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

MAI Ad-Hoc Committee Meeting

Monday, January 6, 2025 - 2:00 – 4:00 PM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

Chair: Mark Schweizer • Vice Chair: Shawn Tinsley

Join the meeting now
https://teams.microsoft.com/l/meetup-join/19%3ameeting_Y2QzYmFkNTctYTEyYi00MTkyLWExYmYtOTgxNzU0YjU2MmRk%40thread.v2/0?context=%7b%22Tid%22%3a%220dd42165-bf27-4e00-9f50-1f4dff8a73f8%22%2c%22Oid%22%3a%22df400b73-e09f-4638-a7b6-0750be4ecb25%22%7d
Meeting ID: 249 748 306 813
Passcode: Zvw54u

This meeting is audio and video recorded.

Quorum for this meeting is 4

DRAFT AGENDA

ORDER OF BUSINESS

I. Call to Order/Establishment of Quorum
   a. Welcome from the Chair
   b. Meeting Ground Rules
   c. Statement of Sunshine
   d. Introductions & Abstentions
II. Moment of Silence
III. ACTION: Approval of the January 6, 2025, Agenda
IV. Public Comment
V. Discussion Items
   a. Action Item: Review and approve the statement of purpose and planned activities for the MAI Subcommittee **(Handout A)**
   b. Action Item: Review MAI data from the Part A Office **(Handout B)**
      i. The specific service categories funded by MAI, along with the corresponding allocation amounts for each.
      ii. A detailed breakdown of the continuum of care data on retention in care and viral suppression rates within the Black/African American population.
      iii. The data should be categorized by sex, sexual orientation, age, ethnicity, housing status, and other relevant factors.

c. Review MAI Service Delivery Models (**MAI Non-Medical Case Management & MAI Substance Abuse)** **(Handouts C1 and C2)**

VI. Unfinished Business

a. None.

VII. New Business

a. None

VIII. Recipient Report

IX. Public Comment

X. Agenda Items for Next Meeting

a. TBD

XI. Next Meeting Date: TBD, at 9:30 a.m. Location: BRHPC and via Microsoft Teams Video Conference

XII. Announcements

XIII. 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.

Broward County Board of County Commissioners
Mark D. Bogen • Lamar P. Fisher • Beam Furr • Steve Geller • Robert McKinzie• Nan H. Rich • Tim Ryan •Hazelle P. Rogers• Michael Udine Broward County Website

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

January 2025

Broward HIV Health Services Planning Council Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Please contact support staff at hivpc@brhpc.org or (954) 561-9681 ext. 1244/1343. Visit HIV Health Service Planning Council for updates.					
			1	2 System of Care Committee Meeting (SOC) 9:30AM – 11:30AM Location: BRHPC/MS Teams	3	4
5	6 MAI Sub-Committee Meeting 2:00PM– 4:00PM Location: BRHPC/MS Teams	7 Community Empowerment Committee Meeting (CEC) 3:00PM– 5:00PM Location: BRHPC/MS Teams	8 Oral Health 3:00PM-4:15PM	9 Membership/Council Development Meeting (MCDC) 9:30AM – 11:30PM Location: BRHPC/MS Teams Medical Provider 2:30PM-3:34PM In-person Workshop at BRHPC World AIDS Day Memorial Event for Past HIVPC Members	10	11
12	13	14 Behavioral Health 2:00PM-3:15PM	15	16 Priority Setting and Resource Allocation (PSRA) 9:30AM-12:30PM Location: BRHPC/MS Teams Executive Committee Meeting Location: BRHPC/MS Teams 12:45PM – 2:45PM	17	18
19	20 Martin Luther King Jr. Day	21 Quality Management Committee Meeting (QMC) 12:30PM– 2:30PM Location: BRHPC/MS Teams	22 Quality Network Meeting (CQM) 9:00AM-10:15AM	23 HIV Planning Council Meeting 9:30AM – 11:30AM Locations: BRHPC/MS Teams	24	25 GET CARE BROWARD TREAT HIV | BEAT HIV RYAN WHITE | PART A
26	27	28	29	30	21	

Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020
Links are active and lead to meetings or Awareness Day Information. **Information is subject to change.**

Meetings in **RED** are canceled. Meetings in **BLUE** are for the HIV Planning Council Committees. Meetings in **GREEN** are for the Provider Network.
Holidays and meetings outside of the HIV Planning Council are in **BLACK**.

