for retention improvement strategies • Baseline measures of client Health Literacy Levels developed and obtained	monthly e-mail blasts • HIVPC and PSRA Committee review access data and use it in the allocations process 5: PE tracks client education and self-reported literacy levels • CQM staff conducted review of materials and health literacy competency at all funded agencies • Pilot completed with the Combined Network's providers and a sample of clients • EMA funding an additional study in 2014 to obtain baseline health literacy data and develop a health literacy plan	
2.2.3 Increase access to non-medical services as critical elements of an effective HIV care continuum [Includes CIED, Food bank/vouchers, Legal services] ~~and Outreach]~~ 1. Maximize access to support services for PLWHA that need them, through Ryan White or other sources 2. Develop QIPs that address identified access barriers and limitations	Ryan White PSRA, Quality Management Committee, QI Networks		• Evidence of increased funding for specified non-medical services through Part A, Part A/MAI, and/or other funding streams • Evidence of increased utilization of specified services compared to baseline level as measured • QIPs developed	• Data already reported on number receiving specified support services and frequency • Questions included in PLWHA survey • Providers to report number of PLWHA indicating a need for specific services • Transportation funded and tracked by Part B and in PE	

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				• Grantee provides information on resources available through other funding streams • Data used to help determine Part A allocations • EMA will obtain baseline data and monitor changes in use of such services	
2.2.4 Provide housing assistance and other services that enable access and adhere to treatment 1. Continue to provide joint Medical Case Management (MCM) trainings to Ryan White and HOPWA case managers 2. Increase proportion of Part A clients who are stably housed 3. Identify barriers to care related to housing and other supportive services and develop QIPs to address barriers	Part A Grantee, PSRA, Quality Management Committee, QI Networks, HOPWA	2012-2015	• Documentation of number of joint trainings on use of MIS to share eligibility information and number of Ryan White and HOPWA case managers participating in each • Percentage of Part A clients who are stably housed in each measurement year, compared to the baseline percentage • Barriers to care related to housing identified • QIPs developed to address barriers	1: Training for all case managers and HOPWA staff mandatory and always joint; quarterly sessions have addressed CIED, Part A, Part C, Part D, and housing issues 2 & 3: Data on unstably housed used by PSRA Committee in setting allocations • Case managers report percent of clients who are unstably housed (HIV performance measure) • Data available from HOPWA due to its use of PE • Additional data on housing needs and barriers obtained through PLWHA survey and annual PIT survey • QM Committee and QI	

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				Networks explore ways to address housing and other identified supportive service gaps and barriers • Helping PLWHA obtain and maintain stable housing always a challenge	
2.2.5 Promote collaboration among providers 1. Continue efforts to recruit Prevention Grantee to join the HIV Planning Council 2. Assess feasibility of combining HIV planning efforts required by prevention and care grants including: Client/Provider Needs (surveys, focus groups, community forums); Funding/Services Inventories/Directories 3. Increase linkage collaboration activities between Part A, testing, mental health, substance abuse and housing 4. Ensure MOUs between testing and Part A-funded ~~outreach,~~ CIED and OAMC are implemented ~~5. Request quarterly linkage updates from all funders~~ Arrange quarterly calls between grantee and other funders	Part A Grantee and Providers, Prevention, ADAP, Jail Linkage Staff, Re-Entry Coordinator, HIVPC	FY 2012/2013	• Prevention Grantee serving on HIV Planning Council • Discussions held regarding combined HIV planning efforts including shared needs assessment and service inventories/directory • Shared needs assessment implemented • Combined service inventory/directory prepared • MOUs between testing and other specified entities in place • Quarterly linkage updates received from all funders	1: HIVPC succeeded in obtaining Prevention representation, but individual changed jobs; Health Department asked to identify a new representative 2: In process: • ICPC Work Group exploring possibilities for joint planning and enhanced cooperation • Focus groups done jointly • Combined inventory in development as of early 2014 3: Progress continuing: • Collaboration with HOPWA facilitated by use of same data system • Providers knowledgeable about mental health and substance abuse; QI Mental Health and Substance Abuse Network playing a	

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				lead role in providing information and facilitating collaboration 4: MOUs in place 5: Quarterly calls have been implemented	
Objective 2.3 Ensure PLWHA access to and maintenance on anti-retroviral therapy					
2.3.1 Ensure that all eligible HIV-positive persons have access to antiretroviral therapy 1. Create a system to obtain real time information for all ADAP clients 2. Ensure linkage to pharmacy programs • Educate MCMs, pharmacists, and Part A clinicians on pharmacy program requirements and eligibility guidelines to ensure that barriers to ART access are addressed • Educate MCMs, pharmacists, and Part A clinicians about emergency ART • Continue to provide emergency ART through Part A LPAC and other community resources to ensure clients do not experience interruption in treatment 3. Continue to monitor changing program guidelines through the Medical Network and ensure	Ryan White Quality Management Committee, QI Networks	Ongoing	• Percentage of all Ryan White Part A clients receiving ART • Documentation of education/training sessions and types of individuals trained • Documentation of regular monitoring by Medical Network • Documentation that clinicians' recommendations for formulary additions are brought before the LPAC for consideration at its biannual meetings • Documentation of provision of emergency ART and any interruptions in treatment • Documentation of grantee materials and/or sessions used to educate MCMs,	1: Grantee receives quarterly reports on all ADAP clients that allows for client matching; real-time data system not yet feasible • Focus on filling data gaps; Ryan White Part A serves about 7,000 clients and has viral load data on about 5,500; ADAP serves provides medications to about 4,000 2: Tasks being implemented; continuous process required: • Education provided about pharmacy program requirements and eligibility and about emergency ART • Emergency ART continuing, usually as a bridge while ADAP eligibility is being determined • Access to emergency ART	

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clinicians' recommendations for additions to Part A Formulary are brought before Local Pharmacy Advisory Committee (LPAC) for consideration 4. Ensure that MCMs and clinicians discuss importance of ADAP 6-month recertification			pharmacists, and Part A clinicians about emergency ART • Grantee documentation of discussion of importance of ADAP recertification with MCMs and clinicians	facilitated by the Medical Exception Form, which a doctor can fax to indicate a client is applying for ADAP but needs specified medications as a bridge; 10-day supply provided, with another 10 days added when necessary. Providers are continuously being educated about the form to ensure access to medications. • Includes any drug in the ADAP formulary as well as emergency access to maintenance medications and others while client waits for PAP application approval 3: Monitoring of program guidelines and recommendations to LPAC in place LPAC meets at least 1-2 times a year, to determine needed changes in guidelines regarding particular drugs, add new ARVs or other drugs, and decide whether to remove drugs that are not being use 4: ADAP Recertification	

