Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

Committee Meeting Agenda: System of Care Committee
Date/Time: Tuesday, March 28, 2017 1:00 p.m.
Location: Children's Diagnostic and Treatment Center
Chair: Marie Hayes **Vice Chair:** Cheryl Edwards

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*

2. **APPROVALS:** 3/28/17 Agenda

3. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Accomplishments*
Committee Overview	ACTION ITEM: Discuss the scope and focus of the System of Care Committee. Review and discuss SOC Policies and Procedures
Work Plan	ACTION ITEM: Review and discuss FY2017 SOC Work Plan
SOC Timeline	ACTION ITEM: Review timeline for next steps in Black Women's Intervention

4. **GRANTEE REPORT**

5. **PUBLIC COMMENT**

6. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** April 25, 2017 1:00 p.m. **VENUE:** CDTC

Goal/Work Plan Objective #:	*Accomplishments*
SOC Policies and Procedures and Work Plan	ACTION ITEM: Approve SOC P&Ps and FY17 Work Plan
Black Women Intervention Study Design	ACTION ITEM: Discuss potential study design, develop questions for focus groups, and provide recommendations for Needs Assessment Consultant

7. **ANNOUNCEMENTS**

8. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

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

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

HANDOUT A

MAI Enhanced Care Coordination Program

Background:

The Quality Management Committee (QMC) drilled down viral load data from FY 14-15 and identified three key populations with the lowest viral load suppression:

1. Non-Hispanic Black Heterosexual Females (Aged 18-38)
2. Non-Hispanic Black MSM (Aged 18-38)
3. Non-Hispanic Black Heterosexual Males (Aged 18-38)

The Priority Setting Resource Allocations (PSRA) Committee has worked to review QM data and previous recommendations regarding these 3 target populations. After a thorough discussion and review of relevant data variables, results, and recommendations for an intervention for unsuppressed individuals ages 18-38, the following recommendations for next steps were made:

Recommendations:

1. Identify one (1) population in which to focus an enhanced MAI Care Coordination program, for the duration of at least 12 months
    a. Population recommendation: Unsuppressed Black Heterosexual Females ages 18-38
2. Implement an enhanced care coordination program (offering home- and field-based patient navigation services, coordinating medical and social services, providing support and coaching for medication adherence, and assisting clients with gaining skills and knowledge to maintain a stable health status) for target population, non-agency specific, employing up to 3 FTE to follow targeted clients through the duration of the program. Upon completion of the program (self-sufficiency), clients will be re-entered into the regular Part A system. Depending on level of need, clients meet weekly, monthly or quarterly with assigned CM/CC staff.
    a. Program components can include:
        i. outreach for initial case finding and after any missed appointment
        ii. case management, including social services and benefits assessments
        iii. multidisciplinary care team communication and decision-making via case conferences
        iv. patient navigation, including appointment reminders, assistance with scheduling appointments, transportation resources, and accompaniment to primary care visits
        v. ART adherence support, including directly observed therapy for individuals with greatest need
        vi. structured health promotion and education resources

Next Steps:

More qualitative information is needed regarding the following: service gaps; unmet need; client's perceptions around taking ART and adhering to treatment; history and effects of trauma exposure; geographic proximity to HIV services; and minorities' needs specific to mental health and substance abuse. The SOC Committee can further explore these elements through surveying, focus groups, forums, etc. to attain more information for the development of this enhanced service. As SOC conducts population studies on each identified MAI population, they may send recommendations regarding targeted interventions specific to the needs of each population back to PSRA.

HANDOUT B

SYSTEM OF CARE COMMITTEE
Policies and Procedures

Approved 11/20/14

Policies

The Committee shall conduct activities to evaluate the system of care and its impact on people living with HIV and receiving Part A services in the Broward County EMA. The Committee will be responsible for advising the Planning Council on how these issues may impact the Broward County EMA and may recommend response strategies.

At a minimum, analyzing and evaluating the system of care for Part A eligible clients will include activities to:

- Identify the inventory of resources available for service delivery for PLWHA in Broward County to ensure a seamless continuum for Part A eligible clients.
- Determine if Part A services are delivered as designed by identifying client needs, service gaps, barriers, and outcomes of subpopulations.
- Ensure that issues pertaining to specific subpopulations are addressed and make recommendations to appropriate HIVPC standing committees.

Procedures

System of Care Components:

- An analysis of utilization trends for the HIV population in the Ryan White Part A system of care;
- The committee will identify capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities.

