Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / www.BRHPC.org

MEETING AGENDA

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Wednesday, July 20, 2016, 12:30 p.m.
Location: Governmental Center Room A-337
Chair: Carla Taylor-Bennett **Vice Chair:** Rick Siclari

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 7/20/16 Agenda and 6/15/16 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
   a. Monthly Expenditure/Utilization Report by Category of Service
4. **UNFINISHED BUSINESS**
5. **MEETING ACTIVITIES**

Goal/Work Plan Objective #:	*Accomplishments*
Review PSRA Data (Handout A-B)	ACTION ITEM: Review relevant data to the PSRA process. Determine how the data relates to the PSRA process and how it can be used in the FY17-18 PSRA process.
Allocations	ACTION ITEM: Allocate Part A & MAI funds by service category.

6. **SUBCOMMITTEE REPORTS**
   None.
7. **GRANTEE REPORTS**
8. **PUBLIC COMMENT**
9. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** TBD **Venue:** A-337

Goal/Work Plan Objective #:	*Accomplishments*

10. **ANNOUNCEMENTS**
11. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

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

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

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MEETING MINUTES

Committee: Priority Setting & Resource Allocation (PSRA)

Date/Time: Wednesday, June 15, 2016, 1:00 p.m. **Location:** Governmental Center Room GC-302

Chair: Carla Taylor-Bennett **Vice Chair:** Rick Siclari

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	Bell, J.	**X**			King, J.
2	DeSantis, M.	**X**			Velez, R.
3	Gammell, B.	**X**			Anderson, S.
4	Grant, C.	**X**			**Grantee Staff**
5	Hayes, M.	**X**			Card, W.
6	Katz, H. B.	**X**			Jones, L.
7	Lopes, R.	**X**			Green, W.
8	Reed, Y.	**X**			Degraffenreidt, S.
9	Schickowski, K.	**X**			**HIVPC Staff**
10	Shamer, D.		**A**		Johnson, B.
11	Siclari, R., *Vice Chair*		**A**		Ewart, L.
12	Taylor-Bennett, C., *Chair*	**X**			Newton, A.
	Quorum = 7	**10**			

1. CALL TO ORDER:

The Chair called the meeting to order at 1:00 p.m. The Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIVPC staff self-introductions were made.

2. APPROVALS:

Motion #1: To approve today's meeting agenda
Proposed by: Reed, Y. **Seconded by:** Katz, H.B.
Action: Passed Unanimously

Motion #2: To approve meeting minutes from 5/25/16
Proposed by: Katz, H.B. **Seconded by:** Lopes, R.
Action: Passed Unanimously

3. STANDARD COMMITTEE ITEMS:

None.

4. UNFINISHED BUSINESS:

None.

5. NEW BUSINESS

a. Needs, Gaps and Barriers (Handout B): The PSRA Chair spoke about past meetings writing how best to meet the need language. The Committee reviewed a document identifying the needs, barriers and gaps identified in the Broward Part A system of care. The information comes from past needs assessments, focus groups, QI provider networks, and identifies recurring themes. Many of the topics included in the document were also addressed in the 1st community feedback session hosted at the Latinos En Accion meeting earlier that day, including housing and transportation. The PC Manager reviewed the data, strengths, limitations and How Best to Meet the Need (HBTMTN) recommended

language for each need, gap or barrier. The Chair reminded the members that the HBTMTN is a directive sent to the Grantee for purposes of RFPs and contracts with providers. The language should be mindful of the limitations of implementing the service, and should keep both clients and providers in mind.

The members reviewed the recommendation to increase the use of peers in case management. A member asked if there are peers at all case management sites, and the Grantee explained that all CM providers have peers as a part of their scope of services. A member stated that at her site peers are charged with implementing social and psychosocial services, but cannot conduct needs assessments nor can they develop a client's care plan. Peers may have different roles at different providers, including attending appointments with the clients. A member stated that this language should also be reflected in any MAI models developed by PSRA. The Grantee stated that currently, CM contracts must have peers, recommended language would increase use of peers in proportion to case managers, e.g. 70% of funded salaries for case managers and 30% for peers. The group discussed changing the language to clarify an increase of the proportion of peers to managers, and the tasks of peers. The Grantee stated the role of peers is outlined in the Case Management service delivery model. The Grantee representative clarified that each year the networks review and update their service delivery models that are then approved by QMC, so there is a mechanism to ensure the reflection of PSRA intent in the provided services. They discussed how to modify the language, and decided on: a minimum of 30% of non-medical case management personnel funding goes to peer mentors. The Grantee told the members that the directives from PSRA go into the RFP where providers will have to answer these requirements when bidding for the contract. He asked everyone to balance the needs of the community and Council along with what is realistic for service delivery. The Chair noted that retention of peers has been a problem, and a member asked for language to read initial and ongoing training and development. The Grantee stated that next step in the PSTA process is the allocation of funding, and reminded the members that principles outlined in HBTMTN language must be addressed during the allocations process.