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				discussed in QI Networks	
2.3.2 Ensure PLWHA who start therapy are maintained on regimen, per HHS guidelines 1. Increase the percentage of clients with a viral load less than 200 copies/mL by monitoring NQC viral load suppression and developing strategies to improve suppression rates	Part A Grantee Quality Management Committee, QI Networks	Ongoing	• Percentage of Ryan White clients with viral suppression, defined as a viral load of less than 200 copies/mL • Documentation of use of data to develop strategies to improve viral suppression rates	• PROACT used to improve retention • Mental Health and Substance Abuse and Combined Networks looking at viral load data by variables and reporting trends and disparities by population group • Focus on determining what groups are most likely to drop out of care, then exploring and adopting strategies to improve retention • Barriers to adherence assessed to some degree in client surveys, focus groups, and the MSM study	
Objective 2.4 Increase proportion of newly diagnosed and lost-to-care patients linked to care within three months by 10% each year	Part A		Proportion of newly diagnosed and lost-to-care patients linked to care within 3 months		
2.4.1 Ensure that 80% of clients referred to PROACT are linked to medical care within 90 days of referral and that at least 80% of PROACT active cases stay in HIV care 1. Monitor utilization of PROACT services 2. Conduct outreach and community education on importance of linkage and maintenance to care and	BCHD Prevention		• Percent of clients referred to PROACT linked to medical care within 90 days of referral • Percent of PROACT active cases who are retained in HIV care as measured • Percent of PROACT active	•	Need to check with the PROACT program re use of suppressed versus undetectable viral load

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treatment 3. Provide education to community and providers on comprehensive HIV treatment and care 4. Conduct clinician outreach project to disseminate guidelines			cases who achieve an undetectable viral load *[not suppressed or undetectable? 200 or 50?]* • Documentation of educational sessions and materials provided to community and providers on comprehensive HIV treatment and care • Documentation of implementation of clinical outreach project to disseminate guidelines		
2.4.2 Ensure that 80% of HIV+ clients are linked to clinical care within 3 months at HIP agencies 1. Monitor HIP contracted agencies on a quarterly basis 2. Provide technical assistance	BCHD Prevention		Percent of HIV+ clients linked to clinical care at HIP agencies within 3 months following diagnosis		
Objective 2.5 Assist and support PLWH eligible for ACA health plans to ensure enrollment, use of services, retention in care, and viral suppression					Added in 2014
2.5.1 Meet HIV/AIDS Bureau (HAB) guidelines for outreach and enrollment support for PLWH eligible for participation through use of Ryan White funds and personnel	Grantee and Planning Council, including PSRA Committee	2014-2015, before and during open enrollment periods	• Number and percent of eligible PLWH who enroll in ACA plans • Documentation of enrollment assistance provided by providers to Ryan White clients		

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2.5.2 Ensure Ryan White capacity to provide post-enrollment assistance to Part A clients to help them identify providers within the health plan network who have HIV expertise and offer culturally appropriate services	Grantee and Planning Council, including Task Force or Committee on System of Care, Planning Committee, Joint Client Community Relations Committee, and PSRA Committee	2014-2015	• Documentation of adjustments in Ryan White service model to establish and maintain post-enrollment assistance • Documentation of policies and procedures in subcontracts that clarify provider roles and responsibilities • PLWH satisfaction or survey data indicating receipt of needed post-enrollment services		
2.5.3 Refine the Ryan White system of care as needed to ensure retention in care for enrolled PLWH: • Ensure coordination of care, through appropriate case management models • Provide for care completion, including access to both core medical-related and support services that are not covered or not fully covered through insurance plans	Grantee, Planning Council – including Task Force or Committee focusing on System of Care – and providers – including QI Networks and QI Committee	2014-2015	• Documentation of refinements in EMA's system of care, including roles of case managers • Retention and viral suppression rates for Ryan White clients enrolled in health plans that are comparable to those for other clients		
NHAS Goal 3 - Reduce HIV-related health disparities By 2015: 1. Increase access to prevention and			• Percent of gay and bisexual men, Blacks, and Latinos who have viral suppression [≤ 200 copies/mL] by 2015,		

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care services 2. Increase the number of gay and bisexual men, Blacks, and Latinos who have an undetectable viral load by 20%			compared with baseline year (2012)		
Objective 3.1 Reduce HIV-related mortality in communities with high risk of HIV infection by 10%		2012-2015	• Number of HIV-related deaths reported annually, by race/ethnicity and sexual orientation		Based on surveillance data
3.1.1 Increase the number of gay and bisexual men, Blacks and Latinos accessing testing for viral hepatitis, sexually transmitted infections (STIs) and HIV by 25% in clinical settings 1. Develop pilot program of private physician network offering integrated rapid testing and Hepatitis screening among gay/bisexual men, Blacks and Latinos 2. Conduct education/testing events each year that screen for both HIV and Hepatitis C in conjunction with medical providers and community-based organizations among gay and bisexual men, Blacks, Latinos, and ages 45 to 65	DOH-Broward Prevention	In Progress In Progress Ongoing	Percent increase of gay and bisexual men, Blacks and Latinos accessing testing for viral hepatitis, sexually transmitted infections (STIs) and HIV by 25% in clinical settings.	Eleven (11) physicians have been identified and been trained for Hep C and HIV routine testing	
3.1.2 Train 50 medical providers and contracted HIP medical providers to engage patients in discussions on sexual health and disclosure 1. Provide trainings for medical providers	DOH-Broward Prevention	In Progress ongoing	Number of medical providers and contracted HIP medical providers to engage patients in discussions on sexual health and disclosure	Discussions will be ongoing with Broward County Medical Association. Continued Technical Assistance with Partnership for Health.	

