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, January 12, 2026, 12:30 p.m.

Meeting Location: Broward Regional Health Planning Council Conference Room

Join the meeting now
https://teams.microsoft.com/l/meetup-join/19%3ameeting_N2U5MDc5ZjItOGVhNy00MzQ3LWJmNzMtZGE0YjVhNDU1OGM5%40thread.v2/0?context=%7b%22Tid%22%3a%220dd42165-bf27-4e00-9f50-1f4dff8a73f8%22%2c%22Oid%22%3a%22df400b73-e09f-4638-a7b6-0750be4ecb25%22%7d
Meeting ID: 253 807 535 170
Passcode: W5un64Pm
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 4

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 January 12, 2025
5. **ACTION:** Approval of Minutes from November 17, 2025 **(Handout A)**
6. Discussion Items:
    a. **Action:** Review Service Delivery Models, *Recipient Office* **(Handout B1)**
        i. Integrated Primary Care and Behavioral Health SDM **(Handout B2)**
        ii. Medical Case Management SDM **(Handout B3)**
        Work Plan Activity 2.2: Review Service Delivery Models as part of the system-wide Quality Improvement Project (QIP) and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.
7. Old Business:
    a. None

8. New Business
    a. **Discussion:** Provider Appreciation Week, CQM staff **(Handout C)**
        i. February 18, 2026, from 11:30 AM to 3:45 PM. Location: Anne Kolb Nature Center (751 Sheridan Street, Hollywood, FL 33019)

    Work Plan Activity 2.3 Receive presentations on Quality Improvement Projects (QIPs) taking place among RW Part A service providers.

    b. **Discussion**: Annual HIVPC Retreat, PCS Staff **(Handout D)**
        i. February 26, 2026, from 9:00 AM to 4:00 PM. Location: Anne Kolb Nature Center (751 Sheridan Street, Hollywood, FL 33019)

    Work Plan Activity 1.1 Review and analyze findings from the annual needs assessment including focus groups, client and provider surveys, and network member evaluations and recommendations.
    Work Plan Activity 2.1 Receive presentation(s) on targeted strategies and interventions for vulnerable populations who may not seek care or who may have fallen out of care.
    Work Plan Activity 2.3 Receive presentations on Quality Improvement Projects (QIPs) taking place among RW Part A service providers.

    c. **Discussion:** Updates regarding the AIDS Drug Assistance Program **(Handout E1, E2)**
9. Recipient's Report
10. Data Request
11. Public Comment
12. Agenda Items for Next Meeting
    a. To Be Determined
    b. **Next Meeting Date:** March 16, 2026, 12:30 p.m. via Microsoft Teams Videoconference and at BRHPC
13. Announcements
14. 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
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200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Quality Management Committee Meeting

Monday, November 17, 2025 – 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: 253 807 535 170 Passcode: W5un64Pm
Or call in (audio only): +1 469-998-5921; Phone Conference ID 226 656 416#

DRAFT MINUTES

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

QMC Members Present: B. Fortune-Evans, V. Biggs, R. Jimenez, F. D'Amore, S. McLeod, O. Davy, C. Williams, M. Patterson
QMC Members Absent: J. De La Nuez
Ryan White Part A Staff Present: T. Thompson
Planning Council Support Staff Present: D. Liao, S Isidore, M. Lacroix, G. Berkeley-Martinez, D. Cestaro-Seifer, M. Rosiere
Guest Present: H. Singh, B. Marciante, R. Campbell, B. Mester, J. Rodriguez, J. Shirley

1. Call to Order, Welcome & Public Record Requirements

The QMC Chair officially convened the meeting at **12:37PM**. and extended a warm welcome to all attendees. 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 November 17, 2025, Quality Management Committee meeting was proposed by V. Biggs. This was seconded by F. D'Amore and passed unanimously.

The approval for the minutes of the August 18, 2025, Quality Management Committee meeting was proposed by V. Biggs. The motion with the correction was seconded by F. D'Amore and passed unanimously.

Motion #1: V. Biggs, on behalf of QMC, made a motion to approve the November 17, 2025 Quality Management Committee agenda and seconded by F. D'Amore The motion was adopted unanimously.

Motion #2: V. Biggs, on behalf of QMC, made a motion to approve the August 18, 2025 Quality Management Committee Minutes with corrections and seconded by F. D'Amore. The motion was adopted unanimously.

4. **Discussion Items**
   a. Review and Approve QMC Workplan Activities for FY2026-2027

M. Lacroix reviewed the QMC Workplan Activities for FY2026–2027. Following the review, the committee provided suggestions and then made a motion to approve the plan.

QMC Recommendations (Workplan)

- Objective 2
  - 2.1: Develop annual QMC goals and identify objectives, strategies/action steps to achieve goals.
  - 2.2: Conduct quarterly reviews of the QMC Annual Workplan
- Objective 5
  - 5.1: Add "Listening Sessions and community forums"
  - 5.1: Remove "during service prioritization/ranking"
- NEW: Review Priority Setting and Resource Allocation (PSRA)Scorecards template and provide feedback to the PSRA Committee

Motion #3: V. Biggs, on behalf of QMC, moved to approve the Quality Management Workplan Activities for FY2026–2027 with corrections to objectives 2 and 5, and with the addition of a new recommendation to review the PSRA scorecard template. The motion was seconded by M. Patterson and adopted unanimously.

5. **Old Business**
   a. **Discussion:** Summary from Listening Tour Session #3, October 20, 2025

M. Lacroix, PCS Support Staff, presented the Listening Tour Session #3 Community Insights and Outcomes. Following the presentation the committee had a discussion.

The committee discussed overall feedback from the Listening Sessions. B. Fortune-Evans noted that most comments were positive and emphasized identifying areas for improvement. G. Berkeley-Martinez explained that challenges from all three sessions would be compiled. Members discussed timing issues, transportation, and whether incentives were allowed. M. Patterson asked about incentive rules, and PCS Staff confirmed that gift cards were provided, with transportation support from Broward House and Broward Health.

Concerns were raised about consumer engagement. B. Fortune-Evans questioned whether provider and Planning Council outreach alone was effective. D. Liao, CQM Support Staff, suggested attending support groups and providing food to boost participation. D. Cestaro-

Seifer, CQM Consultant, stressed meeting people where they are—such as waiting areas—and training peers and outreach staff to engage individuals directly.

V. Biggs questioned why providers were not bringing consumers to the sessions and raised concerns about provider accountability and engagement responsibilities. The group discussed whether requirements could be added to contracts, though T. Thompson noted such mandates would not be approved. M. Patterson suggested creating a phone line for client concerns, and G. Berkeley-Martinez highlighted ongoing PSRA efforts to incorporate consumer voices. Following this the discussion the committee made a few recommendations.

QMC Recommendation (Future Listening Tours)

- Attend existing support groups and engage participants with targeted questions.
- Spend time in agency lobbies and offices to interact with clients and gather feedback directly, rather than requiring clients to come to us.
- Explore the feasibility of establishing a phone bank to collect client grievances and respond to Ryan White–related inquiries.
- Determine whether the Community Empowerment Committee should lead the Listening Tour initiative, given its focus on consumer involvement, or whether it should remain under PSRA.

6. New Business

a. **Discussion:** Update QMC FY2025-2026 Workplan, *PCS Staff*

M. Lacroix conducted a review of the current committee workplan. Following the review the committee had a brief discussion.

B. Fortune-Evans asked whether the committee was on track to review all the Service Delivery Models (SDMs). T. Thompson clarified that not all SDMs would be reviewed this cycle due to it being an RFP last year; instead, the focus will be on those with the most feedback or confusion in January. M. Patterson asked if the older versions and updates could be viewed, and T. Thompson noted that no changes have been made yet.

b. **Discussion:** Update Clinic Quality Management FY2025-2026 Workplan Activities, CQM Support Staff

D. Liao, CQM Support Staff, noted that the Clinic Quality Management FY2025–2026 Workplan Activities will be incorporated into the Network Activities presentation.

c. **Presentation:** Network Activities Updates, CQM Support Staff

D. Liao, CQM Support Staff, presented the Quarter Three Clinical Quality Management (CQM) Support Activities update. Additional updates for the oral health support services network included a review of the Part A Resource Guide, key ACA enrollment changes, current oral health needs and barriers, and an update on the oral health palm card. Following the presentation, B. Fortune-Evans recommended adding a section for emergency dental appointments. D. Liao acknowledged the suggestion and stated she would forward the recommendation.

