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

MAI Ad-Hoc Committee Meeting

Wednesday, November 12, 2025 - 2:00 PM to 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
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 November 12, 2025, Agenda
IV. ACTION: Approval of October 10, 2025, Minutes **(Handout A)**
V. Public Comment
VI. Discussion Items
VII. Old Business: None
VIII. New Business
   a. **Discussion**: Final Findings and Recommendations. **(Handout B)**
IX. Recipient Report
X. Public Comment
XI. Agenda Items for Next Meeting: Committee Dissolved.
XII. Next Meeting Date: Committee Dissolved.
XIII. Announcements
XIV. 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.

November 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	3	4 **Community Empowerment Committee Meeting (CEC)** **3:00PM– 5:00PM** **Location: BRHPC/MS Teams**	5	6 **System of Care Committee Meeting (SOC)** **9:30AM – 11:30AM** **Location: BRHPC/MS Teams**	7 **Medical Case Management Network Meeting (CQM)** **2:30PM-4:30PM**	8
9	10	11  **BRHPC Office Closed**	12 **Minority AIDS Initiative Subcommittee Meeting** **2:00PM – 4:00PM** **Locations: BRHPC/MS Teams**	13 **Oral Health Network Meeting (CQM)** **3:00PM-4:15PM**	14	15
16	17 **Quality Management Meeting (QMC)** **12:30PM– 2:30PM** **Location: BRHPC/MS Teams**	18	19	20 **Priority Setting and Resource Allocation Committee Meeting** **9:30AM – 11:30AM** **Location: BRHPC/MS Teams** **Executive Committee Meeting** **12:45PM – 2:45PM** **Location: BRHPC/MS Teams**	21	22
23	24	25	26	27  **BRHPC Office Closed**	28  **BRHPC Office Closed**	29
30 **CAN Community Health World AIDS Day Concert Las Olas Oceanside Park, Ft. Lauderdale 6:00 PM – 9:00 PM**						

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**.

November 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 living with and affected by 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.

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

MAI Ad-Hoc Committee

Friday, October 10, 2025 - 2:00 PM
LOCATION: Broward Regional Health Planning Council Meeting via Microsoft Teams
Chair: Dr. Mark Schweizer • Vice Chair: S. Tinsley
Join the meeting via phone: +1 469-998-5921 US Toll (access code: 378 156 152)

This meeting is audio and video recorded.

DRAFT MINUTES

MAI Members Present: K. Hayes, M. Schweizer, S. Tinsley, A. Machado

Members Absent: B. Mester, J. Rodriguez (excused)

Ryan White Part A Recipient Staff Present: G. James, T. Thompson, B. Spaulding

Planning Council & CQM Support Staff Present: G. Berkley, M. Lacroix, S. Isidore, D. Liao, J. Beal

Guests Present: A. Bader, C. Montana, O. Desinor, B. Horton, M. Martin, A. Mena, M. Perez, C. Dennis, C. Gilbert, M. Portien, D. James, G. Guerra, B. Barnes, J. Taylor, J. Shirley, M. Anyan, A. Occelien, H. Bahi, T. Pietrogallo, M. Hanni

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

The MAI Chair called the meeting to order at **2:09 P.M.** The MAI Chair welcomed all meeting attendees who were present. Attendees were notified that the MAI meeting is based on Florida's "Government-in-the-Sunshine Law and meeting reporting requirements, including recording minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by the MAI Chair, Committee members, Recipient staff, PCS & CQM staff, and guests by roll call, and a moment of silence was observed.

1. 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.

   There were no public comments.

2. Meeting Approvals

   The approval for the agenda of the October 10, 2025 MAI Ad-Hoc Committee meeting was proposed by **S. Tinsley,** seconded by **K. Hayes** and passed unanimously.

Motion #1: S. Tinsley, on behalf of the MAI Ad-Hoc Committee, made a motion to approve the October 10, 2025, MAI Ad-Hoc Committee agenda as presented. The motion was seconded by K. Hayes and adopted unanimously.

