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

Quality Management Committee Meeting

Monday, May 20, 2024 - 11:30 AM
Meeting Location: Broward Regional Health Planning Council Conference Room

Microsoft Teams Meeting Information:
Join on your computer, mobile app or room device: Click here to join the meeting
Meeting ID: 246 265 146 626 Passcode: R9sBsa
Or call in (audio only): +1 561-437-3349 Phone Conference ID: 143 923 947#

Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore

This meeting is audio and video recorded.

The purpose of the Quality Management Program for Ryan White Part A in the Broward County EMA is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV care and services provided to all clients receiving Ryan White Part A and Minority AIDS Initiative (MAI) funded services in Broward County.

Quorum for this meeting is 5

DRAFT AGENDA

ORDER OF BUSINESS

1. Call to Order/Establishment of Quorum
2. Welcome from the Chair
    a. Meeting Ground Rules
    b. Statement of Sunshine
    c. Introductions & Abstentions
    d. Moment of Silence
3. Public Comment
4. **ACTION:** Approval of Agenda for May 20, 2024
5. **ACTION:** Approval of Minutes from April 15, 2024 **(Handout A)**
6. Standard Committee Items:
    a. None.
7. Unfinished Business
    a. None.

8. New Business
    a. Review Service Delivery Models:
        i. Health Insurance Continuation Program **(Handout B)**
        ii. Integrated Primary Care and Behavioral Health (IPCBH) **(Handout C)**
10. Recipient's Report
11. Data Request
12. Public Comment
13. Agenda Items for Next Meeting
    a. Continue Review of SDMs
        i. Universal SDM
        ii. System Mapping Updating
    b. Next Meeting Date: June 17, 2024, at 11:30 a.m. via Microsoft Teams Videoconference and at BRHPC – *Note: This meeting begins one hour earlier than usual*.
14. Announcements
15. Adjournment

For a detailed discussion on any of the above items, please refer to the minutes available at:
HIV Planning Council Website
Please complete the meeting evaluation.
Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

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

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

HANDOUT A

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

Quality Management Committee Meeting
Monday, April 15, 2024 - 12:30 PM
Meeting Location: Broward Regional Health Planning Council Conference Room and via Microsoft Teams

Microsoft Teams Meeting Information:
Join on your computer, mobile app, or room device: Click here to join the meeting
Meeting ID: 246 265 146 626 Passcode: R9sBsa
Or call in (audio only): +1 561-437-3349 Phone Conference ID 3 923 947#

MINUTES

Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore

QMC Members Present: B. Fortune-Evans, R. Jimenez, V. Biggs, Z. Muneton, F. D'Amore, D. Shamer
QMC Members Absent: J. Casseus
Ryan White Part A Recipient Staff Present: T. Thompson, B. Miller, J. Hidalgo, D. Cestaro-Seifer
Ryan White Part B Recipient Staff Present: J. Rodriguez, S. Cook
Planning Council Support Staff Present: D. Liao, M. Patel, M. Lacroix, G. Berkeley-Martinez
Guest Present: D. Walker, R. McKensie, S. Tinsley

1. Call to Order, Welcome & Public Record Requirements

   The QMC.Vice.Chair.called the meeting to order at 11:42 p.m. The QMC.Vice.Chair.welcomed all meeting attendees who were present. Attendees were notified that the QMC meeting is based on Florida's "Government-in-the-Sunshine Law" and the meeting reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. The PCS staff led roll calls and introductions for the committee members, Recipient staff, PCS staff, and guests. Lastly, a moment of silence was observed.

2. Public Comment

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

   No public comments were made.

3. Meeting Approvals

   The approval for the agenda of the April 15, 2024, Quality Management Committee meeting was proposed by D. Shamer. This was seconded by V. Biggs and passed unanimously. The approval for the minutes of the March 18, meeting was proposed by V. Biggs, seconded by F. D'amore, and passed unanimously.

   Motion #1: D. Shamer, on behalf of QMC, made a motion to approve the April 15, 2024, Quality Management Committee agenda and seconded by V. Biggs. The motion was adopted unanimously.
   Motion #2: V. Biggs, on behalf of QMC, made a motion to approve the March 18, 2024, Quality Management Committee meeting minutes as presented and seconded by F. D'Amore. The motion was adopted unanimously.

4. Standard Committee Items

   None.

5. Unfinished Business

   None.

6. New Business

   Representatives from the Ryan White Part A Recipient office explained revisions of three Minority AIDS Initiative Service Delivery Models.

   <u>Substance Abuse SDM</u>

   R. Pena conducted a detailed overview of the Substance SDM and the recommendations therein. D. Shamer stated that this SDM should include measures to reduce stigma. All concerns raised by committee members were addressed.