7. Recipient Report

T. Thompson, Part A representative, provided a brief report, noting that the Service Delivery Model (SDM) review will begin in January. The Recipient Office is currently conducting monitoring activities. T. Thompson added that, while not making any promises, they are working with an external agency to help publish Care Continuum data on the Broward County website. Two

additional agencies will need to approve it, but this is a step closer to making the data publicly accessible.

8. **Data Request**
   None.

9. **Public Comment**

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

10. **Agenda Items/Tasks for Next Meeting**

    To be Determined.

11. **Announcements**
    - **Save the Date:** Provider Appreciation Week Quality Improvement Project (QIP) Presentations will take place on February 18, 2026, from 11:30 AM to 3:45 PM!

12. **Adjournment**

    There being no further business, the meeting was adjourned at **2:25PM.**

QMC Attendance for CY 2025

Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
	Meeting Date	21	C	17	21	19	C	C	18	C	20 - LT #3	17		
1	Biggs, V.	X	C	X	X	X	C	C	X	C	X	X		
2	D'Amore, F., V. Chair	X	C	X	X	X	C	C	X	C	X	X		
3	Fortune-Evans, B., Chair	X	C	E	X	X	C	C	X	C	X	X		
4	Jimenez, R.	X	C	X	X	A	C	C	X	C	NQA	X		
5	Julio De La Nuez	X	C	A	X	X	C	C	X	C	NQA	A		
6	McLeod, S.	X	C	X	X	X	C	C	X	C	NQA	X		
7	Williams, Colby				N	X	C	C	X	C	NQA	X		
8	Davy, Olivia						N	C	E	C	NQA	X		
	Quorum = 5	6	C	4	6	6	C	C	7	C	3	7		

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

January 2026

Broward HIV Health Services Planning Council Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Please contact support staff at hivpc@brhpc.org or (954) 561-9681 ext. 1244/1343. Visit HIV Health Service Planning Council for updates.					
				1  **BRHPC Office Closed**	2	3
4	5	6 System of Care Committee Meeting (SOC) **9:30AM – 11:30AM** **Location: BRHPC/MS Teams**	7 Oral Health Network 3:00PM-4:15PM	8 Membership/Council Development Committee Meeting (MCDC) **9:30AM – 11:30AM** **Location: BRHPC/MS Teams** Medical Provider Network 2:30PM-3:45PM	9	10
11	12 Quality Management Meeting (QMC) **12:30PM– 2:30PM** **Location: BRHPC/MS Teams**	13 Behavioral Network 2:00PM-3:15PM	14	15 Priority Setting and Resource Allocation Committee Meeting **9:30AM – 11:30AM** **Location: BRHPC/MS Teams** Executive Committee Meeting **12:45PM – 2:45PM** **Location: BRHPC/MS Teams** Executive Committee Meeting **Election Certification 2:45PM** **Location: BRHPC/MS Teams**	16	17
18	19  **BRHPC Office Closed**	20	21 Quality Network Meeting (CQM) 9:00AM-10:15AM	22 HIV Planning Council Meeting **9:30AM – 11:30AM** **Locations: BRHPC/MS Teams**	23	24
25	26	27 Integrated Planning Workgroup **1:00PM – 4:00PM** **Location: BRHPC/MS Teams**	28	29	30	31 

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

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

January 2026

Broward HIV Health Services Planning Council Calendar

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

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

HIVPC Committee Descriptions

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

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

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

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

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

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

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

Handout B1

SDM
Presentation

Presented by Broward County
Ryan White Part A Office

SDM Changes

- **The current SDM changes were requested to Integrated Primary Care and Behavioral Health & Medical Case Management.**

MCM SDM Changes

- **MCM had a lot of nomenclature updates and minor adjustments. The following slides will only showcase either new or significant changes.**

Key activities include:

- Initial assessment of service needs

- Develop a comprehensive ICP with each client that includes person-centered measurable goals with designated action plans, interventions, and dates of anticipated completion. Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ICP
- Re-evaluate the ICP plan at least every six months, with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Ensure Client receives HIV treatment, defined as:
  - A medical visit with a licensed medical practitioner or advanced practice nurse practitioner (ARNP)
  - An HIV viral load lab result drawn within 6 month or fewer months or CD4 test
  - Client picking up a prescription for HIV-related medication and has a 30-day supply or more.
- Client-specific advocacy and/or review of service utilization

SDM Changes

Updated to include information on timely and coordinated access to medically appropriate levels of health and support services and continuity of care.

Updated to include checking if the client has a 30 day supply or more of HIV-related medication.

Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals, including but not limited to attaining and maintaining viral suppression and undetectable status
- Resolve conflicts or strategize solutions

D. Adherence Counseling to Support Medical Care and Treatment

MCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Conducting ARV medications reconciliation sessions with clients at each encounter or contact point, and include strategies to support client adherence to their ARV regimen.
- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions
- Documenting all adherence counseling activities in the designated HIV HSSS

E. Client-Centered Education and Training on HIV Self-Management

MCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression and the goal to become undetectable.
- Retention in HIV and primary medical care, including health promotion activities, including but not limited to oral health and emotional health.
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning

SDM Changes

Updated existing language to reflect more uses around Case Conferencing and Adherence Counseling

Updated two bullet points around Client-Centered Education to be more in line with best practices. Including adding oral and emotional health.

Acuity Scale

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. MCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

Table 1: Acuity Scale Scoring and MCM Management Levels

Management Level	Points	Health Status/ Medical Condition	Client Contact Frequency	Chart Review Frequency
Self-Management	24-34 Points	Medically stable without need of MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up at least once every six months for reassessment	Once every six months
Basic Management	35-49 Points	Medically stable with minimal MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months	Every 3 months
Moderate Management	50-73 Points	At risk of becoming medically unstable without MCM assistance including documented detectable viral load or risk for viremia	Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month	Every 2 months
Intensive Management	74-96 Points	Medically unstable and in need of comprehensive MCM assistance with an accompanying detectable viral load	Face-to-face at least once a month with phone contact weekly	Monthly

SDM Changes

Acuity scale updated to reflect higher chart review frequency for Moderate Management.

Standard	Measure
15. Provider conducts healthcare monitoring as specified by the ICP.	15.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
16. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	16.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
17. Provider conducts adherence assessments and counseling/coaching sessions to support ARV and other prescribed treatments.	17.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
18. Assistance provided to Client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client.	18.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV HSSS.
19. Providers follows up with clients within two (2) business days of the client's requested communication.	19.1. Documentation of client communication in the designated HIV HSSS.
20. Provider conducts MCM chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in *Table 1*.	20.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV HSSS.
21. After each Client's updated Comprehensive Health Assessment, Providers must schedule multidisciplinary case management conference with a client to address barriers to viral load suppression.	21.1. Documentation in client record.
22. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 1*.	22.1. Documentation of client case management conference in the designated HIV HSSS.
23. Providers must attend all Medical Case Management Network and Quality Network meetings that are presented by Broward County's Ryan White Part A	23.1. Documentation of Provider Network meeting attendance in CQM attendance log.

SDM Changes

The standards section saw a lot minor adjustments and minor updates to reflect the body.

The largest change is number 17 and 21 which added a standard on supporting ARVs and other prescribed treatments and for 21 scheduling a multidisciplinary case management conference.

IPCBH SDM Changes

- **IPCBH had several updates to reflect best practices and the national HIV Curriculum, as well as minor clarifications and nomenclature updates.**

Primary Medical Care Health Assessment

The provider must complete an initial comprehensive health assessment within six months of 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.

14. Annually screen individuals at high risk of nonalcoholic fatty liver disease (those who are obese, have metabolic syndrome or have type 2 diabetes) using FIB-4 index and manage per guidelines.	14.1 Documentation of annual screening in designated HIV HSSS.
15. Agency follow-up via phone with the	15.1. Documentation of referral follow-up in the

22. Clients receive colon and rectal cancer screenings with appropriate referrals based upon clinical guidelines. Anal Cancer Guideline & Colon Cancer Guideline.	22.1. Documentation of screening and results in the client chart.