The group reviewed the next recommendation that OAMC integrate mental health assessments into their routine care. This recommendation speaks to either co-location or a collaborative agreement and streamlined referral system between OAMC and Behavioral Health (BH)/Mental Health (MH). The Grantee stated that the key piece of the recommendation is shared outcomes between the two, and that because there is a true connection between mental and physical health, if the services share outcomes then they will be forced to work in a holistic manner for the patient. The group discussed the intersection of mental health and physical care, and the need to address MH aspects that are affecting health outcomes in a primary care setting without stigma. The members discussed the cost of having a psychiatrist located at the provider site, as well as the need for MH employees to be monitored by trained professionals. They spoke about the assumption that behavioral health and mental health are the same, or that every client needs acute mental health care and not minor interventions. A member stated that there is a real need for linkage to MH care and a need to explain to clients how this may be helpful to them. The Grantee spoke about the link between behavioral health and self-management of health issues, he asked the members not to get bogged into the details and to request the concept through the HBTMTN first. A member spoke about her experiences of integration and the problems she saw, and that she has concerns with shared outcomes and the deficiencies associated with the implementation of concept, especially funding. The Grantee stated that this is a concept, and providers bidding on the RFP will have to determine how to integrate this into their service delivery models, and while not everyone needs long-term counseling, people do get lost in the process of referrals and should be able to have the assessment in a non-stigmatized setting. A member stated that they may be overlooking clients under the influence of mental health prescriptions. He stated that 20% of ADAP clients on are on psych medications, and because many of those prescriptions are not on the Part B formulary they cannot pay for the medications, do not take them, and then fall out of care.

The members reviewed the recommendation to improve the referral process across continuum and to increase accountability of providers to coordinate care across service categories with formal policies and collaborative agreements. The Grantee stated that the goal is to accomplish a coordinated system of care for clients across service categories. A member asked about PE referrals, and the Grantee stated that the recommendation is less about the data input system and more about the organizations' commitment to collaborate efficiently and effectively. The member expressed concern about the relationships between providers, and the Grantee recognized that there is no guarantee that providers will work collaboratively but the process starts with documenting that request and including it in the RPF.

They next discussed the recommendation to implement Outreach for "lost to care" clients through Disease Intervention Specialist workers used to reengage clients back into care. DIS Workers are limited to the Florida Department of Health in Broward, and would focus on searching for Part A clients to determine their care status and reengagement if necessary. A member stated that DIS workers should not force clients who are reengaging in care to go back into a specific provider, and also expressed concern about workers leaving DOH envelopes on peoples' doors. While DIS is already an established service in Broward County, this would allow a DIS worker to be funded through Part A to specifically look into Part A clients that might be lost to care. The Grantee explained the DIS service would be required to operate based on a Part A service delivery model and these workers would be accountable to the 8,000 Part A clients. Employing DIS workers also helps the Part A Continuum of Care by reengaging people in care or identifying people who are believed to be out of care but are out of jurisdiction, deceased or duplicated in the system. A member asked about the need to employ a DIS worker specifically for Part A, stating that in her experience DIS workers have done a good job with patients her office has referred to them. The group discussed whether there is a need for more personnel/ money for a service that is currently operating. The Grantee representative stated that there is a need to streamline data collection and that it would be an asset to the Part A system.

The members next discussed the strengths and limitations of implementing a Benefits Navigators program into the Part A system. Currently there are Navigators the help clients enroll in ACA plans, but there is a need to have personnel that can help clients understand eligibility and the dynamics of health insurance services, especially as they move onto a new payer source other than Ryan White. The service would help clients maximize their benefits by providing an insurance specialist, and would need to be funded under non-medical case management. The members debated the need for client services directed specifically for insurance navigation. The CQM Manager stated that the Case Management QI network has talked about the discontinuation of services for their clients on ACA plans, and that they have expressed a need for help with clients that have complex or recurring insurance issues. The PSRA Chair spoke about how clients need help with questions, that some clients have chronic medical conditions and need seamless and efficient navigation through the system, and that support must be provided. A member stated that many clients also go into the ADAP office for help with their insurance, and that a benefits navigator would be helpful. The members spoke about how insurance issues are time consuming and clients who seek help are usually there for an emergency situation. A member spoke about the desire to have the service within CIED or HICP. The PC Manager brought the HRSA's HICP definition to the attention of the members and the group decided to place the service under non-medical CM.

The committee discussed the recommendation for Oral Health Services to separate routine care from specialty care because clients may reach their yearly cap in routine care payments but still need specialty care.