   Motion #3: V. Biggs, on behalf of QMC, made a motion to approve the CIED SDM as presented and seconded by Z. Muneton. The motion was adopted unanimously.

   <u>Non-Medical Case Management SDM</u>

   R. Pena conducted a detailed overview of the Non-Medical Case Management SDM and the recommendations therein. All concerns raised by committee members were addressed.

Motion #4: V. Biggs, on behalf of QMC, made a motion to approve the Non-Medical Case Management SDM as presented and seconded by Z. Muneton. The motion was adopted with five votes in favor and one vote against.

Medical Case Management SDM

R. Pena conducted a detailed overview of the Medical Case Management SDM and the recommendations therein. All concerns raised by committee members were addressed.

Motion #5: V. Biggs, on behalf of QMC, made a motion to approve the Medical Case Management SDM as presented and seconded by D. Shamer. The motion was adopted unanimously.

Quality Improvement Projects Overview – FY2023-2024

D. Liao, Clinical Quality Management Health Planner, conducted a detailed overview of the QI Projects for FY2023-2024.

Recipient Report

None

Data Request

None

7. Public Comment

   The Public Comment portion of the meeting is intended to allow the public to express opinions about items on the meeting agenda or to discuss other matters about HIV/AIDS services in Broward County. No public comments were made.

8. Agenda Items/Tasks for Next Meeting

   The next QMC meeting will be held on May 20, 2024, at 11:30 p.m.

   - Continued review of SDMs
     - Health Insurance Continuation Program HICP,
     - Integrated Primary Care and Behavioral Health (IPCBH)

9. Announcements

   S. Tinsley – Ryan White Clients' Listening Session on April 24, 3 pm- 5 pm, at the AIDS Health Care Foundation

10. Adjournment

    There being no further business, the meeting was adjourned at 1:26 p.m.

QMC Attendance for CY 2024

Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
	Meeting Date	16	12	18	15									
1	Biggs, V.	X	X	X	X									
2	Casseus, J.	A	A	A	X									
3	D'Amore, F., V. Chair	X	X	X	X									
4	Fortune-Evans, B., Chair	X	X	X	X									
5	Jimenez, R.	X	X	X	A									
6	Muneton, Z.	X	X	X	X									
7	Shamer, David	X	X	X	X									
	Quorum = 4	6	6	6	6									

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

Quality Management Committee Minutes.- April 15, 2024 Minutes prepared by PCS Staff

HANDOUT B

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Health Insurance Continuation Program
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

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

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

Local Definition

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

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

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

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

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

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

II. Key Service Components & Activities

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

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

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

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

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

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

Client Orientation

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

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

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

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

Payment Verification

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

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

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

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

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

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

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

Coordination with Third Party Providers

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

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

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

IV. Standards for Service Delivery

Table 2. HICP Standards for Service Delivery

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

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

HANDOUT C

BROWARD COUNTY RYAN WHITE PART A PROGRAM

Integrated Primary Care & Behavioral Health Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

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

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

Local Definition

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

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

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

II. Key Service Components and Activities

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

Primary Medical Care

ART Initiation

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

Laboratory Tests

Providers are expected to conduct testing in compliance with HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV[2]. Testing below may be performed more frequently as clinically indicated. The following laboratory tests are included as a standard treatment of care:

Baseline Visit (Initiation of Medical Care)

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

[2] National HIV Curriculum Hep A Recommendation

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

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

Every Three to Six Months[4]

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

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

Every Twelve Months[3]

- Absolute CD4 cell count with percentage CD4 *(after 2 years of undetectable viral load and CD4 300-500. If CD4 greater than 500, optional to repeat)*
- CBC with Differential *(when no longer monitoring CD4 cell count)*
- Hepatitis C Screening if at risk
- Lipid profile if normal at baseline or with cardiovascular risk and as clinically indicated
- Urinalysis
- Clients on injectable ART may have their labs done every 12 months, providing they are virally suppressed.

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

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

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

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

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

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

Prescribing Providers may refer eligible clients to Medical Nutritional Therapy (MNT)[5]. Clients who receive an MNT referral may have the diagnosis of diabetes, chronic kidney disease, or have had a kidney transplant within the last 36 months. An MNT referral can also be made when a client reports any of the following concerns and agrees to an MNT referral:

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

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

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measures

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

IV. Assessment and Treatment Plan

Primary Medical Care Assessment and Screening Process

The provision of primary medical care assessments and behavioral health screenings must be consistent with the current HHS treatment guidelines, National HIV Curriculum and U.S. Preventative Services Taskforce Recommendations (USPSTF).

Primary Medical Care Health Assessment

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

Medical Care and Treatment Plan

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

- Chief complaint
- Vital signs
- Presenting symptoms list
- Current medications and adherence
- Vaccinations – completed and pending
- Assessment/diagnosis
- Proposed treatment in accordance with current HHS Treatment Guidelines

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

Behavioral Health Assessment

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

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[6]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

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

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

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

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

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

Behavioral Health Treatment Plan Review
A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed professional and the client.