SDM Changes

The three largest changes were as follows:

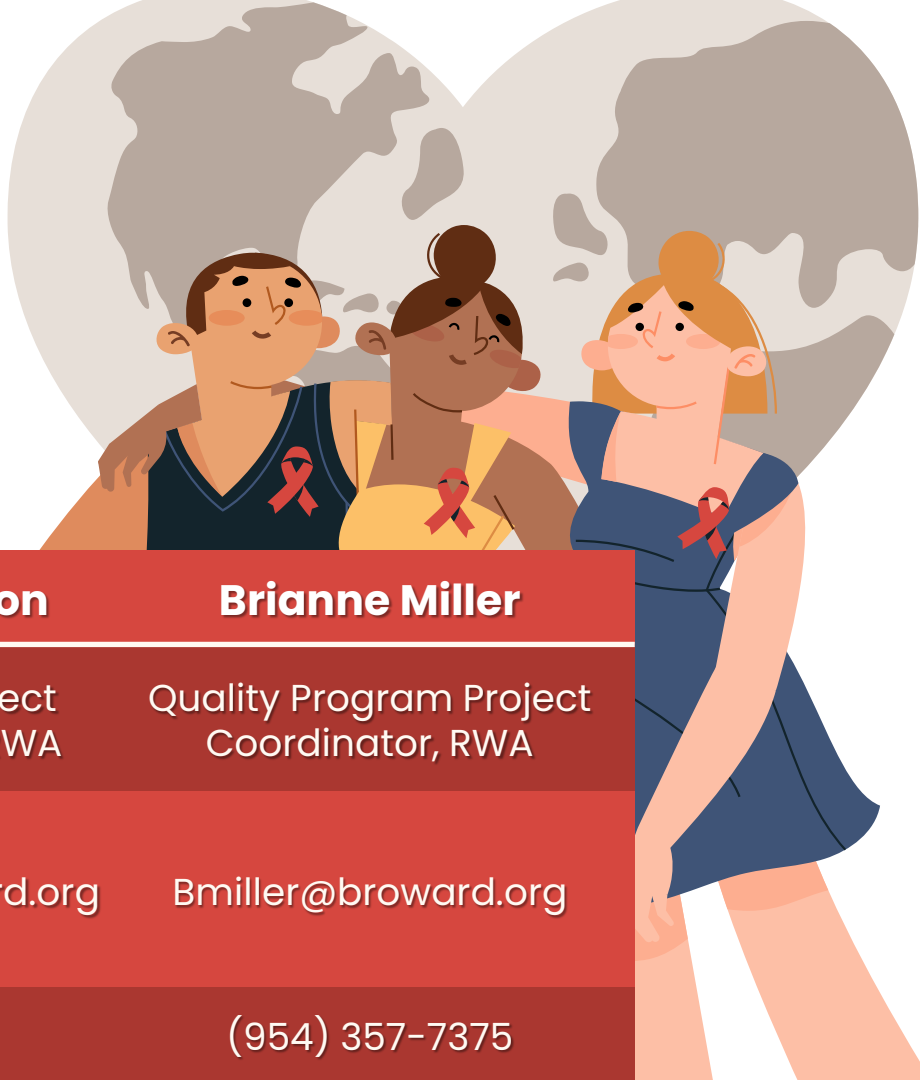
Updated CHA to be within 6 months. Clients often only come a few times a year, or if virally suppressed less. Three sessions could very well go into a year later.

Updated guideline to include annual screening for nonalcoholic fatty liver disease.

Adjusted 22 to include both colon and rectal cancer screening with appropriate guidelines.

THANKS!

Do you have any questions?



Richard Pena	Timothy Thompson	Brianne Miller
Quality Program Project Coordinator, EHE/RWA	Quality Program Project Coordinator Senior, RWA	Quality Program Project Coordinator, RWA
Ripena@broward.org	Timthompson@broward.org	Bmiller@broward.org
(954) 357-5393	(954) 357-7811	(954) 357-7375

Handout B2

BROWARD COUNTY HUMAN SERVICES DEPARTMENT

RYAN WHITE PART A PROGRAM

Integrated Primary Care & Behavioral Health Service Delivery Model

SERVICE DELIVERY MODEL

Broward County Human Services Department
Integrated Primary Care & Behavioral Health
Service Delivery Model

Providers contracted to do business with the Human Services Department are required to follow the policies and procedures in the Standard Terms and Conditions, Unit of Service Funding Agreement, Provider Handbook, Taxonomy Table and the applicable Service Delivery Model, located online at, https://www.broward.org/CommunityPartnerships/Pages/ContractServicesProviderHandbook.aspx#Standard%20Terms%20&%20Conditions,%20Provider%20Handbook%20and%20Taxonomy%20Table%20for%20Unit%20of%20Service%20Shell%20Agreements, to receive reimbursement for services provided to individuals meeting eligibility requirements.

This Service Delivery Model serves as a minimum set of standards to be followed by all providers of Integrated Primary Care & Behavioral Health funded by the Broward County Human Services Department.

For purposes of this Service Delivery Model, the term "Agreement" refers to the executed contract between County and Provider including the Standard Terms and Conditions, Funding Agreement, and all exhibits and documents incorporated by reference. The term "Client" describes eligible individuals receiving Services from a Provider under an Agreement, as more fully described below.

I. SCOPE OF SERVICES: PROGRAM DESCRIPTION, PROGRAM TERMS, AND POPULATION OF FOCUS:

A. PROGRAM DESCRIPTION: 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 rooms or urgent care services are not considered outpatient settings.

In Broward County, Outpatient/Ambulatory Health Services (OAHS) is referred to as Integrated Primary Care and Behavioral Health (IPCBH) and is the systematic coordination of outpatient/ambulatory medical care and behavioral health care services. This includes the provision of professional diagnostic, therapeutic services, and 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 departments and urgent care services are not considered outpatient settings.

B. PROGRAM TERMS:

- **Primary Medical Care** – General health care provided to individuals for the purpose of diagnosing, treating, and managing common illnesses and medical

conditions.

- **Medical Care Assessment** – The systematic evaluation of a patient's health status to identify medical needs, determine the effectiveness of ongoing treatments, and guide future healthcare decisions.
- **Behavioral Health Assessment** – The systematic evaluation of a patient's mental health status to identify mental health needs and determine appropriate treatment recommendations to address mental health concerns.

C. POPULATION OF FOCUS: To be eligible for Integrated Primary Care and Behavioral Health, an individual must meet all the following criteria:

1. **Eligibility Criteria:** To be eligible for Integrated Primary Care and Behavioral Health, an individual must meet all the following criteria:
   - **a.** Be a Broward County resident,
   - **b.** Be age Eighteen Years (18) old or older,
   - **c.** Be diagnosed with a HIV/AIDS.
   - **d.** Must have a household income that does not exceed the 400% of the federal poverty level.
   - **e.** Be uninsured or underinsured, and
   - **f.** Have no other means of funding source to receive Integrated Primary Care and Behavioral Health.
2. **Documentation of Eligibility:** Provider must verify Client financial and program eligibility for treatment prior to Client receiving services. All Clients must be screened for the following:
   - **a.** Verification of Broward County residency,
   - **b.** Completed assessment from Provider or third-party clinician documenting physical and/or developmental disability, as applicable,
   - **c.** Verification of income, and
   - **d.** Verification of insurance.
   - **e.** Verification of Eligibility from Centralized Intake and Eligibility Determination (CIED)

II. STANDARDS AND REQUIREMENTS:

In addition to the Integrated Primary Care and Behavioral Health Service Delivery Model (SDM), all providers must adhere to the minimum requirements outlined in the Broward County Ryan White Part A Universal SDM*. Providers must also adhere to standards and requirements outlined in the* Broward County Human Services Department Provider Handbook for Contracted Service Providers*, individual contracts, and applicable contract adjustments. Providers must refer to their individual contracts for service-specific client eligibility requirements. Providers of oral health care services are expected to comply with*

applicable state, federal, and local standards and guidelines relevant to services delivered within this service category.

Allowable 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

Population of Focus/ Eligibility Criteria

The population of focus for this service category are individuals who are Broward County residents with HIV/AIDS who earn less than or equal to 400% of the Federal Poverty Guidelines, are uninsured or under-insured, have barriers to economic stability, and have no other means or funding source to receive services. The details of the population of focus will be provided in Broward County's Ryan White Part A Universal Service Delivery Model.

Documentation of Eligibility

The provider must verify the Client's financial and program eligibility for treatment prior to the Client receiving services. Client eligibility is verified by examining supporting documentation as indicated in the Documentation of Eligibility section of Broward County's Ryan White Part A Universal SDM. At a minimum, each client must provide a Notice of Eligibility from the Centralized Intake Eligibility Determination Office (CIED).