Version 04/28/21 Information on this calendar is subject to change.

January 2025

Broward HIV Health Services Planning Council Calendar

All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Unless otherwise noted, meetings will be held via WebEx.
Please contact support staff at hivpc@brhpc.org or (954) 561-9681 ext. 1292 or 1343. Visit HIV Health Service Planning Council for updates.

TODOS ESTAN BIENVENIDOS!	ALL ARE WELCOME!	BON VINI!
A menos que se anote de forma diferente en el calendario, todas las reuniones se realizarán en: Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Para confirmar información acerca de la reunión de Consejo de Planeación HIV, o confirmar la reserva de servicios especiales tales como: Traducción Inglés a Español o a Criollo (Haitiano), servicios para discapacitados en visión o audición, por favor llame con 48 horas de antelación para que puedan hacerse los arreglos necesarios.	Unless otherwise noted on the calendar, all meetings are held at: Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 To confirm HIV Planning Council meeting information, or reserve special needs services such as Translation from English to Spanish or Creole, or are hearing or visually impaired, please call 48 hours in advance so that arrangements can be made for you.	Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fét: Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Pou konfime enfòmasyon ou resevwa sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyol; oswa, si ou gen pwoblèm wè oswa tande, rele 48 tè alavans pou yo ka fè aranjman pou ou.

HIVPC Committee Descriptions

HIV Health Services Planning Council (HIVPC) - Monitors, evaluates, and continuously improves systematically the quality and appropriateness of HIV care and ser- vices provided to all patients receiving Part A and MAI-funded services.

Executive Committee - Sets agenda for Council meetings, addresses conflict of interest issues, reviews attendance reports, oversees the planning activities established in the Comprehensive Plan, oversees committee work plans, reviews committee recommendations, ratifies recommendations for removal for cause, and addresses unresolved grievance issues.

Priority Setting Resource Allocation (PSRA) Committee - Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on 'how best to meet the need.

Quality Management Committee (QMC) - Ensures highest quality HIV medical care and support services for PLWHA by developing client and system-based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff/client training/education.

Membership/Council Development Committee (MCDC) - Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

Community Empowerment Committee (CEC) - Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes. Function as a primary level of appeal for unresolved grievances relative to the Council's decisions regarding Ryan White Part A funding.

System of Care (SOC) Committee - Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

Broward Ryan White HIV Health Services Planning Council: MAI SUBCOMMITTEE

October 29, 2024

Purpose: The MAI Subcommittee is dedicated to enhancing health outcomes for minority subpopulations that are disproportionately affected by HIV. To achieve this, MAI services must align with epidemiological data and clearly identify needs while ensuring cultural appropriateness. Additionally, effective service provision should utilize innovative, tailored approaches that specifically address the unique challenges faced by these communities. Ultimately, the MAI aims to achieve viral suppression among identified minority subpopulations, consistent with RWHAP Part A's broader objectives.

Committee Function and Actions Steps to Be Taken by the Committee

- Review existing survey results or conduct a survey of individuals living with HIV to gather insights into their experiences with healthcare services, identify barriers to care, and collect demographic data. To enhance response rates and encourage candid feedback, involve trained peer navigators in the process.

- Analyze the survey results by race and ethnicity to pinpoint which racial and ethnic groups face the most significant barriers to care. Additionally, extract relevant data from the last needs assessment, focusing on Black/African American populations to understand their specific challenges.