The approval of the minutes of the July 9, 2025, meeting was proposed by **S. Tinsley,** seconded by **K. Hayes** and approved with no further corrections.

Motion #2: S. Tinsley, on behalf of the MAI Ad-Hoc Committee, made a motion to approve the July 9, 2025, MAI Ad-Hoc Committee minutes as presented. The motion was seconded by K. Hayes and adopted unanimously.

3. Standard Committee Item

   None.

4. Discussion Items

   None.

5. Unfinished Business

   None.

6. Old Business
   None.
7. New Business

   a. **Discussion**: Strengths and weaknesses of the Minority AIDS Initiative from perspective of Case Managers, Disease Intervention Specialists, CIED Champions, and Peer Navigators.

      The primary discussion focused on the strengths and weaknesses of the Minority AIDS Initiative from the perspective of case managers, peers, and outreach specialists. The group began by examining strategies for engaging newly diagnosed clients in care, particularly during Test and Treat appointments.

      One impactful example shared involved a client who had recently been released from prison and was successfully linked to care through a rapid response and wraparound services approach at Poverello. The team provided immediate medication access, clothing, food, and support services, helping the client reenter the community with confidence and stability.

      Members emphasized the importance of team-based care involving peers, case managers, and clinicians and highlighted “wraparound” models as essential to meeting clients’ holistic needs. C. Dennis of Care Resource discussed her agency’s use of the PREPARE assessment tool, which evaluates social determinants of health to identify client barriers and guides individualized interventions. M. Schweizer requested that the tool be shared with the committee for broader review.

      The committee then discussed factors contributing to client disengagement. A. Bader, J. Taylor, and C. Dennis cited homelessness, substance use, mental health challenges, stigma, and transportation barriers as persistent issues. B. Horton noted that emotional distress following an HIV diagnosis (particularly among older clients) often leads to withdrawal from care. In contrast, younger clients tend to demonstrate greater resilience. M. Perez explained that at Care Resource, newly diagnosed clients are supported by M.

Hanni, the Linkage Coordinator, who personally escorts clients through labs, eligibility screenings, and medical appointments to ensure they feel accompanied throughout the process. Members agreed that this “hand-holding” approach helps build trust and improves retention.

Housing insecurity emerged as one of the most urgent systemic barriers to engagement. Participants, including G. Berkeley and S. Tinsley, discussed the limited availability of housing resources, despite partnerships with programs such as OPRA and AARP. Some agencies, including Poverello, have offered their parking lots as safe overnight spaces for clients living in vehicles. The committee agreed that creating a shared inter-agency resource list could improve access to housing, food, and supportive services.

Discussion also focused on outreach and re-engagement. C. Dennis and J. Castillo emphasized the use of PROACT referrals when clients fall out of care, which is a required follow-up protocol. Agencies reported conducting home visits and wellness checks before initiating these referrals.

Participants discussed growing fears among immigrant populations due to the current political climate, with several members noting that clients have expressed concerns about deportation and safety. To address this, providers are using telehealth visits, medication delivery services, and private intake rooms to protect confidentiality. Care Resource also distributes “Know Your Rights” palm cards to reassure clients of their legal protections.

The conversation then shifted to peer support and client empowerment. C. Gilbert of Care Resource emphasized patience, empathy, and empowerment as vital to building trust with clients and reducing dependency. M. Hanni shared his experience working with clients over time, noting that even small milestones, such as returning for care sooner than before, should be celebrated as progress.

T. Pietrogallo highlighted the importance of visible peer diversity, explaining that seeing long-term survivors in care encourages newly diagnosed clients to envision a healthy future. B. Horton shared a creative practice used by her team, where origami paper cranes are given to clients to commemorate personal achievements, fostering connection and encouragement. Participants also discussed the importance of staff support and the positive impact of small gestures such as remembering birthdays and acknowledging client milestones.