A. Primary Medical Care

Antiretroviral Therapy 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 Ribonucleic Acid (RNA) is "not detected.")
- Absolute CD4 cell count with percentage CD4
- Complete blood count. If a random blood glucose level is abnormal, repeat fasting
- Plasma HIV RNA (Viral Load): 4-8 weeks after ART initiation or modification, if detectable greater than 50 copies/mL, continue every 4-8 weeks until viral load is less than 50 copies/mL.
- Serum lipids (fasting lipids should be obtained if random levels are abnormal). Consider repeating 1-3 months after ART initiation or modification.
- Comprehensive Metabolic Panel (CMP) *(Serum Na, K, HCO3, 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 is abnormal, repeat fasting.* Repeat 4-8 weeks after ART initiation or modification.
- Hepatitis A Antibody total
- 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.
- Toxoplasma Antibody (IgG)
- Urinalysis
- Chlamydia/Gonococcus, NAAT (s*ite specific swabs as indicated and urine)*
- Syphilis Antibody w/cascading reflex
- Resistance Testing for all persons entering care and when ART failing *(HIV-1 Genotype for P.R. and R.T.). Add INSTI genotype if INSTI resistance suspected or if there is a history of CAB- L.A. use for PrEP. Follow guidelines for drug-resistant testing.*
- Quantiferon TB Gold *If CD4 below 200* cells/mm *at testing, repeat when CD4200*cells/mm.
- HLA-B*5701 *(when initiating an abacavir-containing regimen)*
- Pregnancy test *(for people of childbearing potential)*

B. 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 six months of 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 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's 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 a 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 include but are 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

C. 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
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

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

Behavioral Health Treatment Plan

Behavioral Health Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client in defining goals and 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 the client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to

use the terms “as needed,” “p.r.n.,” or to state that the client will receive a service “x to y times per week.”

- Goals that are individualized, strength-based, and appropriate to the client’s diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client’s parent, guardian, or legal custodian (if the client is under 18 years of age)
- Dated signature of a licensed provider
- A signed and dated statement by the licensed 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. A licensed professional and the client must sign and date the treatment plan.

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

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

III. SUMMARY OF REQUIREMENTS:

Table1: Outpatient Ambulatory Standards for Service Delivery

Requirements	Measure
1. Clients have documentation of HIV+ status in their medical records.	1.1. Documentation of HIV+ test and results in the client chart.
2. The client completed an initial comprehensive health assessment within six months from the time of the 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. Men 40 to 49 years of age and premenopausal women 40 years of age and older without major risk factors 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 their 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 client chart.
5. Men with clinical indications for testosterone deficiency receive a testosterone level drawn fasting between 8-10 am.	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 visits.	6.1. Documentation of PHQ-2 or PHQ-9 score in the client chart.
7. The PHQ-9 assesses clients who score 3 or above on a PHQ-2. 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 visits.	8.1. Documentation of GAD-2 or GAD-7 scores in the client chart.

9. The GAD-7 assesses clients who score 3 or above on a general anxiety disorder (GAD)-2. Clients whose score on the GAD-7 is greater than 8 are referred to Behavioral Health services.	9.1. Documentation of GAD-2 score in the client chart. 9.2 Documentation of GAD-7 score in the client chart 9.3 Referral documented in the designated
10. Clients complete a Tobacco, Alcohol, Prescription Medication, and 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 client chart.
13. Clients aged 40 - 75 years with a 10-year Atherosclerotic Cardiovascular Disease (ASCVD) risk estimate of >20% offer moderate-intensity statin therapy.	13.1. Documentation of statin therapy in designated HIV HSSS.
14. Annually screen individuals at high risk of nonalcoholic fatty liver disease (those who are obese, have metabolic syndrome or have type 2 diabetes) using FIB-4 index and manage per guidelines.	14.1 Documentation of annual screening in designated HIV HSSS.
15. Agency follow-up via phone with the clients referred to behavioral health services to remind them of their first scheduled appointment.	15.1. Documentation of referral follow-up in the designated HIV HSSS.
16. 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.	16.1. Documentation of medical care and treatment plan in the client chart.

17. Clients are offered immunizations in accordance with HHS guidelines.	17.1. Documentation of immunizations in the client chart.
18. ART is prescribed as clinically indicated in accordance with HHS guidelines.	18.1. Documentation of prescribed ART in the client chart.
19. Treatment and prophylaxis for opportunistic infections are provided when clinically indicated in accordance with HHS OI guidelines.	19.1. Documentation of treatment in client chart.
20. Female clients receive cervical cancer screenings as clinically indicated. Clients 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	20.1. Documentation of screening and results in the client chart. 20.2. Referral documented in the designated HIV HSSS.
21. Female clients receive a mammogram annually starting at age 40. Clients with an abnormal mammogram are referred to a specialist and have a plan of care.	21.1 Documentation of screening and results in the client chart. 21.2 Referral documented in the designated HIV HSSS.
22. Clients receive colon and rectal cancer screenings with appropriate referrals based upon clinical guidelines. Anal Cancer Guideline & Colon Cancer Guideline.	22.1. Documentation of screening and results in the client chart.
23. Clients receive lung cancer Screenings as clinically indicated.	23.1. Documentation of screening and results in the client chart.
24. Clients are assessed and counseled for medication adherence at every primary medical care visit.	24.1. Documentation of assessment and counseling provided in the client chart.
25. Clients with CD4 T-cell counts below 200 and/or CD4 percentage less than 14% are prescribed PJP prophylaxis as clinically indicated.	25.1. Documentation of laboratory test results in the client chart. 25.2. Documentation of prescription in the client chart.

26. Women of pregnancy potential receive a pregnancy test at ART initiation and, as clinically indicated, be prescribed ART as clinically indicated. Women of pregnancy potentially 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.	26.1. Documentation of pregnancy screening in the client chart. 26.2. Documentation of ART prescription in the client chart. 26.3. Documentation of sexual history discussing the 5 Ps in the client chart. 26.4. Documentation about birth control methods is included in the client chart.
27. Clients receive sexual health education annually, including pregnancy planning, discussion of condom use, risk identification, and PrEP for partners.	27.1. Documentation of sexual health education in the client chart.
28. Clients are referred to oral health care at baseline and assessed for adherence to oral health recommendations.	28.1. Referral documented in the designated HIV HSSS.

Table2: Mental Health Standards for Service Delivery

Requirements	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 must complete a biopsychosocial assessment ("Biopsychosocial") in the designated HIV HSSS with Client within 30 calendar days of the first encounter with the Client.	2.1 Completed biopsychosocial assessment signed by a licensed professional in the Client file.
3. The provider must ensure that the Biopsychosocial is reviewed and signed by a licensed professional.	3.1 Completed biopsychosocial assessment signed by a licensed professional in the Client file.
4. In conjunction with Client, Provider must develop an individualized treatment plan based ("Treatment Plan") based on the Client needs identified in the Biopsychosocial.	4.1 Treatment plan signed and dated by licensed professional and Client in the designated HSSS.
5. The Provider must conduct a formal review of Client's Treatment Plan in collaboration with Client and the treatment team members identified in the Client's Treatment Plan every	5.1 Updated treatment plan with signature and date of licensed professional and Client in the Client file.

Requirements	Measure
six months, at a minimum.	
6. The Provider must ensure that each Client has at least one (1) Open Action Plan goal.	6.1 At least one (1) Open Action Plan goal documented in Client file.
7. The Provider must provide telehealth or other virtual options as appropriate for Clients to receive Services.	7.1 Documentation of telehealth or other virtual options in Client file.
8. The provider must develop and post the Client Grievance Process in a visible location with copies of a client grievance report form available upon request, in accordance with the Florida Patient's Bill of Rights and Responsibilities, Section 381.026, Florida Statutes.	8.1 Documentation of Visible Client Grievance Process in a visible location of facility. Documentation of Client Grievance Report in Client file.
9. The Provider must ensure Clients receive appropriate and necessary referrals and linkages to programs that are part of a network with other community providers to ensure continuity of care.	9.1 Documentation of referrals in Client file.
10. The provider must attend all Behavioral Health Network meetings and Quality Network meetings that are held by County's RWHAP Clinical Quality Management (CQM) team.	10.1 Documentation of attendance at all Behavioral Health Network meetings and Quality Network meetings.
11. The Provider must maintain and update a Continuity Plan that establishes policies and guidance to ensure performance of functions essential to Services identified in this Agreement during (and after) a declared disaster or pandemic. Provider must provide the Contract Administrator with a copy of its Continuity Plan upon execution of this Agreement and annually on April 15th.	11.1 Documentation of Continuity Plan.
12. The Provider must maintain a protocol that ensures Clients receive appropriate referrals and linkages with Baker Act receiving facilities if crisis intervention services are required ("Crisis Intervention Protocol"). Crisis Intervention Protocols must include after-hours access as described below in Section G., Locations, Days, and Hours of Service.	12.1 Documentation of referral protocol in Client file.

