



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, Florida 33020 954-561-9681 • FAX 954-561-9685

Broward County HIV Health Services Planning Council Meeting

AGENDA

Date: March 25, 2021 at 9:30 a.m.

Facilitator: Planning Council Support Staff

Location: [WebEx Virtual Meeting Platform](#)

hivpc@brhpc.org

Chair: Dr. Réquiel Lopes **Vice Chair:** Claudette Grant (954) 561-9681 ext. 1250

HIVPC Purpose: To provide planning, promote the development of HIV/AIDS health services, personnel, and facilities that meet identified health needs cost-effectively, reduce inefficiencies, and develop HIV-related health plans.

1. **Call to Order**
2. **Welcome & Public Record Requirements**
 - a. Welcome
 - b. Review Meeting Ground Rules, Public Comment and Public Record Requirements (Statement of Sunshine)
 - c. Council Member, Guest, and Phone Introductions
 - d. Moment of Silence
3. **Approvals**
 - a. Meeting Agenda
 - b. Last Meeting Minutes
4. **Public Comment (10 minutes)**
5. **Federal Legislative Report – Handout A (Kareem Murphy)**
6. **Consent Items**
 - I. **Disease Case Management (DCM) Service Delivery Model (Handout B)**

Justification: The service delivery model has been approved by the Quality Management Committee.

PROPOSED BY: QMC Committee
 - II. **Centralized Intake and Eligibility Determination (CIED) Service Delivery Model (Handout C)**

Justification: The service delivery model has been approved by the Quality Management Committee.

PROPOSED BY: QMC Committee



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

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: (1) Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care, (2) Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments, (3) Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

Broward County Board of County Commissioners

Mark D. Bogen • Beam Furr • Steve Geller • Dale V.C. Holness • Chip LaMarca • Nan H. Rich • Tim Ryan • Barbara Sharief • Michael Udine
Broward.org

III. Non-Medical Case Management (NMCM) Service Delivery Model (Handout D)

Justification: The service delivery model has been approved by the Quality Management Committee.

PROPOSED BY: QMC Committee

IV. Integrated Primary Care & Behavioral Health (IPCBH) Service Delivery Model (Handout E)

Justification: The service delivery model has been approved by the Quality Management Committee.

PROPOSED BY: QMC Committee

V. Assessment of the Efficiency of the Administrative Mechanism Survey (Handout F1-F3)

Justification: The survey has been approved by the Priority Setting & Resource Allocation Committee and the Executive Committee.

PROPOSED BY: PSRA & Executive Committee

7. Discussion Items

None.

8. New Business

I. Priority Services Resource Allocation (PSRA) Presentation (Handout G)

ACTION ITEM: Receive an overview of the PSRA Process presented by Lorenzo Robertson, PSRA Chair.

II. Community Rightful Center Presentation (Handout H)

ACTION ITEM: Receive an organizational overview of a new Ryan White Part A (RWPA) provider agency.

III. Ryan White Part A (RWPA) Presentation: Ending the HIV Epidemic (EHE) HIVPC (Handout I)

ACTION ITEM: Receive an overview of RWPA's EHE activities presented by Neil Walker and Wismy Cius.

IV. Recruitment Video

ACTION ITEM: Reveal of the new HIVPC Recruitment video edited by Ken Williams.

9. Committee Reports (15 minutes)

I. COMMUNITY EMPOWERMENT COMMITTEE (CEC)

NO MEETING HELD

Chair: Vacant Seat; V. Chair: A. Ruffner

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

C. Data Requests:

None.

D. Rationale for Recommendations:

None.

E. Data Reports/ Data Review Updates:

None.

F. Other Business Items:

None.

G. Agenda Items for Next Meeting:

H. Next Meeting Date:

April 6, 2021 at 3:00 p.m. Room: WebEx Videoconference

II. SYSTEM OF CARE COMMITTEE (SOC)

NO MEETING HELD

Chair: A. Ruffner; V. Chair: J. Rodriguez

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

C. Data Requests:

None.

D. Rationale for Recommendations:

None.

E. Data Reports/ Data Review Updates:

None.

F. Other Business Items:

None.

G. Agenda Items for Next Meeting:

H. Next Meeting Date:

April 1, 2021 at 9:30 a.m. Room: WebEx Videoconference

III. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

NO MEETING HELD

Chair: V. Foster; V. Chair: T. Moragne

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

C. Data Requests:

None.

D. Rationale for Recommendations:

None.

E. Data Reports/ Data Review Updates:

None.

F. Other Business Items:

None.

G. Agenda Items for Next Meeting:

H. Next Meeting Date:

April 8, 2021 at 9:30 a.m. Room: WebEx Videoconference

IV. QUALITY MANAGEMENT COMMITTEE (QMC)

March 15, 2021

Chair: Vacant Seat; V. Chair: B. Fortune-Evans

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

CQM Work Plan Progress Review: The FY2020 Clinical Quality Management (CQM) Work Plan was reviewed (Handout A1 on file). All goals were completed despite the difficulties experienced as a result of the coronavirus pandemic. Following the previous year's review, CQM Support Staff reviewed the FY2021 CQM Work Plan (Handout A2 on file). There were no recommendations to change the FY2021 Work Plan, and it was subsequently approved.

Non-Medical Case Management (NMCM) Service Delivery Model (SDM): The NMCM SDM (Handout B on file) was brought back to QMC for approval to address two points that were omitted from the SDM in error. The revised SDM was approved.

Centralized Intake and Eligibility Determination (CIED) SDM: The CIED SDM (Handout C on file) was updated to include more methods of recertification for clients and an annual marketing plan for sharing information about the Ryan White Part A Program with the community. There were no recommendations to change the CIED SDM, and it was subsequently approved.

Disease Case Management (DCM) SDM: CQM Support Staff reviewed the proposed Disease Case Management (DCM) SDM (Handout D on file). One change to this SDM was the addition of an acuity scale for developing the Individualized Care Plan. QMC voted to approve the DCM SDM.

Integrated Primary Care & Behavioral Health (IPCBH) SDM: The IPCBH SDM (Handout E on file) was developed in keeping with the Department of Health & Human Services guidelines as well as with input from Dr. Jefferey Beal, Medical Director of the Florida Department of Health. QMC voted to approve the IPCBH SDM.

C. Data Requests:

None.

D. Rationale for Recommendations:

- The CQM Work Plan details the work of QMC, Networks, and CQM Support Staff for the fiscal year.
- SDMs provide guidance on the services provided by the Ryan White Part A Program.

E. Data Reports/ Data Review Updates:

None.

F. Other Business Items:

None.

G. Agenda Items for Next Meeting:

H. Next Meeting Date:

April 19, 2021 at 12:00 p.m. Room: WebEx Videoconference

V. EXECUTIVE COMMITTEE

March 18, 2021

Chair: R. Lopes; V. Chair: C. Grant

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

HIVPC Agenda: The Executive Committee voted to approve the HIVPC agenda.

HIVPC Calendar: The Committee reviewed and updated the April HIV Planning Council calendar.

Assessment of the Efficiency of the Administrative Mechanism Survey: The HIVPC Program Manager, reviewed the Assessment of the Efficiency of the Administrative Mechanism (AEAM) Survey. The Committee reviewed the proposed surveys and voted to approve them with the addendum of including a question to assess the timeliness of the notice of contracts.

HIVPC Recruitment Video: The Executive Committee reviewed the second edit of the HIVPC Recruitment Video and provided feedback to Ken Williams.

- C. **Data Requests:**
None.
- D. **Rationale for Recommendations:**
None.
- E. **Data Reports/ Data Review Updates:**
None.
- F. **Other Business Items:**
None.
- G. **Agenda Items for Next Meeting:**
- H. **Next Meeting Date:**
April 15, 2021 at 1:30 p.m. Room: WebEx Videoconference

VI. PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

March 18, 20201

Chair: L. Robertson; V. Chair: Vacant Seat

A. **Discussion Item:**

B. **Work Plan Item Update/Status Summary:**

Monthly Expenditures/Utilization Report: Most core medical and support services were fully expended for the fiscal year, except for some underutilized services, likely due to COVID-19. The Food Voucher service was 0% expended; however, the Recipient's Office anticipates a final invoice by the end of the grant year and allocated funds to be fully expended. Overall, 87% of Part A and MAI funding was utilized, and a limited number of invoices are expected to be submitted. The MAI program expended 69% of its funding, and Part A funds were 89% expended.

Assessment of the Efficiency of the Administrative Mechanism Survey (HANDOUT A1-A3): The HIVPC Program Manager, reviewed the Assessment of the Efficiency of the Administrative Mechanism (AEAM) Survey (Handouts A1-A3 on file). The Committee reviewed the proposed surveys and voted to approve them with the addendum of including a question to assess the timeliness of the notice of contracts.

PSRA Process Presentation (HANDOUT B): *The PSRA Chair* examined the requirements and expectations for the PSRA Process, which included the purpose of PSRA, what to expect, the 4-month timeline of meetings, the allocations process flow chart, and the data-based decision-making. Members reviewed the key participants, funders, and stakeholders that are essential contributors to the process, emphasizing that final review and approval of all priorities, allocations, and how best to meet the need language would occur with the HIV Planning Council.

Part A Eligibility of Service Categories (HANDOUT C): The Planning Council Support (PCS) Staff reviewed the scope of service for each service category

(Handout C on file). Members examined the Part A eligibility for all core medical and support services categories (to include Disease Case Management, Mental Health, and Oral Health), the scope of services, EMA eligibility, and previous utilization of services. B. Barnes inquired about bulk purchases and which services categories would be receiving them. The Part A Office shared that the two service categories that will have bulk purchases from FY2020 are the Food Services and Pharmacy service categories.

C. Data Requests:

- A comparison of client service utilization during COVID-19 and service utilization during a standard fiscal year.
- A cost-savings analysis to highlight the benefits of enrolling Ryan White clients into Affordable Care Act health insurance plans to analyze its impact on service categories.

D. Rationale for Recommendations:

- The purpose of the AEAM is to assess the process by which the Ryan White Part A Recipient executes contracts and reimburses providers for services rendered. The HIVPC, Part A Recipient, and Part A Funded Service Providers complete surveys regarding administrative functions on an annual basis as a part of federally mandated responsibilities for the Part A Program.

E. Data Reports/ Data Review Updates:

None.

F. Other Business Items:

None.

G. Agenda Items for Next Meeting:

H. Next Meeting Date:

April 15, 2021 at 9:00 a.m. Room: WebEx Videoconference

* For a detailed discussion on any of the above items, please refer to the meeting minutes. *
Meeting packets are available at: [The HIV Planning Council Website](#)

10. Recipient Reports

- a. Part A
- b. Part B
- c. Part C
- d. Part D
- e. Part F
- f. HOPWA
- g. Prevention – Quarterly Update (April, July, October, January)

11. **Unfinished Business**
None.
12. **Public Comment (10 minutes)**
13. **Agenda Items/Tasks for Next Meeting**
 - a. Next Meeting Date: April 22, 2021 at 9:30 a.m. via WebEx Videoconference
14. **Request for Data**
15. **Announcements**
16. **Adjournment**

**FOR A DETAILED DISCUSSION ON ANY OF THE ABOVE ITEMS,
PLEASE REFER TO THE MEETING MINUTES.
Meeting Packets are available at: [The HIV Planning Council Website](http://www.brhpc.org/programs/hiv-planning-council/)
(<http://www.brhpc.org/programs/hiv-planning-council/>)**

**Please complete your meeting evaluations [here](#)
Three Guiding Principles of the Broward County HIV Health Services Planning Council
• *Linkage to Care* • *Retention in Care* • *Viral Load Suppression* •**

HIV HEALTH SERVICES PLANNING COUNCIL MEETING GROUND RULES



1. The Council, its members, and the public recognize and respect the committee process adopted by this Council. The Council, its members, and the public recognize that full discussion and analysis of issues occurs at the committee level rather than at Council meetings.
2. Before a member can make a motion or speak in debate, the member must be recognized by the Chair as having the exclusive right to be heard at that time.
3. All speakers are expected to address the Council in a respectful manner to respect time limits, to speak briefly and to the point, and to stay on agenda. All other persons in attendance should not interrupt the speaker who is recognized by the Chair as having the floor.
4. If the member who made the motion claims the floor and has not already spoken on the question, that member is entitled to be recognized in preference to other members.
5. No person is entitled to the floor a second time in debate on the same item as long as any other person who desires the floor has not spoken on the item.
6. Speakers should restrict comments and debate to the pending question or motion. Speakers must address their remarks to the Chair and maintain a courteous tone. The Chair may impose time limits on debate or discussion to ensure efficient conduct of Council business.
7. Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Grantee, outside of the meeting.
8. Members of the public may only address the Council upon recognition by the Chair. They are subject to the same rules of conduct expected of Council members.
9. No alcohol or drug use (unless prescribed by a licensed physician), is permitted at Council meetings, grantee or support staff offices.
10. No abusive language, threats of violence, or possession of weapons are permitted in Council meetings, grantee or staff offices.
11. Repeated violation of these meeting rules may result in no further recognition of the offending member or attendee by the Chair at that meeting. Any serious breach of conduct which disrupts the Council's meeting may subject the offender to removal from the meeting, administrative or legal process.

CONSEJO DE PLANEACIÓN DE SERVICIOS DE SALUD VIH REGLAS BÁSICAS DE LA REUNIÓN



1. Los miembros deberán aceptar y respetar el proceso de comité adoptado por este Consejo. Las discusiones y el análisis en pleno de los temas tendrán lugar a nivel de comité y no en las reuniones plenarias del Consejo.
2. Antes de que un miembro pueda iniciar una moción o de que una persona pueda hablar en un debate, el Presidente de la reunión deberá reconocer que él o ella tienen el derecho exclusivo de hablar en ese momento dado.
3. Se espera que todos los ponentes se dirijan al Consejo de una manera respetuosa, que no se interrumpa al ponente con derecho al habla en el momento, que cuando se hable se haga de forma clara y concisa, y que se mantenga la agenda.
4. Si el miembro que inicia una moción no ha hablado todavía y reclama su derecho a hablar sobre un asunto, él/ella tendrán el derecho a que con preferencia se les reconozca.
5. Nadie tendrá derecho a reclamar el habla por una segunda vez, en un debate sobre el mismo tema, cuando otra persona que no ha hablado todavía, desea hacerlo.
6. Los debates deben ceñirse a los asuntos o mociones que estén pendientes. Al hablar, los ponentes deben referirse al Presidente, y mantener un tono cortés.
7. Los miembros del público solo podrán dirigirse al Consejo cuando hayan sido reconocidos por el Presidente de la reunión. Estarán sujetos a las mismas reglas de conducta que se esperan de los miembros del Consejo. Se establecerán límites de tiempo según sea necesario para garantizar que los asuntos del Consejo cursen de manera eficiente.
8. Miembros del público sólo podrán dirigir el Consejo a partir del reconocimiento por el Presidente. Están sujetos a las mismas reglas de conducta que se espera de los miembros del Consejo.
9. No estará permitido el uso de bebidas alcohólicas o de drogas en las reuniones del Consejo y tampoco en las oficinas del personal de soporte y donatarios.
10. No está permitido el uso de lenguaje abusivo, amenazas de violencia y posesión de armas en las reuniones del Consejo ni en las oficinas del personal de soporte y donatarios.
11. La repetida violación de estas reglas básicas dará como resultado que el Presidente de la reunión deje de reconocer al derecho a participación del ofensor o miembro de la audiencia. Cualquier violación de conducta grave, que perturbe la reunión de Consejo, terminará en la remoción del ofensor, de la reunión.

