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: Wednesday, May 31, 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:** 5/31/17 Agenda, 4/25/17 Meeting Minutes

3. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Accomplishments*
SOC Policies and Procedures and Work Plan	ACTION ITEM: Approve SOC P&Ps and FY17 Work Plan
Black Women Study Questions	ACTION ITEM: Update on progress towards focus group implementation

4. **UNFINISHED BUSINESS**
   a. Data Request- Update on May data requests
5. **GRANTEE REPORT**
6. **PUBLIC COMMENT**
7. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** June 27, 2017 1:00 p.m. **VENUE:** CDTC

Goal/Work Plan Objective #:	*Accomplishments*

8. **ANNOUNCEMENTS**

9. **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 •

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Committee Meeting Minutes: System of Care (SOC) Committee
Date/Time: Tuesday, April 25, 2017, 1:00 p.m.
Location: Children's Diagnostic and Treatment Center
Chair: Marie Hayes **Vice Chair**: Cheryl Edwards

ATTENDANCE					
	Members	**Present**	**Absent**		V. Valverde
1	Hayes, M. *Chair*	**X**			T. Pietrogallo
2	Edwards, C. *Vice Chair*	**X**			J. Starkey
HIVPC Staff					Y. Arencibia
L. Ewart					L. Ivey
B. Johnson					D. Vargas
V. Oratien					Y. Gonzalez
Grantee Staff					Y. Barrientos
L. Jones					J. Rodriguez
Guests					V. Rolle
D. Sabatino					M. Ronik

1. CALL TO ORDER

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

2. APPROVALS:

None.

3. MEETING ACTIVITIES/NEW BUSINESS

a.) Data and Literature Review: The HIVPC Health Planner provided a presentation illustrating the disparities among Black women in the HIV Care Continuum. Black women in the Ryan White Part A system of Broward County are less likely to be virally suppressed than consumers overall as well as their White and Hispanic counterparts. Commonly cited barriers include income, stigma, family obligations, and housing. There is a recognizable drop off point between those prescribed their ARVs and those who are virally suppressed. A guest asked how the suppressed viral load percentage can be higher than the percentage of clients retained in care. The Grantee explained that retention in care is defined as a client who received 2 or more medical visits in the reporting period (1 in each 6 month window). Consumers may have a suppressed viral load without meeting that criteria. The Chair commented that the data shows there were less people in care in 2016 than were prescribed medication. Another guest added that the system fails to look at people who are insured privately because that data is not entered. The Grantee agreed that these results are based on PE data for Part A clients alone. There are 1,839 Black females in the Part A Program. Of those, 89.2% were in care in the past year,

and 64% were retained in care. 90% were prescribed ARVs, but 77% of Black women were virally suppressed.

The Health Planner gave the meeting participants an overview of programs, surveys and QIPs implemented that may provide insight into SOC's proposed Black women study. The Women of Color Initiative was a Special Projects of National Significance (SPNS) project funded by HRSA from 2009 through 2014 that provided grants to ten locations to develop interventions for women of color (WOC) in severely underserved areas. The aim of the program was to increase WOC's access to and retention in care. Results indicated that the likelihood of not being retained in care was associated with indecision about seeking HIV/AIDS care, presence of children under the age of 18, residing in an institutional setting, and women believing that nothing would help them. Reductions in the likelihood of being virally suppressed included increased age, current substance abuse, self-reports of poor health, and reporting 14 or more days of limited activity. Though retention and viral suppression are usually looked at separately in literature, this study examined both measures by focusing on an impoverished, vulnerable prospective cohort of women of color. Findings suggest that retention and viral suppression were influenced by different factors, and that interventions seeking to improve retention may require program components and strategies that differ from interventions aiming to improve viral suppression. Identifying women who are caring for children, uncertain about wanting HIV care, believing that nothing could help them with the HIV may be important indicators of women who will need more intense monitoring of visit patterns of medical/nonmedical care. Women who report current substance abuse/other risk behaviors, have others living with them, self-report themselves as being in fair/poor health or as having activity limitations may all have cognitive/physical limitations that affect their medication adherence, and consequently viral suppression.

