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 23, 2017, 9:30 a.m.
Government Center Room A-337
Chair: Brad Barnes **Vice Chair:** Requel Lopes
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 3/23/17 Meeting Agenda
   f. Approval of 2/23/17 Meeting Minutes
3. **PHONE INTRODUCTIONS**
4. **FEDERAL LEGISLATIVE REPORT (Handout A)**
5. **PUBLIC COMMENT**
6. **CONSENT ITEMS**

#	Motion	Justification	Proposed By
1	To approve the Integrated Primary Care & Behavioral Health Service Delivery Model (New) **Handout C**	Integrated Primary Care and Behavioral Health Service are any professional diagnostic and therapeutic services rendered by a physician, physician's assistant, or nurse practitioner, social worker, psychologist, addictions counselor or other behavioral health provider in an outpatient facility for the treatment of HIV/AIDS.	QMC
2	To approve the Disease Case Management (DCM) Service Delivery Model (New) **Handout D**	DCM refers to a system of coordinated health care interventions to help clients self-manage their HIV infection and prevent complications from other chronic health conditions through health coaching and disease-specific educational materials and care coordination. The goal of DCM is to improve the client's quality of care and health outcomes through services conducted by disease case managers.	QMC
3	To approve the Food Services Service Delivery Model (New) **Handout E**	This program is designed to provide Food Services to Clients who require supplemental nutritional assistance to enhance the efficacy and absorption of medication. Food Services are intended to provide a nutritious and well-balanced food supplement to a Client's diet.	QMC
4	To approve the Health Insurance Benefit Support Service Delivery Model (New) **Handout F**	Health Insurance Benefit Support Services are intended to educate and inform eligible Ryan White Part A Clients about health insurance benefits, requirements and open enrollment periods and how they can navigate and utilize insurance effectively to achieve better health outcomes. These services plays an essential role in helping Clients address their health care needs by educating them about the coverage options, plan limitations, Federal/State requirements, and understanding health insurance finances (i.e. copays, deductibles, tax credits/penalties, etc.).	QMC
5	To approve the Health Insurance Continuation Program (HICP) Service Delivery Model (New) **Handout G**	HICP provides financial assistance to eligible Ryan White Program clients to maintain or obtain medical benefits by way of timely insurance premium payments, copays, and deductibles. HICP services are limited to $6,500 per year per client towards their in-network deductible and copays.	QMC

6	To approve the Mental Health Service Delivery Model (Updated) **Handout H**	The Mental Health Services SDM was updated to reflect a Trauma-Informed strengths-based framework. Mental Health Services allows individuals with a diagnosed mental illness to receive psychological and psychiatric treatment and counseling services by a licensed/authorized mental health professional. Trauma-Informed Mental Health Services include an understanding of trauma and an awareness of the impact it can have across settings, services, and populations.	QMC
7	To approve the Clinical Quality Management Plan (Updated) **Handout I**	The Broward EMA CQM Plan is a written document that outlines the grantee-wide clinical quality management program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the program. The CQM Plan is updated and approved by the Quality Management Committee every three years.	QMC
8	To approve the changes to the Membership/Council Development Committee's Policies & Procedures **Handout J**	The proposed changes to the MCDC P&Ps include language for the advancement of HIVPC Alternates to full members in the screening criteria.	MCDC
9	To appoint Yahaira Barrientos to the Priority Setting and Resource Allocation Committee	Ms. Barrientos serves as a Peer Specialist at Henderson Behavioral Health. Through her active involvement in the community and her daily work with clients, she will be able to provide information regarding the effects of PSRA decisions on the PLWHA community.	PSRA

7. DISCUSSION ITEMS
None

8. NEW BUSINESS
None

9. MARCH COMMITTEE REPORTS (15 minutes)

A. COMMUNITY EMPOWERMENT COMMITTEE (CEC)

March 7, 2017 *Chair: L. Robertson V. Chair: P. Fleurinord*

A. Work Plan Item Update / Status Summary:
Work Plan: Staff reviewed the FY2017-2018 CEC Work Plan with the committee. It is different from past CEC Work Plans, including a yearly goal and activities, as well as correlating document objectives with the Integrated Plan. A lot of those objectives are based around outreach and empowering community members to become community leaders. This committee will be out in the community providing education, and following up with summits and other activities, so that CEC is consistently visible. This committee will also be a part of the ranking process for PSRA. Community Forum: CEC will collaborate with BTAN to get a group of approximately 25-50 people together. The group should be a mixture of front line people and PLWHA. The goal is to capture information on gaps, and give people a comfortable environment to express their feelings about services, referrals, and other aspects of accessing care. The planning process for the next year is upcoming, and should start with a forum. The Vice Chair provided an example of hearing consumers discuss their negative experiences of services with each other, and encouraging them to fill out a provider survey. Without that information, providers will not know what issues consumers are having with accessing services. CEC Survey: The committee reviewed survey results from the National Black HIV/AIDS Awareness Day event held on February 7, 2017. 34 community members took the survey. Participant responses to the question "Have you heard about the Ryan White HIV Planning Council?" were exactly half yes and half no. For the question "Who do you think is most at risk for getting HIV?" most respondents indicated that all people are susceptible to the virus. The Vice Chair commented that people were more engaged when she went to them with the survey and started a conversation with them than when members wait for event-goers to come to the table.
B. Rationale for Recommendations:
None.
C. Data Reports / Data Review Updates:
The members reviewed the CEC Work Plan as well as survey results.
D. Data Requests:
None.
E. Other Business Items:

Agenda Items for Next Meeting: Community Forum *Next Meeting Date:* April 4, 2017 *Location:* Governmental Center Annex Room A-337

B. AD-HOC BY LAWS COMMITTEE

March 8, 2017 *Chair: H.B. Katz*

A. Work Plan Item Update / Status Summary:

Purpose & Goals of the Committee: Planning Council staff reviewed the purpose of this committee as well as the expected length of commitment from members. The current ad-Hoc committee has a parking lot list of six items, and is expected to complete the process of making recommendations by September of 2017. Changes recommended to the By-Laws will be brought to the HIV Planning Council for approval.

Timeline for Completion of Work: The current committee timeline states that parking lot items #1-3 will be addressed in this meeting, item #4 at the April meeting, and #5 at the May meeting. The recommendations for those parking lot items will be voted on at the May HIV Planning Council meeting. Proposal #6 and any additional recommendations from standing committees, if proposed, will be addressed at the June By-Laws meeting. Those changes will be voted on at the July HIV Planning Council meeting.

By-Laws Parking Lot Items: The committee reviewed items #1-3. #1: Reconsider the HIVPC's need for a Needs Assessment/Evaluation (NAE) Committee as the work of this committee is will be done by various other committees. Language from the purpose of NAE was added into the Integrated Comprehensive Plan Work Group. Item #2: Reconsider the HIVPC's need for an ad-Hoc Local Pharmacy Advisory Committee (LPAC). The reasoning for this item is that the committee meets infrequently and PSRA can carry out the formulary reviews and other LPAC tasks when needed. #3: Include language for a standardized application process for Standing Committees. The committee decided to send the suggestion to the Executive Committee for Chairs and Vice Chairs to have committee members create descriptions and procedures to be added to the Policies & Procedures. The committee also decided to utilize the committee application form.

B. Rationale for Recommendations:

#1: Disband the Needs Assessment/Evaluation Committee (NAE). The work of the NAE will be carried out by various committees, including the System of Care Committee, Integrated Work Group, etc.

#2: Disband Local Pharmacy Advisory ad-Hoc Committee (LPAC). LPAC is an ad-Hoc under the Priority Setting and Resource Allocation Committee (PSRA). LPAC meets infrequently and PSRA can carry out the formulary reviews and other LPAC tasks when needed.

#3: Include language for a standardized application process for Standing Committees. There are different processes and requirements for joining each Standing Committee. By-Laws language should only include completion of an application (which will included a questionnaire identifying suggested qualifications for each committee). By-Laws recommends each standing committee address the standardized application process for prospective members in their Policies and Procedures.

C. Data Reports / Data Review Updates:

The members reviewed the Purpose & Goals of the committee, a Draft Timeline, the By-Laws proposed language, and Policies & Procedures language.

D. Data Requests:

None.

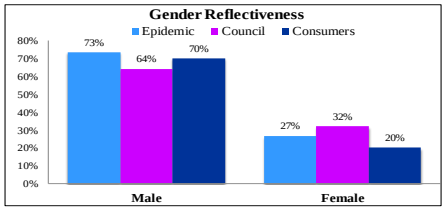
E. Other Business Items:

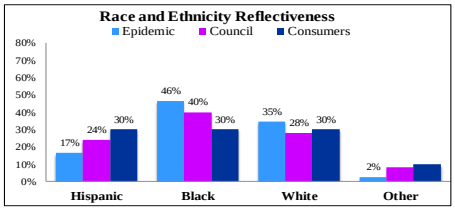
Agenda Items for Next Meeting: Parking lot item #4 *Next Meeting Date:* April 12, 2017 *Location:* Governmental Center Annex Room A-335

C. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

March 9, 2017 *Chair: Vacant V. Chair: V. Foster*

HIV Planning Council Membership Report
Current Through February 2017





Gender	Epidemic		Council		% Difference	Consumers		% Difference
Male	14,372	73%	16	64%	-9%	7	70%	-3%
Female	5,213	27%	8	32%	5%	2	20%	-7%
Transgender	-	-	1	4%	-	1	10%	-
Race	**Epidemic**		**Council**		**% Difference**	**Consumers**		**% Difference**
Hispanic	3,253	17%	6	24%	7%	3	30%	13%
Black	9,100	46%	10	40%	-6%	3	30%	-16%
White	6,777	35%	7	28%	-7%	3	30%	-5%
Other	455	2%	2	8%	6%	1	10%	6%
Total	19,585	100%	25			10		

Current Members	25
Minimum (Per County Ordinance)	20
Maximum (Per County Ordinance)	35
% Unaffiliated Consumers	40%

Vacant Seats
1. Grantees of Other Federal HIV Programs - VA
2. Federally Recognized Indian Tribe Members
3. State Medicaid
4. Individual co-infected with Hep B or Hep C
5. Local Public Health Agency
6. Substance Abuse Provider
7. Alternates

No more than 3 members employed by one governmental agency or provider shall serve on the HIVPC at one time, and no more than 40% of HIVPC members shall be Part A-funded

% Part A-Funded Providers	28%

A. Work Plan Item Update / Status Summary:

Review HIVPC Demographics: The Committee members review the HIVPC and Standing Committee member demographics. The members noted that the HIVPC is underrepresented in males, Blacks and White (both Council members and Ryan White consumers). They also noted the shift in the membership of many committees, and the need to recruit qualified members to each Standing Committee.