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV RÈGLEMAN RANKONT-YO



1. Manm-yo dwe rekonèt epi respekte pwosesis komite-a ke Konsèy-la adopte. Diskisyon ak analiz total pwoblèm-yo fèt nan nivo komite-a; li pa fèt pandan rankont tout Konsèy-la.
2. Anvan yon manm ka fè yon pwopozisyon oswa nenpòt ki moun gen dwa pale pandan yon deba, fòk Prezidan Komite-a bali dwa esklizif pou fè moun tande-li nan moman sa-a.
3. Yo atann-yo aske tout moun k'ap pale ak Konsèy-la fè-li avèk respè, pou pèsonn pa koupe moun ke Konsèy-la bay dwa pale lapawòl, pou moun k'ap pale-a respekte kantite tan yo ba-li pou pale-a, pou li di sa l'ap di-a rapidman epi avèk presizyon, epi pou li respekte ajanda-a.
4. Si manm ki fè pwopozisyon-an mande pou li pale epi si li poko pale sou keksyon-an deja, li gen priorite sou lòt manm-yo.
5. Pèsonn moun pa gen dwa pran lapawòl de fwa sou yon menm sijè si gen lòt moun ki poko pale epi ki vle esprime tèt-yo.
6. Deba-a dwe rete sou keksyon oswa pwopozisyon k'ap fèt-la. Moun k'ap pale-a dwe adrese sa l'ap di-a bay Prezidan Komite-a epi pale sou yon ton ki make ak respè.
7. Manm piblik-la dwe pale ak Konsèy-la sèlman si Prezidan Konsèy-la bay-yo lapawòl. Yo dwe respekte menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesesè pou zafè Konsèy-la byen mache, yo gen dwa bay-yo yon limit tan pou yo pale.
8. Manm nan piblik la sèlman pou adrese a konsèy sou rekonèsans sou chèz la. Yo ka tonbe anba menm lòd de kondwit ki te espere nan manm konsèy yo.
9. Itilizasyon alkòl ak dwòg (sòf si se yon doktè lisansye ki preskri-li), entèdi nan rankont Konsèy-la oswa nan biwo estaf sipò-a oswa Resevè-a.
10. Vye langaj, menas vyolans, oswa posèsyon zam entèdi nan rankont Konsèy-la oswa nan biwo estaf-la oswa Resevè-a.
11. Vyolasyon repete règleman rankont-yo ap lakòz yon manm oswa lòt moun k'ap asiste rankont-lan pa kapab patisipe ankò. Nenpòt ki move kondwit serye ki twouble rankont-la ap lakòz yo mete moun-nan deyò.



Meeting of the
Broward County HIV Health Services Planning Council

Thursday, February 25, 2021

9:30-11:30 AM

By WebEx Videoconference

MINUTES

HIVPC Members Present: R. Lopes (HIVPC Chair), C. Grant (HIVPC Vice-Chair), D. Shamer, H.B. Katz, B. Fortune-Evans, V. Lewis, B. Barnes, V. Foster, A. Cutright, V. Moreno, A. Ruffner, I. Wilson, J. Rodriguez, T. Moragne, R. Siclari, Y. Arencibia, Comm. D. Holness, R. Bhrangger, W. Marcoviche, M. Schweizer

Members Absent: L. Robertson

Ryan White Part A Recipient Staff Present: D. Cunningham, N. Walker, S. Scott, K. Giglioli, T. Thompson, K. Bostick

Planning Council Support Staff Present: G. Martinez, V. Oratien, W. Saint-Fleur, F. Ukpai

Guests Present: S. Cook, B. Mester, K. Murphy, A. Gordon, E. Dsouza, S. Quintero, K. Drummond, G. Cross Hogg, S. Mcshee

Agenda Item #1: Call to Order, Welcome & Public Record Requirements

The *HIVPC Chair* called the meeting to order at 9:32 a.m. The *HIVPC Chair* welcomed all meeting attendees that were present. Attendees were notified that the Exec. meeting is based on Florida's "Government-in-the-Sunshine Law and meeting reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by the *HIVPC Chair*, committee members, Recipient staff, PCS staff, and guests by roll call, and a moment of silence was observed.

Agenda Item #2: Meeting Approvals

The approval for the agenda of the February 25, 2021 HIV Planning Council meeting was proposed by *M. Schweizer*, seconded by *V. Foster*, and passed unanimously. The approval for the minutes of the October 22, 2020 meeting was proposed by *T. Moragne*, seconded by *I. Wilson*, and approved with no further corrections.

Mr. Schweizer, on behalf of the Broward County HIV Health Services Planning Council, made a motion to approve the February 25, 2021, HIVPC agenda as presented. The motion was adopted unanimously.

Mr. Moragne, on behalf of the Broward County HIV Health Services Planning Council, made a motion to approve the October 22, 2020, HIVPC meeting minutes as presented. The motion was adopted unanimously.

Agenda Item #3: Public Comment

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and

services in Broward County. There were no public comments.

Agenda Item #4: Federal Legislative Report

A written legislative report (Handout A on file) was provided to the Council by *Kareem Murphy*. *Mr. Murphy* noted the new Biden Administration has advanced a “skinny budget” highlighting priority programs for 30 key areas. It has not been indicated where the HIV/AIDS services continuum will fit within the list of priorities; however, stakeholders anticipate that the final budget submission will include a minimum of level-funding for Fiscal Year (FY) 2022. The White House has released the [American Rescue Plan Act of 2021](#) (the legislative package designed to fund the response to the COVID-19 pandemic), though few details about the actual budget are known. The plan does not include additional funding for the treatment and care continuum for Ryan White but does cite financial support for COVID response and disease surveillance.

House Representative Barbara Lee has circulated a letter among House colleagues that is addressed to the President and Vice President and calls on increased investment in the HIV/AIDS continuum. The letter has been largely supported by the Congressional Black Caucus and the Congressional Hispanic Caucus.

Lastly, *Mr. Murphy* acknowledged his awareness of some of the challenges several Part A grantees (including the Part A Recipient for the Broward EMA) faces regarding the spend-down of FY 2021 funds due to the COVID-19 pandemic. The concerns have been flagged for the incoming Health and Human Services administration, with hopes of resolve to prevent penalties for grantees for the upcoming awards.

The *HIVPC Chair* inquired about any indication of forthcoming conversations around alternatives for inadequate spend-down. *K. Murphy* stated that the ideal outcome would be communication from the Health Resources and Services Administration (HRSA) to Part A Recipients that directly, or indirectly, says that HRSA will temporarily discount the lack of spend-down or a formal request for a spending plan as proof of intent to establish mechanisms to spend down funds. Another ideal scenario would be for the appropriations bill, that would be written for the federal fiscal year 2022 and passed in 2021, would have provisions stating that no Part A or Part B Recipient would be held harmless for the underspent FY 2021 funding.

Agenda Item #5: Consent Items

The approval for the consent items was proposed by *T. Moragne*, seconded by *A. Cutright*, and passed unanimously.

Mr. Moragne, on behalf of the Broward County HIV Health Services Planning Council, made a motion to approve the consent items as presented. The motion was adopted unanimously.

Agenda Item #6: Discussion Items

There were no discussion items on the agenda for this meeting.

Agenda Item #7: New Business

The *MCDC Chair* updated Council members on current recruitment efforts by the Committee. The MCDC is invested in increasing community engagement and unaffiliated consumer membership and is aware of the underrepresentation of this demographic on the Council. The HIVPC is currently at 27% unaffiliated consumer membership but has tasked themselves with reaching their goal of 37% unaffiliated consumer involvement. *PCS staff* added that this has been an ongoing discussion for the MCDC, and strategies are now in place to address vacancies and increasing

unaffiliated consumer engagement on the HIVPC.

PCS staff noted that a member, who recently gained employment with an agency funded by Ryan White Part A, was removed from the Council. This member occupied an unaffiliated consumer seat. Broward County Ordinance states that if an unaffiliated consumer gains employment with an agency funded by Ryan White Part A, the member must move off the Council and rejoin in a different seat. This member has since applied to rejoin the Council and move into the Local Public Health Agency seat. Once this constituent regains membership, unaffiliated consumer membership will drop to 25%. Additionally, a current member presently occupying the Healthcare Provider seat will switch to the Hospital/Healthcare Planning Agency seat. This will achieve the vacancy's occupancy and will not adjust the HIVPC's current numbers. The Council's goal is to fill ten unaffiliated consumer member seats before seeking to fill the employment-based seats on the Council. Members discussed barriers preventing consumers from actively participating on the HIVPC and recommended adapting to the consumers' needs by simplifying and streamlining the process for participation.

Agenda Item #8: Committee Reports

I. Membership/Council Development Committee & Community Empowerment Committee – February 11, 2021

Chair: V. Foster, Vice Chair: T. Moragne

Chair: Vacant, Vice Chair: A. Ruffner

The report stands. The Chair noted that an approach Broward Health Specialty Care & Comprehensive Care Center has taken with unaffiliated consumers is teaching clients how to download and operate systems like WebEx and Duo. Through practice sessions during waiting room times, they are hopeful that clients will feel more confident and that it may help with recruitment efforts.

II. Quality Management Committee – No Meeting Held

Chair: Vacant, Vice Chair: B. Fortune-Evans

The Vice Chair noted that QMC meetings will resume in March.

III. Executive Committee – February 18, 2021

Chair: R. Lopes, Vice Chair: C. Grant

The report stands. The Chair announced that nominations for HIVPC Chair & Vice Chair are upcoming, and members should start thinking about leadership opportunities.

IV. Priority Setting & Resource Allocation Committee – February 18, 2021

Chair: L. Robertson, Vice Chair: Vacant

The report stands.

V. System of Care Committee – February 4, 2021

Chair: A. Ruffner, Vice Chair: J. Rodriguez

The report stands.

Agenda Item #9: Recipient Reports

- A. Part A: *D. Cunningham, Director Community Partnerships Division*, noted that Ryan White Part A program received notification of a carry-over waiver for FY2020-2021. *Mr. Cunningham* announced that Part A has also received a preliminary notice of award from HRSA in the amount of \$3,544,462 and anticipate the full amount will be awarded in April. Part A is preparing for a HRSA Ending the HIV Epidemic (EHE) site visit scheduled for

March 2nd and March 3rd. Members of the Executive Committee have received invitations to participate during a session of the site visit. *Mr. Cunningham* lastly noted that staff from the Part A office will be providing an EHE presentation to the System of Care Committee and the full Planning Council body in March.

- B. Part B: *J. Rodriguez*, the Part B Recipient, provided a handout detailing the Program's allocations and expenditures through January 2021. There is approximately \$331,000 unexpended; however, funds are expected to be fully expended by March 31st. Part B has seen trends of high utilization across service categories, but especially in Emergency Financial Assistance, where there has been an increase in new clients accessing the services. There were roughly 600 individuals last year that had never retrieved Part B services who have routinely accessed treatment since COVID-19.

The AIDS Drug Assistance Program (ADAP) has a special enrollment period that will run from February 15th until May 15th; interested parties can reach out to Broward Regional Health Planning Council to receive enrollment assistance. Any ADAP client over 100% of the federal poverty level and interested in enrolling into the marketplace can transition into one of the approved marketplace plans. Clients with health insurance historically have better health outcomes. Services covered under the approved plans include emergency visits and lab services. ADAP will be working with Ryan White Part A, the HIVPC, and Centralized Intake Eligibility & Determination (CIED) to ensure that as many clients are enrolled as possible.

B. Barnes inquired about the Medical Transportation service category and how Part B utilized funds since bus passes were the only provision being offered. *Mr. Rodriguez* informed the Council that Part B is developing a Service Delivery Model using Uber to establish criteria that will allow clients to be adherent to medication and doctor visits. Part B has also been purchasing gift cards to subsidize clients' costs for some of those appointments. The Part B Recipient will provide an update once agreements have been signed by the case management agencies providing those services. *V. Foster* had a query regarding the Health Insurance Premium & Cost Sharing service category, which states that only 30 clients were served to date. He inquired if this was due to a delay in reporting. The Part B Recipient confirmed that was the case and noted that the amount expended will reflect an increase once the lag in reporting has concluded.

- C. Part C: The Part C Program is seeing fewer patients and utilizing telehealth to continue providing services to the community. The Program has seen an increase in labs but has not yet reached its target. This year, Part C has only seen a little over 900 patients. The Program was forced to suspend colposcopy procedures due to a shortage in disposable equipment; however, there is now disposable equipment. The Comprehensive Care Center can now resume colposcopy procedures for women in need of the service.

C. Grant, the Part C Recipient, also announced that their Consumer Advisory Board (CAB) has postponed meeting as fears for health and safety continue during the COVID-19 pandemic. Efforts have been made to reengage members of the CAB to resume meeting via conference call. Members were opposed to the idea; Part C's considering recruiting new members for the advisory board.

The program is in the process of completing its Ryan White HIV/AIDS Program Services Report (RSR). The RSR is a client-level data reporting requirement that monitors the characteristics of Ryan White HIV/AIDS Program Parts recipients, providers, and clients served. Part C anticipates submission to the County by March 1st. The Part C Program has been meeting with their Part C Project Officer monthly as the program was awarded \$116,000 in funding to provide COVID-19 related care; Part C is required to submit a COVID

report of clients served. Part C is applying for an extension for COVID-19 award recipients who have been unable to spend down funding. The extension request is due March 1, 2021.

Ms. Grant reported that to date, there have been 39 cases of COVID-19 infection and four deaths. During the month of February, there were no reported cases of COVID-19 infection. Broward Health currently has a vaccine site at Lockhart Stadium (1350 NW 55th St, Fort Lauderdale, FL 33309). Lastly, *Ms. Grant* announced that the criteria for COVID-19 vaccination have expanded from clients 60 years of age and older to clients that are 18 years of age and older who are also considered high-risk. Patients are being canvased to see which are interested in receiving the vaccine, and appointments are being scheduled.

- D. Part D: The Part D Program is still meeting with clients both in-person and via telehealth, limiting the number of individuals in the building at any given time. Retention in care has been satisfactory as clients have returned to care out of concern around the COVID-19 pandemic. Numbers for Test & Treat program have also increased at the Children's Diagnostic & Treatment Center site.
- E. Part F: The Part F Recipient stated that clients are being seen at Nova Southeastern University, and the community partner clinic is currently fully operational.
- F. HOPWA: There is no representative currently. The HIVPC Chair noted that a HOPWA representative has been identified and will hopefully be present for future meetings.
- G. Prevention: The Part B Recipient stated that the Prevention Program is currently working with planning councils, members of the community, the Broward County HIV Prevention Planning Council, and other community partners to provide social services that are aligned with the EHE. The Program received \$1.9 million in EHE funding to fund the plan previously submitted to the Centers for Disease Control & Prevention specific for that area.

The Part B Recipient emphasized the importance of bringing individuals to the table with a vested interest. The Part B Recipient stated that of the \$1.9 million, over 75% of the funding will go towards community initiatives. A Request for Proposal (RFP) was released for organizations to request funding to deliver HIV prevention services. The Recipient is currently in the process of negotiating contracts with hopes for a March 1st start date.

Agenda Item #10: Unfinished Business

There was no unfinished business to discuss at this meeting.

Agenda Item #11: Public Comment

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and services in Broward County. There were no public comments.

Agenda Item #12: Announcements

- The Broward Health Medical Center started the FOCUS Project, which focuses on HIV testing. This service is for any patient coming into the emergency room to receive care or treatment. Patients will be given the option to opt-in or out of HIV testing. If patients do not opt-out, the site will test them for HIV and Hepatitis C. Thus far, there have been more Hepatitis C confirmed cases than HIV+ cases. *Ms. Grant* noted that once a patient has a confirmed positive test, they are referred to the Comprehensive Care Center site for linkage to care and follow-up. To date, there have been four confirmed Hepatitis C positive clients

and at least two HIV+ clients. The Florida Department of Health – Broward County is also involved in these efforts as they receive notifications on all confirmed HIV+ and Hepatitis C positive cases. The FOCUS Project is modeled after a program implemented at Memorial Health and is designed to be implemented within all hospital systems.

- The World AIDS Museum (WAM) is hosting a Community Dialogue Series program to discuss women's perspectives on the history of HIV and what things should be included in its museum collections pertaining to women and girls. "Documenting Herstory: Women's and Girls' Perspectives on HIV" will take place on Wednesday, March 10 at 7:00 p.m. via Zoom and live-streamed to WAM's Facebook page.
- *V. Oratien* announced that she will no longer be apart of the PCS Staff but will be moving into a new role with Clinical Quality Management Support Staff.
- *S. Quintero* with Janssen Pharmaceuticals announced that any provider agencies in need of free trial offer cards, which provide a 30-day supply of medications, can connect with a Janssen representative to receive those cards.
- *PCS Staff* announced that the HIVPC Member Retreat will be held on Friday, February 26, 2021, from 9:00 a.m. – 1:00 p.m. The *HIVPC Chair* emphasized the importance of the HIVPC retreat and encouraged members to attend.

Agenda Item #13: Adjournment

There being no further business, the meeting was adjourned at 10:41 a.m.