- Perform further analyses on the same survey data by defining subpopulations based on multiple characteristics such as race/ethnicity, age, gender, sexual orientation, and other locally relevant factors. Examples include African American Male to Male Sexual Contact (MMSC) under 30, limited English-proficient Latinx immigrants, recently incarcerated African American men, and African American women experiencing homelessness. Identify the subpopulations that encounter the greatest barriers and HIV-related disparities.

- Recommend conducting a specialized needs assessment to the System of Care Committee that may include focus groups, service utilization analysis, and reviews of Clinical Quality Management data, should the committee deem it necessary. This assessment should specifically target the subpopulations identified in previous steps to gain a deeper understanding of the barriers they face and explore potential strategies for overcoming these obstacles. Consider hosting or partnering with listening sessions with both community members and providers to gather insights on barriers to care and to discuss possible solutions

- Use the comprehensive findings from the assessments and listening sessions to inform the prioritization of MAI initiatives and resource allocation, ensuring that efforts are effectively directed toward addressing the unique needs of the most impacted communities.

Data Request MAI Subcomittee				
FY 24-25 Current Funding		**Notes**	[redacted]	
Ambulatory (IPCBH)	$0.00	No provider of this service currently		
Medical Case Management	$93,212.00			
Substance Abuse-Outpatient	$400,000.00			
Non-Medical Case Management (CIED)	$524,066.00	NMCM MAI is CIED		
Total	$1,017,278.00			
Total Demographical Data				
[redacted]	**Black Men**	**Black Women**	**Hispanic Men**	**Hispanic Women**
Total	2401	1763	1896	272
Retained in Care	79.40%	80.12%	82.00%	80.04%
Viral Suppression	86.40%	88.43%	93.30%	90.81%
Permanently Housed	72.76%	82.70%	79.96%	84.93%
Non-Permanently Housed	27.24%	17.30%	20.04%	15.07%
Medicare	18.30%	23.43%	10.55%	19.12%
Private Insurance	27.74%	27.68%	43.30%	38.97%
Uninsured	72.26%	71.36%	56.70%	61.03%

Data Notes: Data pulled from Care Continuum in PE. It should be noted this data is for the entire Care Continuum and not specific to MAI. Non-Permanently Housed does not necessarily mean street homeless.

HANDOUT C1

BROWARD COUNTY HUMAN SERVICES DEPARTMENT

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

RYAN WHITE PART A PROGRAM

Minority AIDS Initiative (MAI)

Non-Medical Case Management

Service Delivery Model

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I. Program Description / Service Definitions

The Health Resources and Services Administration's Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention of needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other services.

NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services include all case management encounters (e.g., face-to-face, telehealth, phone contact, and other communication forms). Key activities for this service category include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
  Ongoing assessment of the client's and other key family members' needs and personal support systems[1]

In Broward County, non-medical case management is defined as supporting clients' achievement of wellness and autonomy by facilitating their social service needs. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs, including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services).

The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care, and addressing any service needs.

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

[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.

Peer Counseling

Peer counseling is a required component of NMCM services. It is recommended that providers of NMCM services utilize at least 30% of all NMCM personnel funds provided under the Ryan White Part A program for Peer Counseling services.

Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the healthcare system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression
- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist the client in reducing barriers to meet action plan goals
- Facilitating peer counselor-led client support groups

II. Population of Focus

Individuals who are Broward County residents with HIV who earn less than or equal to 400% of the Federal Poverty Guidelines, are uninsured or under-insured, have barriers to economic stability, and have no other means or funding source to receive services.

In addition to the requirements listed for MAI funding, the eligibility requirements for clients must also include individuals who are of a racial or ethnic minority population disproportionately affected by HIV, as defined by HRSA.

- HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

Race / Ethnicity categories:

- Hispanic or Latino
- White (non-Hispanic)
- Black or African American (Non-Hispanic)
- Asian (non-Hispanic)
- American Indian or Alaska Native (Non-Hispanic)
- Native Hawaiian or Other Pacific Islander (Non-Hispanic)
- Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, the Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds underrepresented:

- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Other Pacific Islander

• Hispanic (all races)

III. Eligibility Criteria

Individuals must meet the following criteria to receive MAI Ryan White Part A Non-Medical Case Management services.