Attendance: PC Staff noted that there were numerous warnings and removals of Committee and HIVPC members due to attendance in February. 2 MCDC members, 1 PSRA member, and 3 HIVPC members received warning letters, and 1 QMC member received a removal letter. If any of those members warned do not attend their March meetings they may be removed as well.

Year in Review: The Committee members discussed their 2016 Year in Review. The Committee added 7 new HIVPC members, filling 4 HRSA mandated seats. 2 of those seats, the Recently Incarcerated or Their Representative and the Hospital or Health Planning Agency seat were historically hard to fill. Challenges for the MCDC included limited participation in community events, outdated recruitment materials and a vacancy for the MCDC Chair, and waning MCDC membership. To address those issues in 2017, the Committee will focus on targeting recruitment for vacant positions at relevant events (like the upcoming CEC Community Forum). Moving to a quarterly meeting schedule will also help reinvigorate membership and give them more time to recruit new members.

MCDC Work Plan: The Committee members reviewed the FY2017 MCDC Work Plan (on file). The WP reflects the Committee's quarterly meeting schedule, with Post Appointment Trainings and Mentorship opportunities occurring the month after MCDC meets. The Committee discussed recruitment and the application process in between meeting dates, and Staff assured the Vice Chair and members that they will inform them of any applicant updates or relevant recruiting opportunities.

Recruitment Materials: PC Staff presented the Committee members with various samples of recruitment palm cards. The members agreed that they liked the first sample, the most colorful the best. They requested that the HIVPC logo, possibly in a watermark, be incorporated into the card. PC Staff will discuss printing of the recruitment materials with the Grantee, and expects that the materials will have to be approved by Executive and the HIVPC before they can be distributed. The groups discussed the use of a QR code on the palm cards to link to the HIVPC website. The MCDC will receive a status update on the recruitment materials during the next meeting in June.

MCDC P&Ps: PC Staff reminded the members that at the February meeting they discussed the By-Laws Parking Lot, and the opportunity to address some of the Parking Lot items in the MCDC P&Ps instead of making changes to By-Laws. The members reviewed the proposed language regarding the advancement of Alternates to full HIVPC members in the Alternates section as well as the Application Screening Criteria. The discussed capping membership categories, such as Non-Elected Community Leaders. PC Staff will research the membership composition of other EMAs and provide recommendations at the next MCDC meeting.

B. Rationale for Recommendations:

Proposed changes to the MCDC P&Ps will include advancement of Alternates to full HIVPC members in the screening criteria to membership, ensuring that Alternates become full members when applicable

C. Data Reports / Data Review Updates:

None.

D. Data Requests:

None.

E. Other Business Items:

Agenda Items for Next Meeting: MCDC Policies and Procedures updates, Recruitment Materials *Next Meeting Date*: June 8, 2017 9:30 a.m. *Venue*: TBD

C. QUALITY MANAGEMENT COMMITTEE (QMC)

February 27, 2017 *Chair: C. Grant, V. Chair: Vacant*

A. Work Plan Item Update / Status Summary:

Review and approve Service Delivery Models (SDMs) (WP 2.1): The Integrated Primary Care and Behavioral Health SDM was reviewed and conditionally approved pending minor changes requested by the Committee.

Review and Update Three-Year Clinical Quality Management (CQM) Plan (WP 2.4): The three-year CQM Plan was reviewed and conditionally approved pending minor changes requested by the Committee.

Conduct Quarterly Network Update (WP 3.1): Staff did an overview of the QI Networks' activities. The Oral Health (OH) QI Network is currently working on a QIP to identify barriers to care for clients who consistently fail OH appointments. The Mental Health/Substance Abuse (MHSA) QI Network is developing a QIP to increase retention in MHSA care beginning with identifying clients who attended only one MHSA appointment. The Medical QI Network has been reviewing the Ryan White Part A Formulary and making recommendations for additions and changes. The review process will be completed in March. The Case Management (CM) Network completed a QIP looking at barriers to care for black women utilizing CM services. As a result, the Network is implementing an Intervention QIP to address identified barriers to care. The Network will review the complete data in March.

Providers appreciated the recognition for their commitment at last year's Quality Awards so staff would like to hold one for this year in April. Committee members will vote for award winners at the next Committee meeting.

B. Rationale for Recommendations:
The Committee recommended minor changes to the Integrated Primary Care and Behavioral Health SDM and three-year CQM Plan to clarify processes outlined in the model.
C. Data Reports / Data Review Updates:
The Committee reviewed and analyzed annual measures and data.
D. Data Requests:
None.
E. Other Business Items:
None.
F. Agenda Items for Next Meeting:
Agenda Items for Next Meeting: Nominate QI Networks for All Networks Awards and review the NQC end+disparities Campaign. *Next Meeting Date*: March 20, 2017, Governmental Center A-335

March 20, 2017 *Chair: C. Grant, V. Chair: Vacant*

A. Work Plan Item Update / Status Summary:
Introduce the end+disparities National Quality Center (NQC) Initiative: Staff presented the NQC end+disparities Campaign that is an NQC initiative. The Campaign correlates with the recently updated National HIV/AIDS Strategy (NHAS). One NHAS goal is to reduce HIV-related disparities in communities at high risk for HIV infection and this Campaign directly targets this goal. NQC has made several resources available to all involved in the Campaign that can be used to identify and address disparities. Staff also presented a disparity calculator that NQC has created as a resource for the Campaign. Staff demonstrated how the calculator works using data from Provide Enterprise. The Committee is interested in using the Campaign to select projects for this Fiscal Year. *Committee Member Appointment Process:* Staff stated the Committee needs to discuss how they would like the appointment process to be and what kind of members the Committee is in search of. The Recipient stated this is a complex Committee and very data focused so the Committee needs people who will have an interest and basic understanding of data. A member suggested adding qualities/skills the Committee is looking for to the Committee application. Another member suggested adding questions to the application to gather more information on the applicant. A member suggested providing an attachment summarizing each Committee to the application so the applicant knows they are joining the Committee they are best suited for. A member also suggested asking applicants to provider their availability to attend meetings. The chair asked staff to draft a process based on the Committee's suggestions to be approved at the next meeting. *Identify Potential QMC Members:* The Committee has recently lost several members and needs to discuss potential ideas for recruitment. Staff presented the Committee's current demographics as it relates to the epidemic. The Committee is underrepresented on males and blacks, and overrepresented on females, Hispanics, and whites. One member stated the Committee should look at agencies and see if anyone would be available to join. Another member stated he has connections with the School of Public Health at Nova Southeastern University and will see if anyone from the program would be interested in joining. Another member suggested reaching out to the Stempel College of Public Health at Florida International University as well. All recommendations for new Committee members should be sent to staff. *Review Updated Clinical Quality Management (CQM) Work Plan*: Staff reviewed the Committee Work Plan. The Work Plan was created in conjunction with the CQM Plan that was reviewed at the last meeting. Staff stated activities on the Work Plan will be tracked and updated each month. The Committee will also use the Work Plan as a tool to evaluate the progress of goals and tasks.
B. Rationale for Recommendations:
The Committee recommended changes to the Committee's Policies and Procedures to include language about what the Committee is looking for in new Committee members.
C. Data Reports / Data Review Updates:
The Committee reviewed the NQC end+disparities Campaign to utilize when developing Committee activities for this Fiscal Year.
D. Data Requests:
None.
E. Other Business Items:
None.
F. Agenda Items for Next Meeting:
Agenda Items for Next Meeting: Review Fiscal Year 2016 data and Nominate QI Networks for All Networks Awards. *Next Meeting Date*: April 17, 2017, Governmental Center A-335

D. PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)

Meeting Cancelled- No Quorum *Chair: W. Spencer, Vice Chair: R. Siclari*

E. SYSTEM OF CARE COMMITTEE

March 28, 2017 *Chair: M. Hayes, Chair: C. Edwards*

F. EXECUTIVE COMMITTEE

March 16, 2017 *Chair: B. Gammell Vice Chair: R. Lopes*

A. Work Plan Item Update / Status Summary:
Standard Committee Items–The committee members reviewed, edited and approved the April calendar, and March HIVPC agenda and meeting materials. The PSRA Chair proposed moving the PSRA meeting to the 3rd Thursday at 9:00 a.m. before the Executive Committee. The change would allow for members on both committees to streamline their schedules, and hopefully reduce quorum issues. The meeting would have an 8:30 breakfast, meet from 9-11 a.m., and Executive would proceed from 11-1 p.m. FY2017 Executive Work Plan – The Committee members review and approved their FY2017 Executive Work Plan during their last meeting in February, and the members agreed to develop a goal for the Committee at their March meeting. The PSRA Chair suggested that their goal focus on new and different feedback mechanisms for reaching out to the community, consumers, and other HIV+ individuals to get them involved in the HIVPC process. The members discussed how many people each HIVPC member should bring to a meeting, and what a target goal for increased membership on the HIVPC and committees should be. The SOC Chair suggested that the focus should be on recruiting new committee members, as the committee meetings can be less formal and more engaging for newcomers than HIVPC meetings. The PC Manager stated that CEC does outreach at community events, that Committee Chairs should focus on recruitment for their committees and that the MCDC should be tasked will recruitment for vacant mandated seats. The FY2017 Executive Committee Goal- "Increase community engagement and participation by adding 10 new committee and HIVPC members by the end of FY2017." Committee Membership Application – The PC Manager discussed the By-Laws recommendation for each committee to standardize their application process for new members in each Committee's Policies & Procedures. While there currently is a Committee Application and overall process, the By-Laws Committee believed that adding specific language would help streamline a process for membership. It would serve as a tracking system with reflectiveness, contact info, and help Staff with documentation required on their end. The Committee Chairs agreed to discuss a committee membership process with their committees, including revising their P&PS and thinking about the traits needed for potential committee members. Facilitated Planning Body Meeting – There are 3 HIV planning bodies in Broward: BCHPPC (Prevention), SFAN (Ryan White Part B Advisory Board), and the HIVPC (Ryan White Part A Advisory Board). The Broward County Integrated HIV Prevention and Care Plan was submitted in September, 2016, and it is time for the Planning Bodies to figure out how to implement and monitor the Plan. The Grantee has suggested that the 3 Planning Bodies participate in a facilitated meeting to discuss how to move forward. The Grantee hopes that a facilitated meeting would be able to get to the heart of the issues between the bodies, and hopefully help everyone come to a resolution. The Executive members thought it was important for everyone to have an opportunity to air their grievances, and insisted that there should be some summary documentation about the topics and conclusions of the meeting for distribution to the bodies. The group decided that May 2nd was the best date, then April 24th or 28th. Staff will book ArtServe for the meeting, and will ask the IC Part A Vice Chair, Carla Taylor-Bennett, to attend.
B. Rationale for Recommendations:
None.
C. Data Reports / Data Review Updates:
None.
D. Data Requests:
None.
E. Other Business Items:
Agenda Items for Next Meeting: Committee Membership Process *Next Meeting Date*: April 20, 2017