Requirements	Measure
13. Assistance provided to the Client and progress made toward achieving treatment plan goals is documented in the Client file within three business days of meeting with the Client.	5.1 Documentation of Client communication, services provided, and progress made toward treatment plan goals in the Client file.
14. All Client communication is documented in the Client file and includes a date, length of time spent with the 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.
15. Progress notes in the Client file are linked to a treatment plan goal.	7.1 Progress notes in the designated Client file.

IV. OUTCOMES AND INDICATORS:

Outcomes	Outcome Indicators	Data Source (Where the data used to complete the quarterly report is found, verified, and kept)	Measure (Who collects data, when, how; special calculation instructions, if needed)
1. Clients improve overall health through Primary Care Services.	1.1. 85% of clients are retained in Integrated Primary Care and Behavioral Health services.	Client records within the designated HIV Human Services Software System (HSSS)	Quarterly analysis of clients who are considered retained in care. **Calculation:** The number of clients who have received a primary care appointment and/or medication pick-up at least twice a year but no more than three months apart/the number of clients who receive IPCBH services.
	2.1. 90% of clients on ART for more than six months will have a viral load of less than 200 copies/mL.	Client lab records within the designated HIV Human Services Software System (HSSS)	Quarterly analysis of clients who have viral loads of less than 200 copies/mL **Calculation:** The number of clients on ART for more than six months and have a viral load of less than 200 copies/mL/the number of clients who are on ART for more than six months.

Handout B3

BROWARD COUNTY HUMAN SERVICES DEPARTMENT

RYAN WHITE PART A PROGRAM

Medical Case Management

Service Delivery Model

SERVICE DELIVERY MODEL

Broward County Human Services Department
Medical Case Management
Service Delivery Model

Providers contracted to do business with the Human Services Department are required to follow the policies and procedures in the Standard Terms and Conditions, Unit of Service Funding Agreement, Provider Handbook, Taxonomy Table and the applicable Service Delivery Model, located online at, https://www.broward.org/CommunityPartnerships/Pages/ContractServicesProviderHandbook.aspx#Standard%20Terms%20&%20Conditions,%20Provider%20Handbook%20and%20Taxonomy%20Table%20for%20Unit%20of%20Service%20Shell%20Agreements, to receive reimbursement for services provided to individuals meeting eligibility requirements.

This Service Delivery Model serves as a minimum set of standards to be followed by all providers of Medical Case Management] funded by the Broward County Human Services Department.

For purposes of this Service Delivery Model, the term "Agreement" refers to the executed contract between County and Provider including the Standard Terms and Conditions, Funding Agreement, and all exhibits and documents incorporated by reference. The term "Client" describes eligible individuals receiving Services from a Provider under an Agreement, as more fully described below.

I. SCOPE OF SERVICES: PROGRAM DESCRIPTION, PROGRAM TERMS, AND POPULATION OF FOCUS:

A. PROGRAM DESCRIPTION: The Health Resources and Services Administration's Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities undertaken in this service category may be provided by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication), as well as activities taken on behalf of the client (e.g., multidisciplinary case conferences, referrals to other personnel or agencies).

In Broward County, Medical Case Management provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications stemming from co-morbid chronic disease conditions. MCM includes assessment of client needs, development of a coordinated plan of care, and care coordination.

Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments
- Coordinating essential medical and support services and making referrals when

indicated

- Providing adherence counseling to treatment regimens and healthcare and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

B. PROGRAM TERMS

a. Individualized Care Plan: In case management is a personalized roadmap, created collaboratively by a case manager and client, that assesses unique needs, goals, and preferences to coordinate specific services (clinical, social, financial) across a continuum, ensuring patient-centered support for improved health outcomes, quality of life, and autonomy, preventing unnecessary care, and navigating complex systems.

C. POPULATION OF FOCUS: To be eligible for Medical Case Management an individual must meet all the following criteria:

1. Eligibility Criteria: To be eligible for Medical Case Management, an individual must meet all the following criteria:

a. Be a Broward County resident,

b. Be diagnosed with a HIV,

c. Be diagnosed with a HIV/AIDS,

d. Must have a household income that does not exceed the 400% of the federal poverty level.

e. Be uninsured or underinsured, and

f. Have no other means of funding source to receive Medical Case Management.

2. Documentation of Eligibility: Provider must verify Client financial and program eligibility for treatment prior to Client receiving services. All Clients must be screened for the following:

a. Verification of Broward County residency,

b. Completed assessment from Provider or third-party clinician documenting physical and/or developmental disability, as applicable,

c. Verification of income, and

d. Verification of insurance.

e. Verification of Eligibility from Centralized Intake and Eligibility Determination (CIED).

II. STANDARDS AND REQUIREMENTS:

In addition to the MCM 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, Provider Handbook for Contracted Service Providers, individual contracts, and applicable contract adjustments. MCM providers must refer to their individual contract for service-specific client eligibility requirements.

Providers must adhere to standards and requirements set forth in the Provider Handbook, located online at, https://www.broward.org/CommunityPartnerships/Pages/ContractServicesProviderHandbook.aspx#Standard%20Terms%20&%20Conditions,%20Provider%20Handbook%20and%20Taxonomy%20Table%20for%20Unit%20of%20Service%20Shell%20Agreements and applicable amendments and contract adjustments.

Information regarding the Poverty Guidelines may be found online at the Health and Human Services ("HHS") Poverty Guidelines, https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

Providers must comply with the HRSA HIV/AIDS Bureau ("HAB"), Division of Metropolitan HIV/AIDS Program's National Monitoring Standards for Ryan White HIV/AIDS Program (RWHAP) Part A Recipients, accessible online at: https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2023-rwhap-nms-part.pdf.

Providers must follow the guidance in all applicable HRSA HAB Policy Notices and Program Letters to ensure compliance with programmatic requirements. Policy Notices are available online at: https://ryanwhite.hrsa.gov/grants/policy-notices and Program Letters are available online at: https://ryanwhite.hrsa.gov/grants/program-letters.

Providers must comply with 45 C.F.R. Part 75 — Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, accessible online at: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75.

Providers must comply with the Health and Human Services Grants Policy Statement, accessible online at: https://www.hhs.gov/sites/default/files/hhs-grants-policy-statement-april-2025.pdf.

Provider must comply with the federally approved clinical practice guidelines for HIV/AIDS, accessible online at: https://clinicalinfo.hiv.gov/en/guidelines.

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline or the statewide toll-free telephone number (1-800-96ABUSE), in accordance with Chapters 39 and 415, Florida Statutes, as amended. The foregoing provision is binding upon both Providers and its employees.

Providers must register staff to receive alerts regarding revisions to the Provider Handbook and related documents through AccessBROWARD: https://access.broward.org/About.aspx.

MCM providers must comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Key activities include:

- Initial assessment of service needs

- Develop a comprehensive ICP with each client that includes person-centered measurable goals with designated action plans, interventions, and dates of anticipated completion. Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ICP
- Re-evaluate the ICP plan at least every six months, with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Ensure Client receives HIV treatment, defined as:
    - A medical visit with a licensed medical practitioner or advanced practice nurse practitioner (ARNP)
    - An HIV viral load lab result drawn within 6 month or fewer months or CD4 test
    - Client picking up a prescription for HIV-related medication and has a 30-day supply or more.
- Client-specific advocacy and/or review of service utilization

In addition to providing the medically oriented activities above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. Such programs may include Florida Medicaid Managed Care Organizations (MCOs), Medicare Part D, Florida AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's Patient Assistance Programs (PAPs), other state or local healthcare and supportive services, and insurance plans through the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), Marketplaces/Exchanges.

A. Population of Focus/ Eligibility Criteria

The population of focus for this service category are individuals who are Broward County residents with HIV/AIDS who earn less than or equal to 400% of the Federal Poverty Guidelines, are uninsured or under-insured, have barriers to economic stability and have no other means or funding source to receive services. For a full description of the population of focus, the details will be in the Broward County's Ryan White Part A Universal Service Delivery Model.

