FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Broward County HIV Health Services Planning Council Meeting

Thursday, May 23, 2024 - 9:30 AM
Meeting at Broward Regional Health Planning Council and Microsoft Teams

https://teams.microsoft.com/l/meetup-join/19%3ameeting_MTgzNDBjZmEtYzllOS00YzA4LThjMjktOGVjYTI2MTJmOGEz%40thread.v2/0?context=%7b%22Tid%22%3a%220dd42165-bf27-4e00-9f50-1f4dff8a73f8%22%2c%22Oid%22%3a%221bcbe6d6-8962-41e8-b7e5-3cd660df997c%22%7d

Meeting ID: 223 679 016 307 | Passcode: 9Af8tf
Or call in (audio only)
+1 561-437-3349 - Phone Conference ID: 869 406 955#

Chair: Lorenzo Robertson • Vice Chair: Von Biggs

This meeting is audio and video recorded.

Quorum for this meeting is 14

DRAFT AGENDA

ORDER OF BUSINESS

1. **CALL TO ORDER/ESTABLISHMENT OF QUORUM**

2. **WELCOME FROM THE CHAIR**
   a. Meeting Ground Rules
   b. Statement of Sunshine
   c. Introductions & Abstentions
   d. Moment of Silence

3. **PUBLIC COMMENT**
   a. **ACTION:** Approval of Agenda for May 23, 2024
   b. **ACTION**: Approval of Minutes (tabled to correct attendance) from March 28, 2024 **(Handout A)**
   c. **ACTION:** Approval of Minutes from April 25, 2024 **(Handout B)**

4. **FEDERAL LEGISLATIVE REPORT**– Attorney Marty Cassini, Broward County Intergovernmental Affairs Office

5. **STANDARD COMMITTEE ITEMS:**

6. **CONSENT ITEMS:**

   a. **Action Item: Review and approve the HIVPC membership application for Julio De La Nuez**

      Justification: Mr. De La Nuez is a PWH who is committed to advocating for and serving the HIV/AIDS community by improving the quality of life of those affected and diagnosed. Mr. De La Nuez's application was reviewed by MCDC and sent to HIVPC for approval.
      Seat: Affected Communities/Unaffiliated Seat.

      PROPOSED BY: Membership/Council Development Committee

   b. **Action Item: Review and approve the PSRA Membership for Jose Castillio**

      Justification: Mr. Castillio is an active member of the HIVPC who serves as the Chair of System of Care. His request to join the PSRA Committee was approved by the PSRA Chair.

      PROPOSED BY: Priority Setting and Resource Allocation Chair

   c. **Action Item: Review and approve the PSRA Membership for Shawn Tinsley**

      Justification: Ms. Tinsley is a PWH who is committed to advocating for and serving the HIV/AIDS community by improving the quality of life of those affected and diagnosed. She proudly serves on multiple committees to champion the cause of ending the HIV epidemic. Outside of the HIV Planning Council, her passion for ending HIV has enabled her to start multiple non-profit organizations. Her request to join the PSRA Committee was approved by the PSRA Chair.

      PROPOSED BY: Priority Setting and Resource Allocation Chair

7. **OLD BUSINESS: None**

8. **NEW BUSINESS:**

   a. Presentation: Priority Setting & Resource Allocation Process **(Handout C)**

      i. The video and presentation will be emailed later.

9. **DISCUSSION ITEMS**

   a. **ACTION ITEM**: Review Recommendations Made from QMC and Approve Service Delivery Models

      i. Health Insurance Continuation Program **(Handout D1)**

      ii. Integrated Primary Care and Behavioral Health **(Handout D2)**

   b. **ACTION ITEM**: Review and approve the following motion, for Food Services, made by PSRA on May 16, 2024:

      To change Food Bank Services eligibility to 0 – 150% Federal Poverty Level (FPL). Reduce the food units from two units to one unit per month. The one unit can be food voucher or food bank – Client Choice. All Clients – payor of last resort requirements must be acknowledged by a non-medical case manager. Clients receiving Supplemental Nutrition Assistance Program (SNAP) – SNAP benefits greater than $250 per month are not eligible for Part

A food services. Documentation of SNAP benefits application outcome must be documented in PE. This motion does not impact EHE food bank Services. Emergency three (3) units can be dispersed with the approval of a Case Manager.

10. COMMITTEE REPORTS

a) **Community Empowerment Committee (CEC)**
Chair: Shawn Jackson • Vice Chair: Irvin Wilson

May 7, 2024

i. **Work Plan Item Update/Status Summary:** The committee updated the list of planned community outreach activities for FY2024-2025. The committee discussed feedback from the April 24th Listening Session regarding consumer concerns about Ryan White Part A services. The committee ranked core and support services of Ryan White Part A and MAI service categories.
ii. **Data Requests:** None.
iii. **Rationale for Recommendations:** None.
iv. **Data Reports/ Data Review Updates:** None.
v. **Other Business Items:** None.
vi. **Agenda Items for Next Meeting:**
vii. **Next Meeting date:** June 4, 2024, at 3:00 PM at BRHPC and via Microsoft Teams Videoconference

b) **System of Care Committee (SOC)**
Chair: Jose Castillo • Vice Chair: Kendra Hayes
May 2, 2024

i. **Work Plan Item Update/Status Summary:** The committee reviewed the Planning Council Needs Assessment, the FY2023-2024 Broward County Needs Assessment Activities, and How Best to Meet the Need Review for FY2025-2026. The committee reviewed and approved the Health Insurance Continuation Program SDM and the Integrated Primary Care and Behavioral Health (IPCBH) SDM.
ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** Continue reviewing Service Delivery Models
    a. Universal SDM
    b. System Mapping Updating
vii. **Next Meeting date:** June 6, 2024, at 9:30 AM at BRHPC and via Microsoft Teams Videoconference

c) **Membership/Council Development Committee (MCDC)**
Chair: Vincent Foster • Vice Chair: Dr. Timothy Moragne
May 21, 2024 – Emergency Meeting

i. **Work Plan Item Update/Status Summary:** The committee reviewed Lamont Lewis's application and decided to table it again until additional

information regarding his previous conduct as a Planning Council member can be reviewed. They also wish to interview Mr. Lewis before making any final decisions. In addition, the committee decided to table Robert Hadley's application until he has attended three committee meetings. The committee reviewed the updates to the Member Recognition Program.

ii. **Data Requests:** None.
iii. **Rationale for Recommendations:** None.
iv. **Data Reports/ Data Review Updates: None.**
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** To be determined.
vii. **Next Meeting date:** July 11, 2024, at 9:30 AM at BRHPC and via Microsoft Teams Videoconference

d) **Quality Management Committee (QMC)**
Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore
May 20, 2024

i. **Work Plan Item Update/Status Summary:** The committee reviewed and approved the Health Insurance Continuation Program SDM and the Integrated Primary Care and Behavioral Health SDM.
ii. **Data Requests:** None.
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None.
v. **Other Business Items:** None.
vi. **Agenda Items for Next Meeting:** Continued review of SDMs, including the Uhe Universal SDM and System Mapping Updating.
vii. **Next Meeting date:** June 17, 2024, at 12:30 PM at BRHPC and via Microsoft Teams Videoconference

e) **Executive Committee**
Chair: Lorenzo Robertson • Vice Chair: Von Biggs
May 16, 2024
Work Plan Item Update/Status Summary:

i. **Work Plan Item Update/Status Summary:**
ii. The Executive Committee reviewed and approved the agenda for the May 23rd HIVPC meeting and the June 2024 calendar.
iii. **Data Requests:** B. Barnes: Clarified from the Board of Commissions Office with regards to voting, conflicts, and what-if situations during the voting process.
iv. **Rationale for Recommendations:** None
v. **Data Reports/ Data Review Updates:**
vi. **Other Business Items:** None
vii. **Agenda Items for Next Meeting:**
    a. Review and approve June 27, 2024, HIVPC Agenda, Meeting Materials, and Motions
    b. Review the July 2024 HIVPC Calendar
viii. **Next Meeting date:** June 20, 2024, at 12:45 PM at BRHPC and via Microsoft Teams Videoconference

f) **Priority Setting & Resource Allocation Committee (PSRA)**
Chair: Brad Barnes • Vice Chair: Vacant
May 16, 2024

i. **Work Plan Item Update/Status Summary:** The committee reviewed the Ryan White Part A Office: Overall FY24-25 Allocations Expenditure/Utilization Report. The committee discussed Food Bank Utilization, How Best to Meet the Need, Presentation about the PSRA process, and Eligibility Determination FPL for each level.

ii. **Data Requests:** M. Schweizer: Adding data to the monthly utilization report regarding (unduplicated clients) being served in each category. Therefore, we know how many clients are impacted by changes to the categories. Minimum: twice a year, a month before sweeps (July and December).

iii. **Rationale for Recommendations:** None.

iv. **Data Reports/ Data Review Updates:** T. Thompson from the Part A Office presented the Food Services Data Analysis on total funds spent thus far.

v. **Other Business Items:** None.

vi. **Agenda Items for Next Meeting:**
Review Service Categories (Ryan White Part A and B)
Ryan White Funder and Stakeholders (Parts B, C, D, F, and HOPWA)
Presentations including data related to
   a. Client Utilization
   b. Budget
   c. Notable Trends
   d. Recommendations for Part A

Broward MAI & EHE Activities Presentation
Present Notable Trends of Needs Assessment/Community Input:
   a. Consumer Data
   b. Viral Load Suppression

Review 2023 RSR
Review the status of the FL and Broward Integrated Plan
HIV Surveillance Epidemiology Data Presentation focused on:
   a. Trends in new infections
   b. Current and emerging priority populations
   c. Changes in demographics of the EMA's HIV/AIDS cases

Quality Management Part A Client Health Outcomes Presentation
   Analysis of Part A FY2023-2024 client continuum of care health outcomes
FY2023-2024 Service Utilization Scorecards
Review the Community Empowerment Committee's Rankings of Part A Services
Complete Priority Setting and Resource Allocation Rankings

vii. **Next Meeting date:** June 20 and June 21, 2024, at 12:00 PM at BRHPC and via Microsoft Teams Videoconference

11. RECIPIENT REPORTS

a) Part A **(Handout E)**

b) Part B **(Handout F)**

c) Part C

d) Part D **(Handout G)**

e) Part F

f) HOPWA

g) Prevention – Quarterly Update (April, **July,** October, January)

12. DATA REQUEST(S)

13. PUBLIC COMMENT

14. AGENDA ITEMS FOR THE NEXT MEETING

a) Next Meeting Date: June 27, 2024, at 9:30 a.m. at BRHPC and via Microsoft Teams
b) Agenda Items for next meeting:
    a. Review and approve SDM recommendations from QMC.
        i. Universal SDM

15. ANNOUNCEMENTS

16. ADJOURNMENT

For a detailed discussion on any of the above items, please refer to the minutes available at:
HIV Planning Council Website

Please complete your meeting evaluation.
Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

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.