- Broward County Resident living with HIV / AIDS
- Less than or equal to 400% of the Federal Poverty Level
- Un-insured or underinsured or experiencing economic stability barriers
- Meet the Population of Focus criteria for MAI programs

IV. Documentation of Eligibility

The Client completes a benefits assessment with Centralized Intake and Eligibility Determination (CIED) to determine Ryan White Part A services and other third-party benefits. The benefits assessment is documented in the designated HIV Human Services Software System (HIV HSSS), and the Client receives a notice of eligibility to determine if they are eligible for NMCM services.

V. Key Service Components and Activities

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

All MAI-funded programs are expected to adhere to the above service standards.

VI. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's service needs, including a review of medical, financial, social, emotional, resources, and other needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV HSSS and include, at minimum, the following components:

- STI/HIV Health Literacy Assessment, including U=U (undetectable equals untransmittable), knowledge of HIV and STI testing, prevention, and treatment
- Barriers to accessing primary medical care, medication adherence, and other service needs
- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including mental health, oral health, nutritional therapy
- Education and guidance to support a successful transition to an Affordable Care Act (ACA) Insurance, Medicare, and Medicaid

- Support service needs, including advice and assistance in obtaining medical, social, community, legal assistance, finances/benefits, support groups, food bank, vocational, and transportation
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal Violence

Reassessment

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

For MAI programs, the reassessment must identify opportunities for improvement in access to care and disparities in health outcomes.

Relevant Areas of Concern

After completing the assessment or reassessment, the designated HIV HSSS generates a list of the client's "Relevant Areas of Concern." Providers must utilize this list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan

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

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

Case Management supervisors must review, sign, and date All completed action plans.

Progress Notes

Providers must maintain ongoing client monitoring and communication to ensure linkage to and retention of needed services. Providers must document the progress of the action plan, including the assistance provided and communication with clients in the designated HIV HSSS, including phone calls, mail, face-to-face, and electronic communication. Additionally, providers are responsible for checking and verifying lab reports (ensuring correct lab value entry, trending viral load, and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up.

On a monthly basis, Case Management supervisors must review a 5% sample of open client action plans to identify opportunities for improvement. To ensure a high quality of progress notes, NMCM must write effectively to include the following:

- Protected privacy of the client
- Detailed and organized notes documenting activities. All activities must be documented in the client file.
- Facts about your encounter with the client
- The purpose and clear observations of the client interaction
- Describe the next steps, including the purpose and/or goal for the next encounter

Action Plan Review

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

For MAI programs, the action plan must address potential barriers to access and reduce disparities in health outcomes.

VII. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV HSSS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
4. All client records/files will be neatly maintained and organized.	4.1. All client records will contain, at a minimum, the following documentation: brief intake, current notice of eligibility, confidentiality forms (if applicable), case

Standard	Measure
	closure (if applicable), and other documentation an agency deemed appropriate in the designated HIV HSSS. 4.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 4.3. Progress notes in the client file/designated HIV HSSS. 4.4. Confidentiality is released in the client file/designated HIV HSSS.
5. Case managers will participate in professional development activities for case management that focus on HIV/AIDS/STI updates and service delivery.	5.1. Case managers will receive, within 6 months of hire, the following required training: annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended training include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
6. Peer Counselors will participate in professional development activities focusing on HIV/AIDS/STI updates and service delivery.	6.1. Peer Counselors will receive, within 6 months of hire, the following required training: annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (501); code of ethics including cultural diversity and professional boundaries Additional recommended training include: peer counseling training,

Standard	Measure
	mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
7. Case Management supervisors review a 5% sample of open client action plans each month to identify opportunities for improvement.	7.1. Open action plans in the designated HIV HSSS. 7.2. Documentation of monthly reviews and identified opportunities for improvement.
8. Case Management supervisors review completed action plans.	8.1. Completed action plans signed and dated by the Case Management supervisor in the designated HIV HSSS.
9. Assistance provided to the client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	9.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV HSSS.
10. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	10.1. Closed cases include documentation stating the reason for closure and a closure summary. 10.2. Supervisor signs off on closure summary indicating approval. 10.3. Supervisor review is completed when the provider intends to terminate services related to a client who threatens, harasses, or harms staff. 10.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
11. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	11.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcome within each minority population and/or subpopulation.