Eligibility and funding coordination were also addressed. Several case managers expressed confusion between Ryan White Part A and Ending the HIV Epidemic (EHE) eligibility requirements, particularly concerning food bank services. T. Thompson confirmed that updates are underway to align eligibility systems and clarify service distinctions. Members emphasized the need for clearer communication to prevent client frustration and reduce duplication of services.

In closing, the committee outlined next steps and recommendations. Members agreed to develop an updated shared resource list focused on housing, food, mental health, and immigration stressors. The group also recommended continued collaboration with PROACT and a follow-up invitation to Disease Intervention Specialists, who were unable to attend this meeting. Finally, members discussed revisiting MAI service models during future grant cycles to strengthen care coordination and client-centered flexibility. M.

Schweizer concluded by thanking all participants for their insight, dedication, and commitment to improving client engagement and retention in HIV care.

8. Recipient's Report

T. Thompson reported that the Recipient Office will send out an email on Monday regarding changes to PE in the coming weeks. Accounts will be deactivated if not used in 90 days due to the expense accrued from keeping them active. Accounts may be reactivated upon request.

9. 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 raise other matters about HIV/AIDS services in Broward County.

There were no public comments.

10. Agenda Items for Next Meeting
    a. To Be Determined

Next Meeting Date: To be determined. PCS staff will send a Doodle poll to schedule the date of the next meeting.

B. Barnes brought up the need for this committee to establish a timeline and goal-setting for next year. The Chair also included plans to review SDMs for currently-funded MAI service categories and a formal workplan. T. Thompson recommended creating a poll of potential agenda items.

B. Horton mentioned the limited legal aid available to clients and emphasized the importance of access through legal aid for folk dealing with immigration stressors and those coming out of the criminal justice system. B. Barnes also noted that PWH are being released from incarceration without medication or prescriptions.

11. Announcements
    - PCS Staff: Listening Tour Session #3. Gilda's Club South Florida, October 20, 2025 from 4:30 PM to 7:30 PM.

12. Adjournment

There being no further business, the meeting was adjourned at **4:13 P.M.**

MAI Sub-Committee Attendance for CY 2025

Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
		Meeting Date	6	13			13		9	13		10			
1	**1**	Kendra Hayes	X	X			X		X	A		X			
0	**2**	Joshua Rodriguez	X	X			X		X	X		E			
2	**3**	Alondra Machado	E	A			A		E	X		X			
0	**4**	Mark Schweizer **(Chair)**	X	X			X		E	E		X			
0	**5**	Shawn Tinsley **(Vice-Chair)**	X	E			X		X	X		X			
2	**6**	Brad Mester	A	X			X		X	X		A			
		Quorum = 4	4	4			5		4	4		4			

Legend:

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

MAI Ad-Hoc Committee Meeting Minutes – October 10, 2025
Minutes prepared by PCS Staff.

Broward Ryan White HIV Health Services Planning Council Minority AIDS Initiative (MAI) Subcommittee Summary Report September 2024 – October 2025

Purpose of the MAI Subcommittee

The MAI Subcommittee is committed to improving health outcomes among minority subpopulations disproportionately impacted by HIV. Achieving this requires that MAI services are informed by epidemiological data, clearly articulate specific needs, and maintain cultural competence. Effective service delivery should incorporate innovative, targeted strategies designed to address the unique challenges confronting these communities. The overarching goal of the MAI is to realize viral suppression within identified minority subpopulations, in alignment with the broader objectives of RWHAP Part A. *(Approved by Subcommittee January 2025)*.

Subcommittee Function and Action Steps

- Examine results by race, ethnicity, and additional factors to determine which populations—particularly Black/African American groups—experience the greatest challenges.
- Undertake further analyses of subpopulations (e.g., by age, gender, sexual orientation) to identify specific disparities.
- Propose a targeted needs assessment incorporating focus groups, service data, and CQM reviews; also consider organizing listening sessions with both community stakeholders and service providers.
- Utilize these insights to inform MAI priorities and ensure resource allocation aligns with those communities most impacted.