The committee then discussed whether there was a need for medical nutritional counseling to be a stand-alone service from OAMC. Currently nutritional counseling is under medical, and the Staff recommendation for HBTMTN was to hold workshops and education sessions on nutrition through the Food Bank service. A member spoke about past nutritional counseling services, and that he believed

that there is a current need for nutritionists in the Part A system and that there should be a recommendation to have the service available to clients without a referral from a doctor. A member stated that she remembers the individual service category, and that there was not enough funding for all the work required for the service. She believes that once the service was incorporated into OAMC it was streamlined and more effective. While she doesn't agree in a separated service, she does think that every provider should provide nutritional services to their clients. Another member stated that while the priority ranking for the Food Bank has always been ranked high, nutritional services has routinely been ranked low. The member again stressed the need for nutritionists and the need to fund the service, and the committee debated the need for nutritional services, the history of the service and its funding streams. The PSRA Chair stated that she agreed with the recommendation for education sessions seeing that they would meet the needs of the majority of Part A clients, and that those with other needs should be directly linked to counseling through a medical provider. They debated whether there is enough information to determine whether the service is being utilized or not, and whether clients need nutrition education or medical nutritional counseling. The members read the HRSA definition of medical nutritional counseling, and the need for a medical referral for the service. The members discussed moving the recommended language for educational sessions under OAMC since they have licensed nutritionists on staff, but other members argued that educational sessions do not fall within the scopes of licensed nutritionists, but rather in food services. The group requested data on how many people were referred to services to see if the services are offered or utilized, if doctors are providing nutrition screenings, or whether clients were receiving nutritional counseling from the food bank because of convenience since the clients were already there. The PSRA committee decided to do a formal data request for more information regarding utilization and frequency of use of nutritional services.

The committee then reviewed the recommendation to mandate customer service training to the HBTMTN language. The Part B representative explained that when they were looking to improve customer satisfaction at their offices they painted the walls a brighter color and utilized a kiosk that called people out by numbers instead of calling a person's name in the waiting room. The PSRA Chair stated that providers need to be encouraged to review their processes and waiting rooms and other factors that make an inviting and peaceful environment for people in need. A member agreed that there are customer service issues with front desk and front line staff, and that staff may need recurrent customer service training, especially younger or less experienced staff. The members approved HBTMTN language about mandatory customer service training.

The members spoke about transportation needs in Broward. It was recognized that Part B has limitations on the amount of bus passes they can distribute. The Part B member also stated that they are looking to consolidate bus pass expenses and create/improve their services. The members spoke about using a ride sharing service to transport clients to appointments. Members have heard complaints about busses and Tops! taking long times for drop off and clients waiting in the heat for pick up. The Human Services Administrator also stated Part A case managers should not be distributing bus passes as well. However, as other Ryan White parts are charged with implementing transportation services and Part A is the payer of last resort, there was no recommended HBTMTN language regarding transportation for Part A.

The PSRA committee finally spoke about housing gaps and needs, especially need for services for PWAs recently released from substance abuse treatment. The HOPWA representative stated that PWAs can go to the assisted living facilities, and must abide by a 10 p.m. curfew, but can use their time there to get stabilized and save money until they can get PHP to move into units that are available. He stated that the worst time for available units is from November through January when there is a high volume of people in need. The Grantee stated that he has heard about clients close to the end of treatment who intentionally use drugs to delay discharge into an untenable situation without stable housing. Members stated that they have consistently heard about clients' housing issues and that

South Florida has experienced an increase of housing costs the average 1 bedroom costs $1,100 per month). The PSRA Chair stated that this is a recurring issue that needs addressing, and Part A must help in some way, but that there is a need for more data. The Human Services Administrator stated that he has heard from their SA providers that clients are coming out of residential programs after 6 months and are not equipped for independent living; they are in need temporary or half way housing. The members agreed that they need to look at how many clients are coming out to SA, how many are chronically homeless, and how to create a pathway to care and housing. The HOPWA member explained that they are looking to incorporate a vulnerability scoring for housing vouchers and move away from a lottery system. The PSRA Chair stated that they will generate a data request in their next coordination meeting to see how best to address housing gaps.

b. How Best to Meet The Need (Handout C): The members made changes to the HBTMTN language based on their discussions about the needs, gaps and barriers in the Part A system.

Motion #3: To ratify the FY2017-2018 How Best to Meet the Need language **Proposed by:** Grant, C. **Seconded by:** Katz, H.B. **Action:** Passed Unanimously

6. GRANTEE REPORT

a. Part A: None.
b. Part B: None.
c. ADAP Report: None.