HANDOUT A

FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Broward County HIV Health Services Planning Council Meeting

Thursday March 28, 2024 - 9:30AM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

DRAFT MINUTES

HIVPC Members Present: L. Robertson (HIVPC Chair), B. Barnes, R. Bhrangger, V. Foster, T. Moragne, J. Castillo, J. Rodriguez, B. Fortune-Evans, R. Jimenez, K. Hayes, E. Dudelzak, B. Mester, J. Casseus, F. D'Amore, W. Marcoviche, S. Jackson – Tinsley, M. Schweizer, F. D'Amore, I Wilson, A. Cutright, A. Machado, E. Davis

Members Absent: V. Biggs (HIVPC Vice- Chair), E. Dsouza, J. Wright, J. Wynn, J. Casseus, D. Shamer

Ryan White Part A Recipient Staff Present: J. Roy, T. Thompson, G. James, B. Miller, R. Honick, R. Pena, C. Evans, A. Tareq, T. Currie, Q. Cowan,

Planning Council Support Staff Present: G. Berkley-Martinez, M. Patel, D. Liao, M. Lacroix

Guests Present: S. Cook, D. Monestime, Gaby, A. Ruby, K. Bush, B. Baker, M. Cassini, J. Hidalgo, J. Shirley

1. Call to Order, Welcome from the Chair & Public Record Requirements:

The HIVPC Chair called the meeting to order at 9:35 a.m. The HIVPC Chair welcomed all meeting attendees that were present. Attendees were notified that the HIVPC 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 committee members, Recipient staff, PCS/CQM staff, and guests by roll call, and a moment of silence was observed.

2. 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. K. Hayes made a public comment by expressing to the Planning Council that all members must set aside their biases and work together for a shared purpose. B. Barnes noted that the Public Comment is meant for guests, not members.

3. Meeting Approvals:

The approval for the agenda of the March 28, 2024, HIVPC meeting was proposed by V. Foster, seconded by J. Castillio, and passed unanimously. The approval for the minutes of the January 25, 2024, meeting was proposed by M. Schweizer, seconded by B. Mester, and passed unanimously with an amendment by B. Barnes, that those who missed the Annual Retreat should be listed as absent.

Motion #1: V. Foster, on behalf of HIVPC, made a motion to approve the March 28, 2024, HIV Health Services Planning Council Agenda. The motion was seconded by J. Castillio and adopted unanimously.

Motion #2: M. Schweizer, on behalf of HIVPC, made a motion to approve the January 25, 2024, HIV Health Services Planning Council Minutes. The motion was seconded by B. Mester and passed unanimously.

4. Federal Legislative Report:

Attorney Marty Cassini, Broward County Intergovernmental Affairs Office conducted a report regarding several recent legislative actions passed by the county, state, and federal governments and that would affect the funding for Ryan White services.

5. Consent Items:

Motions made from the committee chairs under consent items were approved unanimously by the HIVPC.

a. **Motion to approve Yusimir Arencibia to join the Priority Setting and Resource Allocation Committee** – PROPOSED by: PSRA Committee Chair. Approved unanimously.
Justification: Ms. Arencibia is a current member of the HIV Health Services Planning Council and requested to join this committee. **Seat: Representatives of/or formerly incarcerated PWH.**
b. **Motion to approve the FY2024-2025 PSRA Work Plan and PSRA Process** – PROPOSED by: PSRA Committee Chair. Approved unanimously.
Justification: The Priority Setting and Resource Allocation Committee finalized and approved the work plan and timeline during its March 21, 2024, meeting.

6. Old Business:

None.

7. New Business:

Overview of the Broward HIVPC Accomplishments from March 1, 2023, through February 29, 2024, fiscal year

L. Robertson conducted an overview of accomplishments that members of the Planning Council achieved during FY2023-2024.

Evaluation Report HIVPC Retreat, February 22, 2024

M. Lacroix presented an evaluation report based on the responses of Planning Council members who attended the Annual Retreat on February 22, 2024, and completed a survey regarding their thoughts on the Retreat. J. Roy stated that the Ryan White Part A Office is willing to attend future meetings and retreats hosted by the Planning Council.

8. Discussion Items:

Motion to approve the Centralized Intake Eligibility Determination (CIED) Service Delivery Model

Justification: The CIED- Service Delivery Model was reviewed by the Systems of Care Committee during its March 7, 2024, meeting. SOC provided recommendations to the Quality Management Committee. The CIED SDM was reviewed and approved by the Quality Management Committee during its March 18, 2024, meeting.

Motion #4: QMC made the motion to approve the Centralized Intake Eligibility Determination (CIED) Service Delivery Model. The motion was seconded by J. Castillio and passed unanimously.

9. Committee Reports:

a. Community Empowerment Committee Workshop – March 5, 2024
Chair: Shawn Jackson Vice Chair: Irvin Wilson
The report stands.

S. Jackson explained the results of the "Stigma Smashers" event held on January 31, 2024 and discussed a CEC Marketing Proposal designed to create low-effort systems for staying consistent with social media posting, publicizing CEC events, promoting the HIVPC, press coverage, and event turnout of community members and decision-makers. CEC finalized outreach activities for FY2024-2025.

b. System of Care Committee – March 7, 2024
Chair: J. Castillo, Vice Chair: K. Hayes
The report stands.

J. Castillion explained that committee members reviewed the Service Delivery Model for CIED and made recommendations, which were forwarded to the Quality Management Committee.

c. Membership/Council Development Committee – December 2023: No Meeting Scheduled
Chair: V. Foster, Vice Chair: T. Moragne
The report stands.

d. Quality Management Committee – March 18, 2024
Chair: B. Fortune-Evans, Vice Chair: F. D'Amore
The report stands.

B. Fortune-Evans explained that committee members reviewed the Service Delivery Model for CIED and recommendations from the SOC Committee. The SDM was revised with a final update to the HIVPC. CQM

staff provided an update on revisions to the FY2024- 2025 Quality Improvement Toolkit, which will be shared with the members of the Quality Improvement Network to guide QI projects.

e. **Priority Setting & Resource Allocation Committee – March 21, 2024**
Chair: B. Barnes, Vice Chair: Vacant
The report stands.

f. **Executive Committee – December 2023: No Meeting Scheduled**
Chair: Lorenzo Robertson Vice Chair: V. Biggs
The report stands.

g. **Ad-Hoc By-Laws & MOU Committee, Ad-Hoc Nominations – December 2023: No Meeting Scheduled**
Chair: B. Barnes, Vice Chair: Vacant
The report stands.

B. Barnes explained that Committee members reviewed the expenditure/utilization report, discussed Broward County Taxonomy rate increase with possible impact on Ryan White reimbursement rates, and quarterly updates on clients moving into ACA, which will start in June 2024. Members reviewed the proposed FY2024-

2025 PSRA process timeline and annual workplan. Furthermore, members discussed the Affordable Care Act enrollment of the Ryan White Part A eligible clients. They received a historical overview of the Minority AIDS Initiative program from former PSRA Chair and HIVPC Vice Chair, Ms. Carla Taylor-Bennet, to start the discussion on the effectiveness of the current MAI program and service categories. The Chair discussed the purpose of the April 24th Ryan White Services Listening Session.

The committee members had three data requests during the last meeting.

- How many consumers are currently enrolled with ACA and how many are eligible for ACA.
- All Ryan White money spent on retention in care and viral load suppression broken down into groups (race, ethnicity, Wiki categories).
- Language of MAI funding and spending, to determine what it is intended and used for. What the language says from HRSA. What is allowable for service categories?

10. Recipient's Report:

a. **Part A:** The Recipient Part A Office provided updates on Ryan White Part A Needs Assessment, Service Delivery Models, Services Report (RSR), and Contracting Updates.
b. **Part B:** Recipient provided a written report with Part B's expenditures for February 2024 and the ADAP Quarterly Report with Outcomes.
c. **Part C:** No Report
d. **Part D**: The Part D Representative provided a general report which included

the current number of enrolled HIV positive patients and the overall viral suppression rate.

e. **Part F:** No Report.
f. **HOPWA:** No Report.
g. **Prevention:** Quarterly Update (April, July, October, January)

11. Data Request(s):

B. Mester: How many people were certified and recertified during FY2022-2023, FY2023-2024, FY2024-2025? How many were recertified totally, how many through NOAs, workload, and how that has changed over time.

12. Public Comment:

The Public Comment portion of the meeting provides the public an opportunity 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.