B. Documentation of Eligibility

Providers of MCM services must verify Client's financial and program eligibility for treatment prior to Client receiving services. Verification of Client eligibility is accomplished by examining supporting documentation as indicated in the Documentation of Eligibility section of the Broward County's Ryan White Part A Universal SDM. At a minimum, each client must provide a Notice of Eligibility from the Centralized Intake Eligibility

Determination Office (CIED).

C. Coordination of Medical and Healthcare Improvement Services

Providers must ensure coordination of medical and healthcare improvement services to support Clients in meeting their ICP goals and maintaining their retention in care by engaging in communication, information sharing, and collaboration with other providers serving the Client within and between agencies in the community at intervals dictated by the acuity scale scoring and medical case management level of the Client. Providers must also provide Ryan White Part A or MAI Integrated Primary Care and Behavioral Health Services or have at least one active agreement with a licensed primary care and behavioral health services provider in Broward County for Provider's Clients to receive those services.

Case coordination and case conferencing includes communication, information sharing, and collaboration that occurs regularly with case management and other providers serving the client within and between agencies in the community.

Coordination includes, but is not limited to:

- Coordinating HIV and co-morbid condition (chronic and acute) treatments
- Communicating with the client's primary care and behavioral health providers and other service providers to support client adherence, understanding, motivation, access to services and optimal engagement in care to include case coordination and case conferencing activities
- Coordinating medical and support service use within the RWHAP system of care, addressing barriers to obtaining services, and linking the client to services
- Coordinating obtaining services, identifying rap-around support services and low barrier linkage and access to treatment and care service programs to establish sustainable retention in HIV treatment and care and improve client health outcomes.
- Coordinating specialty medical services outside the RWHAP system of care
- Coordinating with medical practitioners to prioritize HIV treatment, ARV adherence, and goal setting for other medical conditions, including but not limited to, diabetes, chronic renal failure, chronic obstructive pulmonary disease, cardiovascular conditions, neurocognitive disorders, and cancer

Case conferences include multi-disciplinary service providers, including providers within the agency and those from other agencies when possible and relevant. After each Client's updated Comprehensive Health Assessment, Providers must schedule a case management conference with a Client to address barriers to viral load suppression. Case conferences must be face-to-face or via conference call and must be held at routine intervals or during significant care changes or transitions. High acuity levels established by the Acuity Scale informs the frequency of case conferences. The client and their family members, significant others, or designated caregiver(s) should also be included in case conferences when possible and appropriate. These activities must be recorded in the client's progress notes in the designated HIV Human Services Support Services (HIV HSSS).

Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals, including but not limited to attaining and maintaining viral suppression and undetectable status
- Resolve conflicts or strategize solutions

D. Adherence Counseling to Support Medical Care and Treatment

MCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Conducting ARV medications reconciliation sessions with clients at each encounter or contact point, and include strategies to support client adherence to their ARV regimen.
- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions
- Documenting all adherence counseling activities in the designated HIV HSSS

E. Client-Centered Education and Training on HIV Self-Management

MCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression and the goal to become undetectable.
- Retention in HIV and primary medical care, including health promotion activities, including but not limited to oral health and emotional health.
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning

- Recognizing the signs of stress, distress, anxiety, and depression and strategies to access emotional support services
- Adequate nutrition, regular exercise, and the benefits of stress reduction and self-care.
- Managing health-related social needs
- HIV labs, annual health screening labs and vaccines recommended in the HIV Guidelines (www.hiv.gov)
- Guidance on aging with HIV and health screenings that support healthy aging as recommended in the HIV Guidelines.

F. ASSESSMENT AND INDIVIDUAL CARE PLAN

Comprehensive Health Assessment (CHA)
MCMs must evaluate each Client's access to medical care, health status, health maintenance, health knowledge, treatment adherence, behavioral health needs, and environment and complete an assessment within fourteen (14) calendar days of the Client's initial visit ("Comprehensive Health Assessment") to determine the Client's acuity scale and medical case management level. The CHA must be completed within the designated HIV HSSS. The CHA is used to evaluate each client's access to medical care, health status, health maintenance, health knowledge, treatment adherence, behavioral health needs, and environment. Providers must perform an updated CHA for all Clients whose HIV is not virally suppressed after four (4) months of being prescribed antiretroviral therapy. Assessment findings are used to inform the acuity scale component.

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

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

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

Acuity Scale

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. MCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

Table 1: Acuity Scale Scoring and MCM Management Levels

Management Level	Points	Health Status/ Medical Condition	Client Contact Frequency	Chart Review Frequency
Self-Management	24-34 Points	Medically stable without need of MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up at least once every six months for reassessment	Once every six months
Basic Management	35-49 Points	Medically stable with minimal MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months	Every 3 months
Moderate Management	50-73 Points	At risk of becoming medically unstable without MCM assistance including documented detectable viral load or risk for viremia	Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month	Every 2 months
Intensive Management	74-96 Points	Medically unstable and in need of comprehensive MCM assistance with an accompanying detectable viral load	Face-to-face at least once a month with phone contact weekly	Monthly

Reassessment

Reassessments provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous timeframe of activities. Providers must reevaluate the client's unmet needs and related barriers by conducting reassessments every six months after completion of the initial assessment, or sooner if the client's circumstances change significantly. Reassessment findings are used to update the ICP.

Individual Care Plan (ICP)

Providers must develop an Individual Care Plan (ICP) within 30 days of completing the initial Client visit. MCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The MCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the Client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and/or authorized family member. Providers must ensure that each Client has at least one (1) open ICP goal. MCMs must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

Providers must assist the Client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV HSSS.

1. Professional Requirements

Providers must adhere to the required minimum credentials outlined in the Provider Handbook and Taxonomy Table located online at, https://www.broward.org/CommunityPartnerships/Pages/ContractServicesProviderHandbook.aspx#Standard%20Terms%20&%20Conditions,%20Provider%20Handbook%20and%20Taxonomy%20Table%20for%20Unit%20of%20Service%20Shell%20Agreements

III. SUMMARY OF REQUIREMENTS:

Standard	Measure
1. Providers must evaluate each Client's access to medical care, health status, health maintenance, health knowledge, treatment adherence, behavioral health needs, oral health and environment and complete an assessment within fourteen (14) calendar days of the Client's initial visit (Comprehensive Health Assessment)	1.1. Completed Client Comprehensive Health Assessment in the designated HIV HSSS. 1.2. Progress notes in the Client file/designated HIV HSSS.

Standard	Measure
to determine the Client's acuity scale and medical case management level.	
2. Providers must provide telehealth or other virtual options as appropriate for Clients to receive Services.	2.1. Progress notes in the Client file/designated HIV HSSS. 2.2. Documentation of Client appointments in HIV HSSS.
3. Providers must maintain adequate staffing and procedures to provide timely and coordinated responses to Client communications.	3.1. Documentation in providers Policy and Procedure Manual & HIV HSSS.
4. Providers must be able to respond within seventy-two (72) hours of receiving a communication in any format from a Client.	4.1. Progress notes in the Client file/designated HIV HSSS. 4.2. Documentation of Client encounter in designated HIV HSSS.
5. Providers must perform an updated Comprehensive Health Assessment for all Clients whose HIV is not virally suppressed after four (4) months of receiving a prescription for antiretroviral (ARV) medication.	5.1. Completed Client Comprehensive Health Assessment in the designated HIV HSSS. 5.2. Progress notes in the Client file/designated HIV HSSS.
6. Providers develop an Individual Care Plan (ICP) with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client.	6.1. ICP signed and dated by the provider and client in the designated HIV HSSS.
7. Providers must ensure that each Client has at least one (1) open ICP goal.	7.1. ICP signed and dated by the provider and client in the designated HIV HSSS.
8. Providers must ensure each Client received HIV treatment two (2) or more times within a rolling twelve (12) month period, with each HIV treatment occurring at least ninety (90) days apart.	8.1. Progress notes in the Client file/designated HIV HSSS. 8.2. Documentation of Client HIV viral load, CD4 test, or Client picking up a prescription for HIV-related medication in Client file/designated HIV HSSS.
9. Providers complete a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change.	9.1. Completed CHA in the designated HIV HSSS. 9.2. Progress notes in the designated HIV HSSS.