7. PUBLIC COMMENT

None

8. AGENDA ITEMS/TASKS FOR NEXT MEETING: July 20, 2016 **Venue:** A-337

Goal/Work Plan Objective #:	*Accomplishments*
Allocations	

9. ANNOUNCEMENTS

None.

10. ADJOURNMENT

The meeting was adjourned at 4:43 p.m.

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PLWHA	Absences	Count	Meeting Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
			Meeting Date:	20	17	16	20	25	15							
		1	Bell, J.	N-2/17		X	X	X	X							
1		2	DeSantis, M.	X	A	X	X	X	X							
		3	Gammell, B.	X	X	X	X	X	X							
		4	Grant, C.	X	X	X	X	X	X							
		5	Hayes, M.	X	X	X	X	X	X							
1		6	Katz, H.B.	X	X	X	A	X	X							
			Lewis, L.	X	Z-2/1											
		7	Lopes, R.		X	X	X	X	X							N-1/20
1			Proulx, D.	X	X	X	A	Z- 5/1								
2		8	Reed, Y.	X	X	A	E	X	X							
1		9	Schickowski, K.	X	A	X	X	X	X							
		10	Shamer, D.	X	X	X	X	A	A							
		11	Siclari, R., *V. Chair*	X	X	E	X	X	A							
		12	Taylor-Bennett, C., *Chair*	X	X	X	X	X	X							
			Quorum = 8	12	10	11	10	11	10							

Legend:
X - present
A - absent
E - excused
NQA - no quorum absent
NQX - no quorum present
N - newly appointed
Z - removed
C - cancelled
W - warning letter
R - removal letter

HANDOUT A

FY 2015-2016 Expenditures and Utilization By Funder

	Part A & Minority AIDS Initiative (MAI)		Part B / ADAP		Part C		Part D		Part F		HOPWA	
	$	#	$	#	$	#	$	#	$	#	$	#
Outpatient /Ambulatory	$5,232,228	3797			$538,978	297	$466,362	881				
AIDS Drug Asstnc. Prog.				3,947								
Pharmaceutical Asstnc.	$1,462,968	2972		1,137								
Dental	$2,300,848	2861							$212,000	102		
Early Intervention					$713,905							
Health Insur. Premium	$709,620	351	$322,437	120								
Home Health												
Home/Community Hlth.			$10,625	14								
Hospice Services												
Mental Health	$359,808	439			$7,363	167	$199,115	1,058				104
Medical Nutrition							$15,600	850				
Medical Case Mgt.	$1,980,555	2872			$79,643	250	$594,449	1,385			$903,912	1,995
Subst. Abuse - outpat.	$595,812	113										
Disease Case Mgt.	$277,302.00	663										
Child Care							*	332				
Emerg. Financial Aid			$34,773	513			*	1,013				
Food Bank/Deliv. Meals	$752,504	2854	$11,829	9								
Education/Risk Redctn.							*	1,202				
Housing											$7,126,082	1,995
Legal	$120,260	180									$212,989	174
Employment											$9,364	23
Life Skills											$8,600	58
Meals Nutritional											$185,625	173
Linguistics							*	328				
Medical Transportation			$115,638	1,085			*	527				
Outreach												
Psychosocial Support							$104,097	1,483				
Referral/Support Care			$372,594	5,062	$85,625	622	$31,282	1,945				
Rehabilitation												
Respite Care												
Subst. Abuse - residntl.			$110,811	27								
Treatment Adherence					$119,413	860	$29,925	922				
Total Unduplicated	**$13,791,905**	**7782**	**$978,707**	**11,914**	**$1,544,927**		**$1,440,830**		**$212,000**	**102**	**$8,446,572**	**1,995**

*Asterisks indicate service was provided, not funded out of Part D

HOPWA Services ONLY

FY 2015-2016 Total Unduplicated Clients Served By Funder

FY 15-16 Demographics	Part A/MAI	Part B / ADAP	Part C	Part D	Part F	HOPWA
# New Patients		1,220	235	121	102	
# AIDS	1,627	399	260		7	
# HIV/non AIDS	4,886	4,663	1,942		95	
Total	6,513	5,062	2,202	121	102	*844
Race						
Black	4,048	2,481	1,715	1,175	57	543
White	3,615	2,532	301	73	42	298
More than one	26	36	121	2	1	1
Asian	46	46	8	3	1	
American Indian	12	11	3		1	
Other Race	27	1	8	3		2
Ethnicity						
Hispanic	1,350	985	192	74	16	99
Haitian	766			235	4	
Gender						
Male	5,552	3,793	1,399	264	61	499
Female	2,176	1,240	949	1,066	40	335
Transgender	54	29		1	1	10
Exposure Category						
MSM	3,532	2,699	341	27	57	
IV Drug User	146	110	51	1		
Heterosexual	3,413	2,304	1,891	958	43	
Mother at-risk						
Perinatal Infect.	73	47	30	347		
MSM/IV Drug	48		8			
Unknown	105	45	27		2	
Age						
(0-12)			1			
(13-24)		191	62	165		87
(25-44)		1,945	555	591	12	403
(45-64)		3,101	1,547	386	19	320
(65+)		233	183	15	71	34
Insurance Status						
No Insurance	3,526	3,472	502	54	102	
Mdcaid/Mdcare	2,555	626	688	989		
R.White Part A			977	233		
HMO/Private	1,341	1,129	181	108		
Federal Poverty Level						
0-100	4,522	2,422	1,911	1,222	100	357
101-200	2,314	1,536	353	97	2	310
201-300	747	813	50	7		139
301-400	166	289	29	4		20
400+	13		5	2		18