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2. Fund medical providers to implement evidence-based programming		ongoing		Partnering with UM CFAR Community Advisory Board.	
3.1.3 Ensure high-risk groups have access to regular viral load and CD4 tests 1. Ensure access to and retention in high quality HIV-related OAMC, including regular VL and CD4 tests 2. Ensure OAMC meets or exceed HHS guidelines as measured by HAB measures 3. Ensure continuous collection, analysis, and use of viral load and CD4 data to strengthen services • Apply HAB measurement model to QI Networks • Conduct PM quality assessment to ensure data are accurate and meet goals • Address data quality/reporting issues and performance deficiencies • Review progress annually; identify remediation steps and key action steps	Ryan White Part A Grantee, CIED, Quality Management Committee, QI Networks	FY 2012/2013 FY 2012/2014 FY2012/2015	• Documentation of in-care campaigns implemented • Linkage to care: percent of newly diagnosed PLWHA who are linked to care within 3 months • Viral Load Monitoring: percent of Ryan White patients with a viral load test performed at least every six months • CD4 Monitoring: percent of Ryan White patients with a CD4 count performed at least every six months • OAMC: percent of Ryan White Part A patients whose OAMC meets or exceeds HHS clinical guidelines, based on use of HAB measures • Quarterly review by QM Committee to ensure data integrity and determine performance • Reports reviewed and remediation and key action steps documented by QI	• Documenting linkage to care through CIED • Continuous collection of Viral Load and CD4 data by providers • Data on VL and CD4 monitoring and HHS clinical standards collected as part of ongoing reporting of performance measures • Regular review of VL and CD4 data by population group being done by grantee, OAMC QI Network, and QM Committee – comparisons made with baseline data for 2011, just before the In-Care Campaign was started, and with annual data for 2012 and 2013 • Issues of access and retention including VL and CD4 testing being explored through PLWHA survey and focus groups with Black heterosexual men, Black heterosexual women, young	Includes HAB HIV System-wide Clinical Performance Measures

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			Networks and QM Committee	adults 18-26, Hispanic males, and Hispanic females • Special study underway on MSM • Have found and are exploring ways to address very high levels of stigma and denial, which serve as barriers to access to and retention in care among high-risk populations	
3.1.4 Measure Ryan White Part A program viral load as a measure of program quality **1.** Measure suppressed and undetectable viral load baselines for Part A program and subpopulations 2. Assess Ryan White viral load data for reliability, accuracy, completeness, and quality, based on proportion of cases with known viral load 3. Ensure OAMC and MCM (regardless of funder) electronically document VL and CD4 at least every 6 months 4. Request VL/CD4 documentation for recertification for those not in Part A OAMC 5. Develop a QIP for improving incomplete or inaccurate Ryan White data	Ryan White Part A Grantee, Support Staff, Joint Planning Committee, all QI Networks, QI Committee		• Viral Load suppression: percent of Part A patients with suppressed viral load [<200 copies/mL] and with undetectable viral load [<50 copies/mL]; biannual comparisons • Changes in Viral Load: percent of patients with reduced viral load over time, based on baseline and biannual comparisons • Population-specific data: Analysis of Viral Load by race/ethnicity and sexual orientation • Documentation of review of VL data accuracy, completeness, and quality • QIP plans developed	1: Baselines obtained in 2013; can be broken down by subpopulations; have run data for past three years but changes have been made in the reporting system 2: VL data now reported on about 5,500 clients out of about 7,000 enrolled in Part A; most data reported by OAMC provider and are of high quality 3-5:QM staff working to increase reporting of VL test results for PLWHA, including those receiving some services – but not OAMC – through Part A • Data regularly reported for most clients who receive	

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				OAMC through Part A • MCM trained to request and record VL data from clients not receiving OAMC through Part A • MCMs seek lab data for other clients • CIED requests copies of both VL and CD4 count from clients at recertification; grantee considering requiring such documentation for recertification but fear this might become a barrier to care • Part B data periodically shared and can be matched to obtain some lab data missing from PE • Alerts built into PE system to remind physicians to enter VL data • Efforts under way to resolve data entry problems; some providers say the Viral Loads are showing up in the system but a PE alert indicates there are no current results in the system • Issue being discussed by	

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				combined QI Network	
Objective 3.2 Reduce stigma and discrimination against PLWH					
3.2.1 Engage communities to affirm support for people living with HIV 1. Engage communities and affirm PLWH support through HIVPC planning efforts, materials and events	Ryan White Part A Grantee, HIVPC, QI Networks, Quality Management Committee, Joint Client Community Relations (JCCR) Committee		• Documentation of materials developed • Documentation of community engagement activities • Documentation of number of individuals reached through community engagement activities	• Importance of such efforts confirmed by MSM study findings of high levels of stigma and denial in the community • JCCR serving as liaison between consumers and the Planning Council • JCCR organizes several annual community events and is working to improve community attendance	
3.2.2 Promote public leadership of people living with HIV 1. Promote public leadership of PLWHA through actively recruiting PLWHA to serve as HIVPC members and council leadership positions; training; and disseminating national opportunities 2. Integrate Part A and Part B Orientation Manuals	HIVPC, including Membership Committee and JCCR Committee, Joint Planning Committee		• Number of PLWHA recruited and selected as HIVPC members annually • Number of PLWHA in leadership positions at end of each program year • Documentation of training provided • Number of national opportunities provided and used by PLWHA	1: Recruitment and Training • Membership Committee working with JCCR Committee to identify and recruit PLWHA to serve on the HIVPC • Intent is to develop a "waiting list" pool of consumers to become HIVPC members as vacancies occur • Membership Committee provides training for consumer members of the HIVPC, helping to prepare them for leadership	