The Positive Women's Network (PWN) led a Community-Based Participatory Research project to determine what women living with HIV need to stay healthy. One important point about this project is that it was created by HIV-positive women for HIV-positive women. Participants were asked what was working, what was not, and what women needed to remain in care. A significant amount of respondents were low income with 89.7% of participants being below 138% of the Federal Poverty Level (FPL). Many surveyed women were also unstably housed, had family responsibilities, and relied on subsidized health care for primary health care coverage. While most participants were consistently in care, many faced significant barriers. 50% of respondents who had missed a medical appointment in the past year cited transportation as the reason. 32% of respondents had missed filling a prescription for HIV medications in the past year. Primary reasons were: lack of transportation (24%), copay cost (15%), and pharmacy hours (11%). 50% of participants who reported needing child care services on site at their medical provider did not receive those services. The PWN Project found that financial and structural barriers were interrelated. All respondents who reported they had missed filling a prescription due to copay cost in the past year also reported that they had missed a medical appointment due to lack of transportation.

In 2015, the Broward Part A Case Management Quality Improvement (QI) Network conducted a Barriers to Care Quality Improvement Project (QIP). The Case Management QI Network determined that Black females had significantly low rates of viral suppression compared to other populations. The Network was interested in learning why this population was not achieving viral suppression and what barriers to care exist for Black females. The most commonly reported barriers to care were lack of personal financial resources and mental health issues including depression and anxiety. Over 50% of the clients had a reported mental health issue but utilization of mental health services among black females is as low as 1-2%. Additionally, the QIP found that common barriers included lack of

transportation, unstable housing, and not taking medications. Some clients thought of taking their medication as optional while some were concerned with family members and friends seeing them take their medications.

The SOC Chair stated that the System of Care Committee's initial focus will be on Black women's viral suppression rates and retention in care. Guests were asked what information should be collected to improve viral load suppression and retention in care of Black women in Broward County. The Committee is planning to use focus groups, key informant interviews, and limited surveying to collect data. Through analysis of this feedback, SOC will determine gaps and barriers and make recommendations for system improvement. Finally, the Committee will design and implement the MAI Black Women Program.

One guest asked whether or not the needed information could be extracted from Part A's previous needs assessment. The Grantee responded that the most recent needs assessment has been completed and will soon be available for review, but the needs assessment has a broader scope of questions and does not focus on the specific needs of Black women. What SOC is doing now is focusing on this target population and finding out why women are dropping out of care. The needs assessment was more global, this is more specific.

The Chair stated that this information is different from what was previously presented. The indecision about seeking HIV/AIDS care included in the SPNS findings is listed nowhere else. SOC needs to hone the questions to delve into things and figure out next steps for tackling viral load suppression and retention in care from there. Maybe with this population, those two pieces of the Care Continuum do need to be linked closer. The Chair then requested more information on the PWN study, their survey questions and how it implemented.

ACTION ITEM: Provide data on the demographic breakdown of Black women in PE, including Haitian, African American, Caribbean, etc.

One guest commented that oftentimes, the focus is on why people who do not take their medication. It is hard to get that information from people who do not attend meetings. The Chair added to this point, stating that it would be interesting to see what changed for people who were not virally suppressed but now are.

Another guest suggested that women could be engaged through Test & Treat and DIS workers asking a couple of questions. The Grantee said that it is sometimes best to work with focus groups. This needs to be done in an environment in which women are able to have free conversation. It needs to be a series of conversations with a diverse group of women. Barriers will be similar but come from different places. A guest proposed listening tours through providers because he believed people in focus groups do not answer questions with straight answers, they tell stories.