13. Agenda Items for Next Meeting:

a. The next HIVPC meeting will be held on April 25, 2024, at 9:30 a.m. **Location:** Broward Regional Health Planning Council and Virtual through Microsoft Teams
b. Agenda Items for next meeting: **To Be Determined**

14. Announcements:

- PSRA/CEC Listening Tour on RW Part A Services (Handout I)
- S. Jackson: HIV Possible and SOS Broward in partnership with community partners, first annual second quarter events. Step N Mingle.
- K. Hayes: Transgender Visibility Day Events hosted by Transinclusive.
- K. Hayes: Taking Action Together Summit, Texas Conference. Biomedical Certificate and Biomedical Conference.
- L. Robertson: Ujima Men's Collective: Man Up in the Park

15. Adjournment:

There being no further business, the meeting was adjourned at 11:23 p.m.

HIVPC Attendance for CY 2024

Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
		Meeting Date	25	22	28										
	1	Barnes, B.	X	X	X										
	2	Bhrangger, R.	X	X	X										
	3	Biggs, V., V.Chair	X	X	A										
	4	Casseus, J.	A	A	A										
	5	Castillo, J.	X	E	X										
	6	Cutright, A.	A	X	X										
	7	D'Amore, F.	X	X	X										
	8	Davis, E.	A	X	A										
	9	Dsouza, E.	X	A	X										
	10	Dudelzak, E.	X	X	A										
	11	Fortune-Evans, B.	X	X	X										
	12	Foster, V.	X	X	X										
	13	Hayes, K.	X	X	X										
	14	Jackson-Tinsley, S.	X	X	X										
	15	Jimenez, R.	X	X	X										
	16	Machado, A.	A	A	X										
	17	Marcoviche, W.	X	E	X										
	18	Mester, B.	X	X	X										
	19	Moragne, T.	A	X	X										
	20	Robertson, L., Chair	X	X	X										
	21	Rodriguez, J.	X	X	X										
	22	Schweizer, M.	X	X	X										
	23	Shamer, D.	X	E	A										
	24	Wilson, I.	X	X	X										
	25	Wright, J.	A	A	A										
	26	Wynn, J.	A	A	A										
		Quorum = 14	19	18	20		0	0	0	0	0	0	0	0	

Legend:

1 - 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	

HANDOUT B

FORT LAUDERDALE/BROWARD EMA
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(954) 561-9681 • FAX (954) 561-9685

Broward County HIV Health Services Planning Council Meeting

Tuesday, April 25, 2024 - 9:30 AM
Meeting at Broward Regional Health Planning Council and via Microsoft

DRAFT MINUTES

HIVPC Members Present: L. Robertson (HIVPC Chair), B. Barnes, R. Bhrangger, V. Foster, T. Moragne, J. Castillo, B. Fortune-Evans, R. Jimenez, K. Hayes, E. Dudelzak, B. Mester, J. Casseus, F. D'Amore, W. Marcoviche, S. Jackson – Tinsley, M. Schweizer, F. D'Amore, I Wilson, D. Shamer, A. Cutright, V. Biggs (HIVPC Vice- Chair), A. Machado, E. Dsouza, E. Davis

Members Absent: J. Wright, J. Wynn, J. Casseus, J. Rodriguez

Ryan White Part A Recipient Staff Present: J. Roy, T. Thompson, G. James, B. Miller, R. Honick, R. Pena, C. Cook, Q. Cowan, W. Cius,

Planning Council Support Staff Present: G. Berkley-Martinez, M. Patel, D. Liao, M. Lacroix

Guests Present: K. Whyte, B. Baker, C. Evans, N. Burrell, K. Bush, J. Lara, M. Barrett, K. Saiswick, K. Drummond, C. Evans, K. Creary, Y. Vassell

1. **Call to Order, Welcome from the Chair & Public Record Requirements:**

   The HIVPC Chair called the meeting to order at 9:40 a.m. The HIVPC Chair welcomed all meeting attendees who were present. Attendees were notified that the HIVPC 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 committee members, Recipient staff, PCS/CQM staff, and guests by roll call, and a moment of silence was observed.

2. **Public Comment:**
   The Public Comment portion of the meeting is intended to allow the public to express opinions about items on the meeting agenda or to discuss other matters about HIV/AIDS services in Broward County.

No public comments were made.

3. **Meeting Approvals:**

The approval for the agenda of the April 25, 2024, HIVPC meeting was proposed by T. Morange, seconded by V. Biggs, with an amendment by J. Castillio to accept J. De La Nuez to the SOC Committee after acceptance through the MCDC Committee, and passed unanimously. The approval for the minutes of the March 28, 2024, meeting was tabled by B. Barnes, seconded by T. Morange, and passed unanimously.

Motion #1: T. Morange, on behalf of HIVPC, made a motion to approve the April 25, 2024, HIV Health Services Planning Council Agenda with an amendment by J. Castillio to accept J. De La Nuez to the SOC Committee after acceptance to through the MCDC Committee. The motion was seconded by V. Biggs and adopted unanimously.

Motion #2: B. Barnes, on behalf of HIVPC, made a motion to table the approval of the March 28, 2024, HIV Health Services Planning Council Minutes. The motion was seconded by T. Morange and passed unanimously.

4. **Federal Legislative Report:**

Attorney Marty Cassini, Broward County Intergovernmental Affairs Office conducted a report regarding several recent legislative actions passed by the county, state, and federal governments that would affect Ryan White services.

5. **Standard Committee Items:**

None.

6. **Consent Items:**

Motions made by the committee chairs under consent items were approved unanimously by the HIVPC.

a. **Action Item: Review and approve the HIVPC membership application for Karen Creary** – PROPOSED by: Membership/Council Development Committee Chair. Approved unanimously.
Justification: Ms. Creary previously served as a member of the Planning Council and is a PWH who is committed to advocating for and serving the HIV/AIDS community by improving the quality of life of those affected and diagnosed. Ms. Creary's application was reviewed by MCDC and sent to HIVPC for approval. **Seat: Affected Communities/Unaffiliated Seat.**
b. **Action Item: Motion to approve the FY2023 Training Plan** – PROPOSED by: Membership/Council Development Committee Chair. Approved unanimously.
Justification: The MCDC Committee approved the training plan during its April 11, 2024, meeting.

7. **Old Business:**

None.

8. New Business:

None.

9. Discussion Items:

The Minority AIDS Initiative (MAI) Service Delivery Models (SDM) were reviewed by the Systems of Care Committee (SOC) during its April 4, 2024, meeting. SOC provided recommendations to the Quality Management Committee. Upon review, the SDMs were approved by the Quality Management Committee during its April 15, 2024, meeting.

a. Motion to approve the Minority AIDS Initiative Substance Abuse - Outpatient –Service Delivery Model
Justification: Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders.
PROPOSED BY: Quality Management Committee Chair
b. Motion to approve the Minority AIDS Initiative Non-Medical Case Management –Service Delivery Model SDM
Justification: Non-Medical Case Management (NMCM) services provide a range of client-centered activities focused on improving access to and retention of needed core medical and support services.
PROPOSED BY: Quality Management Committee Chair
c. Motion to approve the Minority AIDS Initiative Medical Case Management – Service Delivery Model SDM Request for Approval Form
Justification: Medical Case Management (MCM) provides a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum.
PROPOSED BY: Quality Management Committee Chair

SDM Presentation Presented by Broward County Ryan White Part A Office.

The committee discussed the contents of the presentation and reviewed the scope of the clients that this is intended to serve.

The motion to approve the SDMs was seconded by V. Biggs and passed unanimously.

9. Committee Reports:

a. Community Empowerment Committee Workshop – March 2024: No Meeting Held
Chair: Shawn Jackson Vice Chair: Irvin Wilson
The report stands.

b. System of Care Committee – April 4, 2024
Chair: J. Castillo, Vice Chair: K. Hayes
The report stands.

c. Membership/Council Development Committee – April 11, 2024

Chair: V. Foster, Vice Chair: T. Moragne
The report stands.

d. **Quality Management Committee – April 15, 2024**
Chair: B. Fortune-Evans, Vice Chair: F. D'Amore
The report stands.

e. **Priority Setting & Resource Allocation Committee – March 21, 2024**
Chair: B. Barnes, Vice Chair: Vacant
The report stands.

f. **Executive Committee – April 18, 2024**
Chair: Lorenzo Robertson Vice Chair: V. Biggs
The report stands.

g. **Ad-Hoc By-Laws & MOU Committee, Ad-Hoc Nominations – December 2023: No Meeting Scheduled**
Chair: B. Barnes, Vice Chair: Vacant
The report stands.

10. Recipient's Report:

a. **Part A:** The Recipient Part A Office provided updates on Ryan White Part A Needs Assessment, Service Delivery Models, Services Report (RSR), and Contracting Updates.
b. **Part B:** Recipient provided a written report with Part B's expenditures for February 2024 and the ADAP March 2024 Report with Outcomes.
c. **Part C:** The Part C Representative provided a verbal report regarding the numbers of patients seen and the types of services they received.
d. **Part D**: The Part D Representative provided a general report that included the current number of enrolled HIV-positive patients and the overall viral suppression rate.
e. **Part F:** No Report.
f. **HOPWA:** No Report.
g. **Prevention:** Quarterly Update (April, July, October, January). No Report.

11. Data Request(s):

None.

12. Public Comment:

The Public Comment portion of the meeting is intended to allow the public to express opinions about items on the meeting agenda or to discuss other matters about HIV/AIDS services in Broward County.

Y. Vassell: There needs to be less legislative red tape. We know what the problems and needs are. We need more effective protocols to deal with these issues in real time. The system is overwhelming, and this disenfranchises people seeking services. I am in disgust and dismay with Broward County. Clients don't want to come to meetings and organizations. It would help if you changed the leaders and

had more stringent benchmarks. Clients can't reduce stigma if the agencies cannot provide basic assistance.