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				• HIVPC support staff and grantee provide information on national opportunities for training and leadership development 2: Membership Committee suggested incorporating elements from the Part B (SFAN) orientation manual into the Part A Manual being developed by Joint Planning Committee	
3.2.3 Identify and coordinate 2 social marketing and media campaigns focused on HIP 1. Identify marketing strategies that address role of stigma and barriers to HIV prevention behaviors 2. Support culturally sensitive and linguistically appropriate social marketing and media campaigns 3. Collaborate with local businesses through Business Response to AIDS and Labor Response to AIDS	DOH-Broward Prevention, contracted providers, Broward County Public Schools of BCHPPC	Ongoing	Number of social marketing and media campaigns focused on HIP Using logic model to evaluate effectiveness of social marketing campaigns	Anti-stigma campaign, Phase 1 completed. Phase 2 to be completed 06/2014. As of 01/2014, 209 BRTA sites have been recruited as part of Broward>AIDS	DOH-Broward Prevention, contracted providers, Broward County Public Schools of BCHPPC
3.2.4 Recruit and train 50 Black, Latino, MSM and Transgender leaders and stakeholders to promote HIP 1. Build capacity of community leaders to address disparities with HIP strategies, through training & TA	BCHPPC	12/2015	Number of Black, Latino, MSM and Transgender leaders and stakeholders recruited and trained to promote HIP	Nine (9) community ambassadors recruited	BCHPPC
3.2.5 Include condom distribution	DOH-Broward	Completed	Monitoring of Broward	In the month of January 2014,	

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centers, drop sites and information on Broward>AIDS website 1. Design, launch and promote the Broward AIDS web site 2. Coordinate with the HIP contracted agencies to serve areas 3. Design search engine capabilities for the public to find locations for free condoms 4. Focus messaging on stigma and discrimination against people living with HIV	Prevention	 Ongoing Ongoing Completed 07/2014	Greater Than AIDS monthly website visits	website Hits on Broward>AIDS = 3,539 First Anti-Stigma campaign deployed October, 2014	

Key: Pale Blue = Responsibility of Prevention, not Ryan White Part A

Final Report: Comprehensive Plan Update
For the Broward Regional Health Planning Council
By EGM Consulting, LLC

Summary

This document provides a final report summarizing the work completed by Emily Gantz McKay of EGM Consulting, LLC (EGMC) in updating the 2012-2015 comprehensive plan for the Broward Part A program. The work was provided for the Broward Regional Health Planning Council (BRHPC) from mid-November 2013 and March 2014. EGMC worked closely with BRHPC leadership and staff, and also benefited from the advice and knowledge of the Part A Grantee staff.

The Update was designed to provide a mid-term review and assessment of task completion and progress towards comprehensive plan goals and objectives, and to recommend updates in the work plan as needed. Because the original plan did not provide a work plan chart, the consultant developed a "master chart" including goals, objectives, and tasks, responsibilities for task completion, basic timelines, performance and outcome measures, and progress as of January 31, 2014. Prevention objectives and tasks were updated to reflect the five-year work plan submitted by the HIV Prevention Program to its funder, the Centers for Disease Control and Prevention (CDC). The chart was used to review the content of the plan, assess progress, and suggest additions and revisions – including additions to reflect Part A responsibilities related to the Affordable Care Act (ACA). The master chart can continue to be used to review and update the plan.

The consultant presented recommendations to the Part A program regarding the comprehensive plan, collaboration between HIV Prevention and Care, and responsibilities related to the Affordable Care Act (ACA) and its implementation:

1. Maximize collaboration with Prevention in implementing the current comprehensive plan.
2. Establish priorities and if necessary eliminate some objectives or tasks in the comprehensive plan.
3. Adjust the comprehensive plan timetable to reflect the new due date for the next comprehensive plan.
4. Work towards a joint comprehensive plan in 2016 and ongoing Prevention and Care collaboration.
5. Agree on responsibilities related to the ACA.
6. Refine committee assignments and/or responsibilities to address ACA implementation and related changes in the HIV service system and the broader health care system.

These recommendations were presented to the Planning Council on March 27, 2014. The consultant also assisted the Planning Council's Joint Executive to consider refinements in committee structure and responsibilities and develop committee work plans that include tasks for addressing the changing system of HIV care and financing.

Description of the Assignment

The Broward Regional Health Planning Council (BRHPC) contracted with EGM Consulting, LLC, to review, assess, and update the work plan of its 2012-2015 comprehensive plan. The work, conducted from mid-November 2013 to March 2014, included a number of interrelated tasks and activities, all conducted in collaboration with the Planning Council (primarily the Joint Executive) and its staff and the Grantee:

1. Review of the EMA's 2012-2015 comprehensive plan, including the work plan, which is partly contained in a detailed list of goals, objectives, tasks, and some timelines and responsibilities, and partly in narrative form. Outcome measures are provided for many of the goals and objectives, but there are few progress measures.
2. Review of extensive information provided by Planning Council staff, especially the following:
    - A PowerPoint presentation with slightly revised care and treatment goals, objectives, and tasks, and considerably changed prevention goals, objectives, and tasks. The PowerPoint was used for a presentation by the Grantee to UCHAPS (the Urban Coalition for HIV/AIDS Prevention Services, which brings together grantees with direct funding from CDC for HIV prevention programs). The updated prevention measures come from the most recent HIV prevention 5-year plan.
    - Extensive quality improvement information, including measures, activities, performance and outcomes data, meeting minutes from the Planning Council's Quality Management (QM) Committee, and annual performance and outcomes summaries based on HHS and HIV/AIDS Bureau (HAB) performance measures as well as data on viral suppression and undetectable viral loads.
    - Detailed information about the Planning Council, its committees, and its work plans and activities.
3. Consultation to determine what aspects of work plan the EMA felt needed to be revised or expanded.
4. Development of a comprehensive plan work plan "master chart" that includes the revised goals, objectives, tasks, and responsibilities, and some timelines, along with available information on progress and outcomes as of January 31, 2014. The intent was to put all the updated work plan information into a chart format, to make it easier to review progress and outcomes and help ensure that tasks are not forgotten.
5. Development of measures of progress and outcomes for work plan objectives and tasks where they were not included in the original plan, done in close collaboration with the QI/TA Manager.
6. Process- and outcomes-based evaluation of accomplishments to date and of the availability of data needed to further assess progress and outcomes. Much of the progress information came from meetings with grantee staff, the QI/TA Manager, and Planning Council leadership.