01 – MAI Resource (September 2024)

Purpose: With the recent formation of the MAI Subcommittee, Planning Council Support (PCS) staff identified relevant resources to guide the development of the subcommittee's focus and objectives. One such document, *"Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations"* (EGM Consulting, LLC, n.d.), provides information on the MAI program's aims, background, funding mechanisms, targeted populations, and permissible service categories.

Findings: The subcommittee evaluated this resource to inform its organizational framework, establish objectives, and determine subsequent steps to advance the subcommittee's mission.

02 – MAI Definition (October 2024)

Purpose: As the subcommittee progressed, PCS staff presented the "_U.S. Department of Health and Human Services Notice of Funding Opportunity_" (HRSA, n.d.), which offers comprehensive guidance for federal planning and reporting. This resource is designed to facilitate optimal allocation of MAI funds to address HIV care disparities among racial and ethnic minority groups.

Findings: The subcommittee utilized this material to clarify its mandate and formulate actionable strategies.

03 – MAI Subcommittee Purpose and Action Steps (October 2024)

Purpose: Drawing from the resources *"Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations"* and the *"U.S. Department of Health and Human Services Notice of Funding Opportunity,"* along with member discussions and feedback, the subcommittee finalized its purpose and defined its core functions and action steps.

Findings: The subcommittee officially finalized its Purpose and Action Steps.

04 – MAI Non-Medical Case Management Service Delivery Model (October 2024)

Purpose: The subcommittee reviewed the current MAI Service Delivery Model (SDM) for Non-Medical Case Management (Broward County Human Services Department, 2024). The SDM outlines service definitions, populations of focus, eligibility criteria, key components, and activities, guiding how services should be delivered.

Findings: The Recipient Office recommended that the subcommittee become familiar with the SDMs and prepare feedback for the upcoming review later this year.

05 – MAI Substance Use Service Delivery Model (October 2024)

Purpose: The subcommittee reviewed the current MAI SDM for Substance Abuse (Broward County Human Services Department, 2024). The SDM outlines service definitions, populations of focus, eligibility criteria, key components, and activities, guiding how services should be delivered.

Findings: The Recipient Office **recommended** that the subcommittee review the SDMs and get ready to provide feedback at the upcoming review later this year.

06 – MAI Report (February 2025)

Purpose: The Subcommittee requested a review of demographic data for populations of focus, including Black MSM under 30 and Non-Hispanic, Hispanic, African American, Black, and Haitian women. The analysis also included comparison data between MAI and Part A outcomes, new-to-care clients under MAI, and a breakdown by service category.

Findings: The Subcommittee examined demographic and outcome data for key populations, including Black MSM under 30 as well as Non-Hispanic, Hispanic, African American, Black, and Haitian women. Their analysis compared MAI and Part A outcomes, identified clients who were new to care through MAI, and categorized results by service type. The data indicates that **297 clients are currently accessing MAI services outside of CIED**. Black clients made up the largest group (4,050 individuals) but had lower viral suppression rates (82.22%) and retention in care (82.59%) compared to other demographics. Among

subgroups, Haitians had the lowest retention in care (75.93%) and slightly lower viral suppression (86.02%) than Hispanic clients, who achieved the highest rates for viral suppression (87.54%), retention (87.45%), and private insurance coverage (46.25%). Additionally, client engagement with MAI services may be limited due to there being only two MAI providers available in FY 2024-2025.

Note: MAI providers increased from two to six in FY2025-2026.

07 – MAI Data Presentation (May 2025)

Purpose: The MAI Subcommittee requested data that includes care continuum data year to date breakdown. The data presentation classified clients by race/ethnicity, sex, and age across the care continuum, enabling the subcommittee to determine vulnerable groups who needed specialized interventions.

Findings: The data covered three agencies with about 5,632 clients for Fiscal Year 2024, focusing on viral suppression and retention in care. It was noted that CIED's use of MAI funds prior to its use of RWPA funds may skew viral suppression rates.