K. Creary: We don't have a Legal Aid representative at the Planning Council. Someone needs to update CEID and social workers. Legal Aid is not responsive to the clients. I sought assistance and did not receive adequate help. If Legal Aid receives Part A money, why aren't they helping clients? The members seem more concerned with their time schedules than what the consumers want to say. When new people come to the table, we need to make it easier for them to find the ground rules.

J. Lara: Take guest information before starting. There is a lot of terminology that we don't understand. What about the private facilities for 15-25% of capacity and are taking Ryan White co-payments? It's difficult for clients to gather information regarding referrals.

13. Agenda Items for Next Meeting:

a. The next HIVPC meeting will be held on May 23, 2024, at 9:30 a.m. **Location:** Broward Regional Health Planning Council and Virtual through Microsoft Teams
b. Agenda Items for next meeting: B. Barnes: Updates on the Integrated Planning meeting. Other items to be determined.

14. Announcements:

- PSRA will hold an emergency meeting on April 30, 2024
- S. Jackson: HIV Possible and SOS Broward in partnership with community partners, first annual second quarter events. Step N Mingle, May 11th.
- S. Jackson: Acceptance to the HIV & Faith Ambassador Program through Wake Forest University
- V. Biggs: Acceptance to the NMAC's (National Minority AIDS Council) Treatment division. 2024 HIV 50+ strong and Healthy Program cohort
- L. Robertson: Ujima Men's Collective: Man Up in the Park, Saturday, May 4th

15. <u>Adjournment:</u>

There being no further business, the meeting was adjourned at 11:34 p.m.

HIVPC Attendance for CY 2024

Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
		Meeting Date	25	22	28	25									
	1	Barnes, B.	X	X	X	X									
	2	Bhrangger, R.	X	X	X	X									
	3	Biggs, V., V.Chair	X	X	A	X									
	4	Casseus, J.	A	A	A	A									
	5	Castillo, J.	X	E	X	X									
	6	Cutright, A.	A	X	X	X									
	7	D'Amore, F.	X	X	X	X									
	8	Davis, E.	A	X	A	X									
	9	Dsouza, E.	X	A	X	X									
	10	Dudelzak, E.	X	X	A	X									
	11	Fortune-Evans, B.	X	X	X	X									
	12	Foster, V.	X	X	X	X									
	13	Hayes, K.	X	X	X	X									
	14	Jackson-Tinsley, S.	X	X	X	X									
	15	Jimenez, R.	X	X	X	X									
	16	Machado, A.	A	A	X	X									
	17	Marcoviche, W.	X	E	X	X									
	18	Mester, B.	X	X	X	X									
	19	Moragne, T.	A	X	X	X									
	20	Robertson, L., Chair	X	X	X	X									
	21	Rodriguez, J.	X	X	X	A									
	22	Schweizer, M.	X	X	X	X									
	23	Shamer, D.	X	E	A	X									
	24	Wilson, I.	X	X	X	X									
	25	Wright, J.	A	A	A	A									
	26	Wynn, J.	A	A	A	A									
		Quorum = 14	19	18	20	22	0	0	0	0	0	0	0	0	

Legend:

1 - 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	

HIV Health Services Planning Council Meeting Minutes – April 25, 2024
Minutes prepared by PCS Staff

HANDOUT C

PRIORITY SETTING & RESOURCE ALLOCATION PROCESS PRESENTATION

Broward County HIV Health Services Planning Council

Health Care Services Ryan White Part A Program

Prepared by Planning Council Support Staff: May 2024

PRESENTATION OUTLINE

- Overview
- PSRA Goals and Guiding Principles
- Priority Setting
- Resource Allocation
- Entities Involved
- Data Resources
- PRSA Process: Step-By-Step
- Core & Support Services
- 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**.

PSRA GOALS AND GUIDING PRINCIPLES

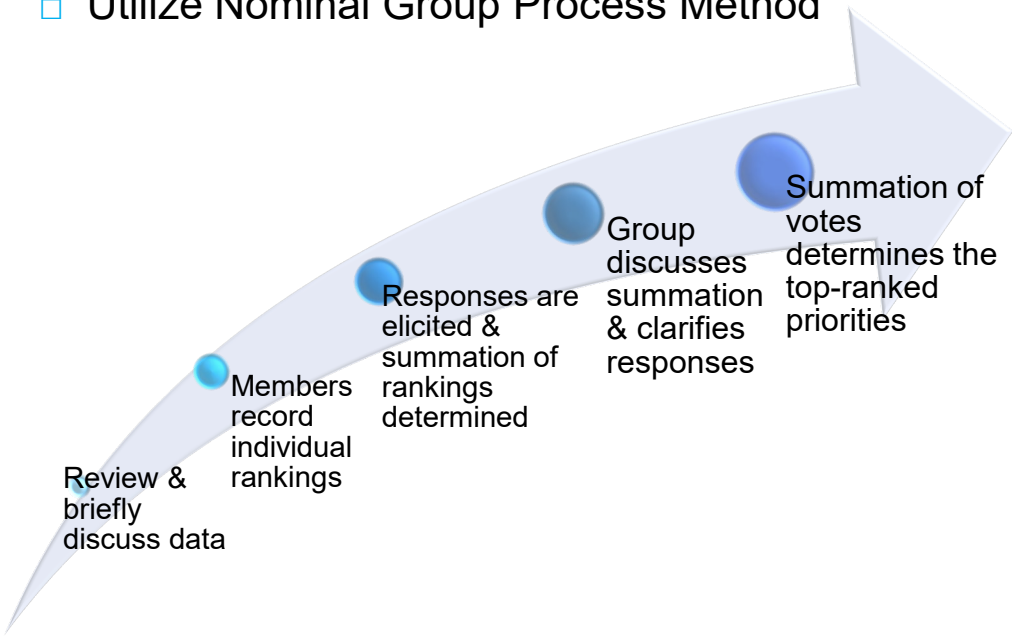
Provide	Provide access to high-quality HIV services for PWHA in Broward County
Optimize	Optimize the HIV Care Continuum's impact
Develop	Develop an integrated PSRA process using data with input from stakeholders and consumer forums
Maintain	Maintain a commitment to ending health disparities
Provide	Provide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

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.

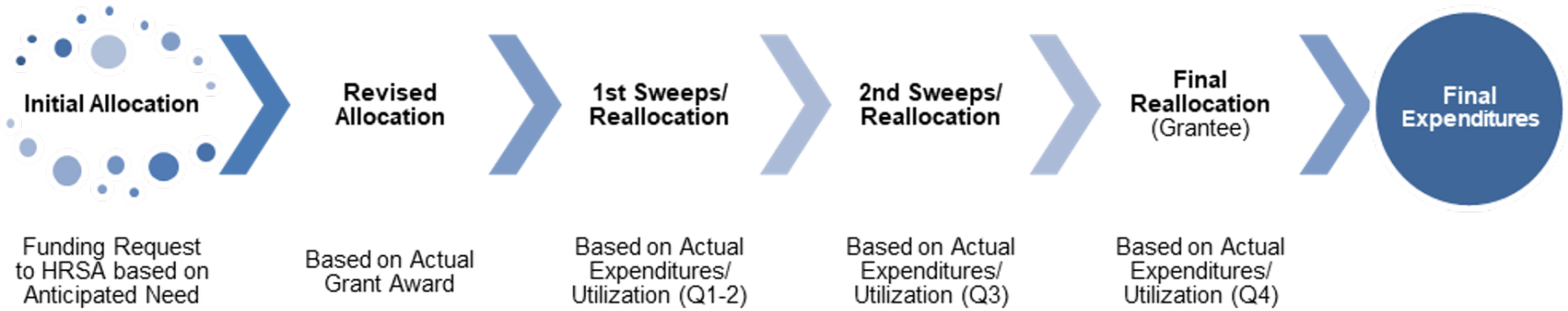
PSRA PRIORITY/ RANKING PROCESS:

- Prioritize all service categories included in Ryan White Part A Legislation
- Utilize CEC priority rankings, consumer feedback, and other PWHA data provided
- Utilize Nominal Group Process Method