Another guest stated that camaraderie and relationship building are part of the successes of SPNS Women of Color study. Women enriched their lives through participating; talking to one another became part of their care and made them feel valued and empowered. By having women talk about their experiences in this way, data can be collected but women can also be engaged by being given the opportunity to share their stories. Another guest agreed that the buddy system will help people to be retained in care.

One guest asked about stigma being an issue. Some women may not want to participate for fear that someone they know will discover their status.

The Chair stated that all three suggested methods of data collection should be employed. She further stated that focus groups should include women who have gone from doing poorly to doing well, women who have fallen out of care should be spoken to one-on-one, and surveys should be implemented through DIS workers. The HIVPC Health Planner emphasized the importance of asking the same questions so that the collected information can be analyzed and themes documented.
A guest stated that we may think that we know what the barriers are and what women need, and that might be 80% accurate. However, we might get that remaining 20% that was completely unknown from having these different strategies to gather that information. Generalizations have been made in the past, and program developed around those haven't been as successful as would have been hoped.
In doing the focus groups, having that peer support component to co-facilitate or do one-on-one interviews will be key. Another guest added that even when a professional is required, a peer can make a huge difference. It has to be genuine because people see through it a mile away. Depending on the scope and scale of the project, these peers may or may not be paid. In order for Part A to cover that cost, this would have to be done in collaboration with others. Partner agencies will be elicited for peers and facilitators to assist with this effort. This is the beginning of the process; SOC is doing something different than has been historically done in Broward. What was before looked at in a broad scope is now focused on a specific population, specific need, and specific solution.
The Committee and guests concluded that with 3 three focus groups each with 25 participants, 20 key interviews, and information from DOH's DIS workers, they would have information from 100 women at different stages. While both women whose viral loads are suppressed and those whose viral loads are unsuppressed may be included, it would be best not to mix the two groups.
The Needs Assessment Consultant reminded the group that there needs to be a standardized process for asking these questions and coding the information. The Grantee will continue to work on details in order to ensure the fidelity of the process.
The goal of gathering this information is to lessen the disparities in viral load suppression and retention in care between Black women in Broward County and White and Hispanic women.

b.) Black Women Study Questions: The Quality Management Committee created some questions which should be incorporated in these surveys, and Committee members and guests were asked what information they may want to add. The Chair asked for PWN's questions so that the Committee could model their questions to elicit responses of similar value.

ACTION ITEM: Find more information on the PWN project.

One guest suggested, "What do you know about HIV?" simply to gauge client understanding. Some clients are not very knowledgeable about the disease or the importance of taking their medication. Other questions included, "how do you feel about taking medication for the rest of your life?" and even "how do you feel about having HIV for the rest of your life?" "Do you have any health care goals for yourself?" Topics included service gaps, barriers to care, history and effects of trauma exposure, geographic proximity to HIV services, minorities' needs specific to mental health and substance abuse, and perceptions of substance abuse and mental health treatment and services. Committee members and guests were encouraged to continue thinking about questions and topics for the next meeting.

4. GRANTEE REPORT

None.

5. PUBLIC COMMENT

None.

6. AGENDA ITEMS/TASKS FOR NEXT MEETING: May 31, 2017 1:00 pm 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 Study Design	ACTION ITEM: Discuss and develop study design, including recruitment of study participants and implementation timeline
Review Data Requests	ACTION ITEM: Review Part A data on Black women, including demographic breakdown of county origin (African American, Haitian, etc.) Review PWN survey questions.

7. ANNOUNCEMENTS

a. As of May 1st, Poverello's food pantry will remain open until 5 p.m.
b. The 3rd annual Behavioral Health Conference will be held from Monday, May 22nd to Tuesday, May 23rd.

8. ADJOURNMENT

The meeting was adjourned at 2:50 p.m.

SYSTEM OF CARE COMMITTEE
Policies and Procedures

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.

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
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
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		

Oct	Nov	Dec	Jan	Feb

Oct	Nov	Dec	Jan	Feb