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

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

- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

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

Standard	Measure
1. Clients have documentation of HIV+ status in their medical record.	1.1. Documentation of HIV+ test and results in the client chart.
2. Client complete initial comprehensive health assessment within three sessions from the time of a client's initial visit, and every twelve months thereafter.	2.1. Documentation of initial comprehensive health assessment in the client chart.
3. All postmenopausal women and men 50 years of age and older receive a bone mineral density screening with a DEXA scan. In men 40 to 49 years of age and premenopausal women 40 years of age and older without major risk factor for osteoporotic fracture risk receive a fracture risk score using the fracture risk assessment tool.	3.1. Documentation of DEXA scan included in the client chart. 3.2. Documentation of fracture risk assessment score included in the client chart.
4. Clients are referred to a nephrologist if Glomerular Filtration Rate (GFR) declines more than 25% from baseline and to a level less than 60/mL/min/1.73 m2 that fails to resolve with the removal of any potential nephrotoxic drugs.	4.1. Referral documentation in clients chart.
5. Men with clinical indication for testosterone deficiency receive a testosterone level drawn fasting between 8-10am.	5.1. Documentation of testosterone level draw included in the clients chart.
6. Clients complete a PHQ-2 or PHQ-9 at baseline, as clinically indicated, and annual medical care visit.	6.1. Documentation of PHQ-2 or PHQ-9 score in the client chart.
7. Clients who score 3 or above on a PHQ-2 are assessed by the PHQ-9. Clients whose score on the PHQ-9 is greater than 11 are referred to Behavioral Health services.	7.1. Documentation of PHQ-2 score in the client chart. 7.2. Documentation of PHQ-9 score in the client chart. 7.3. Referral documented in the designated HIV HSSS.
8. Clients complete a GAD-2 or GAD-7 at baseline, as clinically indicated, and annual medical care visit.	8.1. Documentation of GAD-2 or GAD-7 score in the client chart.
9. Clients who score 3 or above on a General Anxiety Disorder (GAD)-2 are assessed by the GAD-7. Clients whose	9.1. Documentation of GAD-2 score in the client chart.

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

Standard	Measure
with an abnormal PAP test result or documented cervical lesion present receive a referral to a gynecologist. Providers follow guidelines for cervical cancer screening as stated in the National HIV Curriculum	19.2. Referral documented in the designated HIV HSSS.
20. Female clients, starting at age 40, receive a mammogram annually. Clients with an abnormal mammogram are referred to a specialist and have a plan of care.	20.1. Documentation of screening and results in the client chart. 20.2. Referral documented in the designated HIV HSSS.
21. Clients receive colon and rectal cancer screenings as clinically indicated.[7]	21.1. Documentation of screening and results in the client chart.
22. Clients receive lung cancer screenings as clinically indicated.[7]	22.1. Documentation of screening and results in the client chart.
23. Clients are assessed and counseled for medication adherence at every primary medical care visit.	23.1. Documentation of assessment and counseling provided in the client chart.
24. Clients with CD4 T-cell counts below 200 and/or CD4 percentage less than 14% are prescribed PJP prophylaxis as clinically indicated. [8]	24.1. Documentation of laboratory test results in the client chart. 24.2. Documentation of prescription in the client chart.
25. Women of pregnancy potential receive a pregnancy test at ART initiation and as clinically indicated be prescribed ART as clinically indicated. Women of pregnancy potential receive a sexual history screening following the five Ps (Partners, Practices, Protection from STIs, Past History of STIs, and Pregnancy Intention). Clients receive education about birth control methods.	25.1. Documentation of pregnancy screening in the client chart. 25.2. Documentation of ART prescription in the client chart. 25.3. Documentation of sexual history discussing the 5 Ps in the client chart. 25.4. Documentation about birth control methods is included in the client chart.
26. Clients receive sexual health education annually, including pregnancy planning, discussion of condom use, risk identification, and PrEP for partners.	26.1. Documentation of sexual health education in the client chart.
27. Clients are referred to oral health care at baseline and assessed for adherence with oral health recommendations.	27.1. Referral documented in the designated HIV HSSS.
28. Transgender-inclusive healthcare is provided, including:	28.1. Documentation of transgender-inclusive healthcare provided in the client chart.

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

Standard	Measure
• Documentation of birth sex and self-reported gender. • Routine healthcare clinically appropriate for client' birth sex as anatomically permitted. • Assessment of additional medical and mental health needs, in addition to those inherent in birth sex and incurred from additional anatomical changes. • Pronouns • Preferred name • Legal changed name	

Table 3. IPCBH – Behavioral Health Standards for Service Delivery

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

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.

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.