HIVPC Attendance for CY 2021

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	28	25											
0	0	0	1	1 Arencibia, Y.	X	X											
0	1	1	2	2 Barnes, B.	A	X											
1	1	1	3	3 Bhrangger, R.	A	X											
0	0	0	4	4 Cutright, A.	X	X											
0	0	1	5	5 Fortune-Evans, B.	A	X											
0	0	0	6	6 Foster, V.	X	X											
0	0	0	7	7 Grant, C.	X	X											
0	0	0		Holness, Dale V.C. (Mayor)	X	X											
1	1	1	8	8 Katz, H.B.	A	X											
1	1	1	9	9 Lewis, V.	A	X											
0	0	0	10	10 Lopes, R. <i>Chair</i>	X	X											
1	1	1	11	11 Marcoviche, W.	A	X											
0	0	0	12	12 Moragne, T.	X	X											
0	0	0	13	13 Moreno, V.	X	X											
0	1	1	14	14 Robertson, L.	X	A											
0	0	1	15	15 Rodriguez, J.	A	X											
0	0	0	16	16 Ruffner, A.	X	X											
0	0	1	17	17 Schweizer, M.	A	X											
1	1	1	18	18 Shamer, D.	A	X											
0	0	1	19	19 Siclari, R.	A	X											
0	0	0	20	20 Wilson, I.	X	X											
Quorum = 11					11	20	0	0	0	0	0	0	0	0	0	0	

Legend:

X - present	N - newly appointed
A - absent	Z - resigned
E - excused	C - canceled
NQA - no quorum absent	W - warning letter
NQX - no quorum present	R - removal letter
CX - canceled due to quorum	

Update for Broward County HIV Health Services Planning Council

From: Kareem Murphy

Date: February 25, 2021

Federal Funding Update

Skinny Budget

With a little over a month into the new Biden Administration, it is the tradition and expectation that they will release a “skinny budget” that highlights key priorities. Given the current White House focus on passage of the *American Rescue Plan* (the legislative package designed to fund the response to the COVID-19 pandemic), few details about the actual budget are known. Commitments made during the campaign and the nomination of Dr. Rachel Levine as the Assistant Secretary for Health lead stakeholders to expect in the least level funding for the HIV/AIDS prevention, treatment, and care continuum.

Appropriations

The introduction and mark up of the annual funding bills will not commence until after the budget submission, which might be May at the earliest, given the start of this new Administration. However, Rep. Barbara Lee has circulated a letter among her colleagues in the House (asking them to co-sign) that is addressed to the President and Vice President calling on increased investment in the HIV/AIDS continuum. The deadline for co-signers was last week. It’s unknown whether any of the South Florida delegation members signed on, although several have done so in the past.

Expected passage of the *American Rescue Plan* may put additional budget pressures on legislators to hold the line on increased funding. Despite Democratic control of the House, Senate, and White House, budget pressures and concerns about a nearly \$2 trillion in additional emergency funding on top of annual appropriations may lead appropriators to level fund the continuum. It is too early to make accurate predictions however.

Spend Down Challenges

Appropriators are aware of challenges several Part A grantees face in obligating FY 2021 funding because of pandemic. They are aware of requests for policy riders for the FY 2022 bills that would hold grantees harmless for the spend down challenge.



BROWARD COUNTY RYAN WHITE PART A PROGRAM

Disease Case Management Service Delivery Model



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I. Service Definitions

HRSA Definition¹

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities undertaken in this service category may be provided by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication), as well as activities taken on behalf of the client (e.g., multidisciplinary case conferences, referrals to other personnel or agencies).

Key activities include:

- Initial assessment of service needs
- Develop a comprehensive, individualized care plan (ICP)
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ICP
- Re-evaluate the ICP plan at least every six months, with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of service utilization

In addition to providing the medically oriented activities above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. Such programs may include Florida Medicaid Managed Care Organizations (MCOs), Medicare Part D, Florida AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's Patient Assistance Programs (PAPs), other state or local healthcare and supportive services, and insurance plans through the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), Marketplaces/Exchanges.

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) funds the Disease Case Management (DCM) model of MCM. DCM provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications stemming from co-morbid chronic disease conditions. DCM includes assessment of client needs, development of a coordinated plan of care, and care coordination. Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments
- Coordinating essential medical and support services and making referrals when indicated

¹ *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Providing adherence counseling to treatment regimens and healthcare, and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

II. Key Service Components and Activities

In addition to the DCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the [Broward County Ryan White Part A Universal SDM](#). Providers must also adhere to standards and requirements set forth in the [Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers](#), individual contracts, and applicable contract adjustments. DCM providers must refer to their individual contract for service-specific client eligibility requirements. DCM providers must comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Coordination of Medical and Healthcare Improvement Services

Providers must ensure coordination of medical and healthcare improvement services to support clients in meeting their ICP goals and maintaining their engagement in care. Case coordination and case conferencing includes communication, information sharing, and collaboration that occurs regularly with case management and other providers serving the client within and between agencies in the community. Coordination includes, but is not limited to:

- Managing HIV and co-morbid condition (chronic and acute) treatments
- Communicating with the client's primary care and behavioral health providers and other service providers to support client adherence, understanding, motivation, access to services and optimal engagement in care to include case coordination and case conferencing activities
- Coordinating medical and support service use within the RWHAP system of care, addressing barriers to obtaining services, and linking the client to services
- Coordinating specialty medical services outside the RWHAP system of care

Case conferences include multi-disciplinary service providers, including providers within the agency and those from other agencies when possible and relevant. Case conferences must be face-to-face or via conference call and must be held at routine intervals or during significant care changes or transitions. High acuity levels established by the Acuity Scale informs the frequency of case conferences. The client and their family members, significant others, or designated caregiver(s) should also be included in case conferences when possible and appropriate. These activities must be recorded in the client's progress notes in the designated HIV Management Information System (HIV MIS). Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals
- Resolve conflicts or strategize solutions

Adherence Counseling to Support Medical Care and Treatment

DCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions
- Documenting all adherence counseling activities in the designated HIV MIS

Client-Centered Education and Training on HIV Self-Management

DCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression
- Retention in HIV and primary medical care, including health promotion activities
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning
- Recognizing the signs of stress, distress, anxiety, and depression and strategies to access emotional support services
- Adequate nutrition, regular exercise, and the benefits of stress reduction and self-care.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicator(s)	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one (1) or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV MIS.
	1.2. 90% of clients are retained in primary medical care.	1.1.2. Client appointment record in designated HIV MIS.

IV. Assessment and Individual Care Plan

Comprehensive Health Assessment

DCMs must assess client needs by conducting a CHA within 14 days of the client's initial visit. The CHA must be completed within the designated HIV MIS. The CHA is used to evaluate each client's access to medical care, health status, health maintenance, health knowledge, treatment

adherence, behavioral health needs, and environment. Assessment findings are used to inform the acuity scale component.

Acuity Scale

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. DCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

Table 2: Acuity Scale Scoring and DCM Management Levels

Management Level	Points	Health Status/ Medical Condition	Client Contact Frequency	Chart Review Frequency
Self-Management	24-34 Points	Medically stable without need of DCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up at least once every six months for reassessment	Once every six months
Basic Management	35-49 Points	Medically stable with minimal DCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months	Every 3 months
Moderate Management	50-73 Points	At risk of becoming medically unstable without DCM assistance including documented detectable viral load or risk for viremia	Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month	Every 3 months
Intensive Management	74-96 Points	Medically unstable and in need of comprehensive DCM assistance with an accompanying detectable viral load	Face-to-face at least once a month with phone contact weekly	Monthly

Reassessment

Reassessments provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous timeframe of activities. Providers must reevaluate the client's unmet needs and related barriers by conducting reassessments every six months after completion of the initial assessment, or sooner if the client's circumstances change significantly. Reassessment findings are used to update the ICP.

Individual Care Plan (ICP)

Providers must develop an ICP within 30 days of completing the initial client visit. DCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The DCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. DCMs must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV MIS.

V. Standards for Service Delivery

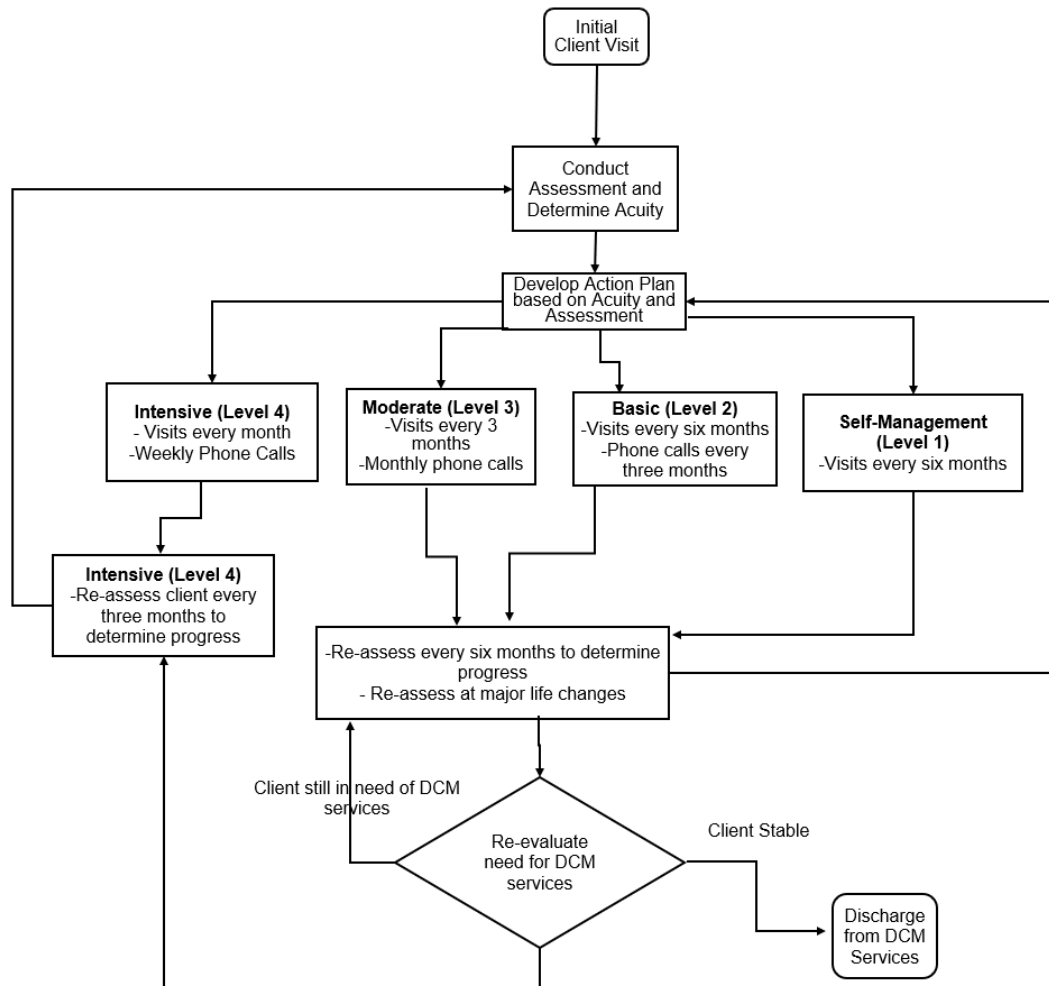
Table 3. DCM Standards for Service Delivery

Standard	Measure
1. Provider completes a CHA with each client within 14 days of their initial visit.	1.1. Completed CHA in the designated HIV MIS.
2. Provider develops an ICP with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client.	2.1. ICP signed and dated by the provider and client in the designated HIV MIS.
3. Provider completes a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change.	3.1. Completed CHA in the designated HIV MIS. 3.2. Progress notes in the designated HIV MIS.
4. Client health needs are assessed and reassessed using the Acuity Scale as outlined in <i>Appendix A</i> .	4.1. Acuity Scale completed and scored in the designated HIV MIS.
5. Client has contact with the provider at the frequency specified by client's management level as detailed in <i>Appendix A</i> .	5.1. Documentation of client communication in the designated HIV MIS.
6. Provider conducts healthcare monitoring as specified by the ICP.	6.1. Documentation of the ICP and progress notes in the designated HIV MIS.
7. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	7.1. Documentation of the ICP and progress notes in the designated HIV MIS.
8. Provider conducts adherence counseling to support treatment regimens and medical care.	8.1. Documentation of the ICP and progress notes in the designated HIV MIS.

Standard	Measure
9. Assistance provided to client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client.	9.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV MIS.
10. Provider follows up with clients within two business days of the client's requested communication.	10.1. Documentation of client communication in the designated HIV MIS.
11. Provider conducts medical chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in <i>Table 2</i> .	11.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV MIS.
12. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in <i>Table 2</i> .	12.1. Documentation of client case management conference in the designated HIV MIS.

VI. Appendix A

The DCM Assessment Model





BROWARD COUNTY RYAN WHITE PART A PROGRAM

Centralized Intake and Eligibility Determination Service Delivery Model

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I. Service Definition

Centralized Intake and Eligibility Determination (CIED) is a standalone intake service, which determines initial client eligibility for Ryan White Part A services, recertifies eligibility for Ryan White Part A services, identifies third-party payers for services and other community resources, and provides information and referrals to eligible clients for needed services. The provider must document the minimum eligibility requirements for clients accessing Ryan White Part A services.

II. Key Service Components & Activities

In addition to the CIED Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the [Broward County Ryan White Part A Universal SDM](#). Providers must also adhere to standards and requirements set forth in the [Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers](#), individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of CIED services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

CIED services must be provided at centralized offices and with staff stationed at Ryan White Part A core medical and support service sites. There must always be a dedicated live telephone operator during business hours. Routine service hours must include evening hours (after 5:00 pm) and weekends to accommodate the needs of clients, including those hospitalized to coordinate services upon discharge. CIED services must also include the provision of home visits for clients who have difficulty ambulating.

Client Orientation

CIED services must ensure that clients are oriented to the Broward Ryan White Part A system of care. This includes providing clients with information regarding Ryan White Part A services and other community resources that the client is eligible for and making referrals when needed. The provider must maintain an updated list of Ryan White Part A providers and service locations to distribute to clients.

Community Outreach

As a part of continuous community outreach, the provider must establish an annual marketing plan detailing specific activity utilized to promote Ryan White Part A services. These activities include hosting and/or attending community resource fairs, community meetings, hosting virtual workshops, etc.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increase access, retention, and adherence to primary medical care.	1.1. 95% of Part A clients who have not had a primary medical care visit within the last six months at the time of recertification shall have a primary medical care or disease case management appointment scheduled within one business day.	1.1.1. Client appointment record in designated HIV Management Information System (MIS). 1.1.2. Progress notes in designated HIV MIS. 1.1.3. Referral record in designated HIV MIS.

	1.2. 80% of clients will not experience a lapse in Ryan White Part A eligibility.	1.2.1. Client appointment record in designated HIV MIS.
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IV. Assessment

The provider must develop and implement a documented policy for verifying and documenting client's Ryan White Part A eligibility, screening for duplication of services, and ensuring Ryan White is the payer of last resort. If a client is eligible for third-party benefits, the provider must assist them in applying for those benefits and develop a benefits service plan. The service plan will ensure that there is follow-up on outstanding benefits applications, steps are taken to resolve benefits issues, and clients have the appropriate referrals in place.

CIED services must schedule Ryan White Part A core medical and support services appointments for new clients within one business day. Emergency transportation services must be available, including bus passes, to ensure engagement in care.

Initial Eligibility Determination

During the initial intake appointment, clients must complete a benefits assessment, including initial eligibility determination for Ryan White Part A services and other third-party benefits. The provider must complete all required fields of the client profile in the designated HIV MIS at the time of intake and include any third-party benefits received. Clients must have a signed and dated [Plan of Care Information System \(PCIS\) Consent Form](#) and [Broward County Ryan White Part A Program Client Rights and Responsibilities Agreement Form](#) in the designated HIV MIS. Clients deemed eligible for Ryan White Part A services must have the following dated eligibility documentation and related progress notes documented in the designated HIV MIS:

1. HIV status (proof of HIV diagnosis) (once) OR Rapid Test Documentation (30-day provisional)
2. Income level (to determine client's federal poverty level and whether they are uninsured or underinsured) (every 6 months)
3. Residency within the County (every 6 months)
4. Insurance eligibility with third party payers (to determine whether client is eligible for Medicaid, Medicare, or has private insurance) (every 6 months)

Recertification

Clients must complete recertification for Ryan White Part A services every six months after initial eligibility determination is completed, or sooner if determinants of eligibility change. The provider must contact clients to schedule their six-month recertification appointment date at least 45-days prior to their eligibility expiration date. Recertification appointment date reminders must be made via text, email, or telephone to clients both two weeks prior and 24-hours prior to their scheduled recertification date, at minimum.

The provider must offer clients the option to recertify through the online Ryan White Part A Client Recertification Portal. The provider will set up user accounts for clients and provide technical assistance as needed. A user guide for using the Ryan White Part A Client Recertification Portal can be found here: [Recertification Portal User Guides \(English, Spanish, & Creole\)](#).