****For detailed discussion on any of the above items, please refer to the meeting minutes. ****

10. GRANTEE REPORTS (20 minutes)

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

11. UNFINISHED BUSINESS

12. PUBLIC COMMENT

13. ANNOUNCEMENTS

14. REQUEST FOR DATA

15. AGENDA ITEMS FOR NEXT MEETING: April 27, 2017 **LOCATION:** GC-430

Tasks for next Meeting	*Responsible Party*	*Action to be taken, presentation, discussion, brainstorm etc.*
Ryan White Part A Formulary	*PSRA*	ACTION ITEM: Review changes to Ryan White Part A Pharmacy Formulary
Broward County Test and Treat	*Part A Grantee*	ACTION ITEM: Receive presentation on Test and Treat Initiative

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE GUIDING PRINCIPLES OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

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 RETREAT

February 23, 2017 Meeting Minutes

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	Arencibia, Y.	**X**			Hyde, S.
2	Bell, J.	**X**			Little, S.
3	Bhrangger, R.	**X**			Barrientos, Y.
4	Burgess, D.	**X**			Rodriquez, J.
5	DeSantis, M.	**X**			Rajner, M.
6	Gammell, B. *Chair*	**X**			Hamlet, L.
7	Grant, C.	**X**			Reeves, L.
8	Hayes, M.		**A**		Corderman, A.
9	Holness, Comm. D.V.C.		**A**		Sabatino, D.
10	Huggins, L.		**A**		Hyde, R.
11	Katz, H. B.	**X**			McGarrity, G.
12	King, J.	**X**			
13	Lint, A.	**X**			**Grantee Staff**
14	Lopes, R. *Vice Chair*	**X**			Jones, L.
15	Marcoviche, W.	**X**			Anderson, T.
16	Moragne, T.	**X**			
17	Parker, P.	**X**			**HIVPC Staff**
18	Robertson, L.	**X**			Johnson, B.
19	Robertson, P.		**A**		Oratien, V.
20	Runkle, D.	**X**			Ewart, L.
21	Schweizer, Dr. M.	**X**			Newton, A.
22	Shamer, D.	**X**			
23	Siclari, R.		**A**		
24	Spencer, W.,	**X**			
25	Taylor-Bennett, C.	**X**			
26	Thomas-Purcell, K.		**A**		
	Quorum=14	**20**			

1. CALL TO ORDER

The Chair called the meeting to order at 9:39 a.m.

2. WELCOME AND PUBLIC RECORD REQUIREMENTS

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

Motion #1: To approve today's agenda
Proposed by: Spencer, W. **Seconded by:** Moragne, T.
Action: Passed Unanimously

Motion #2: To approve the 1/26/17 meeting minutes
Proposed by: Bell, J. **Seconded by:** Katz, H.B.
Action: Passed Unanimously

3. PHONE INTRODUCTIONS

None

4. FEDERAL LEGISLATIVE REPORT

Mr. Murphy presented his legislative report to the Executive Committee the previous week. His report (Handout A) is on file.

5. CONSENT ITEMS

The HIVPC Members reviewed the only Consent Item, the approval of Yahaira Barrientos for HIVPC membership in a Non-Elected Community Leader seat.

Motion #3: To approve Consent Item #1
Proposed by: Katz, H.B. **Seconded by:** Grant, C.
Action: Passed Unanimously

6. DISCUSSION ITEMS:

None

7. FEBURARY COMMITTEE REPORTS

A. COMMUNITY EMPOWERMENT COMMITTEE (CEC)

National Black HIV/AIDS Awareness Day *Chair: L. Robertson, V. Chair: P. Fleurinord*

The CEC members participated in an event for Nation Black HIV/AIDS Awareness Day. The CEC Chair also gave a few highlights of the Committee's work in 2016:

- CEC member participation - HIP Community BBQ, Integrated Plan Community Forums, United States Conference on AIDS (USCA), BTAN Barbershop Event, National Black HIV/AIDS Awareness Day
- 73% of CEC members are HIV+
- Upcoming CEC Initiatives- Community Education and Training Series on Emerging/Important Issues in HIV, collaboration with community partners on community events and outreach, identifying emerging HIV+ community leaders

B. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

February 9, 2017 *Chair: Vacant, V. Chair: V. Foster*

The report stands. The HIVPC Chair reminded the HIVPC members that MCDC is changing to a quarterly meeting schedule beginning March, 2017. The HIVPC Chair also provided a few highlights of the Committee's work in 2016:

- Added 8 new HIVPC members in FY16
- 56% of HIVPC members are HIV+
- 40% of HIVPC members are Unaffiliated Ryan White Consumers
- 2 new HIVPC applicants so far in 2017
- Upcoming MCDC Initiatives- Revising the MCDC recruitment materials, and targeted recruitment of new HIVPC members

C. QUALITY MANAGEMENT COMMITTEE (QMC)

February 6, 2017 *Chair: C. Grant, V Chair: A. Earp*

The report stands. The QMC Chair gave a few highlights of the Committee and QI Network's work in 2016:
QMC:

- Drilled down viral load data from FY 14-15 and identified three key populations with the lowest viral load suppression:
    - Non-Hispanic Black Heterosexual Females (Aged 18-38)
    - Non-Hispanic Black MSM (Aged 18-38)
    - Non-Hispanic Black Heterosexual Males (Aged 18-38)
- Among three populations— Non-Hispanic Black Heterosexual Females, Non-Hispanic Black MSM, and Non-Hispanic Black Heterosexual Females, there were four common variables that impacted viral suppression: HIV therapy, retention in care, retention in Part A OAMC, and oral health services utilization (as shown above with *).
    - Overall, individuals who were virally suppressed were more likely to be on HIV therapy, retained in care, and utilize oral health services.

- In July 2016, the QM Committee participated in a retreat to help better understand the importance of quality, the committee's purpose, and how the important work of the committee impacts other HIVPC standing committees.
    - New members were introduced to the QM Program components while other objectives included learning about performance measures and reporting requirements, ways to review and analyze data, developing directives for the QI networks, and planning for collaboration across committees.
- In October, the QMC reviewed viral load data
    - FY 15-16 Part A viral load suppression: 82.9% (n=6,143)
        - Females: 79.1% (n=1,633)
        - Males: 84.5% (n=4,472)
        - Transgender: 70.4% (n=38)

QI Networks

- Case Management (FY 15-16 viral load suppression: 85.3% n=2,429) : participated in the Barriers to Care QIP which included 60 Non-Hispanic Black Heterosexual Female clients
    - top barriers reported were lack of financial resources, mental health, lack of transportation, lack of adequate housing, and not taking HIV medication
    - using these barriers to care the CM QI Network began the first stages of an intervention QIP and will allow CM to track completed interventions and client's viral load through FY 2017
- Oral Health (FY 15-16 viral load suppression: 89.2% n=2,536): in December, discussed beginning a QIP to track barriers to care for clients who chronically fail dentist appointments
- Medical (FY 15-16 viral load suppression: 81.8% n=3,095): began a barriers to care QIP on all unsuppressed clients in the OAMC service category. The top five reported barriers to care were:
    - Not taking medications, newly enrolled, lost to follow-up, lapse in insurance/benefits, and substance abuse issues
- Mental Health and Substance Abuse (FY15-16 viral load suppression: 85.7% n=438): began a barriers to mental health care and substance abuse QIP on unsuppressed 18-28 and 29-38 year old mental health/substance abuse clients
    - Results data not yet available

D. PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)

February 15, 2017 *Chair: W. Spencer, Vice Chair: R. Siclari*

The PSRA Chair informed the members of the upcoming PSRA process and the work that the Committee has been doing to reexamine MAI programs for Black clients. He gave an overview of the Committee's work in the last year:

- Allocated over $16 million in Part A funding for 11 prioritized services
- Developed "How Best to Meet the Need" language as guidance for the Grantee based on commonly cited barriers in the community. Based on the language, 4 new service components will be implemented in the EMA in FY17, including a Benefits Support Service for client seeking assistance with their ACA plans, increased access to routine and specialty Oral Health Care services, integration of Behavioral Health screening into routine medical care, and the implementation of a trauma-informed mental health model.
- Upcoming PSRA Initiatives- FY2018 PSRA process will look at trends in services, the needs of subpopulations not achieving viral load suppression, analysis of the HIV Care Continuum and client drops offs, and will feature presentations from various Ryan White Programs and HIV Funders in the community about their services and client needs

E. INTEGRATED COMMITTEE (SOC)

No February Meeting *Co-Chair: W. Spencer, Co-Vice Chair: C. Taylor-Bennett*

The Integrated Committee Part A Co-Chair gave the members and guests an overview of the work done to draft and submit the Integrated HIV Prevention and Care Plan:

- IC was made up of members chosen by the HIVPC and the BCHPPC. Members included Ryan White Consumers, community stake holders, and representatives from Prevention Work Groups, housing services, substance abuse and Broward Public Schools.
- The IC met for 7 months and oversaw the development of the Integrated Plan.

- Held 4 Integrated Plan Community Forums and 1 Workforce Forum with over 200 participants to gain feedback on the objectives identified in the Integrated Plan.
- The Integrated Plan was presented and approved by the HIVPC and BCHPPC in August, 2016
- The Broward County Integrated HIV Prevention and Care Plan was submitted to HRSA and the CDC in September, 2016

ACTION ITEM: Send the link to the Integrated Plan to the HIVPC list serve. Send Laura Reeves's slideshow to the HIVPC list serve.