Standard	Measure
10. All Client records/files will be neatly maintained and organized.	4.1. All client records will contain at a minimum the following documentation: brief intake, current notice of eligibility, confidentiality forms (if applicable), case closure (if applicable), and other documentation an agency deemed appropriate in the designated HIV HSSS. 4.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 4.3. Progress notes in the client file/designated HIV HSSS. 10.4. Confidentiality releases in client file/designated HIV HSSS.
11. Medical Case Managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates Guideline updates, MCM service delivery, client coaching, and health-behavioral change strategies.	5.1. Medical Case Managers will receive, within 6 months of hire, the following required training: annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (500 and 501);
12. As needed, case managers routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical, and non-medical, social and support services	12.1. Evidence of timely case conferencing with key providers is found in the client's records through case note documentation in the designated HIV HSSS.
13. Client health needs are assessed and reassessed using the using the Acuity Scale and the ARV Adherence Assessment.	13.1. Acuity Scale completed and scored in the designated HIV HSSS. 13.2. ARV Adherence Assessment documented in the designated HIV HSSS.
14. Client has contact with the provider at the frequency specified by client's management level.	14.1. Documentation of client communication in the designated HIV HSSS.

Standard	Measure
15. Provider conducts healthcare monitoring as specified by the ICP.	15.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
16. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	16.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
17. Provider conducts adherence assessments and counseling/coaching sessions to support ARV and other prescribed treatments.	17.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
18. Assistance provided to Client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client.	18.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV HSSS.
19. Providers follows up with clients within two (2) business days of the client's requested communication.	19.1. Documentation of client communication in the designated HIV HSSS.
20. Provider conducts MCM chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in *Table 1*.	20.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV HSSS.
21. After each Client's updated Comprehensive Health Assessment, Providers must schedule multidisciplinary case management conference with a client to address barriers to viral load suppression.	21.1. Documentation in client record.
22. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 1*.	22.1. Documentation of client case management conference in the designated HIV HSSS.
23. Providers must attend all Medical Case Management Network and Quality Network meetings that are presented by Broward County's Ryan White Part A	23.1. Documentation of Provider Network meeting attendance in CQM attendance log.

Standard	Measure
Clinical Quality Management (CQM) team.	
24. Providers must maintain and update a Continuity Plan that establishes policies and guidance to ensure performance of functions essential to Services identified in this Agreement during (and after) a declared disaster or pandemic.	24.1. Provider documentation of a Continuity Plan available upon request.
25. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	16.1. Closed cases include documentation stating the reason for closure and a closure summary. 16.2. Supervisor signs off on closure summary indicating approval. 16.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 25.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.

IV. OUTCOMES AND INDICATORS:

Outcomes	Outcome Indicators	Data Source (Where the data used to complete the quarterly report is found, verified, and kept)	Measure (Who collects data, when how; special calculation instructions, if needed)
1. Clients achieve Individual Care Plan (ICP) goals.	1.1. 85% of Clients achieve one (1) or more ICP goals by the target resolution date.	Client ICP goals in the designated HIV HSSS (Provide Enterprise).	Providers compiles data and reports to Broward County quarterly, along with a comparison of quarterly averages. **Calculation:** Clients receiving Services who successfully achieved one or more ICP goals by the target date during the reporting period / The total number of Clients who received Medical Case Management Services and had at least one (1) open ICP goal during the reporting period.
2. Clients are retained in care.	2.1. 85% of Clients are retained in care.	Client information in the designated HIV HSSS.	Providers compiles data and reports to Broward County quarterly, along with a comparison of quarterly averages. **Calculation:** The number of Clients who are retained in care / The number of Clients who have received Medical Case Management Services under this program from the service providers for at least 12 months.

Handout C

SHOWCASING QUALITY IN ACTION

DAY TWO

Join us as each agency presents its FY25-26 Quality Improvement Project(QIP), sharing progress, outcomes, and best practices aimed at enhancing quality and performance.

REGISTER NOW

Presented by
RWPA QUALITY NETWORK

11:30am-3:45pm

February 18, 2026

Anne Kolb Nature Center
751 Sheridan St,
Hollywood, FL 33019

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

Handout D

BROWARD HIV HEALTH SERVICES PLANNING COUNCIL

Annual Retreat 2026

To review key data and community needs assessment findings to inform and strengthen strategic planning for the 2027–2031 HIV Prevention and Integrated Care Plan—ensuring a responsive, data-driven approach to improving outcomes.

Voices United:

Planning with Purpose

Thursday, February 26, 2026

10:00AM to 4:00PM

Anne Kolb Nature Center
751 Sheridan St, Hollywood, 33019

Scan QR to RSVP
or Click Link Below

RSVP for HIVPC Annual Retreat

Contact Planning Council Support Staff
Ema h vpc@brhpc org
Te 954-561-9681 x 1244 OR x 1343
Webs te browardh vpc org

From: Choe, Ulyee [redacted]
Sent: Thursday, January 8, 2026 3:27 PM
Subject: ADAP Formulary Changes

Handout E1

Dear Colleagues,

As you are probably aware, ADAP will be moving to a financially sustainable model to benefit the largest population of ADAP clients. We will continue to support the current model (direct dispense, CVS Caremark and insurance) for a two month period to ensure ADAP clients have ample time to seek insurance and medication assistance, if no longer eligible to receive ADAP services through the department. Following this transition period, we will move to direct medication dispensing, capping the eligible federal poverty level at 130%, as well as implementing ADAP formulary changes starting March 1, 2026.

Regarding the formulary changes, Biktarvy will be removed and Descovy will be restricted to only those with renal insufficiency (CrCl <60). All other current ART medications including Tivicay will be available. However, we will monitor cost closely and adjust if needed. A few actions to consider:

- Upon follow up visits, transition to new ART regimen such as Tivicay plus Truvada, other Truvada-based or NRTI-based regimen in combination with integrase inhibitors, or alternative class outside of integrase inhibitors. Please refer to the treatment guidelines: Initiation of Antiretroviral Therapy | NIH.

- For patients on those Biktarvy or Descovy, ensure they have adequate medication until their next clinical visit prior to March 1st.

- For Descovy, providers are required to document the reason: due to CrCl <60 or renal insufficiency on the prescription note section.

Will keep you posted on any additional changes. As always, please reach out if you have any questions.

Bcc: DL DOH CHD Administrators Directors, DL CHD Medical Directors; DL CHD Nursing Directors Only; DL CHD Clinical Providers

Ulyee

Ulyee Choe, DO

Director

Florida Department of Health in Pinellas County

County Health Systems Statewide Medical Director

205 Dr. Martin Luther King Jr. St. N

St. Petersburg, FL 33701

(727) 824-6921

www.PinellasHealth.com

AIDS DRUG ASSISTANCE PROGRAM

UPDATES TO ADAP

Due to rising health care insurance premiums nationwide and lack of additional Ryan White Grant funding, adjustments have been made to ensure resources the greatest number of individuals within our funding constraints.

The Department remains committed to delivering services through this vital program and will instead cover the costs of HIV medications directly for individuals at or below 130% of the **Federal Poverty Level**. The Department will also cover costs during a two-month transition period to ensure clients have adequate time to connect to services if they are impacted by these changes. These adjustments will prevent a shortfall of more than $120 million for Florida.

We encourage those in need to connect with available community resources to help with connection to care:

PATIENT ASSISTANCE PROGRAMS

- National Alliance of State and Territorial AIDS Directors (NASTAD) Pharmaceutical Companies Patient Assistance Programs and Cost-Sharing Assistance Programs
- Patient Advocate Foundation Co-Pay Relief
- HarborPath Non-Profit Assistance

COMMUNITY, STATE, AND FEDERAL RESOURCES

- Florida Association of Community Health Centers
- Florida Non-Profit HIV/AIDS Organizations
- Florida Medicaid
- Medicare (individuals age 65 and older
- Medication Discounts
- Medicine Assistance Tool
- U.S. Department of Veteran Affairs

The AIDS Drug Assistance Program (ADAP) is a statewide, federally-funded prescription medication program for low-income people living with HIV. This program provides access to medications to eligible clients either directly or by purchase of health insurance that includes coverage for HIV medications.