V. Standards for Service Delivery

Table 2. CIED Standards for Service Delivery

Standard	Measure
1. Provider completes client profile in the designated HIV MIS and collects required forms at initial intake appointment.	1.1. Client profile completed in the designated HIV MIS. 1.2. PCIS Form signed and dated by client in the designated HIV MIS. 1.3. Broward County Ryan White Part A Program Client Rights and Responsibilities Agreement Form signed and dated by client in the designated HIV MIS.
2. Client completes a benefits assessment, including initial eligibility determination for Ryan White Part A services and other third-party benefits.	2.1. Dated eligibility documentation in the designated HIV MIS. 2.2. Documentation of third-party benefits eligibility in the designated HIV MIS.
3. Each client is informed about Ryan White services, third-party benefits, and other community resources, and is referred as applicable.	3.1. List of Ryan White Part A providers and service locations distributed to client. 3.2. Referral record in the designated HIV MIS.
4. Provider assists clients eligible for third-party benefits in applying for those benefits and develops a benefits service plan.	4.1. Documentation of third-party benefits eligibility in the designated HIV MIS. 4.2. Benefits service plan and progress notes in the designated HIV MIS.
5. Client completes recertification for Ryan White Part A services every six months after initial eligibility determination is completed, or sooner if determinants of eligibility change.	5.1. Dated eligibility documentation in the designated HIV MIS.
6. Provider schedules six-month recertification appointments at least 45-days prior to client's eligibility expiration date.	6.1. Client appointment record in the designated HIV MIS.
7. Provider conducts recertification appointment date reminders via text, email, or telephone to clients both two weeks prior and 24-hours prior to their scheduled recertification date, at minimum.	7.1. Client progress notes in the designated HIV MIS.
8. Provider offers client the option to recertify through the online Ryan White Part A Client Recertification Portal.	8.1. Client progress notes in the designated HIV MIS.



BROWARD COUNTY RYAN WHITE PART A PROGRAM

Non-Medical Case Management Service Delivery Model

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I. Service Definitions

HRSA Definition¹

Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Local Definition

NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

II. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the [Broward County Ryan White Part A Universal SDM](#). Providers must also adhere to standards and requirements set forth in the [Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers](#), individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Peer Counseling

Peer counseling is a required component of NMCM services. **Providers of NMCM services must utilize at least 30% of all NMCM personnel funds provided under the Ryan White Part A Program for Peer Counseling services.** Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment

¹ Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Support clients in achieving and maintaining viral suppression
- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Management Information System (MIS).
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV MIS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's barriers to primary medical care, medication adherence, and service needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV MIS and include, at minimum, the following components:

- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Support service needs, including financial, support groups, legal assistance, food bank, vocational, and transportation
- Risk assessment, including knowledge of HIV and STD testing, prevention, and treatment
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

Relevant Areas of Concern

Following the completion of the assessment or reassessment, the designated HIV MIS generates a list of the clients "Relevant Areas of Concern." Providers must utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan

Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals. The action plan must be documented in the designated HIV MIS and contain, at minimum, the following components:

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
 - Goal category (access, adherence, and retention)
 - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
 - Specified interventions to achieve the goal statement
 - Date goals are established
 - Target date for goal completion

Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress, assistance provided, and communication with clients in the designated HIV MIS, including phone calls, mail, face-to-face, and electronic communication. Checking lab reports (trending viral load and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. On a monthly basis, Case Management supervisors must review a sample of open client action plans to identify opportunities for improvement. All completed action plans must be reviewed, signed, and dated by Case Management supervisors.

Action Plan Review

An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV MIS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV MIS.

Standard	Measure
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV MIS.
4. Case Management supervisors review a sample of open client action plans each month to identify opportunities for improvement.	4.1. Open action plans in the designated HIV MIS. 4.2. Documentation of monthly reviews and identified opportunities for improvement.
5. Completed action plans are reviewed by Case Management supervisors.	5.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV MIS.
6. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV MIS.



BROWARD COUNTY RYAN WHITE PART A PROGRAM

Integrated Primary Care & Behavioral Health Service Delivery Model

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I. Service Definitions

HRSA Definition¹

Outpatient/Ambulatory Health Services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable OAHS activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Local Definition

Integrated Primary Care and Behavioral Health (IPCBH) is the systematic coordination of outpatient/ambulatory medical care and behavioral health care services. This includes the provision of professional diagnostic, therapeutic services, behavioral health services rendered by a physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse provider, psychiatrist, psychologist, licensed clinical social worker, or other mental health professional licensed or authorized within the State of Florida to render such services in an outpatient setting. Settings include clinics, medical offices, mobile clinics, and telehealth. Emergency department and urgent care services are not considered outpatient settings.

Services provided include diagnostic testing, early intervention and risk assessment, preventive care and screening, behavioral health screening, physical examination, medical history, diagnosis and treatment of common physical and mental health conditions, prescribing and managing medication therapy, education and counseling on health, behavioral and mental health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

¹ Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

II. Key Service Components and Activities

All IPCBH service providers must adhere to the minimum requirements stated in the [Broward County Ryan White Part A Universal SDM](#). Providers must also adhere to standards and requirements set forth in the [Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers](#), individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Provision of IPCBH – Primary Medical Care services must align with the U.S. Department of Health and Human Services (HHS) and U.S. Preventative Services Taskforce Recommendations (USPSTF) best practices and recommendations. Provision of IPCBH – Behavioral Health services must be consistent with [Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook](#). Providers of IPCBH are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Primary Medical Care

ART Initiation

The current federally approved medical practice [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#)² endorse immediate initiation of antiretroviral therapy (ART). Patients who are candidates for rapid ART initiation³:

- Have a new reactive point-of-care HIV test result or a new HIV diagnosis (confirmed through the [Centers for Disease Control and Prevention HIV testing algorithm](#)⁴) or acute HIV infection (HIV antibody negative and HIV RNA positive) or known HIV, and
- Are treatment-naïve, or
- Have a history of limited ART use (e.g., a person who stopped first-line therapy for reasons other than regimen failure), as long as concern for acquired drug resistance is low (requires a case-by-case determination).

Laboratory Tests

Providers are expected to conduct testing in compliance with HHS [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#)². The following laboratory tests are included as a standard treatment of care:

Baseline Visit (Initiation of Medical Care)

- HIV-1/2 Antigen and Antibodies, 4th Gen (*if prior HIV serostatus labs not available*)
- Absolute CD4 cell count with percentage CD4
- CBC with differential and platelets
- Resistance Testing (*HIV-1 RNA Quant PCR*)
- Syphilis Antibody w/cascading reflex

²Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed 10/9/2020.

³ This material was accessed on 10/09/2020 on the HIV Clinical Resource website (<https://www.hivguidelines.org/antiretroviral-therapy>). The HIV Clinical Guidelines Program is a collaborative effort of the New York State Department of Health AIDS Institute and the Johns Hopkins University Division of Infectious Diseases. Copyright © Johns Hopkins University HIV Clinical Guidelines Program 2000-2016.

⁴ Centers for Disease Control and Prevention. Laboratory testing for the diagnosis of HIV infection: updated recommendations. <https://stacks.cdc.gov/view/cdc/23447>

- Comprehensive Metabolic Panel (CMP) (*Basic Chemistry: including ALT, AST, and Total Bilirubin*)
- Hepatitis A Antibody total
- Hepatitis B Serology (*HBsAb, HBsAg, HBcAb total*)
- Hepatitis C Screening (*HCV antibody or, if indicated, HCV RNA*)
- Toxoplasma Antibody (IgG) (*when indicated*)⁵
- Urinalysis
- Chlamydia/Gonococcus, NAAT (*site specific swabs as indicated and urine*)
- Random or Fasting Lipid Profile
- Random or Fasting Glucose
- Resistance Testing (*HIV-1 Genotype*)
- Quantiferon TB Gold (*when indicated*)⁵
- HLA-B*5701 (*when initiating abacavir-containing regimen*)
- Pregnancy test (*for people of childbearing potential*)

Every Six Months

- Basic Chemistry: including ALT, AST, and Total Bilirubin (*when indicated*)
- Absolute CD4 cell count with percentage CD4 (*during first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm³*)
- CBC with Differential (*when monitoring CD4 cell count; perform CBC cell count and CD4 concurrently*)
- Resistance Testing (*HIV-1 RNA Quant PCR*)
- CMP (*while on Tenofovir containing regimen*)
- Urinalysis (*for clients on tenofovir disoproxil fumarate and tenofovir alafenamide containing regimens*)

Every Twelve Months

- Absolute CD4 cell count with percentage CD4 (*after 2 years CD4 and % CD4 in presence of undetectable viral load and CD4 300-500. If CD4 greater than 500, optional to repeat*)
- CBC with Differential (*when no longer monitoring CD4 cell count*)
- Hepatitis B Serology (HBsAb, HBsAg, HBcAb total) (*May repeat if patient is non-immune and does not have chronic HBV infection*)
- Hepatitis C Screening (*HCV antibody or, if indicated, HCV RNA*)
- Urinalysis
- CMP (*while on Tenofovir containing regimen*)

Viral Load Monitoring²

After initiation of ART or modification of therapy because of virologic failure: Plasma viral load (VL) should be measured before initiation of ART and within 2 to 4 weeks, but no later than 8 weeks, after treatment initiation or modification. Repeat VL measurement should be performed at 4- to 8-week intervals until the level falls below the assay's limit of detection.

⁵ Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and Adolescents: Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/adult_oi.pdf. Accessed 10/09/2020.

Virologically suppressed patients whose ART was modified because of drug toxicity or for regimen simplification: VL measurement should be performed within 4 to 8 weeks after changing therapy.

Patients on a stable, suppressive ART regimen: VL should be repeated every 3 to 4 months, or as clinically indicated, to confirm continuous viral suppression. Clinicians may extend the interval to 6 months for adherent patients whose VL has been suppressed for more than 2 years and whose clinical and immunologic status is stable.

Patients with suboptimal response: The frequency of VL monitoring will depend on clinical circumstances, such as adherence and availability of further treatment options. In addition to VL monitoring, additional factors, such as patient adherence to prescribed medications, suboptimal drug exposure, or drug interactions, should be assessed. Patients who fail to achieve viral suppression should undergo resistance testing to aid in the selection of an alternative regimen (see Drug-Resistance Testing ⁶ and Virologic Failure and Suboptimal Immunologic Response ⁷ sections).

Referral Procedures for Behavioral Health Services

A hallmark of integrated primary medical care includes the use of the Patient Health Questionnaire (PHQ-9) as a part of measurement-based care to improve patient outcomes. The PHQ-9 shall be either provider-administered or self-administered.⁸ If a client's score on the PHQ-9 is greater than 11 and/or the client demonstrates or reports signs and symptoms of mental illness or behavioral health concerns, the client must be introduced in person, by phone, or by telehealth platform to a behavioral health professional.⁹ If the primary medical care provider is unable to provide the client with an immediate introduction to a behavioral health professional, the provider must immediately schedule an appointment with a behavioral health professional at the client's earliest convenience prior to leaving the facility. The primary medical care provider is required to follow-up via phone with the client to remind them of their first scheduled appointment and identify and discuss any barriers to the client attending the appointment.

If a client scores 5 – 10 on the PHQ-9, indicating mild depression, a plan for follow-up and rescreening must be noted in the medical care and treatment plan.

Specialist Referrals

Providers must refer clients to specialists for diagnostic and treatment services as determined by the client's clinical status. If the client utilizes Disease Case Management (DCM) services, their disease case manager must be contacted to ensure linkage of the specialist referral and conduct follow-up activities, accordingly.

⁶ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed 10/09/2020 page C-12.

⁷ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed 10/09/2020 page I-1.

⁸ Gelenberg, A.J. (2017) (J of Clinical Psychiatry), Kroenke, K. et al (2001) (J of General Internal Med) and VA/DoD (2016)

⁹ Crane, P. K., Gibbons, L. E., Willig, J. H., Mugavero, M. J., Lawrence, S. T., Schumacher, J. E., Saag, M. S., Kitahata, M. M., & Crane, H. M. (2010). Measuring depression levels in HIV-infected patients as part of routine clinical care using the nine-item Patient Health Questionnaire (PHQ-9). *AIDS care*, 22(7), 874–885. <https://doi.org/10.1080/09540120903483034>

Providers may refer eligible clients to Medical Nutritional Therapy (MNT)¹⁰. Clients who receive an MNT referral must have the diagnosis of diabetes, chronic kidney disease, or have had a kidney transplant within the last 36 months. An MNT referral can also be made when a client reports any of the following concerns and agrees to an MNT referral:

- Physical changes, including weight concerns
- Oral or gastrointestinal symptoms
- Barriers to nutrition such as living environment, functional status, economic and geographic barriers such as living in a food desert
- Changes in diagnosis requiring nutrition intervention

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicators	Measures
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients are retained in Integrated Primary Care and Behavioral Health services.	1.1.1. Client appointment record in the designated HIV Management Information System (MIS).
	1.2. 90% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	1.2.1. Client prescription of ART documented in the designated HIV MIS.

IV. Assessment and Treatment Plan

Primary Medical Care Assessment and Screening Process

The provision of primary medical care assessments and behavioral health screenings must be consistent with the current [HHS treatment guidelines](#) and [U.S. Preventative Services Taskforce Recommendations \(USPSTF\)](#). Primary medical care providers must ensure client completion of the PHQ-9 at every primary medical care visit.

Primary Medical Care Comprehensive Health Assessment

The provider must complete an initial comprehensive health assessment within three (3) sessions from the time of a client's initial visit. The purpose of the initial comprehensive health assessment is to evaluate the client's clinical status, social/lifestyle issues, sexual and emotional health, knowledge of HIV, ability to adhere to prescribed medication regimens, immunization records/needs, and prevention needs for recommended health screenings, including but not limited to, prostate-specific antigen (PSA) screening, mammogram and pap smear, colon cancer screening, or Dual-Energy X-ray Absorptiometry (DEXA) Scan.

Clients must be reassessed within six months after completion of the initial comprehensive health assessment or sooner if the client's circumstances change significantly. Thereafter, reassessments

¹⁰ The Los Angeles County Commission on HIV. *MEDICAL NUTRITION THERAPY SERVICES*. Accessible at <http://hiv.lacounty.gov/LinkClick.aspx?fileticket=q111KKC-ACQ%3d&portalid=22>

are conducted, at minimum, every six months. The initial assessment and reassessment must include, at a minimum:

- General medical history, including sexual history
- Medication reconciliation
- Screening for opportunistic infections
- Comprehensive HIV-related history
- Comprehensive physical examination
- Nutritional assessment
- PHQ-9
- Psychosocial screening, including alcohol and substance use, domestic violence, and housing status
- Tobacco use screening
- Additional screenings as clinically indicated, such as vision and hearing

Medical Care and Treatment Plan

Primary medical care providers must develop a medical care and treatment plan with the client's input based on the results of the client's comprehensive health assessment findings. Providers must update medical care and treatment plans at every client visit, at minimum. If a client declines a treatment, such as vaccination, documentation of the client's denial and reason for the denial must be documented. The client medical care and treatment plan must document:

- Chief complaint
- Vital signs
- Presenting symptoms list
- Assessment/diagnosis
- Current medications and adherence
- Vaccinations
- Proposed treatment in accordance with current HHS Treatment Guidelines
- Follow-up protocol and actions to be taken if client does not attend follow-up appointment
- Referrals and recommendations for treatment and/or intervention
- Client decision to accept offers for treatment, referrals, and recommended support services

Behavioral Health Assessment

Clients referred to Behavioral Health services must complete a biopsychosocial assessment within three treatment sessions. The biopsychosocial assessment must be reviewed and signed by a licensed professional and documented in the designated HIV MIS. During the first encounter with a client, the Behavioral Health provider must establish a provisional diagnosis and treatment plan goal. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening¹¹
- Biological factors
- Psychological factors

¹¹ Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)*. <https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5>.

- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Behavioral Health Treatment Plan¹²

Providers must work with each client to develop a detailed behavioral health treatment plan that directly addresses the primary diagnosis(es) that is(are) consistent with the assessment. The behavioral health treatment plan must be an individualized, structured, and goal-oriented schedule of services with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Behavioral health treatment plans become effective on the date the plan is signed and dated by the licensed behavioral health practitioner and the client.