F. EXECUTIVE COMMITTEE

February 16, 2017 *Chair: B. Gammell Vice Chair: R. Lopes*

The report stands. The HIVPC Chair gave an overview of the Executive Committee's work in 2016:

- 6 new HIVPC chairs and vice chairs appointed under newly elected HIVPC leadership in 2016
- Held Executive Leadership Training series focusing on meeting preparation, organizational change, and management styles
- 6 HIVPC Chairs participated in the National Ryan White Conference and USCA in 2016
- 45% of HIVPC Committee chairs are HIV+

8. NEW BUSINESS

a. Presentation: Laura Reeves, Section Administrator the HIV/AIDS Bureau in the Florida Department of Health addressed the HIVPC members and audience. Ms. Reeves has been working in HIV for 24 years, and has worked with FDOH in various positions including Tuberculosis, health improvement planning, and clinical quality management. Ms. Reeves gave the members an overview of the states' 2015 HIV epidemiology trends, noting that Broward and Miami-Dade were the 2 MSAs with the highest new infections in the US. Orange County MSA was #3. The DOH's goal is to eliminate new HIV infections and reduce AIDS related deaths. She discussed the HIV Continuum of Care, and compared the continuums of Florida, West Palm, Broward and Miami, noting that the Broward continuum has higher viral load suppression and retention in care measures than its neighbors and the state.

She next discussed Florida's Plan to Eliminate HIV Transmission and Reduce HIV-Related Deaths. Strategies include routinized HIV testing in urgent care and hospital settings, focusing on the change from the "informed consent" to the "opt out" HIV testing policy. She spoke about Broward's new Test and Treat initiative. Test and Treat provides rapid access to treatment after an initial HIV+ diagnosis. This new model also places an emphasis on finding and reengaging those lost to care. Broward County is in the process of developing a Test and Treat Program, and the state is waiting to see the results with a goal to replicate it in other counties. Florida's Plan includes improved access to PrEP and nPEP to reduce new infections for those at risk and most in need. Finally, the plan includes an increase in outreach and messaging focused on working with primary care providers to conduct routine health risk assessments with the clients, as well as discuss sexual health and make risk recommendations. She acknowledged the continued stigma around HIV disease and those populations disproportionately affected by HIV. To decrease stigma and increase access, the DOH is looking to develop and improve targeted messages by population and area. They are also looking to establish collaborative partners to streamline and standardize messages about HIV. She noted that the CDC estimates that 12% of people living with HIV have not been diagnosed, and that there were 7 perinatal HIV transmissions in 2015.

Ms. Reeves gave an overview of the various sources of HIV funding in Florida, including Ryan White grants, prevention and surveillance grants through the CDC and state funds. She noted that while Florida receives $295 million in funding each year, there is still the need to leverage and prioritize resources in order to meet the needs of the 111,000 people living with HIV in Florida.

Ms. Reeves opened her presentation up to questions for the HIVPC members and audience. One member stressed the need for stronger messaging about the impact of HIV in Florida. Another member asked about various cities that use client input in their decision making processes. Ms. Reeves stated that she did not know of any current models, but that the DOH's Patient Care Unit is currently monitoring their lead agencies, and might have information about how other agencies use client feedback. The Tobacco Free Florida campaign also might have some models/strategies to share. A member asked if the DOH was seeking money to increase PrEP and nPEP sites, to which she replied they are looking to use current resources to increase access but are limited in the ways that they can use CDC and other categorical funding sources.

Various members asked about social media campaigns and targeted messaging, outreach and education especially for disproportionately impacted minority populations. The state has just signed a new contract to redesign the state's media campaigns. The messages will be targeted to minorities, and will include education on patient care and accesses to HIV services. New campaigns will be designed with input from clients in various parts of Florida, and will researched and evaluated to ensure the right message and medium for each population. A member asked how to best engage local communities and those hidden populations. Ms. Reeves encouraged the members to have local conversations, focus groups and community forums, and to make sure to include Josh Rodriguez (DOH-Broward's local program coordinator), who can relay the outcomes back to the DOH.

A guest asked about access to DOH's Monthly Surveillance Reports (MSR) and the Epidemiological Slide Shows and charts depicted in the presentation. Ms. Reeves stated that MSRs are used to track real-time diagnoses are sent to local DOH staff. However, MSRs may be limited in access as reports include duplication and are not official until the state office is able to clean the data. The 2015 Epi Slideshows will be available on the DOH website soon. For any data requests it is best to contact the local DOH, as they can provide standardized data reports along with trend analysis.

Finally, a guest stated that he disagreed with the "Stop the Spread" campaign as he believes that it perpetuates false stereotypes and creates stigma. He asked if the DOH had any upcoming legislative initiatives and about the prospects of Medicaid expansion in Florida. The DOH will develop legislative strategies for the next year, and are currently looking at how to use their rebate funds for new and current initiatives. She stated that she was not in the position to comment of Medicaid expansion, as it that is a decision for the Florida Governor and Surgeon General.

9. GRANTEE REPORTS

a. **Part A:** The Part A Grantee stated that at the last HIVPC meeting he introduced the "Test and Treat" (TT) initiative. Staff has started drafting program protocol last week, and the rollout of TT will begin May 1st, with presentations for the HIVPC in April. The Grantee's Office is beginning a customer service evaluation of Part A Providers. They will be measuring the consumer experience with secret shoppers as they go throughout the Part A system. The project will start in March. The project will provide both a collective and an individual report for each service and provider. Next steps will include provider trainings to enhance and expand their consumer approach.

b. **Part B:** The Part B Grantee is working on 3 major projects: an RSR to clean client data; a Quality Management plan; and they are revising their contract with BARC. He will provide a financial report at next month's HVPC meeting.

c. **Part C:** The Part C program has also submitted an RSR. They have submitted non-compete application and awaiting response form HRSA. In FY2016 the Part C program provided 319 patients with medical care.

d. **Part D:** The Part D representative was not in attendance at the meeting, so the PSRA Chair provided an update. The Part D program completed their HRSA grant application last week, and are currently having their HRSA site visit. CDTC was recognized by the state for their best practices and will have another site visit to examine program for replication.

e. **Part F:** The Part F Community Partnership dental program continues and services are available through the Broward Community and Family Health Center. The program served 225 unduplicated clients last year. The program is also hosting a provider training for specialty referrals at the Cypress Creek location.

f. **HOPWA:** The HOPWA program has moved. They are now at 914 Sistrunk Blvd., Suite 103. The office is at the intersection of Powerline Rd. and Sistrunk Blvd.

g. **ADAP:** Currently the Florida Blue plan is having problems posting client information and payments. If clients cannot pick up their medications, please have them go to the ADAP pharmacy. If clients need to have their labs done, have them see the Part A Office through CIED as they will not be able to reach their Florida Blue insurance. Finally, the next BCHPPC meeting will be on April 20th.

10. UNFINISHED BUSINESS

None.

11. ANNOUNCEMENTS

a. Nova is participating in AIDS Walk. They have raised almost $3,000 so far. If you want to participate, please see their website. DNCE will be performing.

b. The ADAP Formulary expanded to the pre-wait list capacity. The formulary will now include Hepatitis C medications.
c. A guest stated that there has been a reversal of Department of Education's guidance for transgender students and access to bathrooms in schools. However, Broward and Miami have a Human Rights Act so there should be no changes in local policies. If anyone is being discriminated against, please contact the Broward Human Rights Board.
d. A member sated that the Florida Legislative bodies are debating a bill that would preempt County municipal bills for home rule with House Bill 17. Please call your local representatives to express your disagreement with this bill.

12. PUBLIC COMMENT

13. REQUEST FOR DATA

None.

14. AGENDA ITEMS FOR NEXT MEETING: March 23, 2017 9:30 a.m. **LOCATION:** A-337

Tasks for next Meeting	*Responsible Party*	*Action to be taken, presentation, discussion, brainstorm etc.*

15. ADJOURNMENT

The meeting was adjourned at 11:38 a.m.

HIVPC ATTENDANCE CY 2017

Consumer	PLWHA	Absences	Count	Meeting Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date:	26	23											
		0	**1**	Arenciaba, Y.	X	X											
		0	**2**	Bell, J.	X	X											
1	1	0	**3**	Bhrangger, R.	X	X											
1	1	0	**4**	Burgess, D.	X	X											
		0	**5**	DeSantis, M.	X	X											
	1	0	**6**	Gammell, B., *Chair*	X	X											
		0	**7**	Grant C.	X	X											
		1	**8**	Hayes, M.	X	A											
		2	**A**	Holness, D. V.C. (Comm)	A	A											
1	1	0	**9**	Huggins, L.M.	A	A											
1	1	0	**10**	Katz, H.B.	X	X											
		0	**11**	King, J.	X	X											
1	1	0	**12**	Lint, A.	X	X											
		0	**13**	Lopes, R., *V. Chair*	X	X											
1	1	0	**14**	Marcoviche, W.	X	X											
		1	**15**	Moragne, T.	A	X											

1	1	1	**16**	Parker, P.	A	X												
	1	0	**17**	Robertson, L.	X	X												
1	1	2	**18**	Robertson, P.	A	A												
1	1	0	**19**	Runkle, D.	X	X												
		0	**20**	Schweizer, M.	X	X												
1	1	0	**21**	Shamer, D.	X	X												
		1	**22**	Siclari, R.	X	A												
	1	0	**23**	Spencer, W.	X	X												
		0	**24**	Taylor-Bennett, C.	X	X												
		2	**25**	Thomas-Purcell, K.	A	A												
				Quorum = 14	20	20												

Legend:

X - present

A - absent

E - excused

NQA - no quorum absent

NQX - no quorum present

N - newly appointed

Z - resigned

C - cancelled

W - warning letter

R - removal letter

HANDOUT B

Fort Lauderdale/Broward County EMA

Overview of a Service Delivery Model

This summary will serve as a guide for HIV Planning Council members to better understand Service Delivery Models (SDMs), their purpose, and application as they pertain to Broward County's Ryan White Part A program services.

What is a Service Delivery Model?

A SDM serves as a set of standards, constraints, and policies used to guide and define the design, location, scope and operation of service(s) delivered by a service provider. SDMs are developed and revised in accordance with the most recent clinical practice guidelines and research available. In the Broward EMA, each Ryan White Part A service category has a SDM and all providers of that service are contractually required to comply with the standards and protocol outlined in the model.