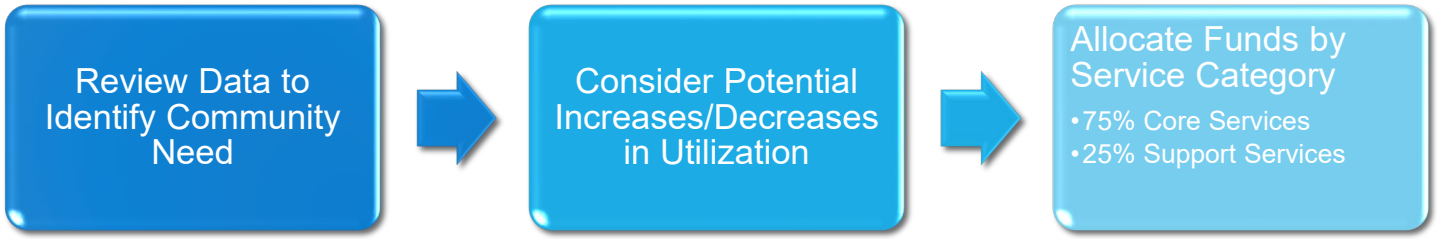
RESOURCE ALLOCATIONS

- **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.*



FORT LAUDERDALE/BROWARD COUNTY ANNUAL RESOURCE ALLOCATION/REALLOCATION CYCLE

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



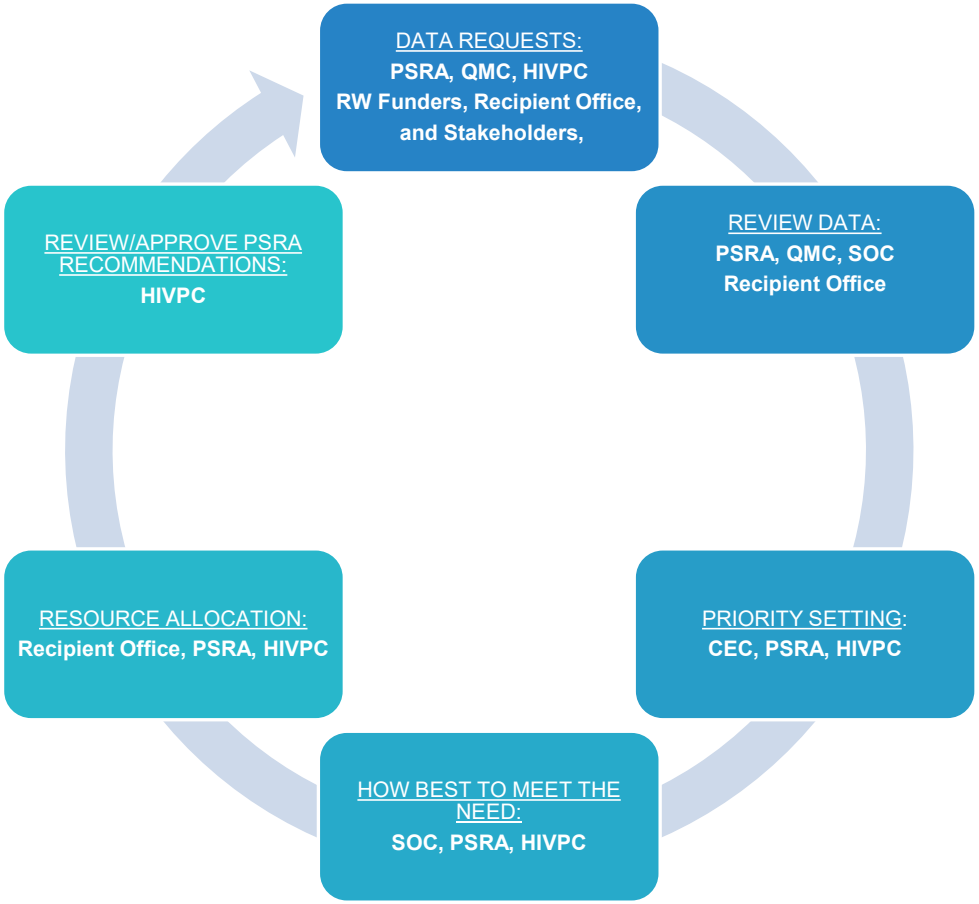
RESOURCE ALLOCATIONS

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 there are less than 120 days left in the fiscal year.**

**Source: HIVPC Bylaws (October 2024)*
***Source: HIVPC Local Procedure Manual (June 2019)*

ENTITIES INVOLVED



PWH INVOLVEMENT IN THE PSRA PROCESS

- **PWH 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 Recommendations
- **Community Feedback Through Needs Assessment Activities**

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:

- HIV Continuum of Care
- Epidemiological Data
- Fiscal and Service Utilization Data
- Needs Assessment Data
- Other Funder's (RW Parts B,C, D, F, HOPWA) Data/Presentation

PSRA DATA SOURCES (CONT'D)

Other factors to consider are:

- Insurance coverage (Medicaid, Medicare, Affordable Care Act
- Developing capacity for HIV services in historically underserved communities
- Priorities of Ryan White Consumers
- Changes in legislative requirements
- National HIV/AIDS Strategy

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 currently funded by RWPA.*

HIVPC
Broward County HIV Health Services Planning Council

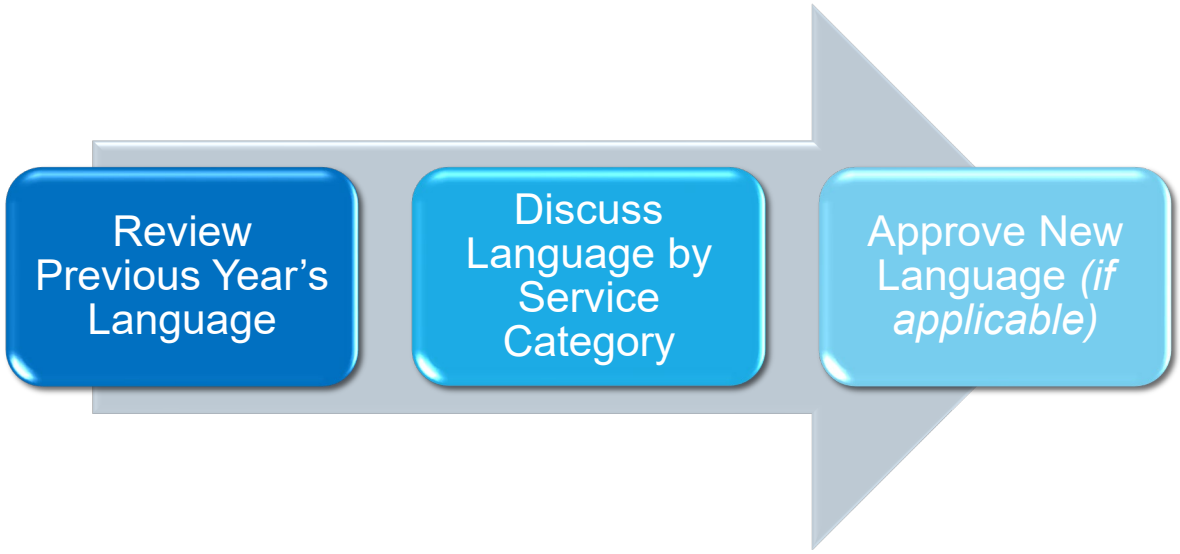
PRIORITY SETTING: SUPPORT SERVICES

1. **Food Bank/Home-Delivered Meals**
2. **Emergency Financial Assistance**
3. **Legal Services**
4. **Non-Medical Case Management and Centralized Intake Eligibility Determination (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 currently funded by RWPA.*

HIVPC
Broward County HIV Health Services Planning Council

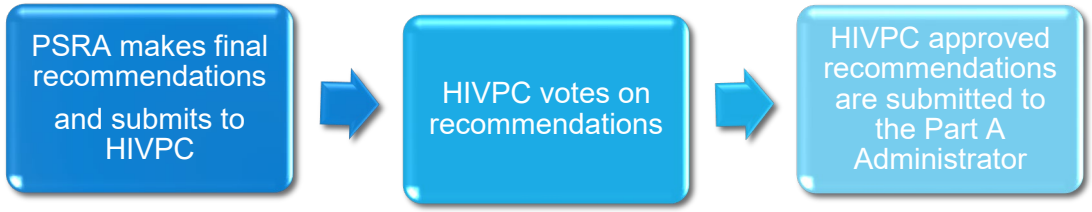
Directives to the Part A Recipient on how best to contractually meet the needs of the prioritized services:



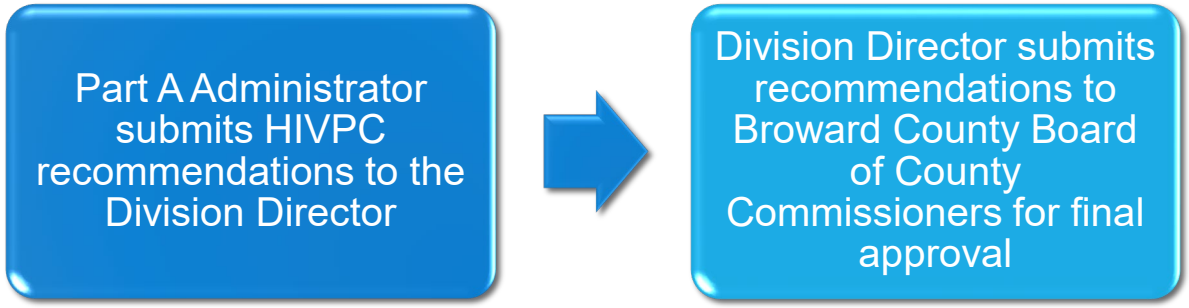
LANGUAGE ON HOW BEST TO MEET THE NEED

PSRA APPROVAL

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



PSRA 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 PWHA 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 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:** 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

HANDOUT D1

GET CARE
BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Health Insurance Continuation Program
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Health Insurance Premium and Cost Sharing Assistance Program provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

Local Definition

The Health Insurance Premium and Cost Sharing Assistance Program, also known as the Health Insurance Continuation Program (HICP), includes the provision of financial assistance paid on behalf of eligible clients living with HIV to maintain continuity of health insurance or to facilitate receiving medical and pharmacy benefits under a Ryan White AIDS Drug Assistance Program (ADAP)-approved Affordable Care Act (ACA) health care coverage program.

The goal of this program is to maintain a client's private health insurance coverage, thus minimizing the client's reliance on the Ryan White Part A program for services. No payments or reimbursements can be made directly to a client.

HICP is available to assist low income, program-eligible clients. HICP assistance is limited to out-of-pocket HIV/AIDS-related healthcare coverage costs including:

- Medical deductibles,
- Copayments,
- Coinsurance (for medications that are not on the Ryan White ADAP Formulary)

These clients must be enrolled in a ADAP Premium Assistance program and an ADAP-approved ACA health insurance plan. The Ryan White Part A program does not assist with ACA premium payments, as these premiums are paid by the Florida ADAP. The coverage of HICP is also **limited** to the annual out of pocket max per client, as detailed in the taxonomy table. In all cases, a complete financial assessment and disclosure from the client is required. The HICP service provider must have policies and procedures to inform and assist clients on how to navigate the service category.