STEP 1: Eligibility and Verification

STEP 2: Enrollment

STEP 3: Getting Prescriptions Filled

SAME DAY Program

ADAP Insurance

Quarterly Reports

Program Assistance

ADAP Medication ADAP Formulary Workgroup

INDIVIDUAL & FAMILY HEALTH

Health Insurance Premium Assistance Program

ACA Insurance Open Enrollment

November 1st – December 15th

for Coverage beginning 1/1

December 16th – January 15th

for Coverage beginning 2/1

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

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

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

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

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

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

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

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

BRHPC

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

HIV HEALTH SERVICES PLANNING COUNCIL MEETING GROUND RULES

1. The Council, its members, and the public recognize and respect the committee process adopted by this Council. The Council, its members, and the public recognize that full discussion and analysis of issues occurs at the committee level rather than at Council meetings.

2. Before a member can make a motion or speak in debate, the member must be recognized by the Chair as having the exclusive right to be heard at that time.

3. All speakers are expected to address the Council in a respectful manner to respect time limits, to speak briefly and to the point, and to stay on agenda. All other persons in attendance should not interrupt the speaker who is recognized by the Chair as having the floor.

4. If the member who made the motion claims the floor and has not already spoken on the question, that member is entitled to be recognized in preference to other members.

5. No person is entitled to the floor a second time in debate on the same item as long as any other person who desires the floor has not spoken on the item.

6. Speakers should restrict comments and debate to the pending question or motion. Speakers must address their remarks to the Chair and maintain a courteous tone. The Chair may impose time limits on debate or discussion to ensure efficient conduct of Council business.

7. Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Grantee, outside of the meeting.

8. Members of the public may only address the Council upon recognition by the Chair. They are subject to the same rules of conduct expected of Council members.

9. No alcohol or drug use (unless prescribed by a licensed physician), is permitted at Council meetings, grantee or support staff offices.

10. No abusive language, threats of violence, or possession of weapons are permitted in Council meetings, grantee or staff offices.

11. Repeated violation of these meeting rules may result in no further recognition of the offending member or attendee by the Chair at that meeting. Any serious breach of conduct which disrupts the Council's meeting may subject the offender to removal from the meeting, administrative or legal process.

Revised 7/24/14

CONSEJO DE PLANEACIÓN DE SERVICIOS DE SALUD VIH
REGLAS BÁSICAS DE LA REUNIÓN

1. Los miembros deberán aceptar y respetar el proceso de comité adoptado por este Consejo. Las discusiones y el análisis en pleno de los temas tendrán lugar a nivel de comité y no en las reuniones plenarias del Consejo.

2. Antes de que un miembro pueda iniciar una moción o de que una persona pueda hablar en un debate, el Presidente de la reunión deberá reconocer que él o ella tienen el derecho exclusivo de hablar en ese momento dado.

3. Se espera que todos los ponentes se dirijan al Consejo de una manera respetuosa, que no se interrumpa al ponente con derecho al habla en el momento, que cuando se hable se haga de forma clara y concisa, y que se mantenga la agenda.

4. Si el miembro que inicia una moción no ha hablado todavía y reclama su derecho a hablar sobre un asunto, él/ella tendrán el derecho a que con preferencia se les reconozca.

5. Nadie tendrá derecho a reclamar el habla por una segunda vez, en un debate sobre el mismo tema, cuando otra persona que no ha hablado todavía, desea hacerlo.

6. Los debates deben ceñirse a los asuntos o mociones que estén pendientes. Al hablar, los ponentes deben referirse al Presidente, y mantener un tono cortés.

7. Los miembros del público solo podrán dirigirse al Consejo cuando hayan sido reconocidos por el Presidente de la reunión. Estarán sujetos a las mismas reglas de conducta que se esperan de los miembros del Consejo. Se establecerán límites de tiempo según sea necesario para garantizar que los asuntos del Consejo cursen de manera eficiente.

8. Miembros del público sólo podrán dirigir el Consejo a partir del reconocimiento por el Presidente. Están sujetos a las mismas reglas de conducta que se espera de los miembros del Consejo.

9. No estará permitido el uso de bebidas alcohólicas o de drogas en las reuniones del Consejo y tampoco en las oficinas del personal de soporte y donatarios.

10. No está permitido el uso de lenguaje abusivo, amenazas de violencia y posesión de armas en las reuniones del Consejo ni en las oficinas del personal de soporte y donatarios.

11. La repetida violación de estas reglas básicas dará como resultado que el Presidente de la reunión deje de reconocer al derecho a participación del ofensor o miembro de la audiencia. Cualquier violación de conducta grave, que perturbe la reunión de Consejo, terminará en la remoción del ofensor, de la reunión.

Revised 7/24/14

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV RÈGLEMAN RANKONT-YO

1. Manm-yo dwe rekonèt epi respekte pwosesis komite-a ke Konsèy-la adopte. Diskisyon ak analiz total pwoblèm-yo fèt nan nivo komite-a; li pa fèt pandan rankont tout Konsèy-la.

2. Anvan yon manm ka fè yon pwopozisyon oswa nenpòt ki moun gen dwa pale pandan yon deba, fòk Prezidan Komite-a bali dwa esklizif pou fè moun tande-li nan moman sa-a.

3. Yo atann-yo aske tout moun k'ap pale ak Konsèy-la fè-li avèk respè, pou pèsonn pa koupe moun ke Konsèy-la bay dwa pale lapawòl, pou moun k'ap pale-a respekte kantite tan yo ba-li pou pale-a, pou li di sa l'ap di-a rapidman epi avèk presizyon, epi pou li respekte ajanda-a.

4. Si manm ki fè pwopozisyon-an mande pou li pale epi si li poko pale sou keksyon-an deja, li gen priyorite sou lòt manm-yo.

5. Pèsonn moun pa gen dwa pran lapawòl de fwa sou yon menm sijè si gen lòt moun ki poko pale epi ki vle esprime tèt-yo.

6. Deba-a dwe rete sou keksyon oswa pwopozisyon k'ap fèt-la. Moun k'ap pale-a dwe adrese sa l'ap di-a bay Prezidan Komite-a epi pale sou yon ton ki make ak respè.

7. Manm piblik-la dwe pale ak Konsèy-la sèlman si Prezidan Konsèy-la bay-yo lapawòl. Yo dwe respektè menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesesè pou zafè Konsèy-la byen mache, yo gen dwa bay-yo yon limit tan pou yo pale.

8. Manm nan piblik la sèlman pou adrese a konsèy sou rekonèsans sou chèz la. Yo ka tonbe anba menm lòd de kondwit ki te espere nan manm konsèy yo.

9. Itilizasyon alkòl ak dwòg (sòf si se yon doktè lisansye ki preskri-li), entèdi nan rankont Konsèy-la oswa nan biwo estaf sipò-a oswa Resevè-a.

10. Vye langaj, menas vyolans, oswa posesyon zam entèdi nan rankont Konsèy-la oswa nan biwo estaf-la oswa Resevè-a.

11. Vyolasyon repete règleman rankont-yo ap lakòz yon manm oswa lòt moun k'ap asiste rankont-lan pa kapab patisipe ankò. Nenpòt ki move kondwit serye ki twouble rankont-la ap lakòz yo mete moun-nan deyò.

Revised 7/24/14

Acronym List

ACA: The Patient Protection and Affordable Care Act

ADAP: AIDS Drugs Assistance Program

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

IW: Integrated Workgroup

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level

FQHC: Federally Qualified Health Center

HAB: HIV/AIDS Bureau

HHS: U.S. Department of Health and Human Services

HICP: Health Insurance Continuation Program

HIV: Human Immunodeficiency Virus

HIV HSSS: HIV Human Services Software System

HIVPC: Broward County HIV Health Services Planning Council

HOPWA: Housing Opportunities for People with AIDS

HRSA: Health Resources Services Administration

IDU: Intravenous Drug User

JLP: Jail Linkage Program

LPAP: Local AIDS Pharmaceutical Assistance Program

MAI: Minority AIDS Initiative

MCDC: Membership/Council Development Committee

MCM: Medical Case Management

MH: Mental Health

MNT: Medical Nutrition Therapy

MOU: Memorandum of Understanding

NBHD: North Broward Hospital District (Broward Health)

NGA: Notice of Grant Award

NHAS: National HIV/AIDS Strategy

NMCM: Non-Medical Case Management

NOFO: Notice of Funding Opportunity

nPEP: Non-Occupational Post Exposure Prophylaxis

NSU: Nova Southeastern University

nPEP: Non-occupational Post-Exposure Prophylaxis

OAHS: Outpatient Ambulatory Health Services

OHC: Oral Health Care

PCN: Policy Clarification Notic

PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

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

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

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

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

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

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

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