7. Preparation of summary data on performance and outcome measures, with comparisons for Program Years 2011-2012, 2012-2013, and 2013-2014, using data provided through Quality Management. This included preparation of three-year data summaries of:
    - The percent of various client subpopulations with viral suppression or undetectable viral loads.
    - The percent of Ryan White clients meeting selected HRSA/HAB performance measures (those for which there are data from at least 3,000 clients, and one female measure with data from at least 1,000 clients), with measures defined.
    - The percent of Ryan White clients meeting various HHS and HAB measures and having suppressed or undetectable viral loads, with demographic breakdowns by race/ethnicity, gender orientation, age, education level, literacy level, and risk factor.
8. Development of proposed additions to the work plan that address the EMA's responsibilities regarding the changing health care system and the implementation of the Affordable Care Act (ACA), with suggested responsibilities and timelines.
9. Participation in a discussion with the Director of HIV Prevention to explore whether Prevention will be able to report on progress towards the Prevention components of the work plan. It was agreed that Prevention staff will provide a progress update in March and will work with Ryan White Part A to determine a timeline for providing periodic Prevention outcomes and progress data. This is important because:
    - Since the 2009 reauthorization, Ryan White has expanded legislative responsibility for engagement in testing and linkage to care.
    - Assessing progress towards comprehensive plan goals, which mirror the NHAS goals, requires information gathered by surveillance or by HIV Prevention.
    - The treatment cascade or continuum of care has become a key tool for assessing progress in dealing with the epidemic, and some data for it come from HIV prevention – particularly the number of individuals testing positive for HIV.
    - The EMA is very interested in expanding collaboration between HIV Prevention and Care, and this information sharing is an important step in increasing mutual understanding of the roles of each entity.
10. Development of recommendations to the EMA based on the work performed, including updating and implementing the revised comprehensive plan using the master chart and making maximum use of the performance and outcomes data generated by the EMA.
11. Participation in two work sessions with the Planning Council Joint Executive, during site visits in February and March, on committee work plans and possible refinement of the committee structure, both of which should enhance Planning Council engagement in comprehensive plan tasks and in use of performance and outcome measures for data-based decision making. In addition, they will help support decision making about how

best to ensure an appropriate system of care for people living with HIV in a changing health care and health financing environment.

12. Presentation of project activities, findings, and recommendations to the Planning Council in March 2014.

The consultant completed these tasks through use of documents, meetings held during visits to Fort Lauderdale in December 2013 and February 2014, and extensive telephone and email consultation. Products include several iterations of the master work plan chart, the recommended ACA-focused additions, the three summaries of EMA performance and outcomes, this report, and a PowerPoint using HHS and HRSA performance measures, and the comparative summary of suppressed and undetectable viral load rates over three years. In addition, the consultant provided a number of materials to assist the Planning Council, among them sample work plans, key needs assessment questions, and model committee structures for Planning Councils.

Observations

Work Plan: As noted, a major task of the review involved preparing an updated work plan for the comprehensive plan in master chart format. This process led to the following observations:

- **Value of a work plan master chart:** The EMA's comprehensive plan as prepared in 2012 includes a great deal of information about goals (based on the National HIV/AIDS Strategy), objectives, and tasks, but does not chart them into a single, comprehensive work plan that specifies responsibilities for all tasks, a timeline for their completion, and process as well as outcome measures. While some very important data for determining EMA outcomes (e.g., extent of viral suppression) are called for, without process measures it is difficult to systematically include necessary tasks in the appropriate committee work plans, or to measure progress along the way. Once the work plan was placed into a chart format, both the range of activities planned and the missing elements were easy to identify – and the challenges in carrying out the entire work plan were clear.
- **Inclusion of Prevention goals, objectives, and tasks:** The plan includes a number of objectives and tasks under two different goals that are the responsibility of HIV Prevention rather than Care. The work plan information comes directly from the County's HIV Prevention 5-year work plan, provided to the Centers for Disease Control and Prevention (CDC). Inclusion of this Prevention information is potentially very useful, particularly given the two recent letters from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) encouraging collaborative HIV prevention and care planning. However, there has not been a process in place to obtain regular updates from Prevention concerning progress towards these objectives. The master chart identifies the Prevention components of the work plan by shading them in light blue. A meeting held with Prevention in mid-March led to agreement that Prevention progress and outcomes data will be shared regularly, which should enhance HIV planning and encourage future collaboration on preparation of the next comprehensive plan – which hopefully will be an integrated joint plan.

- **Limited Planning Council responsibilities and assignments:** A review of stated responsibilities for work plan tasks indicates that QI networks and the Planning Council's QM Committee have considerable ongoing responsibility for monitoring and improving performance, and the grantee has many responsibilities, but the Planning Council as a body and its other committees have few assigned tasks. There is, for example, no committee given responsibility for ensuring needed changes in the system of care to address Affordable Care Act (ACA) implementation and other changes in the health care system. There is no clear assignment for overseeing a multi-year needs assessment and ensuring strong consumer input into that process, or for ensuring that comprehensive needs assessment, client utilization, and cost data are reviewed by the Priority Setting and Resource Allocations (PSRA) Committee, presented to the full Planning Council, and used to guide decisions about service priorities and allocations. This gap can be addressed through review and possible refinement of the committee structure and assignment of tasks to committees as part of their work plans.
- **Feasibility and priorities:** The master chart includes a large number of tasks, many assigned at least partially to the QI networks and the QM committee. The plan may include too many assigned tasks and an expectation for too many new components for QI plans. Although the additional two years before a new plan is due to HRSA/HAB may allow for completion of more of these tasks, there is a need to prioritize and focus on those actions considered most important.
- **Large number of target populations:** In various parts of the comprehensive plan, many different subpopulations of people living with HIV disease are identified as priority or target populations. Various sections of the plan identify all the following as target populations:
  - Individuals unaware of their status
  - Individuals aware of HIV status but not in care, individuals receiving medical care but not HIV care, individuals lost to follow-up, and sporadic users of HIV care
  - HRSA target populations as listed in the Comprehensive Plan Guidance: adolescents, homeless, IDUs, and transgenders
  - Gay/bisexual men, transgenders, Blacks, Latinos, and substance users
  - Emerging populations: homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM

  While there are reasons for listing all of them, it may be difficult for the EMA to address so many priority populations at once. Some of them overlap; for example, individuals of any race/ethnicity may be unaware of their status. It would be helpful to identify the highest priority target populations and use them in shaping activities. For example, if gay/bisexual men are a priority, then perhaps outreach and testing should focus on gay/bisexual men who are unaware of their status.

  Performance and Outcomes Data: It is clear from the QI materials and data summaries provided by the EMA that it is gathering and reporting considerably more data on HHS and HAB performance measures than most Part A programs, as well as regularly reviewing data on viral suppression and undetectable viral loads. The EMA deserves considerable credit for

this focus on performance and outcomes. It provides important opportunities to assess the effectiveness of EMA services in contributing to high rates of viral suppression, and to identify areas of high performance as well as aspects of services that need to improve.