[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 & Activities

In addition to the HICP 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 HICP services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

As a service category, HICP can assist with HIV-related medication copayments and deductibles as well as HIV-related doctor visits, lab visits, and outpatient procedure visits. This assistance is limited, not guaranteed and is dependent on funding availability.

Prior to receiving health insurance assistance, clients must review, understand, and accept in writing, all HICP policies and procedures approved by the Broward County Ryan White Part A Recipient Office and the HICP service provider. Documentation of acceptance of these policies must be signed and dated by the client.

Medical Services	**Medications**
Medical service(s) must be covered by a client's ADAP-approved health insurance plan.	Medications must be covered by a client's ADAP-approved health insurance plan.
Medical service(s) must be provided by an **in-network** provider on the client's insurance plan. Out of network provider visits, labs, and other services are not covered.	Medications **cannot** be listed on the Florida ADAP Formulary.
Payments cannot be made for services provided in the emergency department or for hospital-based inpatient service, or for conditions that are not related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment.	Payments cannot be made for medications to treat conditions that are not related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment.

The HICP service provider will coordinate with third party providers to assist with client access to services and maintain a list of providers for medical and pharmaceutical services that accept HICP payments. This provider list must be updated, at minimum, each time a new provider agrees to be added to the list and may be shared with clients upon request. The HICP service provider must also communicate, at minimum upon client request, with third party providers to inform them of

the details of HICP reimbursement and assist in gaining provider acceptance of HICP third-party reimbursement.

Client Orientation

The HICP service provider must ensure that new and returning clients are familiarized with the HICP process. The HICP service provider must review all orientation materials, policies and procedures, and client acknowledgement forms with the client that are approved by the Broward County Recipient Office. Documentation of acceptance of the client acknowledgement form must be signed and dated by the client at the end of the orientation. Clients must be informed that the Ryan White Part A program is not allowed to assist with paying any fees/penalties from prior years that are associated with the client not having an ADAP-approved health insurance plan. Clients must also be notified that a service provider does not have to accept third party payments. Ultimately, it is up to the service provider to agree to third-party payments.

Clients must be informed that it is their responsibility to share information regarding HICP reimbursement with their service provider at least four (4) weeks prior to their next scheduled appointment date to gain provider buy-in, and to encourage the service provider to coordinate payment assistance set-up with the HICP service provider. The HICP service provider must make clear to the client that HICP cannot reimburse the client for co-pays, deductibles, or other co-insurance that the client pays out-of-pocket to a provider.

If the facility chooses not to accept, the client can either:

1) Choose another service provider that accepts HICP payment assistance or
2) Proceed with the appointment, which will make the client responsible for making the payment themselves. Payments made by the client **cannot** be reimbursed by HICP.

Payment Verification

The HICP service provider must, upon request by a client or service provider, inform healthcare providers about the HICP process, including billing setup, steps, covered services, and expected timelines. The HICP service provider must have a system in place to ensure funds pay only for eligible pharmaceuticals and in-network outpatient services. The HICP service provider must ensure that all funds are being used as a last resort when clients utilize their existing ADAP-approved ACA insurance plan.

The HICP service provider must examine documentation to ensure copayments, coinsurance, and deductibles are valid based on eligible insurance plan benefits, insurer, and HICP policies.

The HICP provider must encourage clients to schedule relevant medical appointments before January since the Ryan White fiscal year ends on February 28 (29) and reimbursements cannot be made across Ryan White fiscal years. HICP clients are responsible for submitting a request for payment to HICP within 30 calendar days of the rendered service(s) and must be encouraged to proactively follow up with their providers if billing for services is not received in a timely manner. Payment of invoices received after 30 calendar days are dependent on HICP funding availability. The HICP service provider must notify clients within 5 calendar days if they will not accept their payment request for any reason.

All invoices for payment may be sent via email or fax and include the following:

- Client's Legal Name
- Date of Birth
- Date of Service
- Amount, and type of payment request (Copayment, Coinsurance, or Deductible)

Payment verification documentations must show that the insurance covered the service(s) and that those service(s) were HIV-related to the extent that the services were intended to treat conditions related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment. The HICP service provider must receive documentation from a medical practitioner indicating a client received a HIV-related service for eligible payments to be processed.

The HICP service provider cannot process any invoices after the closeout period at the end of the Ryan White fiscal year nor pay the service provider on the client's behalf after the indicated deadline.

Coordination with Third Party Providers

The HICP service provider must educate clients on services available through HICP and provide guidance on HICP processes, timelines, and limitations. The HICP service provider must strongly encourage clients to use their insurance plan in-network providers. Failure of clients to utilize their in-network insurance plan will result in a disallowance of cost sharing support.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Clients maintain consistent access to medical care due to prompt payment of invoice(s).	1.1. 85% of provider(s) payments are processed within 10 calendar days of receiving all required payment documents from clients.	2.1.1 *Numerator:* The total number of invoices processed within 10 calendar days. *Denominator:* The total number of submitted eligible invoices within the reporting period. Calculated by the HIV Human Services Software Systems (HSSS).

IV. Standards for Service Delivery

Table 2. HICP Standards for Service Delivery

Standard	Measure
1. Clients acknowledge acceptance of HICP policies, procedures, timelines, and limitations during orientation to HICP.	1.1. The HICP Policies and Procedures Acknowledgment form is signed and dated by the client and uploaded in the designated HIV Human Services Software System (HIV HSSS).
2. Clients are instructed to offer information regarding HICP to their medical and pharmaceutical service providers no fewer than four (4) weeks before the next scheduled appointment.	2.1. The HICP Policies and Procedures Acknowledgment form is signed and dated by the client and uploaded in the designated HIV HSSS.
3. The HICP service provider verifies that the eligible insurance plan was effective on the date of service.	3.1. Active insurance policy documented in designated HIV HSSS.
4. The HICP service provider verifies that services were provided by a service provider that is in the insurance plan's network.	4.1. Documentation of the service provider's participation of being in network in HIV HSSS.
5. The HICP service provider must develop a system to ensure funds pay only for in-network outpatient services.	5.1. Documentation of HICP policies and procedures in designated HIV HSSS.
6. The HICP provider must scan invoices and proof of payment.	6.1. Documentation of insurance information in the designated HIV HSSS. 6.2. Verify invoice and payment is correct. 6.3. Duplication of documents will not be accepted. 6.4. All invoices for payment must include Client's legal name, Date of Birth, Date of Service, Amount, and type of payment request (Copayment, Coinsurance, or deductible)
7. The HICP service provider must process eligible health insurance invoice(s) within 15 calendar days of receiving payment requests from the client.	7.1. Documentation of date if receipt of copay, coinsurance, and/or deductible payment request, in designated HIV HSSS. 7.2. Proof of payment (invoice) documented in designated HIV HSSS.
8. The HICP service provider will, at the request of the client or a medical or pharmaceutical service provider, orient/educate service providers	8.1. Documentation of orientation/education interaction enter in the designated HIV HSSS.

	regarding the benefits of HICP to gain the provider's acceptance of HICP third-party payments.	
9.	The HICP service provider will maintain a list of providers for medical and pharmaceutical services that accepts HICP payments.	9.1. Documentation of provider list is updated, at minimum once a year and distributed to clients with physical and/or digital copies.

HANDOUT D2

BROWARD COUNTY RYAN WHITE PART A PROGRAM

Integrated Primary Care & Behavioral Health Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

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

Providers are expected to adhere to the Federally Approved Clinical Practice Guidelines for HIV/AIDS.

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]. Testing below may be performed more frequently as clinically indicated. The following laboratory tests are included as a standard treatment of care:

Baseline Visit (Initiation of Medical Care)

- HIV antigen/antibody testing (if prior documentation is not available or if HIV RNA is "not detected".)
- Absolute CD4 cell count with percentage CD4
- Complete blood count. If random blood glucose level is abnormal, repeat fasting
- Plasma HIV RNA (Viral Load) and 4-8 weeks after ART initiation or modification and if detectable greater than 50 copies/mL continue every 4-8 weeks until viral load less than 50 copies/mL.
- Serum lipids (if random levels are abnormal, fasting lipids should be obtained). Consider repeating 1-3 months after ART initiation or modification.
- Comprehensive Metabolic Panel (CMP) *(Serum Na, K, HCO_3, Cl, BUN, creatinine, glucose,Cr-based eGFR ALT, AST, total bilirubin. Serum phosphorous should be monitored in patients with CKD on TDF-containing regimens. If glucose abnormal repeat fasting.* Repeat 4-8 weeks after ART initiation or modification.
- Hepatitis A Antibody total[2]
- Hepatitis B Serology *(HBsAb, HBsAg, HBcAb total) Vaccinate if not immune*
- Hepatitis C Screening *(HCV antibody or, if indicated, HCV RNA)* HCV antibody may be inadequate for screening if recent infection (less than 6 months) or CD4 < 100 cells/mm^3.

[2] National HIV Curriculum Hep A Recommendation

- Toxoplasma Antibody (IgG)[3]
- Urinalysis
- Chlamydia/Gonococcus, NAAT (s*ite specific swabs as indicated and urine)*
- Syphilis Antibody w/cascading reflex

- Resistance Testing for all persons entering care and when ART failing *(HIV-1 Genotype for PR and RT). Add INSTI genotype if INSTI resistance suspected or if history of CAB-LA use for PrEP. Follow guidelines for drug resistant testing located on* the clinicalinfo.hiv website
- Quantiferon TB Gold[5] *If CD4 below 200* cells/mm^3 *at testing, repeat when CD4≥ 200* cells/mm^3.
- HLA-B*5701 *(when initiating abacavir-containing regimen)*
- Pregnancy test *(for people of childbearing potential)*

Every Three to Six Months[4]

- Practitioners may adjust laboratory schedule to best fit injectable needs of their patients to prevent requiring an additional visit.