Behavioral health treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- Modality of treatment to be provided
- A list of the services to be provided to client (behavioral health treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the behavioral health provider for the development of the behavioral health treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month behavioral health treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed behavioral health provider
- A signed and dated statement by the licensed behavioral health provider stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)

Behavioral Health Treatment Plan Review

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any

¹² Agency for Health Care Administration. *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook*. 2014.

modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed professional and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed professional who participated in the review of the plan
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. IPCBH - Primary Medical Care Standards for Service Delivery

Standard	Measure
1. Clients have documentation of HIV+ status in their medical record.	1.1. Documentation of HIV+ test and results in the client chart.
2. Client complete initial comprehensive health assessment within three sessions from the time of a client's initial visit, and every six months thereafter.	2.1. Documentation of initial comprehensive health assessment in the client chart.
3. Clients complete a PHQ-9 at every primary medical care visit.	3.1. Documentation of PHQ-9 score in the client chart.
4. Clients whose score on the PHQ-9 is greater than 11 are referred to Behavioral Health services.	4.1. Documentation of PHQ-9 score in the client chart. 4.2. Referral documented in the designated HIV MIS.
5. Providers follow-up via phone with the clients referred to behavioral health services to remind them of their first scheduled appointment.	5.1. Documentation of referral follow up in the designated HIV MIS.
6. Providers develop a medical care and treatment plan with the client's input based on the results of the client's comprehensive health assessment findings.	6.1. Documentation of medical care and treatment plan in the client chart.
7. Clients are offered immunizations in accordance with HHS guidelines, including: • Pneumococcal vaccine and a follow up booster 5 years later	7.1. Documentation of immunizations in the client chart.

Standard	Measure
- Annual influenza immunization - Hepatitis A and B vaccine as clinically indicated.	
8. ART is prescribed as clinically indicated.	8.1. Documentation of prescribed ART in the client chart.
9. Treatment for opportunistic infections and prophylaxis for opportunistic infections is provided when clinically indicated.	9.1. Documentation of treatment in client chart.
10. Female clients receive cervical cancer screenings as clinically indicated. Clients with an abnormal PAP test result or documented cervical lesion present receive a referral to a gynecologist.	10.1. Documentation of screening and results in the client chart. 10.2. Referral documented in the designated HIV MIS.
11. Female clients, starting at age 40, receive a mammogram annually. Clients with an abnormal mammogram are referred to a specialist and have a plan of care.	11.1. Documentation of screening and results in the client chart. 11.2. Referral documented in the designated HIV MIS.
12. Clients receive colon and rectal cancer screenings as clinically indicated. ¹³	12.1. Documentation of screening and results in the client chart.
13. Clients are assessed and counseled for medication adherence at every primary medical care visit.	13.1. Documentation of assessment and counseling provided in the client chart.
14. Clients with CD4 T-cell counts below 200 and/or CD4 percentage less than 14% are prescribed PJP prophylaxis as clinically indicated. ¹⁴	14.1. Documentation of laboratory test results in the client chart. 14.2. Documentation of prescription in the client chart.
15. Clients with potential to be pregnant must receive pregnancy test at ART initiation and as clinically indicated be prescribed ART as clinically indicated.	15.1. Documentation of pregnancy screening in the client chart. 15.2. Documentation of ART prescription in the client chart.
16. Clients are referred to oral health care, if not engaged in the last six months.	16.1. Referral documented in the designated HIV MIS.
17. Clients receive an annual oral examination.	17.1. Documentation of oral health examination in the client chart.
18. Clients receive sexual health education annually, including birth control methods, pregnancy planning, discussion of condom use, risk identification, and PrEP for partners.	18.1. Documentation of sexual health education in the client chart.

¹³ National HIV Curriculum. *Primary Care Management*. Accessible at [National HIV Curriculum, Basic HIV Primary Care, Primary Care Management, Cancer Screening](#).

¹⁴ National HIV Curriculum. *Opportunistic Infections: Treatment*. Accessible at <https://www.hiv.uw.edu/page/qb/topic/co-occurring-conditions/opportunistic-infections-treatment>

Standard	Measure
19. Transgender-inclusive healthcare is provided, including: • Documentation of birth sex and self-reported gender. • Routine healthcare clinically appropriate for client's birth sex as anatomically permitted. • Assessment of additional medical and mental health needs, in addition to those inherent in birth sex and incurred from additional anatomical changes.	19.1. Documentation of transgender-inclusive healthcare provided in the client chart.

Table 3. IPCBH – Behavioral Health Standards for Service Delivery

Standard	Measure
1. Client is asked to give expressed and informed consent for treatment.	1.1. Signed informed consent form in the client chart.
2. Providers conduct a biopsychosocial assessment with each client prior to the development of a treatment plan within three treatment sessions.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HIV MIS.
3. Providers conduct additional behavioral health clinical scales, when clinically indicated.	3.1. Completed clinical scales signed by the licensed practitioner in the client chart.
4. Providers work with each client to develop a detailed treatment plan.	4.1. Treatment plan signed and dated by licensed professional and client in the designated HIV MIS.
5. Providers conduct a formal treatment plan review at least every six months.	5.1. Updated treatment plan with signature and date of licensed professional and client in the designated HIV MIS.
6. Assistance provided to clients and progress made toward achieving treatment plan goals is documented in the client chart within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client chart.
7. All client communication is documented in the client chart and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	7.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client chart.
8. Progress notes in the client chart is linked to a treatment plan goal.	8.1. Progress notes in the client chart.

Assessment of the Administrative Mechanism FY 2020 – HIVPC Survey

Background Information

1. Your Name *

2. Community needs were evaluated on an ongoing basis effectively: *

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

Comments

3. I was given enough notice of HIVPC planned activities and meetings: *

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

Comments

4. In terms of structure and process, the Ryan White Part A HIVPC is effective as a planning body: *

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

Comments

5. I have been given enough training/education to understand the structure and process of the Ryan White Part A HIVPC: *

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly Agree

Comments

FY2020 Administrative Mechanism- Recipient Survey

Contracts

1. On what date did the Broward EMA receive its notice of grant award for FY2020 funding?

2. On what date were award letters sent to funded agencies for FY2020?

3. How were agencies notified of their award? Please select all that apply.

- ☐ Award Letter (hard copy)
- ☐ Award Letter (electronic)
- ☐ Email
- ☐ Other (please explain)

4. On what date were contracts uploaded into Provide Enterprise for funded agencies? Please note multiple dates for multiple contracts.

5. On what date were contracts with funded agencies fully executed? Please note multiple dates for multiple contracts.

6. List/describe any obstacles contributing to the delay in executing provider contracts.

Service Provider Reimbursements

7. What procedures, documents and policies are used to guide the payment of invoices/reimbursements?

8. Please provide policies and procedures regarding the payment of invoices/reimbursements, if available.

Browse...

9. Over the past year, what is the approximate amount of time between submission of an accurate invoice/end-of-month report and receipt of a reimbursement check?

- ☐ 0-7 days
- ☐ 8-14 days
- ☐ 15-21 days
- ☐ 22-28 days
- ☐ 29-35 days
- ☐ 36-42 days
- ☐ 42+ days

10. List/describe any obstacle contributing to the delay in reimbursement to providers.



11. Have there ever been discrepancies in reimbursement checks (checks were more or less than amount due)?

- ☐ Yes
- ☐ No

12. If yes, how were those discrepancies resolved?

13. Over the past year, has the Recipient's Office contacted agencies to review utilization and expenditures that were not on target (over or under targets for utilization or expenditures)?

☐ Yes

☐ No

14. If yes, did the Recipient's Office provide feedback or solutions to help agencies get back to target utilization and expenditures? Please explain.

15. Over the past 12 months, how would you rate the communication between the Recipient's Office and funded agencies?

- ☐ Keeps agencies fully informed
- ☐ Keeps agencies fairly well informed
- ☐ Keeps agencies adequately informed
- ☐ Gives out only a limited amount of information
- ☐ Doesn't communicate much at all about what is going on

☐ Comments:

16. How would you rate the Recipient's timeliness in responding to questions and requests for information over the past year?

- ☐ Excellent (within one day)
- ☐ Good (within two days)
- ☐ Average (within three days)
- ☐ Poor (more than five days)

☐ Comments:

17. How would you rate the Recipient's Office in providing agencies with programmatic and/or fiscal technical assistance or training over the last 12 months?

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Poor
- ☐ Very Poor
- ☐ Comments:

Procurement and Allocation

18. What percent of the overall award for the last fiscal year was used for Recipient Support, Planning Council Support and Quality Management?

19. What percent of formula funds were unexpended at the end of FY 2020? Please explain.

20. What percent of supplemental funds were unexpended at the end of FY2020? Please explain.

21. Please provide a final expenditure report for FY2020.

Browse...

22. Please provide a final allocation report for FY2020.

Browse...

23. Please provide a list of all Part A-funded service providers in the Broward EMA for FY2020 (including contract information), as well as the categories for which each provider is contacted.

Browse...

Assessment of the Administrative Mechanism FY 2020 – Provider Survey

Background Information

1. Please provide the following contact information: *

Name *

Job Title *

Agency *

Phone Number *

Email *

2. My agency is contracted to provide the following Ryan White Part A services (select all that apply): *

- ☐ Outpatient Ambulatory Health Services (OAHS)
- ☐ Minority AIDS Initiative (MAI) OAHS
- ☐ Pharmacy
- ☐ Oral Health Care
- ☐ Health Insurance Continuation Program (HICP)
- ☐ Disease Case Management
- ☐ Mental Health
- ☐ MAI Mental Health
- ☐ MAI Substance Abuse
- ☐ Substance Abuse
- ☐ Centralized Intake and Eligibility Determination (CIED)
- ☐ MAI CIED
- ☐ Case Management
- ☐ Food Services
- ☐ Legal Services
- ☐ MAI Medical Case Management

3. How long has your agency been a Ryan White Part A provider? *

- ☐ This is my agency's first year as a provider
- ☐ 2-3 years
- ☐ 4-9 years
- ☐ 10-15 years
- ☐ 16+ years

Contracts

For the last fiscal year (beginning March 1, 2020), on approximately what date was your agency notified that you would be receiving funding for [question("piped value")]? *



4. How were you notified of your award? Please select all that apply. *

☐ Award Letter (hard copy)

☐ Award Letter (electronic)

☐ Email

☐ Other (please explain)

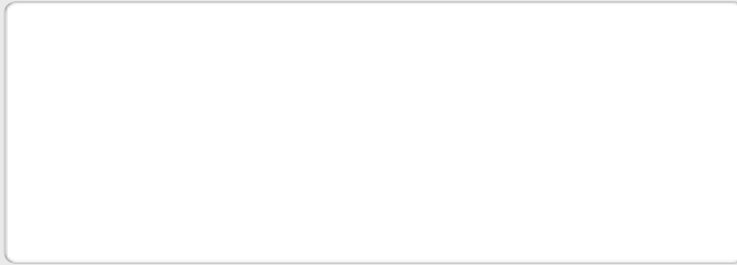
On approximately what date was your agency notified that the contract(s) were uploaded into Provide Enterprise [question("piped value")]? *



On approximately what date did you receive a fully executed contract for the [question("piped value")]? *



5. What additional comments do you have about the Ryan White Part A contracting process? *



Service Provider Reimbursements

6. Over the past year, what is the approximate amount of time between submission of an accurate invoice/end-of-month report and receipt of a reimbursement check? *

- ☐ 0-7 days
- ☐ 8-14 days
- ☐ 15-21 days
- ☐ 22-28 days
- ☐ 29-35 days
- ☐ 36-42 days
- ☐ 42+ days

7. Have there ever been discrepancies in your reimbursement checks (checks were more or less than amount due)? *

- ☐ Yes
- ☐ No

8. How were those discrepancies resolved? *

9. Over the past year, has the Recipients' Office contacted your agency to review utilization and expenditures that were not on target (over or under targets for utilization or expenditures?) *

☐ Yes

☐ No

10. Did the Recipient provide feedback or solutions to help your agency get back to target utilization and expenditures? *

☐ Yes

☐ No

Comments

11. What additional comments do you have about the reimbursement process?

Recipient Communication & Technical Assistance/Training

12. In your experience over the past 12 months, how would you rate the communication between your agency and the Recipients' Office? *

- ☐ Keeps agency fully informed
- ☐ Keeps agency fairly well informed
- ☐ Keeps agency adequately informed
- ☐ Gives out only a limited amount of information
- ☐ Doesn't communicate much at all about what is going on
- ☐ Comments:

13. How would you rate the Recipients' Office in responding to questions and requests for information over the past year? *

- ☐ Excellent (within one day)
- ☐ Good (within two days)
- ☐ Average (within three days)
- ☐ Poor (more than five days)
- ☐ Comments:

14. Please rate the timeliness of the Recipients' Office in responding to questions or requests for information. *

- ☐ Excellent (within one day)
- ☐ Good (within two days)
- ☐ Average (within three days)
- ☐ Poor (within five days)
- ☐ Comments:

15. How would you rate the Recipients' Office in providing your agency with programmatic and/or fiscal technical assistance or training over the past 12 months? *

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Poor
- ☐ Very Poor
- ☐ Comments:

16. Do you have any additional comments about communication with the Recipient or technical assistance/training?

PRIORITY SETTING & RESOURCE ALLOCATION PROCESS PRESENTATION

MARCH 25, 2021

Lorenzo Robertson, PSRA Chair



Broward County HIV Health Services Planning Council
Broward County Health Care Services Ryan White Part A Program
Broward County Board of County Commissioners
Presented as of March 18, 2021

PRESENTATION OUTLINE

- Overview
- What is PSRA?
- PSRA Goals and Guiding Principles
- Who's Involved?
- PSRA Process
- Required Grant PSRA Documentation
- PSRA Data Resources
- PRSA Process: Step-By-Step
- Ground Rules
- What to Expect



OVERVIEW

- **HRSA Requirements:** The Planning Council is required by HRSA to “set priorities and allocate resources for service categories and provide guidance (directives) to the Part A Recipient on how best to meet these priorities.”
 - ▶ The Priority Setting & Resource Allocation (PSRA) Committee shall **recommend priorities** and **resource allocations** to the Broward County HIV Health Services Planning Council (HIVPC) to **disburse Ryan White Part A funds** in Broward County.
 - ▶ Priority Setting and Resource Allocation to service categories **involves all members of the HIVPC.**



PRIORITY SETTING

- **Priority setting** is the process of deciding which HIV/AIDS services are the most important according to the criteria your EMA/TGA has established.



RESOURCE ALLOCATIONS

- **Resource allocation** is the process of distributing available Ryan White Part A program funds for your EMA/TGA across the prioritized service categories.
- **Reallocation** is the process of moving program funds across service categories after the initial allocations are made. This may occur **right after grant award** and **during the program year** when funds are underspent in some service categories and additional needs exist in other service categories.
- *The planning council must approve such reallocations.*

