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

MEETING AGENDA

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Wednesday, October 19, 2016, 12:30 p.m.
Location: Governmental Center Room A-337
Chair: Will Spencer **Vice Chair:** Rick Siclari

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 10/19/16 Agenda and 8/17/16 Meeting Minutes
3. **PUBLIC COMMENT:** *PSRA Leadership*
   a. Message from former PSRA Chair
4. **COMMITTEE LEADERSHIP DISCUSSION** – HIVPC Chair
5. **STANDARD COMMITTEE ITEMS**
   a. Reallocations "Sweeps"- Recommend reallocations ("Sweeps") to ensure sufficient core funding and the distribution of additional funds.
6. **UNFINISHED BUSINESS**
   a. MAI Strategies- Discuss MAI strategies that will be included in the MAI Service Delivery Model
7. **MEETING ACTIVITIES**

Goal/Work Plan Objective #:	*Accomplishments*
HICP	ACTION ITEM: Follow-up with proposed changes to ADAP Premium Plus eligibility and its impact on Part A HICP.
Food Bank	ACTION ITEM: Discuss Food Bank/Food Voucher eligibility criteria and impact on client utilization.

8. **SUBCOMMITTEE REPORTS**
   None.
9. **GRANTEE REPORTS**
10. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** November 16, 2016 **Venue:** Government Center Room A-337

Goal/Work Plan Objective #:	*Accomplishments*

11. **ANNOUNCEMENTS**
12. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

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

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

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MEETING MINUTES

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Wednesday, August 17, 2016, 12:30 p.m. **Location:** Governmental Center A-337
Chair: Carla Taylor-Bennett **Vice Chair:** Rick Siclari

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

1. CALL TO ORDER:

The Chair called the meeting to order at 12:42 p.m. The Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIVPC staff self-introductions were made.

2. APPROVALS:

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

Motion #2: To approve meeting minutes from 7/20/16
Proposed by: Lopes, R. **Seconded by:** Katz, H.B.
Discussion: A member requested an edit to Motion #19 to include that the allocations were for "MAI" SA
Action: Passed Unanimously

3. STANDARD COMMITTEE ITEMS:

a. Monthly Expenditure/Utilization Report by Category of Service – William Card reviewed the FY16-17 Part A Service Category Expenditures to date, and he noted that the handouts in the PSRA packets needed corrections while passing out amended handouts to the members. A member asked about the timeline for invoice processing, and it was explained the new county system takes approximately 30 days for processing.

Reviewing the FY16-17 Expenditures he noted that after 4 months of the fiscal year a service should have expend 33% of their allocated funds. Currently Part A funds have been 29% expended, but that since many providers expend their MAI funds first (60% to date), this number is not unusual.

Mr. Card then reviewed bulk purchase data with the PRSA members. He explained that the Food Bank expended 42% of their bulk purchases, mostly in Bank not Vouchers. The Grantee's office is working to revamp the food voucher distribution system, and are reviewing programmatic details

with the provider. A member was curious to know about the eligibility and guidelines for voucher distribution that would have most of the FB bulk expended but very little FV. The Grantee stated that they were working with the provider to alleviate limits on food vouchers that in place due to cost containment strategies, and they are now looking to revise the strategies to create increased utilization to the voucher that's used as a nutritional supplement. The vouchers prohibit the purchase of alcohol or tobacco with the voucher, and while the vouchers should be used as a supplement some clients use the vouchers to purchase high quality proteins and other similar items. Eligible clients should receive either 2 food boxes or a box and a voucher, although they are currently receiving either a box or a voucher per month. The group discussed whether or not it was appropriate to place limitations on products that can be purchased with vouchers and how it may or may not fit within HRSA guidelines. The Food Bank is used as both an emergency provision as well as a sustainable food source, which conflict in philosophies. The committee discussed the history of the Food Bank service, the difficulty in tying the service to measurable health outcomes, the need make food accessible to the community while controlling spending, and whether or not the service delivery had been changed with PSRA notice or approval. The Grantee will present to the PSRA committee at their next meeting about Food Bank and Food Vouchers, and suggested implementing a client survey to gain qualitative information on the voucher utilization. The Human Services Administrator also using CIED to educate clients on eligibility criteria for all service categories.