Work Plan Components:

- Assist in the Priority Setting and Resource Allocation (PSRA) process, including developing language on "How Best to Meet the Need" (*HRSA-defined*);
- Collaborate with community partners to evaluate the HIV Care Continuum in Broward County.
- Conduct utilization focused evaluation of the HIV Care Continuum to identify and address the drop-offs along the stages specific to service provider, geographic location and individual characteristics (Integrated Plan Strategy 2.2.a)
- Develop strategies specific to the needs, attitudes and behaviors of the identified priority/MAI populations (Integrated Plan Strategy 3.1.a)

Assess Effectiveness of Services Offered in Meeting the Identified Needs:

1. Identify and approve tools/data needed to perform an assessment, including relevant reports, questionnaires, or other sources of information.
   a. Aggregate Service Outcome Data
   b. Initial and Updated Implementation Plans
2. Develop those tools not currently available
3. Review data
4. Evaluate the Assessment Process

Membership

Prospective members of the SOC shall complete a Standing Committee application to be returned to Planning Council Staff or the Committee Chair. Council Committee Chairs shall appoint, with the approval of the Council, the members of each committee. Committee membership should reflect the demographics of the local epidemic and consideration shall be given to race, ethnicity, self-acknowledged HIV-positivity, and gender. Membership should include Broward's community stakeholders, Ryan White consumers, and HIV frontline workforce across different stages of the HIV Care Continuum. Members should be individuals who bring skills related to the needs of HIV-positive Broward County residents, and who can provide insight into the needs, gaps and barriers facing Part A clients in the county.

HANDOUT C

FY 2017-18 System of Care Committee Work Plan

The work plan is intended to help guide the work of the committee and to assist the System of Care Committee in achieving its objectives in the coming year. For each activity, the time period of activity is highlighted in blue and the completion date is noted with an "X".

GOAL: Develop an intervention program targeting identified populations

Objective 1: Improving engagement at each stage of the HIV Care Continuum

Activities	Frequency	Responsible Party	Outcomes	Action Items/Data Prep	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
1.1 Collaborate with community partners to evaluate the Broward County Ryan White Part A Program's HIV Care Continuum	Ongoing	SOC	Establish an Integrated System of Care to evaluate Broward's HIV Care Continuum	Invite community partners to discuss HIV testing, linkage, care and treatment and adherence, etc. Analyze systems, successes and failures along the bars of the Continuum as it pertains to MAI target populations.												
1.2 Conduct utilization focused evaluation of the HIV Care Continuum to identify and address the drop-offs along the stages specific to testing site, service provider, geographic location and individual characteristics (Integrated Plan Strategy 2.2.a) **(YEAR 1-2)**	Ongoing	SOC/QM	Increase access to care and improve health outcomes	Collect and compare qualitative and quantitative data (QM, focus groups, community forums, key informant interviews) to identify trends in utilization and barriers for identified MAI target poulations: 1. Black heterosexual females 2. Black heterosexual males 3. Black MSM Develop recommendations to address identified trends and send to PSRA.												
1.3 Develop strategies specific to the needs, attitudes and behaviors of the identified priority/MAI populations (Integrated Plan Strategy 3.1.a) **(YEAR 1)**	As Needed	SOC/PSRA/QMC	Address and reduce HIV-related health disparities and health inequities	Review QMC and Needs Assessment data and send the PSRA Committee recommendations for MAI models and other relevant strategies that address barrier reduction and identified needs of identified minority populations.				X								
1.4 Design a Ryan White/Prevention Collaborative to create a model that ensures a seamless continuum for HIV+ individuals to transition from testing and counseling sites to linkage, treatment and retention in Medical Care (Integrated Plan Strategy 2.1.a) **(YEAR 1-2)**	Integration Year 2	SOC	Increase access to care and improve health outcomes	Involve community stakeholders in the process. Develop a process map of the HIV Care Continuum.												

Objective 2: Develop a coordinated and integrated priority setting and resource allocation process and combined funding initiatives (Integrated Plan Strategy 4.1.a)

Activities		Responsible Party	Outcomes	Action Items/Data Prep	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2.1 Review needs assessment data to guide the development of How Best to Meet the Need (HBTMTN) language.	Annually	Staff/SOC/ PSRA	Data driven PSRA process	Develop language for HBTMTN and send recommendations to PSRA					X							
2.2 Make recommendations for eligibility changes and service categories to be funded	Annually	Staff/SOC/IC	Integrated System of Care	Review data and make recommendations for an integrated System of Care					X							

HANDOUT D

SOC's Black Women Intervention Timeline

March:

- Discuss MAI target populations and background
- Identify target population for SOC study
- Review timeline of next steps

April:

- Discuss potential study design
- Develop questions for focus groups
- Provide recommendations for Needs Assessment Consultant

May:

- Discuss recruitment of study participants
- Discuss study implementation beginning in June
- Determine next meeting date for update/preliminary study results