*FY 2014-2015, 1,995 clients received HOPWA services. Specifically, 844 participants received a financial subsidy while 1,151 participants only received housing case management services without a financial subsidy. We are working with PE to develop a report that captures missing information on the 844 clients who got a subsidy and captures information on all of 1,151 participants who did not receive housing subsidy.

HANDOUT B1

Rank	Providers	Service	FY 15 Clients	% of Total Clients	FY 15 Final Expenditure	FY 16 Initial Allocation		FY 15 Avg Client Cost	FY 15 New Clients		FY 17 Projected Clients	Factors to Consider	Increase/Decrease Due to Factors		Increase/Decrease Due To Client Utilization		Recommended FY 17 Allocation	
#	#		#	%	$	$	%		#	%	#		%	$	%	$	%	$
1	5	OAMC	3,797	49%	$4,967,642	$5,355,047	42%	$1,308.31	1,189	31%	4,986	Approx. 1,245 clients enrolled in ACA Marketplace plans through ADAP/HICP, with a potential 10% decrease for FY 2016 OAMC expenditures. Populations NOT achieving VL suppression in OAMC include BNHM (240), WMSM (188), & BNHF (152). **In addition to a 20% increase in service utilization due to BH integration which equates to an overall 10% increase.**	10%	$535,505	10%	$535,505	43%	$6,426,056
2	3	Pharmacy	2,972	38%	$1,462,968	$677,165	5%	$492.25	677	23%	3,649	Approx. 1,245 clients enrolled in ACA Marketplace plans through ADAP/HICP. FY 15 had a 6% decreases in Pharmacy utilization. **Potential decrease in funding by the establishment of the Emergency Financial Assistance service for stop-gap medications should also be taken into account.** Populations NOT achieving VL suppression in Pharmacy include BNHM (170), BMSM (68), & BNHF (102).	-10%	($67,717)	10%	$67,717	5%	$677,165
3	2	Oral Health	2,861	37%	$2,300,848	$2,336,564	18%	$804.21	611	21%	3,472	Fully functioning Part F & one new community clinic may decrease number of clients seen through Part A. **HBTMTN language expanding dental funding into 2 components: routine and specialty care may increase expenditures for clients in need may affected expenditures.** Populations NOT achieving VL suppression in OHC include HF (11), BNHF (96), & BNHM (78).	10%	$233,656	5%	$116,828	18%	$2,687,049
5	1	HICP	351	5%	$709,620	$760,000	6%	$2,021.71	23	7%	374	Part A will continue to pay for wrap-around for premiums and co-pays. $6,500 cap per client. Anticipate plan premiums will continue to increase for next year's enrollment. Projected clients includes ADAP clients that will use Part A for wrap-around. **However, ADAP is currently considering increasing ADAP Premium Plus eligibility to 400% FPL, which will impact client premiums, not co-pays or wrap-arounds in the future.**	0%	$0	0%	$0	0%	$760,000
4	4	MCM (Disease)	663	9%	$231,909	$338,000	3%	$349.79	186	28%	849	The newly implemented DCM Program is new and client utilization increased 90% as the program became more established through FY 15.	50%	$169,000	5%	$16,900	3%	$523,900
6	3	Mental Health	439	6%	$340,438	$368,438	3%	$775.49	143	33%	582	Approx. 1,245 clients enrolled in ACA Marketplace plans through ADAP/HICP. Will need to continue tracking expenditures to see true impact, but MH had a 3% decrease for FY 2015 expenditures. Increased need for mental health services, and a number of comorbidities with substance abuse. **Integration of Behavioral Health screenings during primary care visits may increase MH referrals and utilization.** Populations NOT achieving VL suppression in MH include BNHM (15), BNHF (10) & BMSM (7).	0%	$0	2%	$7,369	2%	$375,807
8	2	Substance Abuse (outpatient)	113	1%	$222,308	$212,509	2%	$1,967.33	30	27%	143	Approx. 1,245 clients enrolled in ACA Marketplace plans through ADAP/HICP. Will need to continue tracking expenditures to see true impact, but Substance Abuse had a 12% decrease for FY 2015 expenditures. **Projecting an increase in SA utilization as a result of BH/ Medical integration screenings in addition to the increasing use of drugs in South FL such as cocaine, meth, and heroine (IDU drugs on the rise).** Populations NOT achieving VL suppression in SA include BNHM (7), BNHF (7) & BMSM (3).	10%	$21,251	2%	$4,250	2%	$238,010
		CORE			**$10,235,733**	**$10,047,723**								**$891,696**		**$748,568**	**78%**	**$11,687,987**