ACTION ITEM: Add Grantee presentation on Food Bank/Food Voucher eligibility to the September PSRA agenda.
Data Requests: Current eligibility criteria and SDM; past ad-hoc Food Service committee minutes; effect of "cost containment" on voucher eligibility and utilization; Grantee and provider strategies enhancing service; further breakdown of bulk purchase data by FB and FV; administrative fees.

4. UNFINISHED BUSINESS:

b. Transportation- The Part B representative stated that they were evaluating all of their services to align them with HRSA guidelines, and have determined that the way the EMA distributed bus passes violated HRSA policies. This includes over 500 lost passes and 250 passes for non-Ryan White clients. The state has also codified "payer of last resort," and only programs that are not covered by federal, state or local programs can be funded by Part B. As the Broward County Transportation Disadvantage Program provides 31 day bus passes or Tops! to residents who make 100-400% FPL, Part B is transferring all eligible clients onto the county bus pass program. 80 clients were transitioned in the last month, and clients seem pleased with the service. Case managers educated their clients on the changes, and reported less complaints than past months. Those clients who do not qualify for County passes will receive daily passes from their case managers. The Part B representative stated that the medical transportation service is more than bus passes, and that there should be a conversation about use of vans, ride sharing accounts or other options for clients.

The Grantee stated that there are only 776 clients who receive bus passes and no wait list for services, yet participants at community forums regularly cite transportation as a major barrier to care. There must be some gap in service or information that acts as a barrier to utilization. Common complaints regarding public transportation, Medicaid transportation and Tops! include long wait times in intense heat, clients dropped off hours early for appointments or still waiting for providers after they have closed, clients in wheel chairs left on the wrong side of the road, etc. The Part B representatives asked that if any members hear of issues or concerns to please contact their office. The PSRA Chair asked the members if the FY17-18 Allocations needed to be modified to reflected changes in Part B transportation policies. A member suggested revisiting the subject in 3

months to see if there were any developing issues with the service.

ACTION ITEM: Send Justin Bell the minutes from the CEC Transportation Hot Topic. Add "Update on Part B Transportation" to October/November agenda. Send PSRA Summary to HIVPC member.

5. NEW BUSINESS

a. MAI –

Motion #3: To table the MAI discussion until the next PSRA meeting **Proposed by:** Katz, H.B. **Seconded by:** Bell, J. **Action:** Passed with 2 objections

b. HICP- The Grantee explained that last week he and Josh Rodriguez from the ADAP office went to Orlando to talk potential changes in ADAP Premium Plus eligibility. Currently, ADAP-PP covers clients making ≥ 250%FPL, while Part A's HICP covers clients from 250-400% FPL. ADAP has recently proposed increasing Premium Plus eligibility to cover all clients to 400% FPL, which would have a significant impact on the Part A HICP service. The question then posed by the Grantee was, with changes to ADAP-PP, will HICP be cost effective enough to warrant continuation of the service?

Part A would be responsible for medical co-pays, insurance deductibles, and pharmaceutical co-pays for medications not on the Part B formulary. Without the payment of client premiums HICP would greatly reduce their expenditures, without reducing their administrative fees. The change would lead to a $30 co-pay with a $16.50 administrative fee.

While the Grantee supports the state's expansion of ADAP-PP eligibility, he has informed them that it would have a significant impact on HICP in such a way in which he does not think it would be feasible to continue.