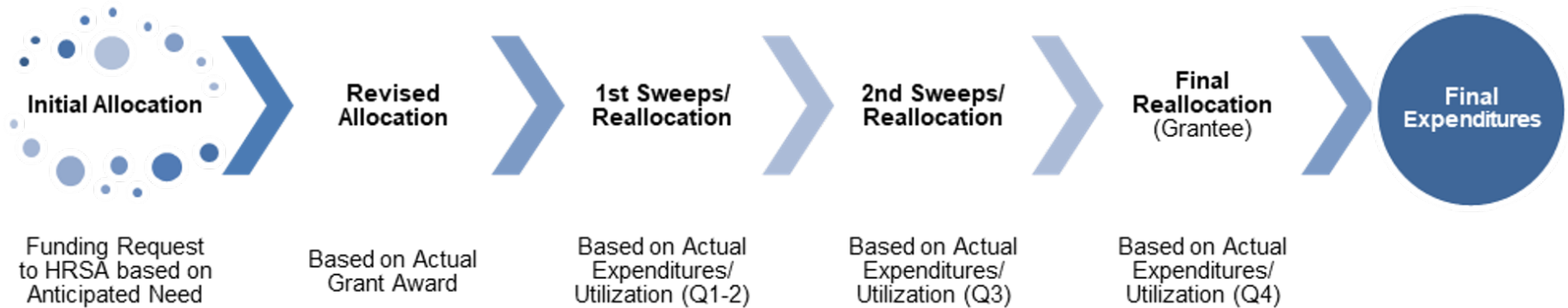


PSRA GOALS AND GUIDING PRINCIPLES

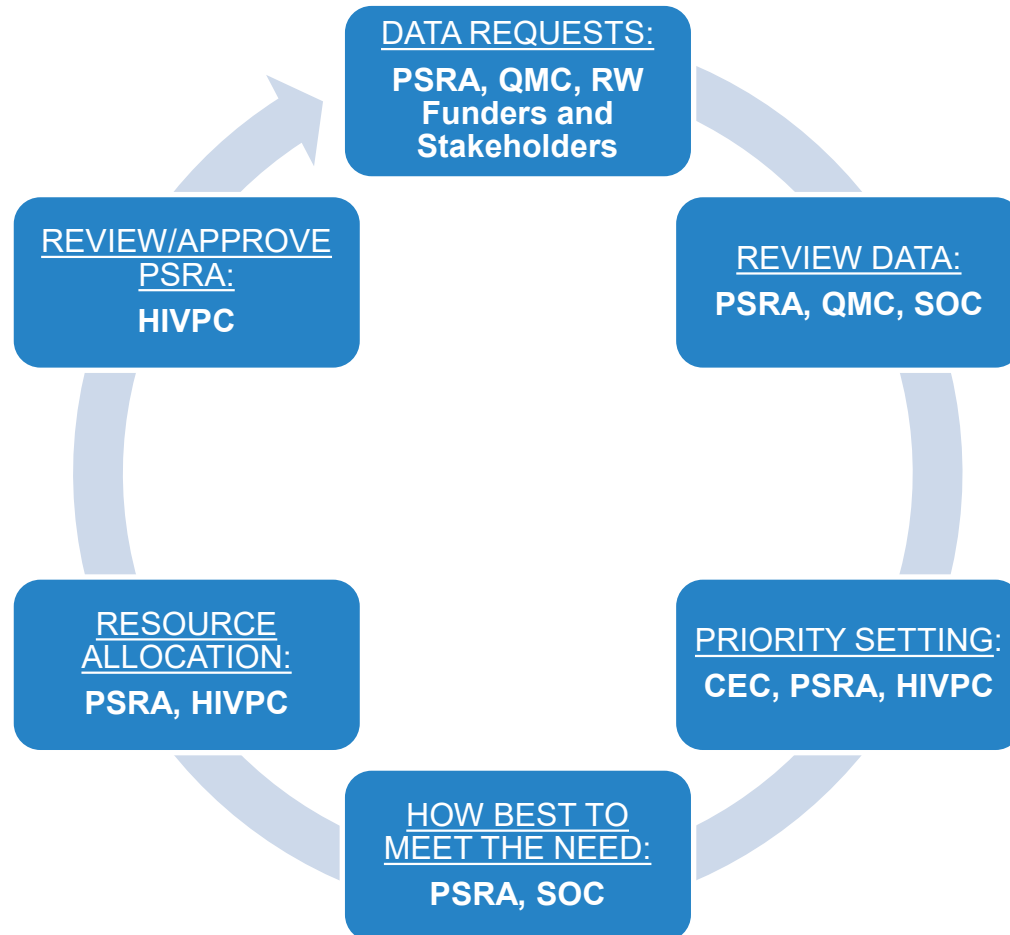
- ❑ Provide access to high quality HIV services for PLWHA in Broward County
- ❑ Optimize the HIV Care Continuum's impact
- ❑ Develop an integrated PSRA process using data with input from stakeholders and consumer forums
- ❑ Maintain a commitment to ending health disparities
- ❑ Provide client centered and coordinated services
- ❑ Integrate Prevention and Care
- ❑ Maintain and require collaborative partnerships among service providers
- ❑ Encourage early and meaningful involvement from PLWHA in the development, implementation, and evaluation of service delivery
- ❑ Engage continuous training, capacity building, and leadership development
- ❑ Provide culturally and linguistically appropriate services



FORT LAUDERDALE/BROWARD COUNTY ANNUAL RESOURCE ALLOCATION/REALLOCATION CYCLE



WHO IS INVOLVED?



PLWHA INVOLVEMENT IN THE PSRA PROCESS

□ **PLWHA Serve as Committee Members:**

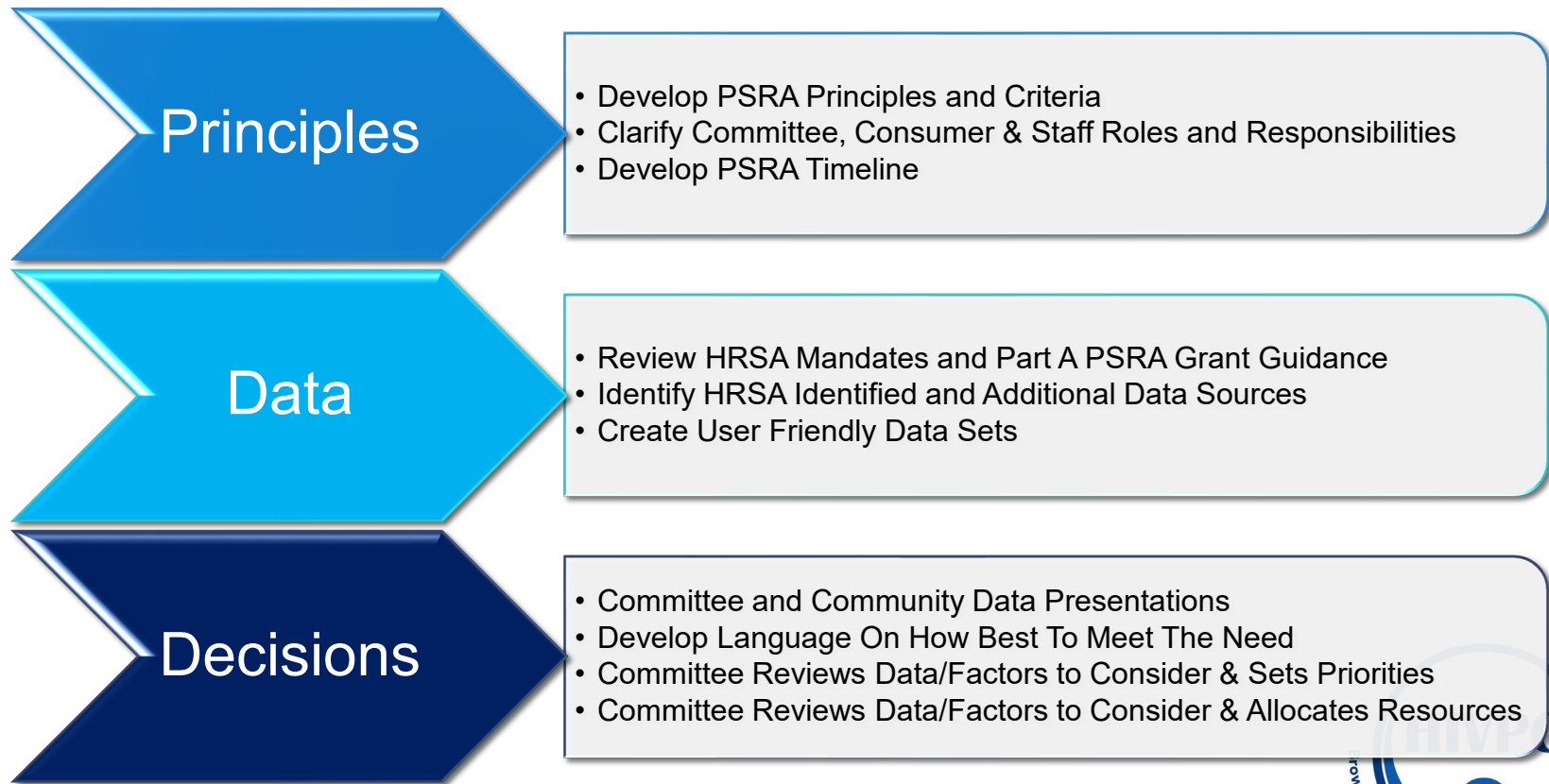
- ▶ **Community Empowerment Committee - CEC**
 - Data Collection (focus groups/feedback forums) & Presentation
 - Rank Core Services Priorities
 - Rank Support Service Priorities
- ▶ **System of Care Committee – SOC**
 - How Best to Meet the Need
- ▶ **PSRA**
 - Priority Setting & Resource Allocation
- ▶ **HIVPC**
 - Approves All PSRA Decisions

□ **Community Feedback Through Needs Assessment Activities:**

- ▶ **2020 Needs Assessment**
 - (Considers the needs of PLWHA from differing populations and geographic locations, including those in and out of care.)



THE PSRA PROCESS



REQUIRED PART A GRANT PSRA DOCUMENTATION

The Part A Grant Application requires documentation about the PSRA process annually.

- ▶ Questions to be aware of includes:
 - How PLWHA were involved in the PSRA process and how their priorities are considered in the process
 - How data were used in the PSRA processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care
 - How the HIVPC used changes and trends in HIV/AIDS epidemiology data in the PSRA process
 - How the Planning Council used cost data in making funding allocation decisions
 - How the Planning Council used unmet need data in making priority and allocation decisions
 - How the Planning Council's process will prospectively address any funding increases or decreases in the Part A award



PSRA DATA SOURCE

Priorities and allocations are data based. **Decisions are based on the data**, not on personal preferences.

The PSRA Committee will have access to information to enhance their efforts in the decision-making process.

The data collected includes:

- ❑ Epidemiological Data
- ❑ Fiscal and Service Utilization Data
- ❑ Needs Assessment Data
- ❑ Others Funder's Data/Presentation



PSRA DATA SOURCES (CONT'D)

Other factors to consider are:

- ❑ Funding from other sources such as Medicaid and Medicare
- ❑ Developing capacity for HIV services in historically underserved communities
- ❑ Priorities of Ryan White Consumers
- ❑ Changes in legislative requirements
- ❑ National HIV/AIDS Strategy
- ❑ Affordable Care Act



OTHER RESOURCES

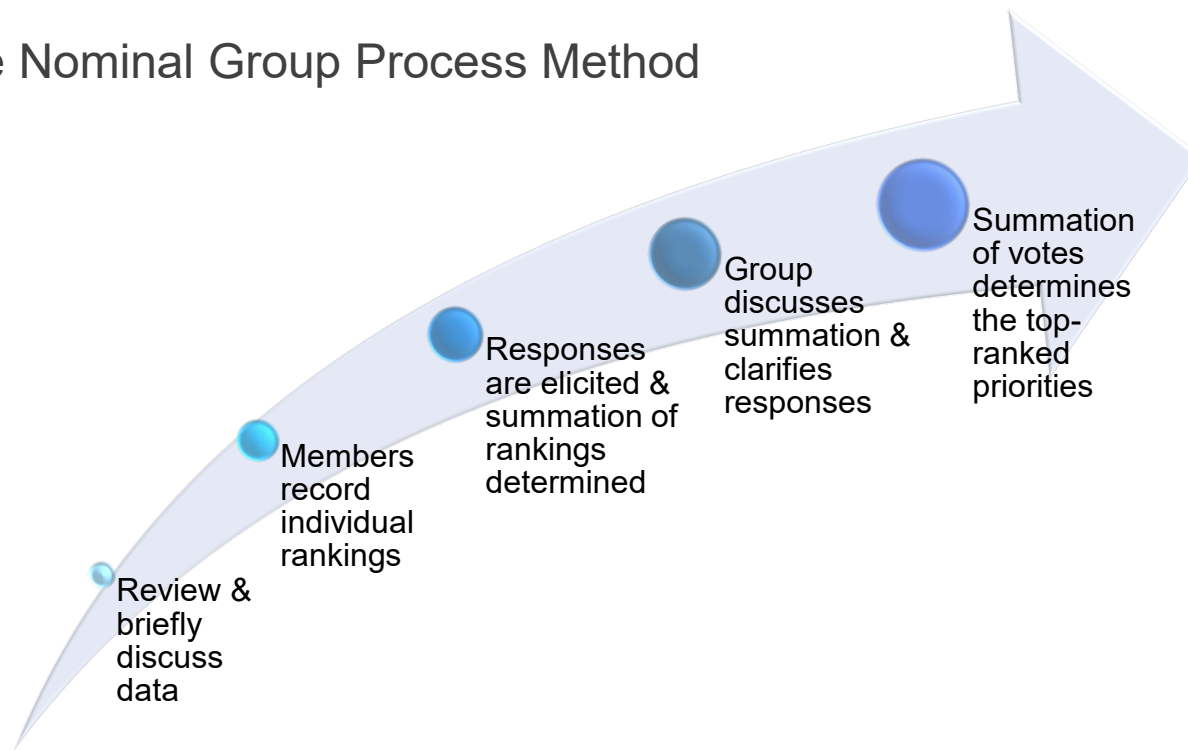
- ❑ PSRA Policies and Procedures
- ❑ FDOH HIV/AIDS Partnership 10 Epidemiological Profile, 2017
- ❑ FY2020 Other Funders Table
- ❑ FY2020 Part A Scorecards, Expenditures Spreadsheet, and Projections Table
- ❑ Needs Assessment Activities Report
- ❑ FY2021 CEC Rankings Table
- ❑ FY2021 Part A Allocations Table



PSRA PROCESS: STEP-BY-STEP

PRIORITY SETTING

- Prioritize all service categories included in Legislation
- Utilize CEC priority rankings, consumer feedback, and other PLWHA data provided
- Utilize Nominal Group Process Method



PRIORITY SETTING: CORE SERVICES

1. **Outpatient/Ambulatory Health Services**
2. **AIDS Pharmaceutical Assistance (Local)**
3. **Health Insurance Premium & Cost-Sharing Assistance (HICP)**
4. **Medical Case Management (Disease)**
5. **Mental Health Services**
6. **Oral Health Care (Dental)**
7. **Substance Abuse Services – Outpatient**
8. AIDS Drugs Assistance Program Treatments (ADAP)
9. Medical Nutrition Therapy
10. Early Intervention Services
11. Home and Community-Based Health Services
12. Home Health Care
13. Hospice Services

*Note: **Bolded** Services are funded by RWPA*



PRIORITY SETTING: SUPPORT SERVICES

1. **Food Bank/Home-Delivered Meals**
2. **Emergency Financial Assistance**
3. **Legal Services**
4. **Non-Medical Case Management (CIED)**
5. Housing Services
6. Medical Transportation Services
7. Substance Abuse Services - Residential
8. Psychosocial Support Services
9. Outreach Services
10. Health Education/Risk Reduction
11. Referral for Health Care/Supportive Services
12. Linguistics Services (Integration and Translation)
13. Other Professional Services
14. Child Care Services
15. Rehabilitation Services
16. Permanency Planning
17. Respite Care

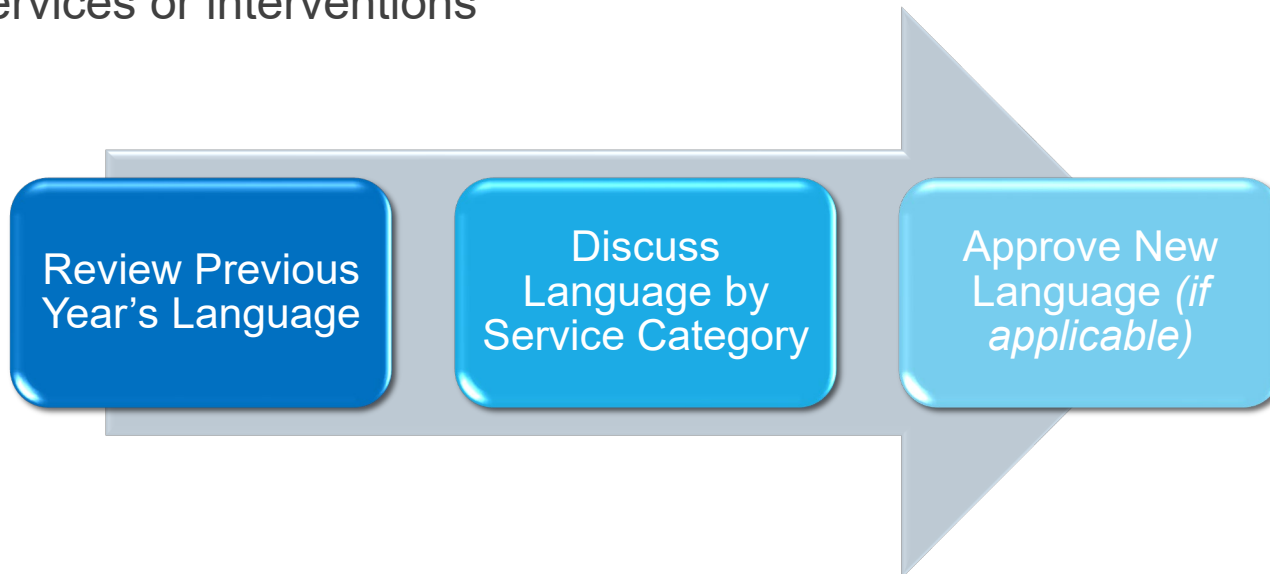
Note: **Bolded** Services are funded by RWPA



LANGUAGE ON HOW BEST TO MEET THE NEED

Directives to the Part A Recipient on how best to meet the service priorities identified, such as:

- Where geographically to fund services
- Specific models to use
- Identify target populations for which to implement new/improved services or interventions