The revised HAB performance measures will be entered into the data system and used as of the new 2014-2015 program year. The various QI networks are reporting and reviewing a great deal of performance data, and presumably using them for program improvement. Less clear is the extent to which the Joint Planning Committee or the PSRA Committee are reviewing these data and ensuring that the Planning Council uses them in decision making about priorities, allocations, and directives on how best to meet those priorities, including needed refinements in the system of care. The lack of a committee addressing the system of care or looking at all aspects of the comprehensive plan may limit use of these data.

Recommendations

1. **Maximize collaboration with Prevention in implementing the current comprehensive plan:** As part of the update, the Prevention goals, objectives, and tasks that are part of the comprehensive plan but not within the scope of authority or responsibility of the Part A program have been clearly identified. HIV Prevention staff have agreed to provide periodic updates on Prevention-related performance and outcome measures. The Planning Council and Grantee should continue to focus on collaboration with Prevention. The Planning Council should also find ways to engage and work with HIV Prevention staff or planning group members and to ensure that Prevention data are understood and are used in planning and decision making.
2. **Establish priorities and if necessary eliminate some objectives or tasks in the comprehensive plan.** The Planning Council and staff, especially QI Networks and staff and the QM Committee, need to review and prioritize the many objectives and tasks stated in the comprehensive plan work plan, decide whether some should be eliminated and clarify responsibilities for the implementation of all remaining tasks.
3. **Adjust the comprehensive plan timetable to reflect the new due date for the next comprehensive Plan:** The current plan, with any desired updates, will now be in place until September 2016, when the new plans for both Care and Prevention will be due. The Planning Council and Grantee should adjust and update the current plan to reflect the due date for the new plan. This can provide time to complete some of the objectives and tasks that cannot realistically be completed by the original end date for the plan.
4. **Work towards a joint comprehensive plan in 2016 and ongoing Prevention and Care collaboration:** The EMA should continue working towards preparation of an integrated prevention/care comprehensive plan in September 2016, as recommended by HRSA/HAB and the CDC. It should also continue other collaboration efforts between Prevention and Care planning bodies, perhaps through a joint Part A-Prevention Planning Committee.
5. **Agree on responsibilities related to the Affordable Care Act (ACA):** The Planning Council should review, refine as necessary, and add to the comprehensive plan the suggested objectives and tasks related to the implementation of the Affordable Care Act (ACA). The

HIV/AIDS Bureau has provided guidance on Part A responsibilities related to ACA and encouraged use of specified core medical and support service categories to support outreach and enrollment as well as post-enrollment care completion and care coordination by Ryan White. Objectives and tasks for addressing these responsibilities need to be part of the comprehensive plan so that they receive needed priority in the work of the Planning Council as well as the Grantee.

6. **Refine committee assignments and/or responsibilities to address ACA implementation and related changes in the HIV service system and the broader health care system.** Important changes are taking place in health care structure and financing that will ultimately change the roles of the Ryan White program. To fulfill its responsibilities as a key decision maker in how Ryan White funds are used, the Planning Council needs to:

   - Be sure all Planning Council members are familiar with HIV/AIDS Bureau policies and guidance on ACA, including their responsibilities and those of the Grantee. There should also be a shared understanding of State and local views about ACA and how that will affect Ryan White responsibilities and actions.
   - Establish a task force or assign a committee responsibility for leading efforts to address ACA, and be sure all committees understand their responsibilities.
   - Be sure the Joint Planning Committee includes ACA implementation issues in needs assessment activities.
   - Closely engage the Joint Client Community Relations Committee in ensuring regular input regarding how implementation is affecting PLWH.
   - Have the PSRA Committee review all service categories in the context of ACA and refine the priority setting and resource allocations process as needed to reflect expected changes in service needs.

Outcomes Summary – Broward County EMA, Program Years 2011-2012, 2012-2013, & 2013-2014													
In+Care Measures	12.1.11	2.1.12	4.1.12	6.1.12	8.1.12	10.1.12	12.1.12	2.1.13	4.1.13	6.1.13	8.1.13	10.1.13	12.1.13
Gap Measure*	30%	28%	22%	23%	23%	23%	22%	20%	19%	17%	18%	21%	22%
Medical Visit Frequency**	49%	47%	48%	49%	49%	51%	51%	52%	54%	56%	55%	55%	58%
Patients Newly Enrolled in Medical Care***	35%	44%	46%	41%	40%	47%	50%	53%	51%	54%	52%	46%	39%

* Percent of patients with no medical visit in last 6 months of the measurement year.
** Percent of patients with 1 visit in each of last 4 6-month periods, with at least 60 days between visits.
*** Percent of newly enrolled patients with 1 medical visit every 4 months in the measurement year.

	FY11-12	FY12-13	FY13-14 Year to Date (1-03-2014)
Retention in HIV Medical Care	38%	55%	54%
Late HIV Diagnosis	3%	2%	1%
ART Among People in Care	75%	83%	87%
Viral Load Suppression	65%	68%	64%
Housing Status (Homeless)	18%	18%	18%

HAB Measures	FY 11-12	FY12-13	FY 13-14 (Not Yet Final)
CD4 Count	77%	79%	63%
HAART	95%	96%	97%
Medical Visits	81%	84%	81%
Oral Exam	45%	42%	47%
Lipid Screening	82%	79%	74%
TB Screening	72%	70%	71%
Chlamydia Screening	50%	68%	50%
Gonorrhea Screening	45%	68%	45%
Syphilis Screening	79%	78%	77%
Cervical Cancer Screening	52%	41%	41%
Hepatitis B Screening	85%	85%	86%
Hepatitis C Screening	77%	79%	76%

Broward County EMA Performance on HAB Measures

Notes: Includes measures with ≥2,000 HIV clients, except for Women's measure, presented separately and included with at least 1,000 clients.
Unless otherwise noted, "patient" or "client" means a person with HIV who has had at least one medical visit with a provider with prescribing privileges during the measurement year and is enrolled in the Ryan White program