The results showed that the Hispanic/Latino population had higher viral suppression rates, while the Black, African American, and Haitian populations had challenges with adherence and viral suppression. Haitian clients were the most likely to be retained in care, followed by Hispanic/Latino clients, while Black/African American clients were the least likely to be retained in care. Men were more likely to be virally suppressed and retained in care than women. Viral suppression and retention in care rates did not show consistent patterns.

08 – Needs Assessment and HIV Care Continuum Presentation (May 2025)

Purpose: (1) To assess the various services offered by the Broward Ryan White Part A EMA and measure/learn how well the services enhance the ability of clients to become sustainably virally suppressed. (2) Continue with the HIV Care Continuum data presentation with a focus on viral suppression and retention in care.

Findings: (1) The Needs Assessment consisted of client focus groups, subrecipient Medical Case Management and Peer job descriptions, MCM and Medical Provider-focused Needs Assessment activities, and interviews with collaborative community partners and programs. The presentation offered recommendations to improve health outcomes for clients and increase client satisfaction. These include establishing a measurable understanding of trauma; implementation of "walk-in" HIV care and "on-demand" HIV telehealth services; and partnering with non-RW providers and unconventional entities to raise awareness.

(2) During FY2024–2025, the overall MAI program served a total of 5,632 clients, with 89.6% achieving viral suppression and 9.7% remaining unsuppressed. When examining outcomes by ethnicity, both Black/African American and Haitian clients reported viral suppression rates of 89%, while Hispanic Latino/a clients demonstrated the highest rate at 94%. Gender disparities were evident, as Black females

recorded the lowest viral suppression at 88%, coupled with the lowest retention in care at 76%. Across age groups, Hispanic Latino/a clients consistently showed the highest engagement, whereas Black/African American clients exhibited slightly lower viral suppression among younger adults aged 18–28, at 83%, and the lowest retention at 78%.

09 – MAI Data Request (July 2025)

Purpose: To examine the operational structures of Ryan White HIV/AIDS MAI programs in different Eligible Metropolitan Areas (EMAs) throughout the United States.

Findings: The presentation outlined the various funded services provided across five Eligible Metropolitan Areas (EMAs): Broward County, Florida; Orange County, Florida; Fulton County, Georgia; Palm Beach County, Florida; and Miami-Dade County, Florida. The Recipient presenter noted that, due to its "_very large and diverse_" population, the Fulton County EMA must employ a strategic approach in how its subrecipients deliver services.

The Recipient Office recommended: Broadening efforts by training subrecipients to reach target populations and strengthen capacity; assessing staff fit for the communities served; evaluating health related social needs like housing, food security, and immigration-related stressors; and creating actionable plans to reduce health disparities.

10 – MAI Data Request 1 (August 2025)

Purpose: To analyze a sample size of 15 clients and discuss the correlation of their viral suppression, health outcomes, and Ryan White Part A services utilized.

Findings: Findings showed recurring issues with clients cycling in and out of care, often linked to expired eligibility, relocation, incarceration, or loss of contact. This led to the clients not renewing eligibility or missing appointments. Frequent repeat clients in the test-and-treat program were noted as a key issue. Some clients continued accessing EHE services despite being inactive under Part A.

Follow-Up: The Broward County, Florida Department of Health (FDOH) conducted an additional review of the 15-client sample and updated their statuses. This review revealed that some clients previously identified as out of care had either moved to a different jurisdiction or were referred to other services by Disease Intervention Specialists (DIS).This interaction underscores the importance of periodic reviews of PE data between RW and DOH to ensure client notes remain accurate and up to date.

11 – MAI Data Request 2 (August 2025)

Purpose: Compare and contrast various service categories to identify and address service gaps for clients within the Broward EMA. The data presented examines the distinctions among the Part A, MAI (Minority AIDS Initiative), and EHE (Ending the HIV Epidemic) funding streams.

Findings: The MAI program shares most service categories with Part A but is designed to specifically serve underserved racial and ethnic minority populations, such as Black non-Hispanic, Hispanic/Latino,

and Haitian communities. In contrast, EHE provides additional support through the funding of medical transportation and housing services.