Elements of a SDM:

- Definition of the service**:** Explanation of what the service is and will provide to eligible clients.
- Client outcomes and outcome indicators:
  - *Client outcomes:* Expectations for clients that may occur during or after their participation in the service.
  - *Outcome indicators:* Specific measures used to monitor progress towards achieving client outcomes.
- Standards for service delivery: Guidelines that the service provider should follow to ensure service is delivered to clients as intended.
- Protocol: The code of procedure that the service provider should follow when delivering the service.

Purpose

The SDM outlines how the service can best be delivered to clients and allows for consistent service experiences. The SDM acts as a tool for clear communication between service providers and the Recipient and forms the basis for on-going monitoring and evaluation by the Recipient.

Application

After approval of each SDM, the model is disseminated to all service providers and used routinely to ensure the service is executed correctly. CQM staff measure service category client outcomes and indicators each quarter and the Recipient monitors compliance with standards of service delivery on an annual basis.

HANDOUT C

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	3/23/17
Service Delivery Model	Integrated Primary Care and Behavioral Health Services
Status	New

Background/summary of service delivery model:

Integrated Primary Care and Behavioral Health Services are any professional diagnostic and therapeutic services rendered by a physician, physician's assistant, or nurse practitioner, social worker, psychologist, addictions counselor or other behavioral health provider in an outpatient facility for the treatment of HIV/AIDS. Integrated Primary Care and Behavioral Health Services are characterized by the following elements:

1. Strong partnerships between behavioral health and primary care, where providers function as a true team, sharing space and resources.
2. Clinical Delivery workflows that include shared screening tools and shared treatment planning and treatment planning documents.
3. Patient Experiences that are seamless and team-based.
4. Practices and Organization that embrace integrated care as a core value.
5. Business models that include shared policies and procedures and funding opportunities.

Services include the general management of acute and chronic medical and behavioral health conditions through initial visit and intake, complete history and physical examination, lab tests necessary for evaluation and treatment, prescribing and medication therapy, care of minor injuries, minor surgery and assisting at surgery, education and counseling on health and medical nutritional therapy, nutritional issues, immunizations, and follow-up visits. Integrated Primary Care and Behavioral Health Services are designed to provide psychosocial assessment and evaluation using evidence based screening tools, diagnosis, shared treatment planning, crisis intervention, periodic reassessments, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other therapeutic services as appropriate in order to improve adherence to treatment and improve patient health outcomes.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

Integrated Primary Care and Behavioral Health Services will assess client adherence and will address any identified barriers to care. Clients will be involved in creating their treatment plan and as such have a vested interest in their health outcomes and steps to achieve better health. Clients who miss two appointments in a row will be contacted by their medical case manager to bring the client back to care.

Refer to the following standards for service delivery outlined in the model that specifically ensure all steps in the HIV Care Continuum are met: 16, 18, 21, 26, 27.

HANDOUT C

THIS SECTION IS INTENDED FOR STAFF USE ONLY.	
Quality Management Committee:	
Service Delivery Model Request for Approval Decision ☑ Approved ☐ Denied Date: 02/27/2017	Reason(s) for denial:
HIV Planning Council:	
Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

HANDOUT D

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	3/23/17
Service Delivery Model	Disease Case Management
Status	New

Background/summary of service delivery model:

Disease Case Management (DCM) refers to a system of coordinated health care interventions to help clients self-manage their HIV infection and prevent complications from other chronic health conditions through health coaching and disease-specific educational materials and care coordination. The goal of DCM is to improve the client's quality of care and health outcomes through services conducted by disease case managers. Clients will be provided means to improve and sustain adherence to their medication regimen through education interventions, training, techniques to manage side effects and drug interactions, support regarding adherence to recommended therapeutic regimens, and self-care for clients that require ongoing medical management for their HIV medical condition.

DCM conducts care coordination for Integrated Primary Care and Behavioral Health Services. Through Care Coordination, DCM can optimize retention in care, improve client's self-management of HIV/AIDS by identifying and addressing specific client medical challenges, goals, interventions, and risk behavior reduction. Other components of Disease Case Management include:

1. Reduce intensity and frequency of HIV-related symptoms and co-morbidities.
2. Conduct interventions designed to improve treatment adherence.
3. Conduct Client self-management education to increase awareness about transmission of HIV and manage the treatment of HIV disease.
4. Ongoing documented communication with members of the Clients primary care and behavioral health treatment team.
5. Track and support Clients when they obtain services outside the organization.
6. Communicate test results and treatment plans with Clients and their families.
7. Improve coordination of client care across health conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-centered.
8. Provide care management services to clients at high-risk.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

DCM assists clients with adherence to prescribed medical protocols, retention in medical care, and achieving viral suppression and utilizes a comprehensive approach to address all aspects of the client's health needs that includes client self-management of their HIV infections and prevention of complications from chronic health conditions, comorbidities, or opportunistic infections. DCM refers to activities and interventions that attempt to reduce fragmentation and improve the quality of referrals and transitions. The disease case manager assists the client to access primary medical care using information provided in the health assessment. The disease case manager works to address client barriers to care and coordinate services and treatments when needed. The agency in which the DCM program is housed is encouraged to identify gaps in services within their organization and reach out to other organizations to bridge these gaps according to the specific needs of identified client populations. Disease case managers maintain a unique relationship with clients and are well positioned to re-engage clients lost to care back into care. The disease case manager also ensures client participation in the development of the POC. Clients' individualized POC includes client-driven needs that can be met using strategies that have realistic time frames. The POC is used to support the primary medical provider's treatment plan. Disease case managers collaborate with primary medical providers to address gaps in health care and to facilitate interventions related to specific gaps in care.

Refer to the following standards for service delivery outlined in the model that specifically ensure all steps in the HIV Care Continuum are met: 2-5, 7, 9, 14-16.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

HANDOUT D

Quality Management Committee:	
Service Delivery Model Request for Approval Decision ☑ Approved ☐ Denied Date: 02/06/2017	Reason(s) for denial:
HIV Planning Council:	
Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

HANDOUT E

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	3/23/17
Service Delivery Model	Food Services
Status	New

Background/summary of service delivery model:

This program is designed to provide Food Services to Clients who require supplemental nutritional assistance to enhance the efficacy and absorption of medication. Food Services must be provided in consultation with a nutritionist or other health professional who are involved in the completion of a nutritional assessment and plan for the Client. The plan shall identify nutritional and dietary factors which impact Client HIV conditions, and include nutritional strategies targeted at improving Client's overall health. Food Services are intended to provide a nutritious and well-balanced food supplement to a Client's diet. The provision of food services under this funding category is of two distinct types as defined below:

1. A **Food Bank** is a central distribution center that warehouse and provides nutritious groceries for indigent HIV+ clients. The food is distributed in cartons, bags or assorted products to eligible Ryan White Program clients.
2. **Food Vouchers** shall be in the form of a certificate/gift card for a grocery store, allowing clients to purchase nutritious food. Clients must be able to shop for and prepare their own meals. Provider must ensure that the majority of the food purchased is of nutritional value.

Food services are targeted to uninsured individuals with HIV/AIDS in Broward County and earn less than or equal to 150% of the Federal Poverty Guidelines, experience barriers to economic stability, and have no other means to receive services. More specific to administration of food services, all providers shall comply with applicable laws, health codes and national standards, and ensure food received by the client is from the five basic food groups. All food service clients shall receive a client intake, annual nutritional assessment, nutrition education or referral for medical nutrition therapy, one box of food once per week or one food voucher per month.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

Food services provide supplemental nutritional assistance to clients for the purpose of enhancing the efficacy and absorption of medication. The provision of these services is completed exclusively through a food bank or food voucher with separate criteria for respective usage. 85% of clients receiving food services should be retained in Outpatient/Ambulatory Medical Care and all clients not retained in care should be referred to an appropriate provider for follow-up. Medical indicators suggest all client viral loads and CD4 counts will be requested and recorded at least semi-annually and all consenting clients receive referrals to primary medical care. Staff will discuss the need to remain in primary medical care with the client as a condition to continue receiving food services. A referral to the case manager will be offered to address client barriers to care. Staff will review client's eligibility for all funding streams and services for which clients may qualify and follow up with referrals as appropriate. Chart reviews will be completed quarterly to ensure documentation of service, referrals, and follow-up. These actions will have a positive effect on clients' viral load suppression and adherence to treatment.

Refer to the following standards for service delivery outlined in the model that specifically ensure all steps in the HIV Care Continuum are met: 4, 5, 10, 11.

HANDOUT E

THIS SECTION IS INTENDED FOR STAFF USE ONLY.	
Quality Management Committee:	
Service Delivery Model Request for Approval Decision ☑ Approved ☐ Denied Date: 02/06/2017	Reason(s) for denial:
HIV Planning Council:	
Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

HANDOUT F

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	3/23/17
Service Delivery Model	Health Insurance Benefits Support
Status	New

Background/summary of service delivery model:

Health Insurance Benefit Support Services are intended to educate and inform eligible Ryan White Part A Clients about health insurance benefits, requirements and open enrollment periods and how they can navigate and utilize insurance effectively to achieve better health outcomes. These services plays an essential role in helping Clients address their health care needs by educating them about the coverage options, plan limitations, Federal/State requirements, and understanding health insurance finances (i.e. copays, deductibles, tax credits/penalties, etc.). This service category targets Broward residents with HIV with an income below or equal to 400% of the Federal Poverty Guidelines who are currently enrolled in either a Medicare, Medicaid, Veterans Benefits, employer sponsored health insurance, or ACA Qualified Heath Plan (QHP).

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

Benefits Support staff will discuss the benefits of primary medical care and the referral process to access primary medical care through the case manager. Staff will ensure the referral of the consenting client to their case manager to access primary medical care as well as document the assistance provided in the client record. Staff will also assist the client to remain in primary medical care and discuss the need to remain in care. This service category will provide increased access to medical care services thereby increasing the likelihood of client linkage to and retention in medical care services and eventually viral load suppression.

Refer to the following standards for service delivery outlined in the model that specifically ensure all steps in the HIV Care Continuum are met: 2, 4-6.