VIII. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, Data Source, and Measure

Outcomes	Outcome Indicators	Data Source (Where the data used to complete the quarterly report is found, verified, and kept)	Measure (Who collects data, when, how; special calculation instructions, if needed)
1. Clients successfully adhere to action plan goals.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1. Client action plan in designated HIV Human Services Software System (HSSS). 1.2. MAI Annual Report.	Comparison of quarterly averages. **Calculation:** Clients receiving MAI – Non-Medical Case Management services whose closed action plan was successful and completed by the target date / The total number of Clients who received MAI – Non-Medical Case Management services and had at least one (1) action plan goal closed during the reporting period.
2. Clients are successfully linked to medical services to enable adherence and stability.	2.1. 80% of Clients are linked to medical care as documented by at least one medical visit, viral load, or CD4 test in the reporting period.	1.1. Client medical appointment scheduled in the designated HIV HSSS. 1.2. Client viral load test or CD4 test in the designated HIV HSSS. 1.3. MAI Annual Report.	Comparison of quarterly averages. **Calculation:** The total number of Clients who kept appointments in the designated HIV HSSS / The total number of Clients who had at least one non-medical Case Management encounter in the reporting period.

HANDOUT C2

BROWARD COUNTY HUMAN SERVICES DEPARTMENT

RYAN WHITE PART A PROGRAM

Minority AIDS Initiative (MAI)

Substance Use – Outpatient

Service Delivery Model

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I. Program Description / Service Definition

HRSA Definition[1]

Substance Use Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under the Substance Use Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder.
  - Outpatient drug-free treatment and counseling
  - Medication-assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

- Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds Substance Use – Outpatient services are medical or other treatment and/or counseling services provided to clients to address substance use disorders (SUDs) (i.e., recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or impairment in physical, social or occupational functioning). These services will be provided by appropriately credentialed and/or licensed treatment professionals. Substance Use – Outpatient services include psychological assessment and evaluation, drug testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments, outpatient day treatment, intensive day/night treatment, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate to improve adherence to treatment and improve client health outcomes.

[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. Population of Focus

Individuals who are Broward County residents with HIV who earn less than or equal to 400% of the Federal Poverty Guidelines, are uninsured or under-insured, have barriers to economic stability, and have no other means or funding source to receive services.

In addition to the requirements listed for MAI funding, the eligibility requirements for clients must also include individuals who are of a racial or ethnic minority population disproportionately affected by HIV, as defined by HRSA.

- HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

Race / Ethnicity categories:

• Hispanic or Latino
• White (non-Hispanic)
• Black or African American (Non-Hispanic)
• Asian (non-Hispanic)
• American Indian or Alaska Native (Non-Hispanic)
• Native Hawaiian or Other Pacific Islander (Non-Hispanic)
• Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, the Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds as underrepresented:

• American Indian or Alaska Native
• Black or African American
• Native Hawaiian or Other Pacific Islander
• Hispanic (all races)

III. Eligibility Criteria

Individuals must meet the following criteria to receive MAI Ryan White Part A Substance Use services.

- Broward County Resident living with HIV / AIDS
- Less than or equal to 400% of the Federal Poverty Level
- Un-insured or underinsured or experiencing economic stability barriers
- Meet the Population of Focus criteria for MAI programs

IV. Documentation of Eligibility

Notice of Eligibility from the Centralized Intake Eligibility Determination Office (CIED).