Measure	Percent Meeting Measure		
	PY 2011-12	PY 2012-13	PY 2013-14 [Not final]
HAB Group 1 Clinical Performance Measures			
1. CD4 T-cell Count [% of patients with a medical visit who had ≥ 2 CD4 T-cell tests during yr.]	77%	79%	63%
2. Medical Visits [% of MCM clients with ≥ 2 medical visits during yr.]	81%	84%	81%
3. MCM Care Plans [% of MCM patients with care plan developed and/or updated ≥ twice during yr.]	17%	13%	17%
5. **MCM Medical Visits** [% of MCM patients with ≥ 2 medical visits in an HIV care setting during yr.]	100%	100%	100%
HAB Group 2 Clniical Performance Measures			
5. Hepatitis B Vaccination [% of clients who completed the vaccination series for Hepatitis B]	13%	11%	9%
6. Hepatitis C Screening [% of clients for whom Hepatitis C (HCV) screening was performed at least once since HIV diagnosis]	77%	79%	76%
7. HIV Risk Counseling [% of clients who received HIV risk counseling during yr.]	13%	3%	8%
8. Lipid Screening [% of clients on HAART who had a fasting lipid panel1 during yr.]	82%	79%	74%
9. Oral Exam [% of clients who received an oral exam by a dentist at least once during yr.]	45%	42%	47%
1**0. Syphilis Screening** [% of adult clients who had a test for syphilis performed within yr.]	79%	78%	77%
11. TB Screening [% of clients who received testing with results documented for latent TB infection (LTBI) since HIV diagnosis]	72%	70%	71%
HAB Group 3 Clinical Performance Measures			
12. Hepatitis B Screening [% of clients who have been screened for Hepatitis B virus infection status]	85%	85%	86%
13. Influenza Vaccination [% of clients who received influenza vaccination during yr.]	21%	21%	19%
14. Toxoplasma Screening [% of clients who received toxoplasma screening since HIV diagnosis]	39%	41%	43%
Women-Focused Measure			
15. Cervical Cancer Screening [% of women who had a Papanicolaou screening during yr.]	52%	41%	39%

Percent of Ryan White Clients with Viral Suppression/Undetectable Viral Load by Subpopulation - Broward County EMA			
Note: Percent with Suppressed or Undetectable Viral Load (≤ 200 copies/mL); includes PLWH with known VL only. Combines groups when N in cell is <6.			
	PY 2010-2011 N=5,167	**PY 2011-2012 N=5,434**	**PY 2012-2013 [Partial Year\l]**
TOTAL	**70%**	**73%**	**77%**
Race/Ethnicity			
Black Non-Hispanic/Latino Male	67%	70%	72%
Black Non-Hispanic/Latino Female	64%	67%	74%
Subtotal, Black Non-Hispanic/Latino	**66%**	**69%**	**73%**
Hispanic/Latino Male	76%	80%	84%
Hispanic/Latino Female	73%	75%	80%
Subtotal, Hispanic/Latino	**76%**	**79%**	**83%**
White Non-Hispanic/Latino Male	75%	79%	80%
White Non-Hispanic/Latino Female	78%	77%	78%
Subtotal, White Non-Hispanic/Latino	**78%**	**79%**	**80%**
Haitian	74%	76%	80%
Non-Haitian	70%	73%	75%
Gender			
Male	72%	75%	79%
Female	65%	81%	74%
Transgender [All Male to Female]*	56%	61%	65%
Non-Transgender	70%	73%	77%
Age			
18-28	42%	50%	58%
29-38	59%	63%	70%
39-48	67%	70%	76%
49-58	76%	80%	81%
59+	82%	84%	85%
Sexual Orientation			
Gay/Lesbian/Homosexual	73%	77%	83%
Bisexual	68%	71%	78%
Heterosexual	69%	71%	75%
Living Arrangements			
Permanently Housed	74%	76%	79%
Non-Permanently Housed	59%	64%	69%
Institution*	41%	45%	60%

Literacy Level			
Illiterate (Level 0)*	84%	68%	65%
Less than 4th Grade (Level 1)*	73%	75%	84%
5th to 8th Grade (Level 2)	69%	73%	79%
9th - 12th Grade (Level 3)	68%	71%	74%
Above 12th Grade (Level 4)	73%	76%	80%
Educational Level			
8th Grade or Less	68%	71%	78%
9th - 12th Grade	69%	72%	75%
College	73%	76%	80%
HIV Risk Factor (Selected)			
MSM	72%	76%	79%
Heterosexual	69%	72%	76%
IDU	76%	76%	75%
Perinatal/Mother*	44%	44%	54%
Hemophilia/Transfusion*	77%	82%	76%
HIV Stage			
HIV/Not AIDS	72%	74%	77%
AIDS	72%	73%	76%
HIV-Positive/AIDS Status Unknown	65%	73%	76%
HIV Therapy			
HAART	75%	78%	81%
Dual	76%	78%	83%
Single*	73%	71%	79%
None	28%	34%	44%

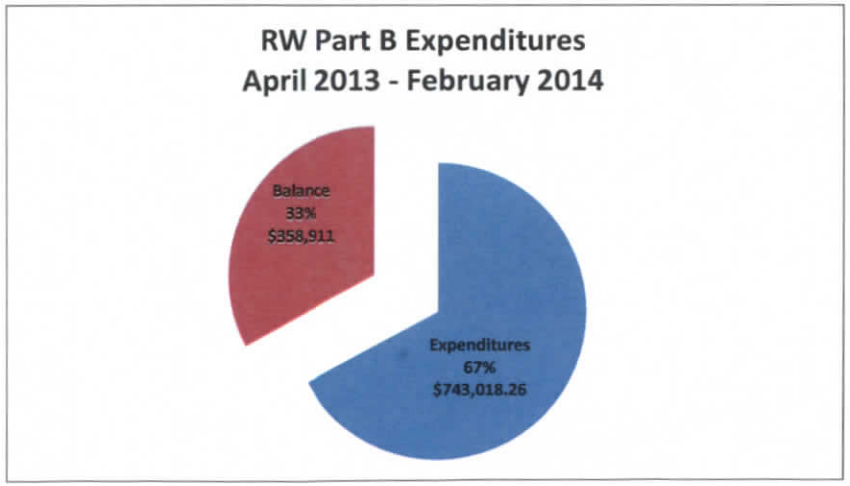
* Small population group (N <100 in at least one program year)