HANDOUT F

THIS SECTION IS INTENDED FOR STAFF USE ONLY.	
Quality Management Committee:	
Service Delivery Model Request for Approval Decision ☑ Approved ☐ Denied Date: 02/06/2017	Reason(s) for denial:
HIV Planning Council:	
Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

HANDOUT G

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	3/23/17
Service Delivery Model	Health Insurance Continuation Program
Status	New

Background/summary of service delivery model:

Health Insurance Continuation Program (HICP) provides financial assistance to eligible Ryan White Program clients to maintain or obtain medical benefits by way of timely insurance premium payments, copays, and deductibles. Eligible individuals are Broward County residents with HIV/AIDS who are privately insured through pre-approved insurance plans, unable to meet the costs of maintaining their private health insurance payments, and have an income between 250% and 400% of the Federal Poverty Guidelines. HICP services are limited to $6,500 per year per client towards their in-network deductible and copays. Funds will be allocated for the client's premium payments and the remaining balance may be used to fund deductibles and copays. All payments and allocations will be documented for each HICP client in the client record and MIS system.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

HICP staff will assess client participation in primary medical care and will ensure access to primary medical care within six months from the beginning of the HICP service contract year. Staff will discuss the benefits of primary medical care and the referral process to access primary care through the case manager. Additionally, staff will discuss with the client the need to remain in primary medical care as a condition to continue receiving primary medical care. HICP allows eligible clients to receive health insurance without financial responsibility thereby granting access to medical care and removing financial barriers. Additionally, clients may receive help with copay and deductible payments to further lessen the financial burden of medical care. By removing the financial barriers to care, clients are better able to access medical services and positively impact viral load suppression and retention in care.

Refer to the following standards for service delivery outlined in the model that specifically ensure all steps in the HIV Care Continuum are met: 2, 4, 6.

HANDOUT G

THIS SECTION IS INTENDED FOR STAFF USE ONLY.	
Quality Management Committee:	
Service Delivery Model Request for Approval Decision ☑ Approved ☐ Denied Date: 02/06/2017	Reason(s) for denial:
HIV Planning Council:	
Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

HANDOUT H

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	3/23/17
Service Delivery Model	Mental Health Services
Status	Revised

Background/summary of original service delivery model and proposed changes:

Mental health services allows individuals with a diagnosed mental illness to receive psychological and psychiatric treatment and counseling services by a licensed/authorized mental health professional. Trauma-Informed Mental Health Services include an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. Trauma-Informed Mental Health services refer to prevention, intervention, or treatment strategies that address traumatic stress as well as any co-occurring disorders developed during or after trauma. Trauma-Informed Mental Health Services focus on prevention strategies to avoid re-traumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. Trauma-Informed Mental Health Services is a strengths-based framework grounded in an understanding of, and responsiveness to, the impact of trauma. Clients will be assessed using the Biopsychosocial Evaluation form by a practitioner prior to providing treatment or intervention to the client. These results will be used to formulate an individualized treatment plan, with client input, that addresses identified needs and will be reviewed every six months.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

Trauma-Informed Mental Health Services includes an individualized care plan developed collaboratively with clients and, when appropriate, with family and caregivers. Individualized care plans include trauma-specific interventions and approaches that are designed specifically to address the consequences of trauma and to facilitate healing. Interventions should promote recovery and resilience for those who have experienced traumatic events and involves developing and implementing support that specifically considers the event and trauma experienced. Interventions should also include examining ways to reduce re-traumatization.

Clients are engaged in the development of their individualized treatment plan and provide their signature to show evidence of their involvement. Quarterly updates will be completed with client participation and documented in the client's progress notes. Clients will be assessed for potential barriers to retention in mental health treatment and will identify action steps that assist them to stay in treatment. Mental health services and trauma-informed services must include case conferencing for clients that are not achieving treatment plan goals, at risk for falling out of care, and that are experiencing virologic failure. Practitioners will help the client adhere to mental health treatment as well as medical care.

Refer to the following standards for service delivery outlined in the model that specifically ensure all steps in the HIV Care Continuum are met: 4, 5, 7, 10-14.

HANDOUT H

THIS SECTION IS INTENDED FOR STAFF USE ONLY.	
Quality Management Committee:	
Service Delivery Model Request for Approval Decision ☑ Approved ☐ Denied Date: 02/06/2017	Reason(s) for denial:
HIV Planning Council:	
Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

HANDOUT I

Fort Lauderdale/Broward County EMA

Clinical Quality Management Plan Approval Form

Date	3/23/17

What is the Clinical Quality Management (CQM) Plan?

The Broward EMA **CQM Plan** is a written document that outlines the grantee-wide clinical quality management program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the program. The CQM Plan is updated and approved by the Quality Management Committee every three years.

Main updates made to the CQM Plan include:

- Inclusion of the HIV Care Continuum and Integrated Plan into CQM Process.
- Newly established CQM Goals and Objectives.
- Updated systemwide and internal evaluation methods.
- Restructured CQM Performance Measures and Work Plan.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee:	
CQM Plan Request for Approval Decision ☑ Approved ☐ Denied Date: 02/27/2017	Reason(s) for denial:
HIV Planning Council:	
CQM Plan Request for Approval Decision ☐ Approved ☐ Denied Date: _____	Reason(s) for denial:

MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE
Policies and Procedure

Approved 1/26/17

Policies

The Membership/Council Development Committee (MCDC) shall solicit and screen applications for appointment of all members and alternates of the Broward County HIV Health Services Planning Council (Council) by the Broward County Board of County Commissioners.

The Membership/Council Development Committee shall meet quarterly (or as needed) to conduct committee business. Planning Council applications will be reviewed on a quarterly basis, or as needed, by the Committee. MCDC Committee members will be subject to Broward County Code of Ordinances for meetings scheduled on a quarterly or less frequent basis, with Committee members removed after two (2) consecutive unexcused absences or missing two (2) properly noticed meetings in one (1) calendar year.

The term of office for members and alternates shall be at the pleasure of the Board of County Commissioners. The Committee shall ensure that Council and committee members are knowledgeable about their duties, the functions of the Council, and the Council's role in the organization and delivery of HIV/AIDS health and support services. The Committee shall institute orientation and training programs for new and incumbent members. Orientations will be scheduled as needed by the Committee and support staff (Approved 2/20/14).

An individual may serve on the Council only if the individual agrees that if the individual has a financial interest in an entity, if the individual is an employee of a public or private entity, or if the individual is a member of a public or private organization, and such entity or organization is seeking amounts from a grant under the Ryan White CARE Act (Act), the individual will not, with respect to the purpose for which the entity seeks such amounts, participate (directly or in an advisory capacity) in the process of selecting entities to receive such amounts for such purpose.

The membership categories for the Council shall be consistent with those defined in the Act. No less than 33 percent of the Council shall be individuals who are receiving HIV-related services from Part A funded providers, are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV as determined annually. For purposes of the preceding sentence, an individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services. This may not be construed as having any effect on entities that receive funds from grants under any other Act or program but do not receive funds from grants under Part A, on officers or employees of such entities, or on individuals who represent such entities.

The Committee will recommend for appointment no more than 40% of the Council Members who are providers of HIV-related services who receive funds under Part A of the CARE Act (Approved 11/19/2009). No more than 3 members employed by one governmental agency or provider shall serve on the Planning Council at one time (Approved 1/28/10).

Affirmative outreach shall be made to attract qualified candidates for membership on the Council with particular attention to gender balance and adequate representation from racial and ethnic minorities. As part of the Council's efforts to increase the percentage of individuals with HIV on the Council, the Broward County Commission should strive, whenever possible, to appoint individuals with HIV to vacancies not only in that category but to other categories as appropriate.

There shall be a minimum of three individuals with HIV who shall serve as alternates appointed and approved by the Broward County Commission (Approved 2/20/14). The latter may only serve as voting members in Council meetings for any period of time that a member with HIV is unable to serve due to HIV-related illness. In such case, the Chair shall appoint an alternate who, to the greatest extent possible, matches the gender, race and/or ethnic background of the individual with HIV that is absent. Thereafter, alternates, as directed by the Chair, shall alternate their substitution for PWA members unable to serve due to HIV-related illness. Alternates shall comply with attendance requirements at Council meetings.

Council members and alternates as well as committee members must meet attendance requirements in accordance with the Code of the County, except that absences from meetings by individuals because of illness related to their HIV shall not be counted as an absence. Council members and/or alternates (appointed by the County Commission) and committee members will automatically be removed from the Planning Council or committee that meets more frequently that quarterly if he/she: 1) has three (3) consecutive unexcused absences regardless of year, or 2) misses four (4) meetings in one (1) calendar year (January-December) because of unexcused absences. A committee member will automatically be removed from a committee that meets on a quarterly or less frequent basis if he/she: 1) has two (2) consecutive unexcused absences regardless of year, or 2) misses two (2) meetings in one (1) calendar year (January-December) because of unexcused absences. (Approved 9/2008 for Council, 9/2009 for Committees). A letter signed by the Planning Council Chair or Vice Chair will be sent to Council members and/or alternates and committee members at risk of exceeding allowed number of absences, informing them of their attendance record and stating that one more additional absence will result in their removal from the Council.

Council members and alternates are required to serve on at least one standing committee. If a Council member/alternate should resign or be removed from a committee, s/he will have 30 days to select a new committee in which to become a member. If a committee is not selected within the 30 day timeframe, the member/alternate will be removed from the Council (Approved 2/20/14).

The Committee shall be responsible for recommending removal of Council members and Alternates in accordance with the Council By-Laws. Council members and Alternates may be removed for cause by a full Planning Council vote. Cause for removal may include failure to fully participate on the Planning Council, including not participating on a standing committee. Other causes for removal may include misrepresentation of the Council and/or failure to abide by the Council By-Laws.

If a Council member is removed from the Council, to be recommended for reappointment, s/he must go through the original membership process as stated in the MCDC Policies and Procedure. The Council may recommend the reappointment of members whose absences were caused by extenuating circumstances.

REMOVAL PROCESS

A. Removal for Attendance

Members or alternates who fail to comply with the Planning Council Attendance Policy will be automatically removed from the Planning Council. The Membership/Council Development Committee will report removals to the Executive Committee. Removals due to Attendance Policy violations will be reported to the Planning Council in the Executive Committee Report.

B. Removal for Cause

1. All recommendations for removal of a Member for cause must be documented as follows and submitted to the Membership/Council Development Committee:
    a. Name(s) of Council or Committee Member(s) recommending the removal (required).
    b. Name of Council Member or alternate recommended for removal.
    c. Written description of the action(s) prompting the request.
    d. Date(s) and location(s) where the action(s) took place.

e. Signature(s) and date of submission of Council or Committee Member(s) recommending the removal.
f. Written notice of recommendation for removal must be given to a member or alternate.