The ADAP representative stated that without HICP wraparound services clients who have not met their out-of-pocket maximums ($6,500) and need services like labs or procedures will have unaffordable bills. He believes that clients will not want to transition onto ACA plans if they have no supportive services to pay their co-pays and deductibles. The ADAP representative stated that problems will also occur if clients cannot get the medications for their co-morbidities paid then they will drop out of the ACA plan. The PSRA Chair asked what prevents ADAP from covering client co-pays and deductibles. He responded that ADAP is a pill program that can only par for HIV drugs, and that the state does not the infrastructure in place to cover those costs across the entire state, nor the time to put one in place before the next enrollment period in November.

The members reviewed the average cost of Part A and ADAP copays and deductibles, and discussed how most fees range between $10 and $49. They spoke about how the transaction fee would go up if transactions would go down, as personnel and administrative costs are fixed. A member asked about expanding the Emergency Financial Assistance service to help clients with copays, yet the question still goes back to capacity to administer those dollars.

There are currently 200 clients between 250-400% FPL who are fully covered by HICP. The Grantee explained that those clients are most expensive because they do not qualify for a tax credit, but they do have a greater income to support their medical needs. If HICP continues as is, the cost to administer the program will double because the number of transactions will significantly decrease. A member asked if the administrative employee could be part time to cut expenses. The Grantee did not think that would work because clients may call and need co-payments at any time, and visits and access points cannot be controlled to maintain a part time employee.

The members discussed next action steps. As the state has not made a final decisions, the members discussed delaying a vote on any issue until the next scheduled PSRA or HIVPC meeting in

October. They discussed drafting a letter to the State detailing the impact of ADAP-PP changes on Part A expenditures, and who if anyone should write the letter (PSRA committee, HIVPC Chair, Grantee, etc.) The Grantee stated that he has already spoken to the State about its implications for Part A, and that the HIVPC must make the final decision about the future of the HICP service. A member expressed concerns about defunding the service. Any changes would not take effect until the next Fiscal Year (March 2017). The Grantee explained that the HIVPC has 2 options going forward: fund the HICP service despite the high administrative costs or defund the service. The ADAP representative stated that the issue is not just about the cost effectiveness of the program, but the health outcomes of the client, the continuum of care and the community viral load. The PSRA Chair asked if ADAP could cover the copay and deductible payments if Part A provided the funding, but the ADAP representative explained that Tallahassee processes all payments, and that the HRSA manual for ADAP stipulates that they can only provide copays for pharmaceuticals, not medical copays or deductibles (although Part B can). The members decided to schedule a PSRA meeting in September to follow-up with the Grantee and further discuss ADAP-PP and its implications for Part A HICP.

ACTION ITEM: Next meeting- September 28th, 2016. Add HICP follow-up to the agenda.

6. GRANTEE REPORT

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

7. PUBLIC COMMENT

None

8. AGENDA ITEMS/TASKS FOR NEXT MEETING: September 28, 2016 **Venue:** GC-301

Goal/Work Plan Objective #:	*Accomplishments*
MAI Strategies	ACTION ITEM: Discuss MAI Strategies that will be included in the MAI Service Delivery model.
Food Bank	ACTION ITEM: Discuss Food Bank/Food Voucher eligibility criteria and impact on client utilization.
HICP	ACTION ITEM: Follow-up with proposed changes to ADAP Premium Plus eligibility and its impact on Part A HICP.

9. ANNOUNCEMENTS

None.

10. ADJOURNMENT

The meeting was adjourned at 3:31 p.m.

PSRA Attendance CY 2016

Consumer	PLWHA	Absences	Count	Meeting Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date:	20	17	16	20	25	15	20	17					
			1	Bell, J.	N- 2/17		X	X	X	X	A	X					
1			**2**	DeSantis, M.	X	A	X	X	X	X	X	X					