V. Key Service Components & Activities

In addition to the Substance Use – Outpatient Service Delivery Model (SDM), all providers must adhere to the minimum requirements outlined in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements outlined in the Broward County Human Services Department, Community Partnerships Division, Housing Options, Solutions and Supports Division, individual contracts, and applicable contract adjustments. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be licensed professionals or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, individual contracts, and applicable contract adjustments. Providers must refer to their individual contracts for service-specific client eligibility requirements. Providers of Substance Use – Outpatient services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

All MAI-funded programs are expected to adhere to the above service standards.

Outpatient Care

Outpatient Substance Use care treats, ameliorates negative symptoms from SUDs and restores effective functioning in persons diagnosed with substance-use dependency or addiction. Outpatient care is appropriate as an initial level of care for clients with less severe disorders, in the early stages of change (as a "step down" from more intensive services), or stable and ongoing monitoring or disease management. Outpatient care is provided for less than nine hours weekly.

Intensive Outpatient Services

Intensive outpatient services, which vary in intensity, provide essential addiction education and treatment to clients with SUDs. At a minimum, they provide a support system including medical, psychological, psychiatric, laboratory, and toxicology services within 24 hours via telehealth or within 72 hours in person. Intensive outpatient services are provided from 9 to 19 hours weekly.

Day Treatment

Day treatment services differ from intensive outpatient services in the intensity of clinical services that are directly provided. Day treatment is appropriate for clients who are living with unstable medical and psychiatric conditions. At a minimum, day treatment meets the same treatment goals as described in Intensive Outpatient Services, with psychiatric and other medical consultation services available within eight hours via telehealth or within 48 hours in person. Day treatment services must be continuously provided at a minimum from 9:00 a.m. until 10 p.m. during a single 24-hour period.

VI. Assessment and Treatment Plan

Assessment

During the first encounter with a client, the 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

[2] FLA. STAT. § 394.

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[3]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

Additional assessments may be completed when clinically indicated, as indicated in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

The assessment must identify opportunities for improvement in access to care and disparities in health outcomes for MAI programs.

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 in defining goals and documenting the progress and assistance provided. 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 the 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 the client is under 18 years of age)
- Dated signature of a licensed provider
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

[3] 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.

- Discharge criteria (individualized, measurable criteria that identify the client's readiness to transition to a new level of care or out of care)

For MAI programs, the treatment plan must address potential barriers to access and reduce disparities in health outcomes.

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. A licensed practitioner and the client must sign and date the treatment plan.

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 the aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if the client is under 18 years of age)
- Dated signature of a licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

VII. Standards for Service Delivery

Table 2. Substance Use – Outpatient Service Delivery Standards

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 a licensed practitioner in the designated HSSS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by a licensed practitioner 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 practitioner and client in the designated HSSS.

Standard	Measure
5. Assistance provided to the 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 toward treatment plan goals in the designated HSSS.
6. All client communication is documented in the client file and includes a date, length of time spent with the client, the person(s) included in the encounter, a summary of what was communicated, and the provider's signature.	6.1. Detailed documentation with provider signature of all client communication in the designated HSSS.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HSSS.
8. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	8.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcome within each minority population and/or subpopulation.

VIII. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, Data Source, and Measure

Outcomes	Indicators	Data Source	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary Substance Use diagnosis.	1.1. 85% of clients achieve treatment plan goals by the designated target date.	1.1.1. Client's Provide Enterprise Profile.	1.1.2. Treatment plan documented in designated Human Services Software System (HSSS). 1.1.3. Data obtained from the MAI Annual Report. **Calculation** *Numerator* – Clients in the denominator whose closed treatment plan goal was successful and completed by the target date. /

			Denominator: Clients who received MAI—Substance Use services during the reporting period and had at least one (1) treatment plan goal closed during the reporting period. **Numerator Divided by the Denominator multiplied by 100 = Percentage Attained.**

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.