ADDITIONAL PRIORITIES & LANGUAGE CONSIDERATIONS

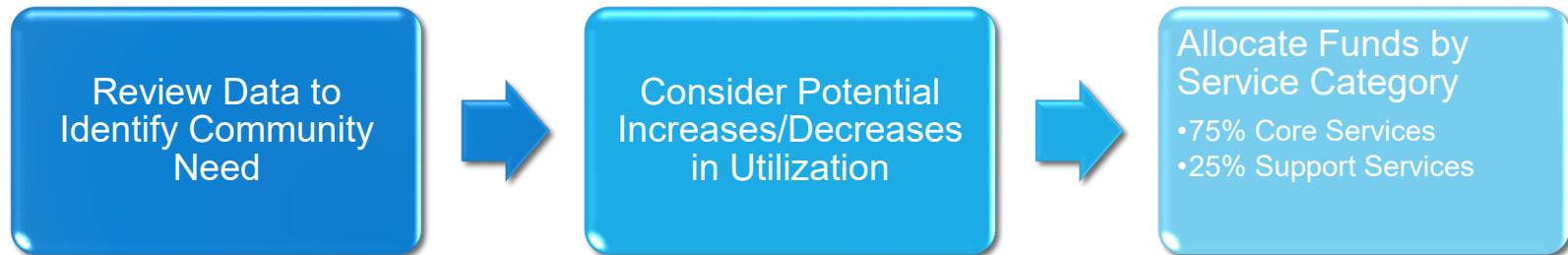
Priorities and HBTMTN Language should be based on:

- ❑ Documented need
- ❑ Cost and Outcome Effectiveness
- ❑ Priorities of PLWHA
- ❑ Availability of other resources



RESOURCE ALLOCATIONS

- Decide how much funding will be used for each service category



REALLOCATIONS (SWEEPS)

- **Reallocation** is the process of moving program funds across service categories after the initial allocations are made. The PSRA Committee shall **review, at least quarterly, any deviations in planned expenditures exceeding 10%* in any given funding category for possible reallocation and/or reprioritization.**
 - ▶ **Periodic Reallocation:** The Part A Recipient will present the Committee with estimates of funding deviations with an explanation as to possible causes of the deviation. The funding should be maintained within the service category if possible.
 - ▶ **Final Reallocation:** To fully expend funds at the end of the fiscal year, the PSRA Committee authorizes the Part A Recipient to move funds between categories within a service provider's contract. This authority is given to understand that the reallocation process has occurred before this shifting of funds. The number of dollars involved should be less than 10% of the funding award, and that there are less than 120 days left in the fiscal year.**

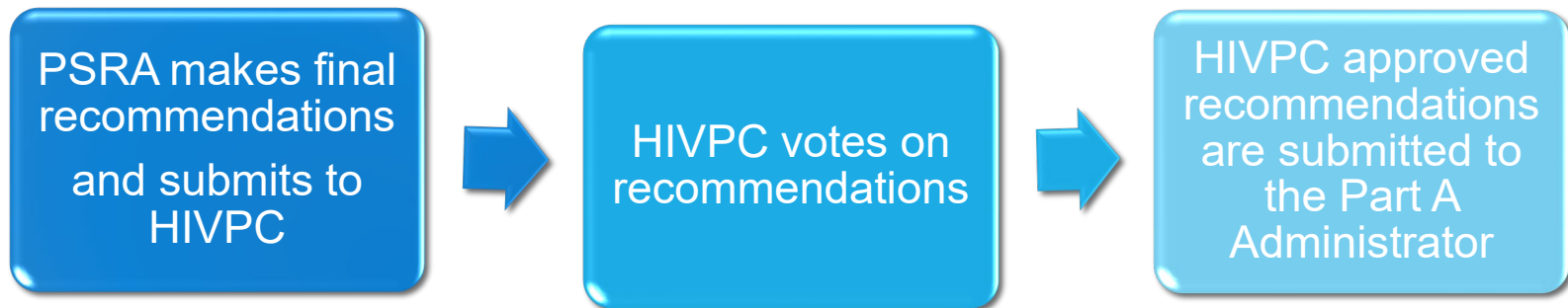
*Source: HIVPC Bylaws (October 2018)

**Source: HIVPC Local Procedure Manual (June 2017)



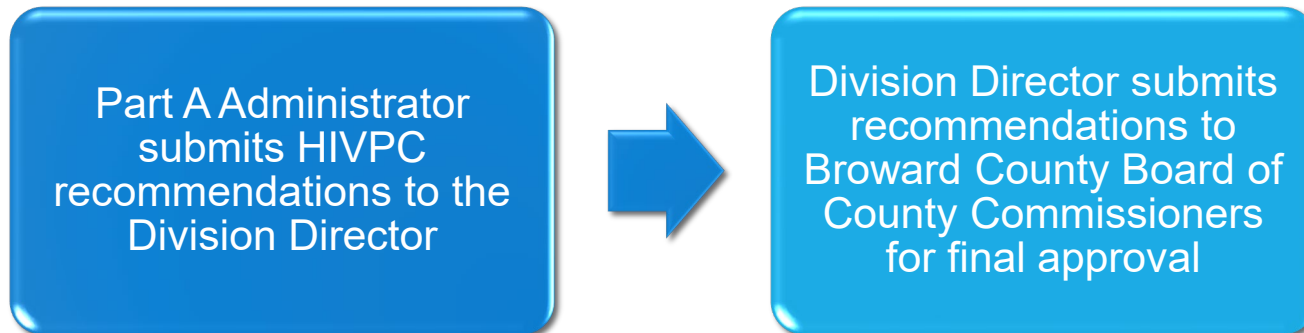
PSRA APPROVAL

- The PSRA Committee forwards all recommendations to the HIV Planning Council for approval.



PSRA APPROVAL

- The Grant Administrator (Part A Recipient) submits the Planning Council's PSRA recommendations to the Board of County Commissioners' designated Division Director, who in turn forwards them to the Broward County Board of County Commissioners for its approval.



GROUND RULES

- Every member will treat every other member with the courtesy and respect resulting from their legitimate right to be part of discussions and decision making. All members/participants in meetings will have the opportunity to speak and be listened to without interruptions.
- There will be no personal attacks, and disagreements will focus on issues, not upon individuals.
- Once decisions are made, every member of the Committee will support the decision, regardless of their personal position.
- A member will behave in a manner that reflects recognition of their responsibility to present and consider the concerns of specific communities or population groups while considering the overall needs of PLWHA and acting on their behalf, not to for personal benefit.
- Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Recipient outside of the meeting.
- Every member will take responsibility for abiding by these rules of conduct personally and for speaking out to assure that all members abide by them.



PSRA COMMITTEE: WHAT TO EXPECT

- The Planning Council support staff will provide the essential materials needed for all activities. All Committee members will be given a **PSRA resource manual, guided by HRSA PSRA standards, to provide background and support to all presentations for an informed decision-making process.**
- **An immense amount of information will be distributed and presented within a short period of time:** Since a tremendous amount of information needs to be considered for members to prioritize services and allocate funds, each member is obligated to become familiar with how to read the data being presented and to use the information to make informed decisions.



QUESTIONS?
DISCUSSION





COMMUNITY RIGHTFUL CENTER (CRC), INC.

WHO WE ARE...

Created in 2009, the Community Rightful Center (CRC) is a South Florida non-profit organization, which provides an array of services for the socio-economically disenfranchised. Our services include medical case management to people living with AIDS, HIV testing and counseling, targeted case management, mental health counseling, substance abuse counseling, employment training and placement services for the disabled, and home maker services for the homebound.

Community Rightful Center's vision is to become a one-stop social support center for persons who are disabled and/or disadvantaged.

OUR MISSION...

- The mission of the Community Rightful Center is to enhance the lives of socio-economically disenfranchised clients and their families through universal access to healthcare, case management, social, and employment services.

BACKGROUND INFORMATION...

While the organization provides an array of services to a variety of populations, CRC's main clients have always been persons with HIV.

Organization founder, Executive Director, Roseline Louis XVI has served persons with HIV for over 20 years, pioneering the Ryan White Program's medical case management services at the Village South. She later worked as a supervisor of the PAC Waiver Case Management Program at Borinquen Health Center. She has participated on Haitian TV network programs educating the community on HIV prevention, ART adherence and helping to destigmatize HIV. CRC staff are closely familiar with the community, and this familiarity is one of the hallmarks of the staff's ability to target and serve the population.

BACKGROUND CONT.

- Community Rightful Center, Inc. served about 1 500 individuals between 2017-2020. About 300 individuals with HIV have been referred for services and 289 have been referred for employment services. Overall, 98 percent of our clients are retained in outpatient medical care and other essential services.

SERVICES WE OFFER...



- Case Management
- Employment & Training Services
- HIV Testing
- Transitional Youth Employment Services

OUR TEAM...



- Full/Part-time, Case Managers, Certified HIV Counselors, and Certified Employment Specialists.
- Multi-Lingual Team: English, Spanish, Creole and French
- Servicing Miami-Dade and Broward Counties. Monday to Friday, 8:00A.M. -5:00P.M., Sat by appt. only.

OUR LOCATIONS...

- MIAMI-DADE COUNTY, FLORIDA
- CRC's Headquarters in Miami-Shores, Florida
- 9526 N.E. 2nd Avenue, Suite 202D, Miami-Shores, FL 33138

BROWARD-COUNTY, FLORIDA

- CRC's Second Locations are in Lauderhill and Carol Springs Florida
- 7481 West Oakland Park, Suite 302B, Lauderhill, FL 33319
- 1801 N. University Drive, Suite 210, Carol Springs, FL 33071
- Appointment only at the Lauderhill Location.



THANK YOU

For more info, please contact:

Mrs. Roseline LouisXVI (Executive Director)

9526 N.E. 95th Street, Suite 202D

Miami Shores, FL 33138

Rlouisxvi@communityrightfulcenter.org

(305) 754-5701



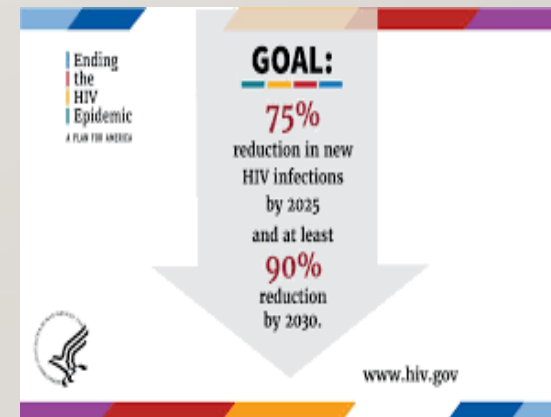
Ending The HIV Epidemic

BROWARD
ELIGIBLE METROPOLITAN
AREA (EMA)

- Presented by Neil Walker and Wismy Cius

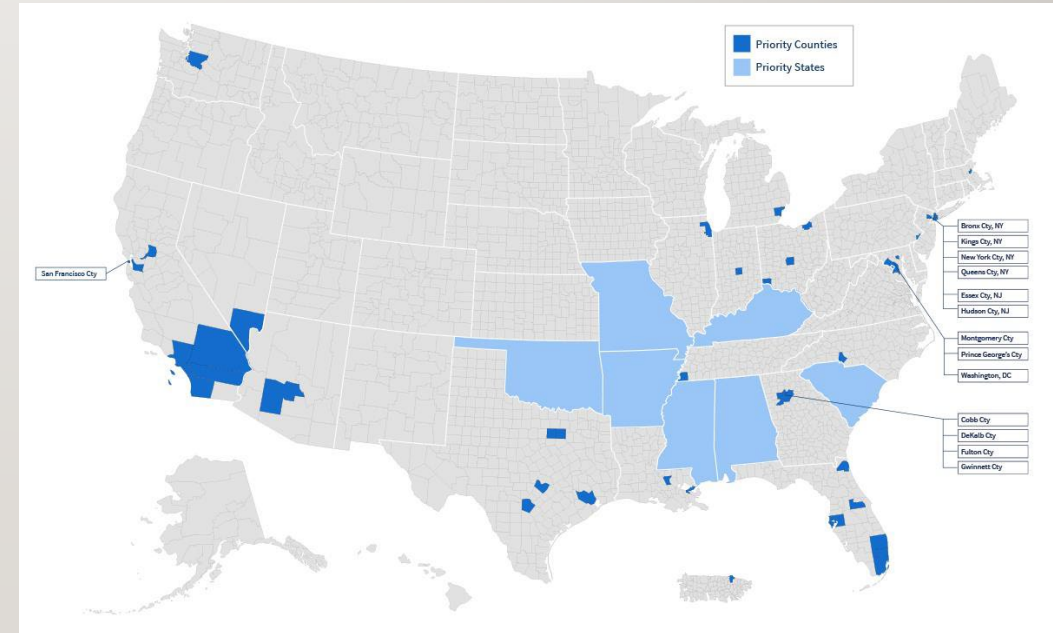
WHAT IS *ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA*?

- *Ending the HIV Epidemic: A Plan for America* (EHE) is a bold plan that aims to end the HIV epidemic in the United States by 2030. EHE is the operational plan developed by agencies across the U.S. Department of Health and Human Services (HHS) to pursue that goal.
- *Ending the HIV Epidemic: A Plan for America* is working to reduce new HIV transmissions by 75 percent by 2025 and by 90 percent by 2030, averting more than 250,000 HIV infections in that span.



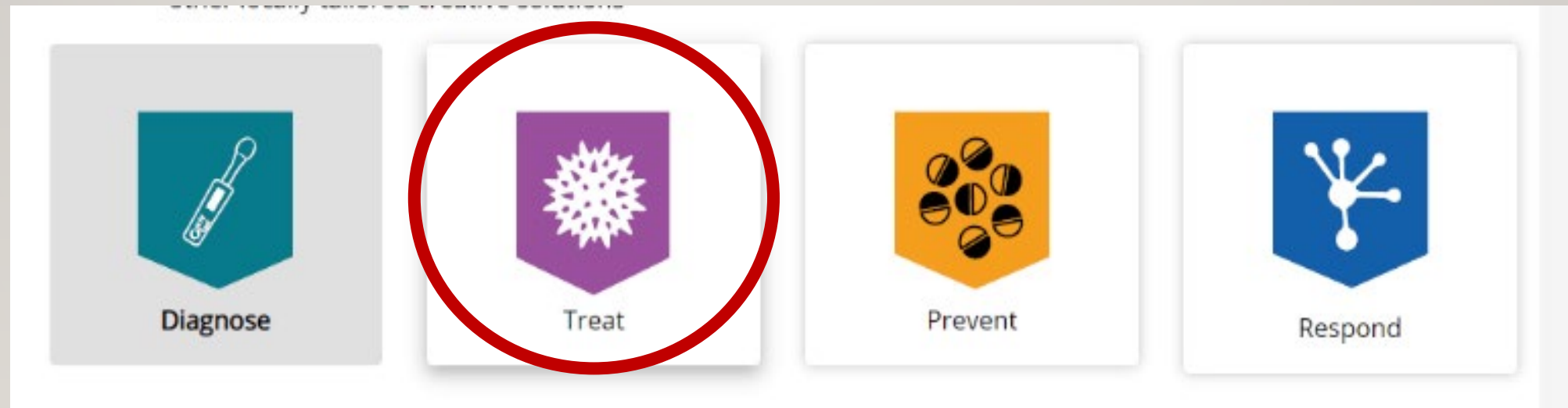
PRIORITY JURISDICTIONS: PHASE I

- The Ending the HIV Epidemic initiative focuses its Phase I efforts as followed:
 - In 48 counties, Washington, DC, and San Juan, Puerto Rico, where >50% of HIV diagnoses occurred in 2016 and 2017
 - In an additional seven states with a substantial number of HIV diagnoses in rural areas, bringing the total number of Phase I jurisdictions to 57.
 - Broward County is one of the 7 Counties in Florida identified as Priority Phase I Counties.
- To achieve the aforementioned goals, Phase I of the initiative focuses on a rapid infusion of additional resources, expertise, and technology into the 57 geographic focus areas.