HANDOUT G

Ryan White Part B
Expenditure Report
February 2014

Service Category	Part B 2013-14 Allocated	Part B 2013-14 (February / Encumbered)	Part B 2013-14 Monthly Average Left	Part B 2013-14 (YTD Spent/ Encumbered)	Part B 2013-14 (% Encumbered)	Part B 2013-14 (% Left)	Part B 2013-14 (Balance)
Home Delivered Meals	$ 2,479	$ -	$ 2,059	$ 420.00	17%	83%	$ 2,059
Medication Co Pay	$ 310,000	$ 51,851.87	$ 91,840	$ 218,160.00	70%	30%	$ 91,840
Case Management (non-med)	$ 304,928	$ 24,227.01	$ 58,906	$ 246,022.00	81%	19%	$ 58,906
Residential Substance Abuse	$ 240,000	$ 21,583.02	$ 192,878	$ 47,122.26	20%	80%	$ 192,878
Medical Transportation	$ 134,330	$ 42,021.00	$ 2	$ 134,328.00	100%	0%	$ 2
Administration	$ 110,192	$ 15,296.68	$ 13,226	$ 96,966.00	88%	12%	$ 13,226
TOTALS	**$ 1,101,929**	**$ 154,979.58**	**$ 358,911**	**$ 743,018.26**	**67%**	**33%**	$ 358,911.00

Home Delivered Meals Served 2 clients in February
Non-Medical Case Management conducted 808 eligibility interviews in February
Medication Co Payment served 121 clients in February
117 Clients served in Medication Co Payment
4 Clients served in Mail Order
Medical Transportation 685 (31) day passes were distributed in February. A total of 1254 unduplicated clients have received passes April-February.
Residential Substance Abuse served 28 unduplicated clients thru February.



BROWARD COUNTY CODE OF ORDINANCES
CHAPTER 1, ARTICLE XII. BOARDS, AUTHORITIES AND AGENCIES GENERALLY

GENERAL REQUIREMENT AND POLICIES

Sec. 1-233. Terms of appointees to Broward County agencies, authorities, boards, committees, commissions, councils, and task forces; quorum

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Removal based on Attendance

1. Board meetings on a quarterly or less frequent basis: Members will be removed after two (2) consecutive unexcused absences or missing two (2) properly noticed meetings in one (1) calendar year.
2. Board meetings more frequently than quarterly: Members will be removed after three (3) consecutive unexcused absences or missing for (4) properly noticed meetings in one (1) calendar year.

Excused Absences

Require written notice to the chair of the board prior to the meeting (when practicable). The chair of the board shall determine whether the absence meets the criteria for an excused absence. Members may be excused **ONLY** for the following reasons:

1. Member performing an authorized alternative activity relating to outside advisory board business that directly conflicts with the properly noticed meeting;
2. Death of an immediate family member (spouse, father, mother, stepparent, in loco parentis, child, or stepchild domiciled in member's household);
3. Death of member's domestic partner;
4. Member's hospitalization;
5. Member summoned for jury duty; or
6. Member is issued a subpoena by a court of competent jurisdiction.

Non-excused absences

1. Out of town business.
2. Doing business or attending a meeting for member's company.
3. Attending another meeting as an elected official.
4. Car problems.

Requirements of Appointment

Any advisory board appointee who fails to meet the requirements of his or her appointment, including residency, if required to live in the district, is automatically disqualified, and his or her appointment shall immediately cease and be deemed vacant.

Quorum Rules

Once a quorum has been established by members physically present at a meeting, members who are not physically present may attend and participate in such meeting by telephone.

Appointees shall notify the board coordinator *at least two (2) business days prior* to the scheduled meeting date as to whether they will or will not attend the meeting. This will allow the cancellation of a meeting due to a lack of quorum prior to the actual meeting date.

If a board member does not confirm to the board coordinator that he or she will be present, at least 2 days prior to the meeting, he or she will be marked absent where such failure results in the meeting being cancelled for lack of quorum.

If a meeting is **scheduled and a sufficient number of members to constitute a quorum CONFIRMED** that they will be physically present at the meeting:

- Members present will be marked as attending.
- Members who telephone in, will be marked as attending.
- Members not present will be marked absent.
- Members, who did not confirm they were attending and attend, will be marked present.

If a meeting is **scheduled and a sufficient number of members to have quorum DID NOT CONFIRM** that they will be physically present at the meeting, **THE MEETING WILL BE CANCELLED PRIOR TO THE MEETING DATE**:

- Members who intended to telephone in, will be marked absent.
- Members, who did not confirm that they were attending, will be marked absent.
- Members who confirmed they would be attending will be marked *present* and it will be noted on the attendance sheet that the meeting was cancelled.

If a meeting is **scheduled and sufficient number of members to constitute a quorum CONFIRMED** that they will be physically present at the meeting, **BUT QUORUM WAS NOT PRESENT AT THE MEETING, THE MEETING WILL BE CANCELLED**:

- Members present will be marked as attending but it will be noted that the meeting was cancelled.
- Members not present will be marked absent.
- Members, who telephone in, will be absent.
- Members, who did not confirm that they were attending, and attend, will be marked present.
- Members who did not confirm that they were attending, and do not attend, will be marked absent.

(Ord. No. 79-36, § 1, 6-20-79; Ord. No. 89-19, § 1, 5-9-89; Ord. No. 92-4, § 1, 3-10-92; Ord. No. 92-13, § 1, 5-12-92; Ord. No. 92-46, § 1, 11-10-92; Ord. No. 95-18, § 1, 4-11-95; Ord. No. 1999-06, § 1, 2-23-99; Ord. No. 2001-01, § 1, 1-9-01; Ord. No. 2001-10, § 1, 3-27-01; Ord. No. 2002-10, § 1, 3-18-02; Ord. No. 2003-21, § 1, 6-10-03; Ord. No. 2005-01, § 1, 1-11-05; Ord. No. 2005-16, § 1, 6-28-05; Ord. No. 2006-17, § 1, 6-13-06; Ord. No. 2008-36, § 1, 9-9-08; Ord. No. 2009-39, § 1, 6-23-09; Ord. No. 2012-30, § 1, 10-23-12; Ord. No. 2014-08, § 1, 02-25-14)