HANDOUT B1

Rank	Providers	Service	FY 15 Clients	% of Total Clients	FY 15 Final Expenditure	FY 16 Initial Allocation		FY 15 Avg Client Cost	FY 15 New Clients		FY 17 Projected Clients	Factors to Consider	Increase/Decrease Due to Factors		Increase/Decrease Due To Client Utilization		Recommended FY 17 Allocation	
#	#		#	%	$	$	%		#	%	#		%	$	%	$	%	$
1	1	CM (CIED)	7,452	96%	$556,701	$560,513	4%	$74.70	1,352	18%	8,804	Almost 6% increase in new infections in 2015 (~1,200 new cases) calendar year in Broward, CIED had 18% new clients in FY 2015. Populations NOT achieving VL suppression include transgender (16), BNHF (323), BNHM (361), BMSM (172).	0%	$0	10%	$56,051	4%	$616,564
1	6	CM (non-medical)	2,872	37%	$1,132,897	$1,252,719	10%	$394.46	608	21%	3,480	CM utilization has decreased over past several years, clients can also get CM services through Medicaid, some Marketplace plans. Clients also have access to MCM (Disease). **HBTMTN language includes a stipulation for 30% increase in funded personnel dedicated to peers. HBTMTN also includes Benefits Support Service case managers to assist clients with insurance navigation. Will need to increase funding for hiring personnel and training.** Populations NOT achieving VL suppression include Transgender (8), BNHM (169), BNHF (99), BMSM (83).	20%	$250,544	5%	$62,636	10%	$1,565,899
3	3	Emergency Financial Assistance	N/A	N/A	N/A	$25,000	N/A	N/A	N/A	N/A		**HRSA has mandated that emergency and stop-gaps medications be distributed to clients through EFA, not LAPA. Factors for funding allocation must include # of clients receiving emergency meds annually and dispensing fees.**	170%	$42,500	0%	$0	0%	$67,500
7	1	Outreach	N/A	N/A	N/A	$0	N/A	N/A	N/A	N/A		**Projected cost for new engagement program.**	%	$250,000	1%	$0	2%	$250,000
4	1	Food Bank/Home-Delivered Meals	2,854	37%	$752,504	$780,446	6%	$263.67	480	17%	3,334	Changes to eligibility may be primary cause for the decreased number of clients utilizing service category. **HBTMTN language includes delivery of workshops and trainings on healthy eating and nutrition as it relates to management of clients' health and should be considered during funding allocations.** Populations NOT achieving VL suppression include Transgender (7), BNHF (131), & BMSM (63).	-23%	($179,503)	13%	$101,458	5%	$702,401
5	1	Legal	180	2%	$120,260	$121,426	1%	$668.11	81	45%	261	Legal services have gone up and down over the past several years, but the agency has been able to maintain expenditures. Populations NOT achieving VL suppression include MSM (13) & Black non-Hispanic heterosexual (8).	-17%	($20,642)	44%	$53,427	1%	$154,211
		SUPPORT			**$2,562,362**	**$2,740,104**								**$342,899**		**$273,573**	**22%**	**$3,356,575**
		TOTAL	7,782	100%	$12,798,095	$12,787,827												$15,044,562

$17,301,246.66

% Allocated to core services:
% Allocated to support services:

Blue highlight indicates ACA Marketplace covered service

HANDOUT B1

Rank	Providers	Service	FY 15-16 Clients	% of Total Clients	FY 15-16 Final Expenditure	FY 16-17 Initial Allocation		FY 15 Avg Client Cost	FY 15-16 New Clients		FY 17-18 Projected Clients	Increase/Decrease Due To Client Utilization		Recomended FY 17 Allocation	
#	#		#	%	$	$	%		#	%	#	%	$	%	$
1	1	OAMC	605	15%	$264,586	$286,596	26%	$437.33	62	10%	667		$ 291,699		$291,699
2	1	MCM	155	4%	$45,393	$55,997	5%	$292.85	19	12%	174		$ 50,956		$50,956
6	1	Mental Health	73	2%	$19,370	$62,469	6%	$265.34	27	37%	100		$ 26,534		$26,534
8	1	Substance Abuse (outpatient)	69	2%	$373,504	$400,000	36%	$5,413.10	24	35%	93		$ 503,418		$503,418
		CORE			**$702,853**	**$805,062**	**73%**				**0**		**$872,607**		**$872,607**
1	1	CM (CIED)	3,962	97%	$290,957	$290,957	27%	$73.43	433	11%	4,395		$ 322,725		$322,725
		SUPPORT			**$290,957**	**$290,957**	**27%**						**$ 322,725**		**$322,725**
		TOTAL	4,080		$993,810	$1,096,019	100%								$1,195,332

Utilization & Change 2011-2015 and Projections for FY 2017

Services	2011	2012	% Δ 2011-2012	2013	% Δ 2012-2013	2014	% Δ 2013-2014	2015	% Δ 2014-2015	% Δ 2011-2015	Projections for FY 2017
Outpatient /Ambulatory Health	3,506	3,790	8.1%	3,958	4.4%	4,103	3.7%	3,797	-7.4%	8.3%	4,986
Local Pharmaceutical Assistance	2,061	2,551	19.2%	3,108	21.8%	3,145	1.2%	2,972	-5.5%	44.2%	3,649
Oral Health Care	2,768	2,751	-0.6%	3,182	15.7%	3,020	-5.1%	2,861	-5.3%	3.4%	3,472
Health Insurance Premium	0	0	N/A	0	N/A	186	N/A	351	56.7%	N/A	374
Mental Health Services	419	508	21.2%	537	5.7%	453	-15.6%	439	-3.1%	4.8%	582
Medical Case Management (DCM)	0	0	N/A	0	N/A	52	N/A	663	860.9%	N/A	849
Substance Abuse - outpatient	124	126	1.6%	122	-3.2%	128	4.9%	113	-11.7%	-8.9%	143
Case Management (non-Medical)	3,551	3,509	-1.2%	3,332	-5.0%	3,155	-5.3%	2,872	-8.97%	-19.1%	3,480
Case Management (CIED)	6,333	6,629	4.7%	6,953	4.9%	7,665	10.2%	7,452	-2.8%	17.7%	8,804
Food Bank/Home-Delivered Meals	2,019	2,188	8.4%	2,496	14.1%	3,019	21.0%	2,854	-5.47%	41.4%	3,334
Legal Services	164	214	30.5%	183	-14.5%	210	14.8%	180	-14.29%	9.6%	261
Total Unduplicated	**7,022**	**7,064**		**6,953**		**7,962**		**7,782**			

FY 2017/2018 HOW BEST TO MEET THE NEED LANGUAGE

All Services
Recommended Language
Ensure Part A Providers document collaborative agreements with all and other organizations within their continuum of care, and across systems to help clients get all their needs addressed.
Provide Care Coordination across multiple service categories.
Ensure high client satisfaction with services through consistent feedback opportunities such as surveys or focus groups, annual customer service trainings for staff, and provide follow up as needed.
Collaborative agreements with treatment adherence programs and other key points of entry to facilitate rapid eligibility determination for the newly diagnosed and for clients who have fallen out of care
Enhance the emphasis on adherence and retention in medical care inclusive of sub-populations not achieving viral load suppression, including but not limited to: Black heterosexual men and women Black men who have sex with men (MSM) 18-38 years of age
Integrate care collaboration with members of the client's service providers.
Collect client level data on stages of the HIV Care Continuum to identify gaps in services and barriers to care.
Implement formal policies addressing referrals amongst internal and external providers to maximize community resources.
Co-locate services where applicable, to facilitate medical home model for Part A clients.
Core Medical Services
Service Criteria: (<400% FPL)
Outpatient Ambulatory Health Services (OAMC)
Recommended Language
Integrate Primary Care & Behavioral Health Services funded agencies to provide Outpatient Ambulatory Medical Care, Behavioral Health, and Care Coordination services.
Providers are responsible for providing assessments, brief therapy interventions, and referrals for clients that require a higher level of care
Integrate Care provider collaboration with members of the client's treatment team outside of the organization.
Establish shared clinical outcomes and data sharing to maximize coordination and tracking of client health outcomes.
Care Coordinators will monitor delivery of care; document care; identify progress toward desired health outcomes; review the care plan with clients in conjunction with the direct care providers; interact with involved departments to ensure the scheduling and completion of tests, procedures, and consult track and support patients when they obtain services.
Provide after-hours service availability to include Crisis Intervention.
Coordinate referrals with other service providers; conduct follow-ups with clients to ensure linkage to referred services.
Ensure providers are knowledgeable regarding management of patients co-infected with HIV and HCV.
Incorporate prevention messages into the medical care of PLWHA.