- Basic Chemistry: including ALT, AST, and Total Bilirubin every six months
- Absolute CD4 cell count with percentage CD4
- CBC with Differential *(when monitoring CD4 cell count if required by lab); perform CBC cell count and CD4 concurrently)*
- CMP
- Urinalysis (*for clients on tenofovir disoproxil fumarate and tenofovir alafenamide containing regimens, CKD or DM)*
- HIV viral load every six months

Every Twelve Months[3]

- Absolute CD4 cell count with percentage CD4 *(after 2 years 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 C Screening if at risk
- Lipid profile if normal at baseline or with cardiovascular risk and as clinically indicated
- Urinalysis
- Clients on injectable ART may have their labs done every 12 months, providing they are virally suppressed.

[3] All opportunistic infections need to follow the guidelines set forth within the HIV Clinical Guidelines.
[4] Time frames for lab testing need to follow the Laboratory Testing Schedule for Monitoring People with HIV.

Referral Procedures for Behavioral Health Services
A hallmark of integrated primary medical care includes the use of the Patient Health Questionnaire (PHQ) as a part of measurement-based care to improve patient outcomes.

Providers may utilize the PHQ-2 as a precursor to the PHQ-9. If a client screens positive on the PHQ-2 (3 or above) they must be assessed with the PHQ-9.

The PHQ-9 shall be either provider-administered or self-administered. 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. 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 may refer clients to specialists for HIV related diagnostic and treatment services as determined by the client's clinical status. If the client utilizes Medical Case Management (MCM) services, their medical case manager must be contacted to ensure linkage of the specialist referral and conduct follow-up activities, accordingly. It must be documented that the referred specialist will accept Ryan White fee schedules if there is no other payment option.

Prescribing Providers may refer eligible clients to Medical Nutritional Therapy (MNT)[5]. Clients who receive an MNT referral may 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

[5] Refer to the Medical Nutritional Therapy SDM for additional information

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, National HIV Curriculum and U.S. Preventative Services Taskforce Recommendations (USPSTF).

Primary Medical Care 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, pregnancy planning, 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.

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. 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
- Current medications and adherence
- Vaccinations – completed and pending
- Assessment/diagnosis
- Proposed treatment in accordance with current HHS Treatment Guidelines

- Follow-up protocol and actions to be taken if client does not attend follow-up appointments
- Referrals for HIV-related conditions and recommendations for treatment and/or intervention
- Client decision to accept offers for treatment, referrals, and recommended support services
- PHQ-2 followed by PHQ-9 at baseline assessment, whenever clinically indicated, and annual reassessment
- GAD-2 followed by GAD-7 at baseline assessment, whenever clinically indicated, and annual reassessment
- TAPS Tool Part 1 at baseline assessment, whenever clinically indicated, and annual reassessment
- Social determinants of health including but not limited to mental/behavioral health screening (alcohol and substance use), food insecurity/nutrition, tobacco use screening, domestic violence, and housing status
- Additional screenings as clinically indicated, such as vision and hearing

Behavioral Health Assessment

During the first encounter with a client, the (behavioral health?) provider must establish a provisional diagnosis and treatment plan goal. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HSSS within 30 calendar days of the first encounter with a client and be reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[6]
- Biological factors
- Psychological factors
- 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.

[6] 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.

Behavioral Health Treatment Plan
Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client.

Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the 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 in duration 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 provider
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identify 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 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 twelve months thereafter.	2.1. Documentation of initial comprehensive health assessment in the client chart.
3. All postmenopausal women and men 50 years of age and older receive a bone mineral density screening with a DEXA scan. In men 40 to 49 years of age and premenopausal women 40 years of age and older without major risk factor for osteoporotic fracture risk receive a fracture risk score using the fracture risk assessment tool.	3.1. Documentation of DEXA scan included in the client chart. 3.2. Documentation of fracture risk assessment score included in the client chart.
4. Clients are referred to a nephrologist if Glomerular Filtration Rate (GFR) declines more than 25% from baseline and to a level less than 60/mL/min/1.73 m2 that fails to resolve with the removal of any potential nephrotoxic drugs.	4.1. Referral documentation in clients chart.
5. Men with clinical indication for testosterone deficiency receive a testosterone level drawn fasting between 8-10am.	5.1. Documentation of testosterone level draw included in the clients chart.
6. Clients complete a PHQ-2 or PHQ-9 at baseline, as clinically indicated, and annual medical care visit.	6.1. Documentation of PHQ-2 or PHQ-9 score in the client chart.
7. Clients who score 3 or above on a PHQ-2 are assessed by the PHQ-9. Clients whose score on the PHQ-9 is greater than 11 are referred to Behavioral Health services.	7.1. Documentation of PHQ-2 score in the client chart. 7.2. Documentation of PHQ-9 score in the client chart. 7.3. Referral documented in the designated HIV HSSS.
8. Clients complete a GAD-2 or GAD-7 at baseline, as clinically indicated, and annual medical care visit.	8.1. Documentation of GAD-2 or GAD-7 score in the client chart.
9. Clients who score 3 or above on a General Anxiety Disorder (GAD)-2 are assessed by the GAD-7. Clients whose	9.1. Documentation of GAD-2 score in the client chart.

Standard	Measure
score on the GAD-7 is greater than 8 are referred to Behavioral Health services.	9.2. Documentation of GAD-7 score in the client chart. 9.3. Referral documented in the designated HIV HSSS.
10. Clients complete a Tobacco, Alcohol, Prescription Medication, other Substance Use Screening (TAPS) at baseline, as clinically indicated, and annual medical care visit.	10.1. Documentation of TAPS assessment score in the client chart.
11. Clients who indicate higher risk (2+) on the TAPS assessment are referred to Behavioral Health Services.	11.1. Documentation of TAPS score in the client chart. 11.2. Referral documented in the designated HIV HSSS.
12. Clients receive a one-time Abdominal Aortic Aneurysm (AAA) screening with ultrasonography for men 65 to 75 years of age who have ever smoked. Per USPSTF Guidelines	12.1. Documentation of AAA screening with ultrasonography in clients chart.
13. Clients who are Age 40 - 75 years when 10 year Atherosclerotic Cardiovascular Disease (ASCVD) risk estimate is <20% offer moderate intensity statin therapy.	13.1. Documentation of statin therapy in designated HIV HSSS.
14. Agency follow-up via phone with the clients referred to behavioral health services to remind them of their first scheduled appointment.	14.1. Documentation of referral follow up in the designated HIV HSSS.
15. 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.	15.1. Documentation of medical care and treatment plan in the client chart.
16. Clients are offered immunizations in accordance with HHS guidelines.	16.1. Documentation of immunizations in the client chart.
17. ART is prescribed as clinically indicated in accordance with HHS guidelines.	17.1. Documentation of prescribed ART in the client chart.
18. Treatment for opportunistic infections and prophylaxis for opportunistic infections is provided when clinically indicated in accordance with HHS OI guidelines.	18.1. Documentation of treatment in client chart.
19. Female clients receive cervical cancer screenings as clinically indicated. Clients	19.1. Documentation of screening and results in the client chart.

Standard	Measure
with an abnormal PAP test result or documented cervical lesion present receive a referral to a gynecologist. Providers follow guidelines for cervical cancer screening as stated in the National HIV Curriculum	19.2. Referral documented in the designated HIV HSSS.
20. 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.	20.1. Documentation of screening and results in the client chart. 20.2. Referral documented in the designated HIV HSSS.
21. Clients receive colon and rectal cancer screenings as clinically indicated.[7]	21.1. Documentation of screening and results in the client chart.
22. Clients receive lung cancer screenings as clinically indicated.[7]	22.1. Documentation of screening and results in the client chart.
23. Clients are assessed and counseled for medication adherence at every primary medical care visit.	23.1. Documentation of assessment and counseling provided in the client chart.
24. Clients with CD4 T-cell counts below 200 and/or CD4 percentage less than 14% are prescribed PJP prophylaxis as clinically indicated. [8]	24.1. Documentation of laboratory test results in the client chart. 24.2. Documentation of prescription in the client chart.
25. Women of pregnancy potential receive a pregnancy test at ART initiation and as clinically indicated be prescribed ART as clinically indicated. Women of pregnancy potential receive a sexual history screening following the five Ps (Partners, Practices, Protection from STIs, Past History of STIs, and Pregnancy Intention). Clients receive education about birth control methods.	25.1. Documentation of pregnancy screening in the client chart. 25.2. Documentation of ART prescription in the client chart. 25.3. Documentation of sexual history discussing the 5 Ps in the client chart. 25.4. Documentation about birth control methods is included in the client chart.
26. Clients receive sexual health education annually, including pregnancy planning, discussion of condom use, risk identification, and PrEP for partners.	26.1. Documentation of sexual health education in the client chart.
27. Clients are referred to oral health care at baseline and assessed for adherence with oral health recommendations.	27.1. Referral documented in the designated HIV HSSS.
28. Transgender-inclusive healthcare is provided, including:	28.1. Documentation of transgender-inclusive healthcare provided in the client chart.

[7] National HIV Curriculum. *Primary Care Management.* Accessible at National HIV Curriculum, Basic HIV Primary Care, Primary Care Management, Cancer Screening.
[8] National HIV Curriculum. *Opportunistic Infections: Treatment.* Accessible at https://www.hiv.uw.edu/page/qb/topic/co-occurring-conditions/opportunistic-infections-treatment

Standard	Measure
• Documentation of birth sex and self-reported gender. • Routine healthcare clinically appropriate for client' 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. • Pronouns • Preferred name • Legal changed name	

Table 3. IPCBH – Behavioral Health Standards for Service Delivery

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within 30 calendar days of the first encounter.	2.1. Completed biopsychosocial assessment signed by licensed professional in the designated HSSS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed professional and client in the designated HSSS.
4. Provider conducts a formal treatment plan review at least every six months.	4.1. Updated treatment plan with signature and date of licensed professional and client in the designated HSSS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the designated HSSS.
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the client file.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HSSS.