2. The Membership/Council Development Committee will review the status of current members and alternates and recommend removal from the Council by the Board of County Commissioners if the member or alternate:
   a. Refuses to cooperate in a conflict of interest review;
   b. Has been found to have knowingly taken action(s) intended to influence the conduct of the Council in a manner as defined in the By-Laws as a conflict of interest; or
   c. For violation of the Broward County HIV Health Services Meeting Ground Rules
   d. Any violation of the By-Laws
   e. Violation of Sunshine Law or Code of Ethics
   f. Does not attend a post-appointment training within 3 months of appointment to the Planning Council by the Broward County Board of County Commissioners.
3. The Membership/Council Development Committee will:
   a. Review all such requests for removal from the Council at its regular Committee meeting, unless the Chair of the Council or the Chair of the Committee requests that a special meeting be convened.
   b. If Committee determines a complaint has merit, the Committee will proceed with the investigation to be completed within sixty (60) days from date of merit determination. The Member being recommended for removal will be notified by certified mail once the complaint is determined to have merit.
   c. The Membership/Council Development Committee will investigate and may call witnesses, which should include the Member being recommended for removal, to ensure that all pertinent information is considered. The Member being recommended for removal may also call witnesses or bring written documentation to address the allegations.
   d. Following consideration of all the information available to the Committee, a majority vote of the Committee will make recommendations to the Executive Committee for appropriate action.
   e. Final disposition must be reported to the Executive Committee, the Member filing the complaint and the Member being recommended for removal. In addition, the final disposition will be reported in the Executive Committee Report on the Planning Council Agenda.

C. Removal Recommendation

The final decision to remove a Member must be ratified by the Planning Council. Once ratified, the Planning Council will forward all recommendations for removal to the Board of County Commissioners.

REINSTATEMENT POLICY

A. Any member may elect to resign for personal reasons, and have the right to re-apply for reinstatement at any time. Any member seeking reinstatement after resignation shall:
   a. If seeking reinstatement less than 90 days after resignation or removal, submit a letter to the MCDC, which will be forwarded to the Executive Committee, which will be forwarded to the HIVPC for approval.
   b. If seeking reinstatement more than 90 days after resignation or removal, shall submit a new application and follow the same process as new members.
   c. The letter requesting reinstatement must be submitted to the Chair and/or Vice Chair of the MCDC.
B. A member may only be reinstated once within a 12-month period. A member who is reinstated and subsequently removed may not reapply for reinstatement for the 12-month period following a second removal.

Procedures

Membership:

Open, well publicized recruitment activities will occur. Membership applications and "Interested Party" brochures are available at all meetings of the Council and at all outreach and business meetings in the community. The MCDC Chair is responsible for offering to visit, specifically, case management agencies in efforts to encourage the recruitment of consumers for potential Council membership. While conducting recruitment, members should encourage interested parties to join committees or the HIVPC, and may discuss the roles, purpose, and benefits of serving on the HIVPC or its committees. Members may not, however, offer an official opinion or statement of the HIVPC, or speak on behalf of the HIVPC.

Council staff will verify that all active/pending applications meet the non-conflict of interest requirements as applicable, note any changes in employment or affiliation status, and present the eligible applications to the Membership Committee for review. All prospective Planning Council members other than those in mandated seats by virtue of employment are required to participate in any three HIVPC Standing Committee meetings within a 120 day period, and attend a membership orientation prior to being considered for appointment to the Planning Council (Approved 11/19/15). Applicants will receive a package of information that contains specific questions regarding the applicant's interest in becoming a Council and/or a Committee member. Committee information will be included in the package.

Applications will be screened and rated based on (Approved 1/26/17):

1. Ability to fulfill membership representation deficiencies/vacancies;
2. Experience and expertise to fulfill a particular category of membership;
3. Status as current HIVPC Alternate;
~~3.~~4. Participation on Committees;
~~4.~~5. Attendance at Orientation; and
~~5.~~6. Other identified criteria.

As part of the MCDC's selection process for new applicants, the following will be used based on priority (Approved 1/26/17):

1. Unaffiliated consumers
2. Demographic reflectiveness
3. Federally mandated seats
4. Vacant seats based on categories

In its review and recommendation process, The Membership Committee is further guided by the Ryan White CARE Act Part A Manual (Section X *Planning Council Membership; Planning Council Nominations*) (Approved 2/20/14). These Sections give the legislative background of the CARE Act that requires the Planning Council to be both reflective and representative of the demographic composition of the population of individuals living with HIV in the geographical area served. The Committee will, to the best of its ability, strive to achieve an optimal balance of Council composition that is reflective, representative, and, statistically, most closely approximates the HIV/AIDS prevalence in the geographical area served.

Recommendations for appointment as members and/or alternates will be forwarded to the Council for recommendation to the Broward County Board of County Commissioners for consideration and appointment.

The current membership will be evaluated annually for compliance with local, state and federal policies. Deficiencies through attrition, or change in qualifications of members will be documented. A member's qualification may change because of excess absences or by change of employment. Any changes to member's affiliation status will also be noted. Council support staff will report on absences. Current members will be surveyed each year using a form similar to the application. Individuals with HIV who experience extended absence due to illness will be moved to alternate status until they are able to regularly participate again.

The Committee will create a roster of current members and identify membership deficiencies and vacancies. 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 the qualifications set forth in Broward County Resolution #94-1286 (or its successors);

MCDC and the Council shall be notified of changes to representation involving members who are on the Council by virtue of holding a mandated seat due to their employment (e.g. Medicaid). Such changes shall be informational in nature and immediately forwarded to the Broward County Board of County Commissioners for appointment. At such time as a member's professional responsibilities changes 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 (Approved 11/19/2009). If a member does not notify the Council within 10 business days, the member will automatically be removed by the will of the MCDC (Approved 2/20/14).

Post-appointment training will occur quarterly for new members and other interested parties. New appointees will be offered the guidance of a mentor. The Membership Committee will conduct mentoring training for Council members (Approved 11/19/15).

Alternates:
Interested parties will be made Alternate Planning Council members when the following occurs:

- Member does not meet any of the requirements for any vacant seat.
- Planning Council demographics are overrepresented of unaffiliated PLWHAs
- To fulfill By-Laws mandate of a minimum of 3 Alternates (Approved 1/26/17)

~~Alternates will be acknowledged for their commitment when attending Planning Council meetings.~~ When eligible, Alternates will be advanced to full HIVPC membership status based on screening criteria.

Council Development:
The Committee will develop and implement an annual Council Development training plan which meets requirements in the Act.

HIV Planning Council Members – Service Descriptions

(Approved by HIV Planning Council 11/19/15)

The purpose of HIV Planning Council membership categories:

- "*Each category of membership meets a specific need*."
- "*Other membership categories, comprising government and health professions, are intended to enhance service delivery. This includes coordination of funding streams to better address gaps in care, avoid overlaps in services, and create comprehensive service delivery systems that meet the multiple care needs of clients*."
- *"All categories of membership are designed to bring together expertise in such areas as health planning, service delivery, client perspectives and financing of care."*

From HRSA

Planning Council Members Major Duties

1. Prioritize Part A services and allocate Ryan White funds among them.
2. Assess the needs of the community for HIV/AIDS services.
3. Develop a Comprehensive Plan to guide how services will be provided.
4. Monitor the quality and effectiveness of Ryan White programs, and recommend improvements.
5. Assess the effectiveness of administrative performance by the Part A Grantee.

Member Qualifications

1. Fit the membership requirements of a specified category of Council seat, per legislation and HRSA rules.
2. Ability to communicate ideas freely, honestly and respectfully.

3. Commitment to adhere to Council by-laws, policies and procedures.

Member Responsibilities (Approved 11/19/15)

1. Be willing to commit at least six to eight hours monthly to the HIV Planning Council – approximately two hours monthly at Planning Council meetings, two to three hours monthly at Committee meetings, and two to three hours monthly for background reading and to complete assigned tasks.
2. Members in leadership roles attend one extra meeting per month, requiring two to four hours more time.
3. Work collaboratively within the Planning Council and with other entities that provide or fund HIV-related services.
4. Commit to actively participate in recruitment for HIVPC and Committees.
5. Regularly participate in ongoing education and training provided by the Council.
6. Be willing to participate in discussions mindful of the needs of the EMA, as opposed to an interest group or category of representation.
7. Be willing and able to contribute professional and personal expertise to further the work of the Council.
8. Supply data requested from the category of seat to which the member is appointed. Examples of data that may be requested:
   a. HIV/AIDS funding received, per service category
   b. Number of Clients Served / Utilization
   c. Client Demographics
   d. How Services Are Coordinated with Part A and other funders

PLANNING COUNCIL MEMBERSHIP CATEGORIES (Approved 1/26/17)

1. Affected Communities

Definition of Affected Communities: Include People With HIV/AIDS, Members Of A Federally Recognized Indian Tribe As Represented In The Population, Individuals Co-Infected With Hepatitis B or C, and Historically Underserved Groups and Subpopulations.

The Ryan White HIV/AIDS Program Part A Manual states:

- "Involvement of those who use Ryan White services ensures crucial input from persons closest to care delivery. Legislative provisions require that consumers be free of conflict of interest in relation to funding decisions"
- "33% of Council members must be consumers receiving Ryan White Part A services, or the parents and caregivers of minor children who are receiving such services. These members should reflect the epidemic in the EMA and be unaligned, meaning that they "are not officers, employees or consultants" of any providers receiving Ryan White funds, and they "do not represent any such entity."

"Consumers who volunteer with a Part A-funded provider are not considered to 'represent' that entity and are eligible for consumer membership on the planning council as unaligned members. The legislation permits a PLWHA to serve as a volunteer at a Part A-funded agency and still be considered unaligned."

Roles and Responsibilities for Affected Communities:

a. Provide strong and informed feedback about the effect of Planning Council actions and decisions on Ryan White clients and PLWHAs.
b. Help develop ideas to engage and educate PLWHAs in the community.
c. Affected Community seats are designated for Unaffiliated Consumers.

2. Non-Elected Community Leader

Definition of Non-Elected Community Leader:

HIVPC By-Laws: "Someone active in the community not elected in formal government elections."