FY 2017/2018 HOW BEST TO MEET THE NEED LANGUAGE

Report clients who have fallen out of care to DIS Outreach workers to determine if clients are really not in care or have moved away/to a different payer source.
AIDS Pharmaceuticals (Local)
Service Criteria: (<400% FPL)
Recommended Language
Report clients who have fallen out of care to DIS Outreach workers to determine if clients are really not in care or have moved to a different payer source.
Oral Health Care (OHC)
Service Criteria: (<400% FPL)
Recommended Language
Maintain specialty oral health care services and provide care beyond extractions and restoration to include, but not be limited to, full or partial dentures and surgical procedures, periodontal work, and root canals.
Increase Oral Health Care collaboration with mental health providers.
Expand and separate Oral Health Care (Dental Services) funding into two components: routine maintenance care and specialty care.
Health Insurance Continuation Program (HICP)
Service Criteria: (250%-400% FPL)
Recommended Language
Develop materials for clients to use as quick references.
Provide assistance with Prior authorizations and appeals process.
Maintain routinized payment systems to ensure timely payments of premiums, deductibles, and co-payments .
Mental Health Service (MH)
Service Criteria: (<300% FPL)
Recommended Language
Provide Trauma-Informed Mental Health Services referring clients to the prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.
Provide after-hours availability to include Crisis Intervention.
Disease (Medical) Case Management
Service Criteria: (<400% FPL)
Recommended Language
Coordinate referrals with other services providers; conduct follow-ups with clients to ensure linkage to referred services.
Report change in viral load status as clients progress through the program.
Substance Abuse- Outpatient
Service Criteria: (<300% FPL)
Recommended Language

FY 2017/2018 HOW BEST TO MEET THE NEED LANGUAGE

NO RECOMMENDED LANGUAGE FOR THIS SERVICE CATEGORY
Support Services
Case Management (Non-Medical)
Service Criteria: (<400% FPL)
Recommended Language
Specially train personnel to ensure client education about transitioning to insurance plans, including medication pick up, co-payments, staying in network, etc.
Provide education to reduce fear and denial and promote entry into primary medical care.
Educate clients on the importance of remaining in primary medical care.
At least 30% of Non-Medical Case Management funded personnel be dedicated to Peers.
Incorporate prevention messages into the medical care of PLWHA.
Educate consumers on their role in the case management process.
Provide information about Ryan White programs to reduce financial concerns about seeking care.
Provide initial/ongoing training and development for HIV peer workers.
Provide Benefits Support Services to deliver information to about their health insurance coverage such as how they can navigate and utilize insurance effectively to achieve better health outcomes.
Overview of health care plan summary of benefits (coverage and limitations).
Educate the client on the different types of health care providers (i.e. Primary Care, Urgent Care, and Specialty Care).
Centralized Intake and Eligibility Determination (CIED)
Service Criteria: HIV+ Broward Resident
Recommended Language
Ensure the locations and service hours target historically underserved populations that are disproportionately impacted with HIV.
Maintain collaborative agreements with treatment adherence programs and other key points of entry to facilitate rapid eligibility determination for the newly diagnosed and for clients who have fallen out of care.
Following up with all newly diagnosed clients within 90 days of certification to ensure they are engaged in care.
Distribute client handbook to provide an overview of the purpose of Ryan White Part A services and includes the following: 1) Client rights and responsibilities, 2) Names of providers complete with addresses and phone numbers, and 3) Grievance procedures.
Offer dedicated live operator phone line at all times during normal business hours.
Ensure that intake data collected for transgender clients is sufficient to make full use of transgender related categories in PE.
Follow up with all newly diagnosed clients within 90 days of certification to ensure they are engaged in care.
Emergency Financial Assistance
Service Criteria:
Recommended Language
Provide limited one-time or short-term pharmaceutical assistance for Ryan White Part A clients.
Outreach

FY 2017/2018 HOW BEST TO MEET THE NEED LANGUAGE

Service Criteria:
Recommended Language
Utilize DIS workers to locate clients who are “lost to care” to determine retention status and re-engage as necessary.
Track the barriers to care that caused clients to cease medical care, and provide an annual report to the HIVPC.
Food Services
Service Criteria: (<250% FPL)
Recommended Language
Increase communication with client primary care physicians and nutrition counselors to ensure client nutritional needs are being met.
Provide workshops and training forums focused on improving Clients’ knowledge of healthy eating and nutrition as related to management of their health.
Legal Services
Service Criteria: (<300% FPL)
Recommended Language
NO RECOMMENDED LANGUAGE FOR THIS SERVICE CATEGORY