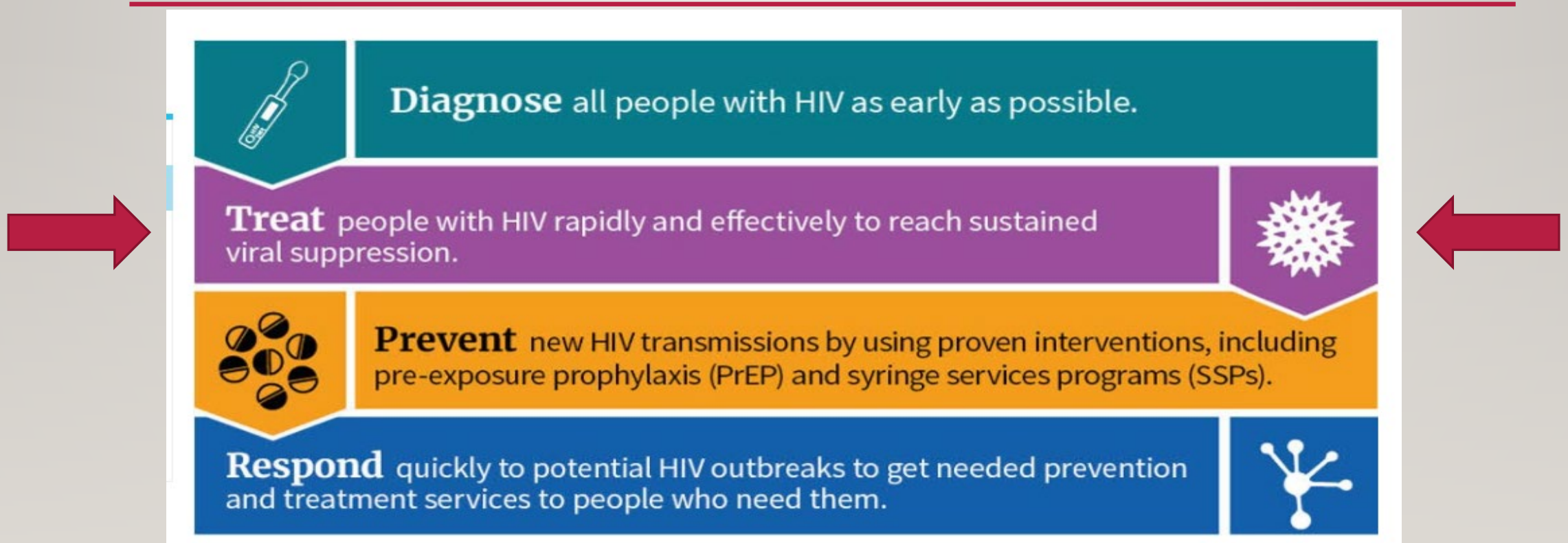


KEY EHE INITIATIVE STRATEGIES

To achieve the goal of reducing new HIV infections in the United States by 75% by 2025 and 90% by 2030, *Ending the HIV Epidemic: A Plan for America* focuses on four key strategies that together can end the HIV epidemic in the U.S.:

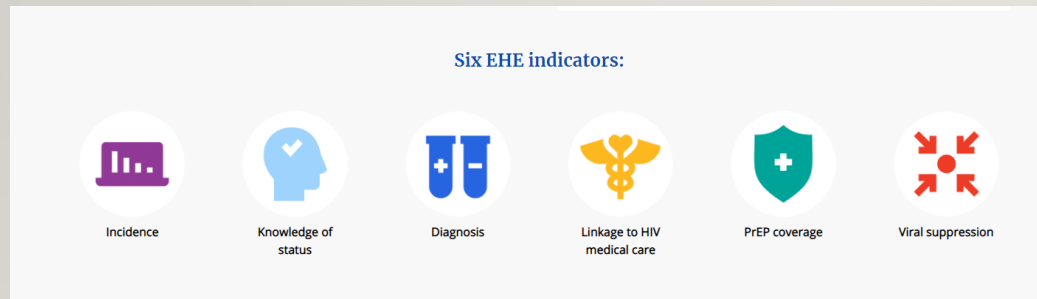


KEY EHE INITIATIVE STRATEGIES CONT...



AMERICA'S HIV EPIDEMIC ANALYSIS DASHBOARD (AHEAD)

WHAT IS AHEAD?



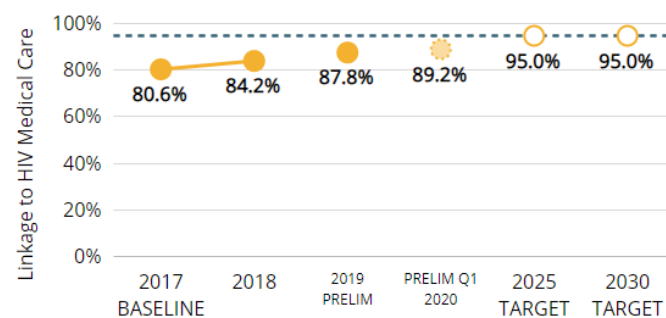
- The U.S. Department of Health and Human Services (HHS), through its Office of Infectious Disease and HIV/AIDS Policy (OIDP), has developed the **America's HIV Epidemic Analysis Dashboard (AHEAD)**, a unique data visualization tool that will provide the federal government, Ending the HIV Epidemic jurisdictions, and stakeholders a site where validated data sources can be accessed for use in decision making to help reach the goal of the Ending the HIV Epidemic: A Plan for America (EHE) initiative.
- AHEAD currently displays baseline data, progress data, and indicator targets for the six indicators below. Using 2017 baseline data for the HIV indicators, AHEAD will enable users to monitor progress towards meeting targets.

AHEAD DASHBOARD INDICATORS

Linkage to HIV Medical Care



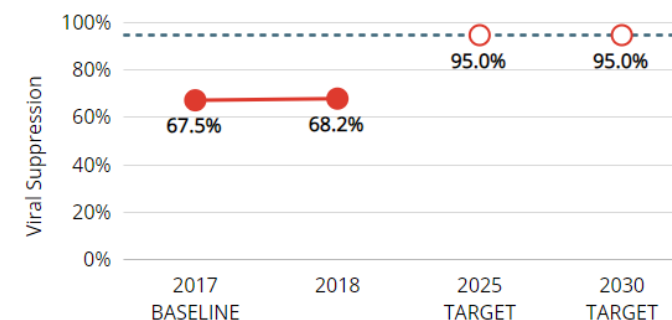
Linkage to HIV medical care is the percentage of people diagnosed with HIV in a given year who have received medical care for their HIV infection within one month of diagnosis.



Viral Suppression



Viral suppression is the percentage of people living with diagnosed HIV infection who have an amount of HIV that is less than 200 copies per milliliter of blood, in a given year.



BROWARD EMA'S ENDING THE HIV EPIDEMIC INITIATIVE

Historical Events

- Notice of funding opportunity – August 2019
- Grant application submission – October 2019
 - Applied for \$9 million
- Notice of award – February 2020
 - Received \$1.2 million
- Work plan submission/approval – April 2020/September 2020
- Training curriculum outline finalized – September 2020
- Development of marketing materials – September 2020 & ongoing
- Service Delivery Model (SDM) finalized – October 2020
- Provide Enterprise (PE) updates – December 2020 & ongoing
- Notice of award – March 2021
 - Received \$2 million



BROWARD EMA'S ENDING THE HIV EPIDEMIC INITIATIVE

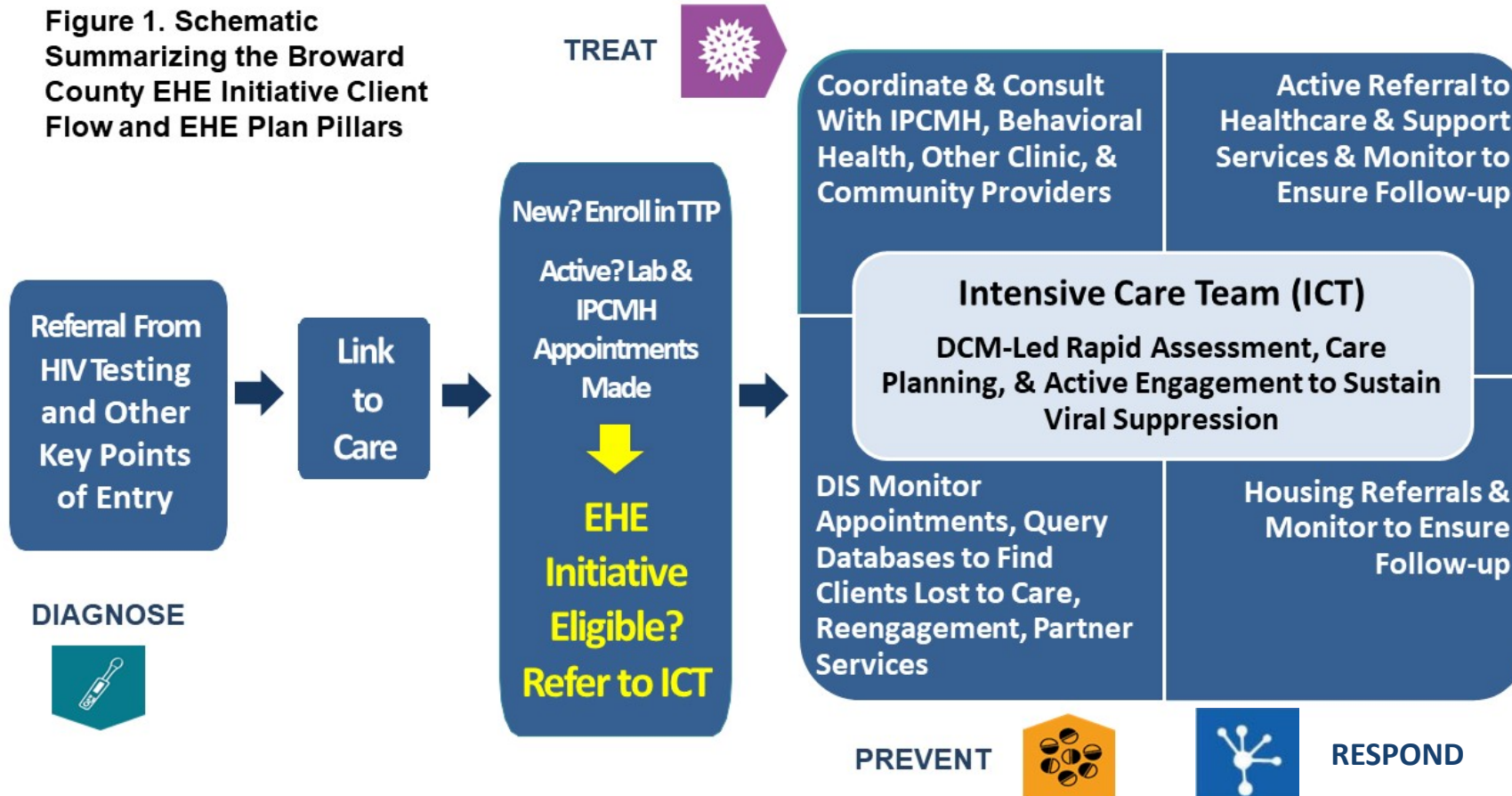
Funded Services

- **Disease Case Management (DCM)**
Establishes the Intensive Care Team (ICT) to provide intensive, coordinated healthcare interventions to assist clients in achieving retention in care and viral load suppression
- **Food Services (Food Bank and Food Voucher)**
Provides food service units to Part A clients that have reached the Part A service cap.
- **Medical Transportation**
Ride share or taxi services that assist clients with keeping their appointments.
- **Disease Intervention Specialist (DIS)**
Provide outreach services to clients and are a critical part of the ICT. They will utilize resources available to them to identify, locate, and re-engage EHE clients.



ILLUSTRATING THE ICT MODEL APPLIED IN THE BROWARD'S EHE INITIATIVE

Figure 1. Schematic Summarizing the Broward County EHE Initiative Client Flow and EHE Plan Pillars





BROWARD EMA'S ENDING THE HIV EPIDEMIC INITIATIVE

Client Eligibility

- Newly diagnosed/engaged in HIV care and/or the Broward RWHAP with evidence of a highly detectable HIV VL (HIV RNA $\geq 100,000$ copies/ml); or
- Enrolled RWHAP clients with sustained highly detectable HIV VL evidenced by having two or more consecutive HIV RNA VL laboratory values demonstrating HIV RNA $\geq 100,000$ copies/ml; or
- RWHAP clients whose last HIV VL result was $\geq 100,000$ copies/ml and who were not retained in care.

BROWARD EMA'S ENDING THE HIV EPIDEMIC INITIATIVE

Direct Service Providers

- AIDS Healthcare Foundation
- Broward Community and Family Health Centers
- Broward House
- Care Resource
- Florida Department of Health in Broward County
- North Broward Health District
- Poverello





BROWARD EMA'S ENDING THE HIV EPIDEMIC INITIATIVE

NEXT STEPS

- Service implementation
- Foster collaborative relationships with key stakeholders and the community
- EHE Network meetings every two months
- Program evaluation



USEFUL RESOURCES

- **EHE AHEAD Website**
 - <https://ahead.hiv.gov/locations/broward-county> (Broward Info)
 - <https://ahead.hiv.gov/> (overall info)
- **HIV.gov/EHE Website**
 - <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>
- **Broward EHE Service Delivery Model (SDM)**
 - <https://www.broward.org/HumanServices/CommunityPartnerships/Documents/RW%20Ending%20the%20HIV%20Epidemic%20SDM%20Final%2010.13.20.pdf>

CONTACT INFORMATION

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QUESTIONS



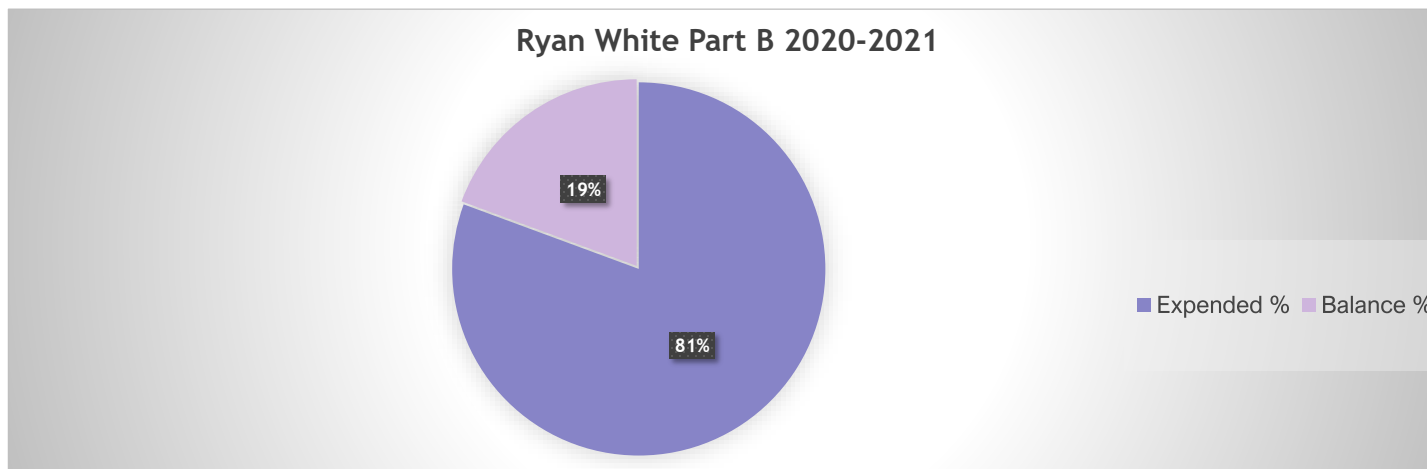
Ryan White Part B

PTC19: April 1, 2020 to March 31, 2021

Expenditures for February 2021

<i>Service Category</i>	<i>Allocated</i>	<i>Expended February 2021</i>	<i>Expended this Year</i>	<i>Clients Served</i>	<i>Expended %</i>	<i>Balance %</i>	<i>Balance</i>
Administrative Services	\$ 75,535	\$ 2,164	\$ 75,535		100%	0%	\$ -
Health Insurance Premium/Cost Sharing	\$ 101,319	\$ 6,230	\$ 88,319	8	87%	13%	\$ 13,000.04
Home & Community Based Health	\$ 20,352	\$ 1,775	\$ 16,873	5	83%	17%	\$ 3,479.10
Medical Nutritional Therapy	\$ 12,336	\$ 940	\$ 10,836	8	88%	12%	\$ 1,500.22
Emergency Financial Assistance	\$ 386,545	\$ 55,293	\$ 218,172	71	56%	44%	\$ 168,372.79
Home Delivered Meals	\$ 7,000	\$ -	\$ 5,406		77%	23%	\$ 1,594.03
Medical Transportation	\$ 45,476	\$ 3,784	\$ 40,985		90%	10%	\$ 4,490.70
Non-Medical Case Management	\$ 321,770	\$ 50,000	\$ 315,511	766	98%	2%	\$ 6,258.94
Residential Substance Abuse	\$ 133,500	\$ 26,028	\$ 107,055	2	80%	20%	\$ 26,444.69
Clinical Quality Management	\$ 58,096	\$ 564	\$ 58,096		100%	0%	\$ -
Planning and Evaluation			\$ -				\$ -
TOTALS	\$ 1,161,929	\$ 146,780	\$ 936,788	860	81%	19%	\$ 225,140.51

**Clients were served; however delayed invoicing impacted timely posting.



ADAP FEBRUARY 2021

Total Enrolled	5,031
Total Virally Suppressed	4,615
Percentage of Virally Suppressed (91.73%)	92%
ADAP Enrollments and Re-enrollments Processed	845
Enrolled in Mail Order Delivery	1,681
Total Enrolled in Direct Dispense	3,360
Total Enrolled in Online Recertification	1,705
No Show Report	23.04%