12 – Case Manager and Peer Specialist Discussion (October 2025)

Purpose: To enable Case Managers, Peers, Disease Intervention Specialists (DIS), and CIED Champions or professionals receiving MAI funding to share their perspectives on MAI services, pose relevant questions, identify potential gaps, and provide observations regarding the program and their respective roles.

Findings: Attendees underscored the significance of team-based care encompassing peers, case managers, and clinicians, and identified "wrap-around" models as integral to addressing clients' comprehensive needs. Several case managers noted ambiguity regarding Ryan White Part A and Ending the HIV Epidemic (EHE) eligibility requirements, particularly in reference to food bank services. Members highlighted the necessity for enhanced communication to mitigate client frustration and minimize service duplication.

The Subcommittee agreed to create an updated, shared resource list concentrating on housing, food, mental health, and immigration-related stressors. The group further advocated for ongoing collaboration with PROACT and proposed extending another invitation to Disease Intervention Specialists, who were unable to participate in this meeting. Additionally, members suggested revisiting MAI service models in future grant cycles to improve care coordination and introduce greater flexibility centered on client needs.

Executive Summary

Minority AIDS Initiative (MAI) Subcommittee – Broward County Ryan White Part A

Reporting Period: September 2024 – October 2025

The MAI Subcommittee was established to address persistent disparities in HIV care among racial and ethnic minority populations in Broward County. This executive summary outlines key findings and strategic recommendations based on a year-long review of service models, demographic data, and stakeholder feedback.

Summary of Key Findings

- The MAI program served 5,632 clients in FY2024–2025; 89.6% were virally suppressed, 9.7% unsuppressed.
- Suppression rates: Black/African American and Haitian—89%; Hispanic Latino/a—94% (highest).
- Black females had the lowest suppression (88%) and retention (76%).

Age Trends: Hispanic Latino/a clients demonstrated the highest levels of engagement across all age groups. Black/African American clients experienced lower viral suppression rates among younger adults (ages 18–28), at **83%**, with retention at **78%**.

Provider Network Limitations: Engagement was impacted by a limited number of MAI-funded providers; the network expanded from **2 to 6 providers** in FY2025–2026.

Service Confusion: Case managers indicated challenges distinguishing between Ryan White Part A and EHE services, particularly regarding food bank eligibility.

Continuity of Care Barriers: Clients often transition in and out of care due to expired eligibility, relocation, incarceration, or loss of contact.

Culturally Responsive Care: Analysis of quantitative data and focus group input highlights the ongoing need for trauma-informed and culturally specific interventions.

Recommendations to the PSRA Committee

1. **Increase Provider Capacity and Accessibility**
   1.1 Expand the number of providers funded by MAI and introduce or grow mobile and telehealth options.
2. **Focus on High-Need Populations**
   2.1 Target interventions for Black MSM under 30, Haitian women, and other groups with low viral suppression rates.
   2.2 Create peer-led navigation and support services.
3. **Enhance Data Usage**
   3.1 Perform regular analyses of subgroups to inform resource distribution.
   3.2 Track health-related social needs and assess how they affect care results.

3.3 Conduct periodic reviews of PE data between RW and FDOH to ensure client notes remain accurate and up to date.

4. **Strengthen Eligibility and Re-engagement Efforts**
   4.1 Use automated reminders and allow more flexible processes for re-entering care.
   4.2 Collaborate with correctional facilities and transitional housing organizations.
5. **Improve Communication and Coordination**
   5.1 Create a resource guide that can be shared among providers and clients. (This has been completed by the RW Part A Recipient.)
   5.2 Offer staff training on RW services and referral protocols.
6. **Innovate Service Delivery**
   6.1 Launch pilot programs that are based on "walk-in" and "on-demand" HIV care models.
   6.2 Work with non-traditional partners to boost outreach and education efforts.
7. **Enhance Subrecipient Capabilities**
   7.1 Provide cultural competency and population-focused training.
   7.2 Match staffing profiles to the demographics of those being served.