Roles and Responsibilities for Non-Elected Community Leader:

a. Be actively involved with a community organization or ongoing community activities.
b. Provide strong and informed feedback about the effect of Planning Council actions and decisions on the community, especially Ryan White clients and PLWHAs.

3. Health Care Providers, including Federally Qualified Health Centers

Roles and Responsibilities for Health Care Providers:

a. Share information about how Council actions will affect providers and their HIV/AIDS clients.
b. When requested, provide data on funding sources and on utilization by their clients.

4. AIDS Service Organizations and Community-Based Organizations Serving Affected Populations

Roles and Responsibilities for ASO/CBO:

a. Share information about how Council actions will affect service organizations, community organizations and their Ryan White clients.
b. When requested, provide data on funding sources and on utilization by their HIV/AIDS clients.

5. Social Service Providers, including Providers of Housing and Homeless Services

Roles and Responsibilities for Social Service Providers:

a. Share information about how Council actions will affect social service agencies, providers and clients.
b. When requested, provide data on funding sources and on utilization by their HIV/AIDS clients.

6. Mental Health Providers and Substance Abuse Providers

Roles and Responsibilities for Mental Health Providers and Substance Abuse Providers:

a. Share information about how Council actions will affect mental health providers and clients.
b. When requested, provide data on funding sources and on utilization by their HIV/AIDS clients.

7. State Government (Agency Administering Program under Part B)

Roles and Responsibilities for State Government (Agency Administering Program under Part B):

a. Provide the Council and its Committees with detailed insight about the area's Ryan White Part B programs.
b. Provide monthly and annual data reports on utilization and expenditures of Part B and ADAP programs.
c. Bring back to the agency Council recommendations on changing and improving Part B programs.
d. Share information about how Council actions will affect the community's health system and status.

8. State Medicaid Agency

Roles and Responsibilities for State Medicaid Agency:

a. Supply the Council and its Committees with detailed insight about Medicaid services available to PLWHAs in the community.
b. Provide annual reports on utilization and expenditures by Medicaid HIV/AIDS programs in Broward County.
c. Bring back to the agency Council recommendations on changing and improving Medicaid programs.
d. Share information about how Council actions will affect the community's overall health system and status.

9. Ryan White Part C Grantee

Roles and Responsibilities for Ryan White Part C Grantee:

a. Provide the Council and its Committees with detailed insight about the area's Ryan White Part C programs.
b. Provide quarterly reports on unduplicated utilization, expenditures (overall and by service category) and client demographics for the Part C program in Broward County.
c. Bring back to the agency Council recommendations on changing and improving the Part C programs.
d. Share information about how Council actions will affect the community's overall health system and status.

10. Ryan White Part D Grantee

Roles and Responsibilities for Ryan White Part D Grantee:

a. Provide the Council and its Committees with detailed insight about the area's Ryan White Part D programs.
b. Provide quarterly reports on unduplicated utilization, expenditures (overall and by service category) and client demographics for the Part D program in Broward County.
c. Bring back to the agency Council recommendations on changing and improving the Part D programs.
d. Share information about how Council actions will affect the community's overall health system and status.

11. Grantees of Other Federal HIV Programs, including but not limited to providers of HIV Prevention Services

Definition of Grantees of Other Federal HIV Programs: The category is to include, at a minimum, a representative from each of the following:

- Federally-funded HIV prevention services
- Grantees providing services in the EMA that are funded under Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs) and Ryan White Dental Programs (Part F)
- Housing Opportunities for Persons With AIDS (HOPWA) program
- Other Federal programs if they provide treatment for HIV/AIDS, such as the Veterans Administration

Roles and Responsibilities for Grantees of Other Federal HIV Programs:

a. Supply the Council and its Committees with detailed insight about the federal program's HIV/AIDS services.
b. Provide annual reports on unduplicated utilization, expenditures (overall and by service category) and client demographics of the programs in Broward County.
c. Bring back to the agency Council recommendations on changing and improving the agency's programs.
d. Share information about how Council actions will affect the community's health system and status.

12. Hospital Planning Agencies or Health Care Planning Agencies

Roles and Responsibilities for Hospital Planning Agencies or Health Care Planning Agencies:

a. Share information about how Council actions will affect the community's health system and status, with emphasis on hospital outpatient care for HIV/AIDS.
b. When requested, make a data presentation on issues involving the community's public and private health care systems for HIV/AIDS services.

13. Local Public Health Agencies

Roles and Responsibilities for Local Public Health Agencies:

a. Share information about how Council actions will affect the community's health system and status.
b. When requested, make a data presentation on issues involving the community's public and private health care systems for HIV/AIDS services.
c. The representative appointed to this seat should be an employee of a local governmental agency.

14. Representatives of Individuals who formerly were Federal, State, Or Local Prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV/AIDS as of the date on which the individuals were so released:

HRSA Definition of Consumer Representation of Recently Incarcerated Populations: Because of the high infection rate among the incarcerated, Congress has mandated that at least one seat on each HIV planning council be filled by EITHER a recently incarcerated person OR a representative of the formerly incarcerated.

An individual who is formerly incarcerated must meet the following three criteria:

1. Have been in Federal, State, or local prison and released during the preceding three years at time of appointment.
2. Have been HIV-positive on the date of release

3. Be able to adequately represent or advocate correctional health care and support services needs of formerly incarcerated persons.

A representative of the formerly incarcerated must have strong linkages with formerly incarcerated and the knowledge and experience to meet the third criterion.

Roles and Responsibilities for Consumer Representation of Formerly Incarcerated Populations:

a. Speak out on behalf of PLWHAs who were incarcerated and about their ability to access Ryan White services.
b. Represent the health care and support services needs of formerly incarcerated persons to the Council and its Committees through written and verbal reports.
c. If working for an agency serving inmates or former inmates, provide them with education and information about Ryan White services. If possible, provide the Council with reports on the agency's unduplicated utilization, expenditures (overall and by service category) and client demographics.

MCDC Mentoring Program

(Approved 11/19/15 by HIVPC)

In order to increase new members' knowledge of the HIV Planning Council and retain membership participation in Council meetings, the MCDC Committee will institute mandatory orientation, training and voluntary mentoring programs. An important segment of this training is the Mentoring Program, which will be offered to all new Council members and alternates. Mentoring helps new members feel welcome, learn individual member perspectives, and become comfortable with Council processes and interaction. Mentoring also ensures that the new member understands the background and context of discussions and actions, and gets an explanation of the many acronyms used in meetings.

A letter introducing the Mentoring Program will be sent to new Council members, and prospective mentees will be given the opportunity to sign up for a mentor at their Post Appointment Training. Council members who have volunteered their time to be Mentors will be assigned by the MCDC Chair. Interested Parties who are interested in becoming involved in a particular committee will be assigned a mentor by the Chair of the Committee the party is interested in (Approved 11/19/15).

The new member and alternate should, when possible, sit near his/her Mentor during all meetings. (Non-voting alternates are reminded they may sit near their mentor, but not at the table.) This will allow the Mentor to easily answer any questions the new member might have.

Volunteer Mentors will receive training according to the schedule set forth in the Committee Work Plan. Mentors should strive to educate new members on the following points:

1. Review of Orientation Manual
2. Reminders of Meetings
3. Availability of Transportation
4. Day care reimbursement benefit
5. Reimbursement of lost wages
6. Explanation of complex language
7. Empowerment and respect for individual opinions and ideas.
8. A summary of Robert's Rules of Order

If needed and requested by the new member/alternate, the Mentor may also remind the new member of upcoming meetings which might be of interest to that person.

Note on the Florida Sunshine Law: Members and Mentors should be careful to follow the Sunshine Law, which forbids Members from discussing Council or Committee business outside of official meetings. The County definition is as follows:

"Except at a public meeting, there shall be no communication between any two members of the same collegial body on any matter which they may foreseeably be required to address jointly in an advisory or decision-making capacity."

1. Below are example situations prohibited by law for Members: Discussing Council or Committee business on the phone;
2. Discussing Council or Committee business at a gathering that is not an official meeting;
3. Discussing Council or Committee business indirectly, such as by passing information through an intermediary;
4. Meeting at a restaurant or someone's home to discuss Council or committee business;

Mentoring Components of HIV Planning Council Members:
Provides support of new members (within the guidelines of the Florida Sunshine Law) on the following:

a. Help new members, including PLWHA, feel welcome, learn individual member perspectives, and become comfortable with planning council processes and interaction
b. Provide strong and informed feedback about the effect of Planning Council actions and decisions on Ryan White clients and PLWHAs.
c. Take special responsibility for making sure the new member understands the background and context of discussions and actions.
d. Increase new members' knowledge of the HIV Planning Council and retain attendance and membership participation in Council meetings.
e. Complete the Mentor/Mentee evaluation at the conclusion of the mentorship period.

HIVPC Buddy System for Interested Parties

Guidance for Committee Chairs
(Approved 11/20/14 by HIVPC)

In order to increase interested party's knowledge of HIV Planning Council Committees and retain membership participation in meetings, the MCDC will institute a voluntary buddy system.

Committee members who have volunteered their time to be a Buddy will be assigned by the Committee Chair. The MCDC Chair will notify Committee Chairs of interested parties that would like to be assigned a Buddy. The assigned Buddy should be a Committee member and may also be a Planning Council member.

The interested party should, when possible, sit near his/her Buddy during meetings. This will allow the Buddy to easily answer any questions the interested party might have.

Committee Chairs will instruct Buddies to educate interested parties on the following points:

1. Review of Committee Descriptions
2. Reminders of Meetings and Events
3. Reimbursement benefits
4. Explanation of complex language
5. Empowerment and respect for individual opinions and ideas.
6. A summary of Robert's Rules of Order
7. Committee Policies and Procedures

If the interested party expresses interest in becoming a full Planning Council member, then the Committee Chair will assign a Mentor who is a member of the Planning Council.

Buddies **provide support to interested parties on the following:**

1. Help interested parties, including PLWHA, feel welcome, learn individual member perspectives, and become comfortable with planning council processes and interactions.
2. Provide strong and informed feedback about the effect of Committee actions and decisions on Ryan

White clients and PLWHAs.

3. Take special responsibility for making sure the interested party understands the background and context of discussions and actions.
4. Increase interested party's knowledge of the Committee and retain attendance and membership participation in Committee meetings.
5. Complete the Buddy/Interested Party evaluation at the conclusion of the coaching period (conclusion will be upon mutual agreement between the coach and the interested party).