HANDOUT E

BROWARD COUNTY FLORIDA

Ryan White Part A

Administrative Update

Notice of Award

- The Ending the HIV Epidemic (EHE) Notice of Award is now posted.
- The Ryan White Part A (RWA) Notice of Award is expected to be posted soon.

Service Delivery Models

- All Service Delivery Models (SDMs) have been finalized, with the exception of the Universal Service Delivery Model.

- The Universal Service Delivery Model is not tied to any specific categories.

Part A Office RW RFP Timeline

- All RW RFP Documents Drafted - **June-July 2024**
- Quality Raters Identified **- July 2024**
- RFP Released - **August 2024**
- Applicant Interviews - **October 2024**
- Award Notices - **January 2025**

Listening Session

The Part A Recipient Office met this month
on to review feedback from the listening sessions

Next Steps:

- Second meeting scheduled the end of May to review final recommendations and engage consultants for input
- Part A Office will formally present a summarize responses and recommendation in June

Data Sharing Agreement

- A data sharing agreement between the Broward County EMA and the State of Florida has been established.

- Provide Enterprise (PE) received the sample file from the state this week, the Part A office will be reviewing the XML (Extensible Markup Language) file for data elements to incorporate into PE.

Questions?

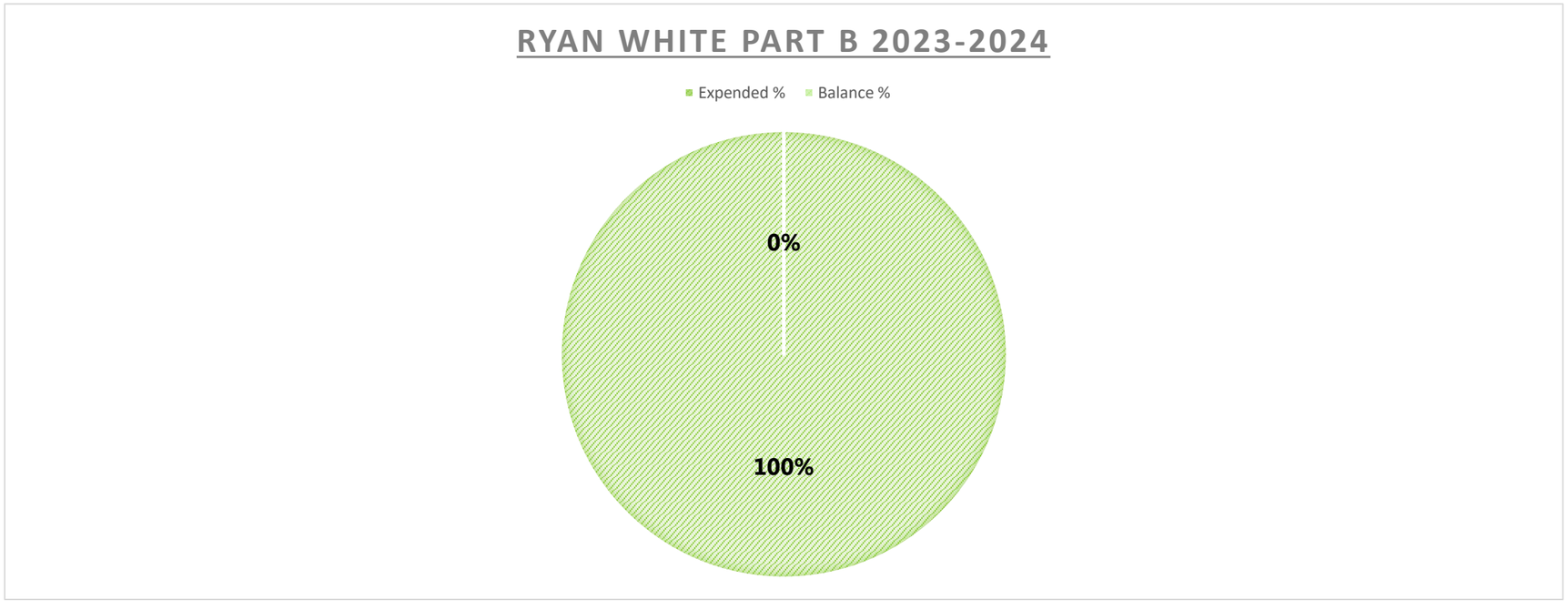
HANDOUT F

Ryan White Part B

PTC24: April 1, 2023 to March 31, 2024

Expenditures for March 2024

Service Category	Allocation	March 2024	Expended to Date	Expended %	Balance %	Balance
Administrative Services	$ 85,825	$ -	$ 85,825	100%	0%	**$ -**
Health Insurance Premium/Cost Sharing	$ 190,324	$ 26,954	$ 190,324	100%	0%	**$ -**
Home & Community Based Health	$ 7,240	$ 800	$ 7,240	100%	0%	**$ -**
Medical Nutritional Therapy	$ 23,324	$ 1,760	$ 23,324	100%	0%	**$ -**
Emergency Financial Assistance	$ 242,540	$ 20,987	$ 242,540	100%	0%	**$ -**
Home Delivered Meals	$ 2,000	$ -	$ 2,000	100%	0%	**$ -**
Medical Transportation	$ 95,476	$ 5,756	$ 95,476	100%	0%	**$ -**
Non-Medical Case Management	$ 346,770	$ 3,639	$ 346,770	100%	0%	**$ -**
Referral for Health Care/Support Services	$ 56,126	$ 11,586	$ 56,126	100%	0%	**$ -**
Residential Substance Abuse	$ 62,217	$ 9,082	$ 62,217	100%	0%	**$ -**
Clinical Quality Management	$ 48,512	$ -	$ 48,512	100%	0%	**$ 0.01**
Planning and Evaluation	$ 1,575	$ -	$ 1,575	100%	0%	**$ 0.01**
TOTALS	**$ 1,161,929**	**$ 80,564**	**$ 1,161,929**	**100%**	**0%**	**$ 0.02**



HANDOUT G

Ryan White Part D Report

Children's Diagnostic & Treatment Center (CDTC)

Comprehensive Family AIDS Program (CFAP)

- Total # of clients provided an HIV RWHAP support service- 1516
- Total Number of HIV Positive Individuals <u>enrolled in Program</u> - **601**
  - Total Number of HIV Exposed – Indeterminate Individuals between the ages of 0 - 24 months old **-57**
  - Total number of HIV Positive Individuals enrolled in Program break down-**Women-549 Children-7 Youth-45**
- HIV positive individuals **<u>enrolled in medical care at CDTC/Outside Provider</u>** – **601**

  (333 CDTC, 268 Outside provider) Over all Viral Suppression 88%
- HIV positive individuals who **<u>attended medical care</u>** as of **<u>1/1/2024- Current Date</u>** - **359**

- <u>New Referrals as of **1/1/2024- Current Date**</u>
  - Infants (HIV exposed) - 6
  - Children (3 – 11) - **0**
  - Adolescent (12 -24) – 2
  - Adult (25 +) - 9
  - **Total** – 17
- Total Pregnancies (previously known and new) – 27 (24 previously known/ 3new)

5/2/2024

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.

Revised 7/24/14

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.

Revised 7/24/14

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 priyorite 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 respektè 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 posesyon 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.

Acronym List

ACA: The Patient Protection and Affordable Care Act 2010

ADAP: AIDS Drugs Assistance Program

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BISS: Benefit Insurance Support Service

BMSM: Black Men Who Have Sex with Men

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CM: Case Management

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

DCM: Disease Case Management

DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
HAB: HIV/AIDS Bureau
HHS: U.S. Department of Health and Human Services
HICP: Health Insurance Continuation Program
HIV: Human Immunodeficiency Virus
HIVPC: Broward County HIV Planning Council
HMSM: Hispanic Men who have Sex with Men
HOPWA: Housing Opportunities for People with AIDS
HRSA: Health Resources and Service Administration
HUD: U.S Department of Housing and Urban Development
IW: Integrated Workgroup
IDU: Intravenous Drug User
JLP: Jail Linkage Program
LPAP: Local AIDS Pharmaceutical Assistance Program
MAI: Minority AIDS Initiative
MCDC: Membership/Council Development Committee
MCM: Medical Case Management
MH: Mental Health
MNT: Medical Nutrition Therapy
MOU: Memorandum of Understanding
MSM: Men Who Have Sex with Men
NBHD: North Broward Hospital District (Broward Health)
NGA: Notice of Grant Award
NHAS: National HIV/AIDS Strategy
NOFO: Notice of Funding Opportunity
nPEP: Non-Occupational Post Exposure Prophylaxis
NSU: Nova Southeastern University
OAHS: Outpatient Ambulatory Health Services
OHC: Oral Health Care
PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

PROACT: *Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH-Broward's treatment adherence program.*

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SA: Substance Abuse

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

Recipient: Government department designated to administer Ryan White Part A funds and monitor contracts.

Planning Council Support (PCS) Staff/'Staff': Provides professional staff support, meeting coordination, and information to the HIVPC, its standing and ad-Hoc Committees, Chair, and Recipient.

Clinical Quality Management (CQM) Support Staff: Provides professional support, meeting coordination, and technical assistance to assist the Recipient through analysis of performance measures and other data with the implementation of activities designed to improve patient care, health outcomes, and patient satisfaction throughout the system of care.

Provider/Sub-Recipient: Agencies contracted to provide HIV Core and Support services to consumers.

Consumer/Client/Patient: A person who is an eligible recipient of services under the Ryan White Act.