Conclusions and Recommendations

During the reporting period, the MAI Subcommittee's activities reflect both advancement and ongoing challenges in mitigating HIV care disparities among minority populations in Broward County. Although overall viral suppression rates are commendably high at nearly 90%, notable disparities remain among Black/African American clients—particularly younger adults and women—who exhibit lower rates of suppression and retention relative to other demographic groups. Hispanic Latino/a clients consistently achieve superior engagement and health outcomes, illustrating the effectiveness of culturally tailored interventions.

Future priorities must include enhancing provider capacity, optimizing care coordination, and adopting innovative service delivery models such as mobile and telehealth solutions. In addition, addressing health-related social needs and reinforcing culturally responsive strategies will be essential to promote equitable access and sustained engagement for all populations.

References

Broward County Human Services Department. (2024). *MAI Non-Medical Case Management Service Delivery Model*. MAI Non-MCM SDM - HIV Health Service Planning Council

Broward County Human Services Department. (2024b). *MAI Substance use – Outpatient Service Delivery Model*. MAI Substance Use SDM - HIV Health Service Planning Council

EGM Consulting, LLC. (n.d.). Using MAI funds effectively: tailoring services for locally identified subpopulations. *Developed by EGM Consulting, LLC for Planning CHATT*. https://targethiv.org/sites/default/files/media/documents/2023-05/MAI%20Resource-2023%20Final%20designed_508.pdf

U.S. Department of Health and Human Services, Woodland, C. A., & Division of Metropolitan HIV/AIDS Programs. (2024, July 3). *NOTICE OF FUNDING OPPORTUNITY* [Press-release]. U.S. Department of Health and Human Services. HRSA-25-054 (HAB) RWHAP Part A ERGP_v2 for OA review TRACKED

Health Insurance Premium Assistance Program

ACA Insurance Open Enrollment

November 1st – December 15th

for Coverage beginning 1/1

December 16th – January 15th

for Coverage beginning 2/1

Step #1: Enroll In an APPROVED Health Insurance Plan (required)

For assistance with enrolling in Insurance: call 1-844-441-4422 or visit: https://enroll.brhpc.org

Step #2: Enroll In Premium Assistance @ Enroll.BRHPC.org (required)

- Clients MUST directly enroll in the premium assistance program every year at https://enroll.brhpc.org or by calling 1-844-441-4422. Anyone who has not directly enrolled in the program will be disenrolled for 2026 and NO future payments will be made.
- If you are enrolled in BlueOptions Platinum (24J01-05, -08, or -21S) or Silver (24J01-03 or -19S), you MUST choose a NEW PLAN for 2026 to continue receiving premium assistance.

Step #3: Use *CVS Copay Card When You Fill A Prescription (required)*

For medication copayment assistance, the call Pharmacy Help Desk at 1-800-364-6331

Step #4: *Recertify Eligibility Annually & Don't Let It Expire (required)*

If your eligibility expires, your premium payments will no longer be made by the program.
For State of Florida Drug Assistance Program eligibility assistance, call 1-844-381-2327.

BRHPC

For premium assistance program enrollment or payment questions, contact: Broward Regional Health Planning Council or our enrollment partner, American Exchange at **1-844-441-4422.**

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

ADAP: AIDS Drugs Assistance Program

Administration HUD: U.S Department of Housing and Urban Development

IW: Integrated Workgroup

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

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

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

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

HIV HSSS: HIV Human Services Software System

HIVPC: Broward County HIV Health Services Planning Council

HOPWA: Housing Opportunities for People with AIDS

HRSA: Health Resources Services Administration

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

NBHD: North Broward Hospital District (Broward Health)

NGA: Notice of Grant Award

NHAS: National HIV/AIDS Strategy

NMCM: Non-Medical Case Management

NOFO: Notice of Funding Opportunity

nPEP: Non-Occupational Post Exposure Prophylaxis

NSU: Nova Southeastern University

nPEP: Non-occupational Post-Exposure Prophylaxis

OAHS: Outpatient Ambulatory Health Services

OHC: Oral Health Care

PCN: Policy Clarification Notic

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

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

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.