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1		**3**	Gammell, B.	X	X	X	X	X	X	X	X					
		4	Grant, C.	X	X	X	X	X	X	X	X					
		5	Hayes, M.	X	X	X	X	X	X	X	A					
1	1	**6**	Katz, H.B.	X	X	X	A	X	X	X	X					
1			Lewis, L.	X	Z-2/1											
		7	Lopes, R.		X	X	X	X	X	A	X					N-1/20
	1		Proulx, D.	X	X	X	A	Z- 5/1								
1	2	**8**	Reed, Y.	X	X	A	E	X	X	A	X					
	1	**9**	Schickowski, K.	X	A	X	X	X	X	X	X					
1		**10**	Shamer, D.	X	X	X	X	A	A	X	X					W- 7/1
		11	Siclari, R., *V. Chair*	X	X	E	X	X	A	X	A					
		12	Taylor-Bennett, C., *Chair*	X	X	X	X	X	X	X	X					
			Quorum = 8	12	10	11	10	11	10	9	10					

Legend:

X - present

A - absent

E - excused

NQA - no quorum absent

NQX - no quorum present

N - newly appointed

Z - removed

C - cancelled

W - warning letter

R - removal letter

October 17, 2016

An Open Letter to the PSRA Committee,

In life there are experiences that make you wiser, and there are experiences that make you stronger. I was blessed enough to say that my years leading PSRA have made me both. Change is almost always a part of any process; doing the same thing expecting a different result is called insanity. The infusion of new people and new ideas is often part of the process of growth. Just as the HIV epidemic has changed, so must our response, our systems and our process.

As many of you are aware, the Committee Chairs serve at the pleasure of the Council Chair and Co-Chair. They reserve the sole authority to appoint committee chairs in accordance with the council by-laws. After 10 years of serving a chair of the PRSA Committee the current Chair and Co-Chair have determined that my leadership is longer needed as it relates to the PRSA committee and have decided to discontinue my appointment as Chair effective immediately.

As my desire is not to be an unnecessary distraction and to allow the newly appointed Chair every opportunity to be successful in the role, I will be resigning from the PRSA Committee. The work that we have done and you will continue to do is important. We have done so much together and that my absence, however abrupt, cannot interfere with the committee's growth and progress. The greatest salute to my legacy would be for you to support the new Chair and as he continues on the journey.

I must say that it has been an absolute honor to serve as you Chair. I am blessed to work with such a passionate committed group of people who have been tireless in their efforts to ensure sufficient funding and access to valuable services for the clients we serve. I can only express gratitude for allowing me the opportunity to lead you through this journey. The road we have trudged together was often not easy or uncomplicated but many of you have stayed the course. I feel like I am a better person today, than when I started this and you all were a big part of that. You taught me patience, tolerance, tenacity, diplomacy, temperance and too many others to list. You showed me that passion has a role at the table, and that we all bring our unique expressions and perspectives to the table.

Thanks so much for allowing me to challenge you to make the difficult decisions that had to be made. Thanks for allowing yourselves to ask those challenging and sometimes confrontational questions. Thanks for moving our process from emotion-driven to data –driven. Thanks so much for your unyielding advocacy for the clients we serve. It is those experiences that have allowed all of us to grow both individually and as a collective body. Continue to challenge yourselves . . . . . the clients depend on it. Always remember Joe Client in all your decisions . . . . . .He/she is the reason why we have a role in the process.

To my Vice-Chair, Rick, thanks so much. You made me laugh, when I wanted to scream and you were often the voice of clarity. When the meeting got heated I could always depend on you--during the ADAP Crisis, ACA, bus passes you name it I never had to think for a moment that you were not right beside me. Thank you.

To Council Support, you are an amazing group of people who have skills and talents . . . . . never forget that. Thanks for tolerating me and making sure that everything was ready for the meeting I could not been successful without you To Grantee staff, words cannot express my gratitude, thanks for the challenge, we are all better for it.

With all the love, respect and admiration for who you are and the important work you do. God's grace and peace be with you always

-Carla

HANDOUT A

MAI PROGRAM CLIENT OUTCOMES

The Broward Part A Program's MAI model is designed to improve rates of viral load suppression in Black MSM, and Black heterosexual males and females. The model will utilize evidence-informed strategies to increase engagement and retention in HIV care through specialized outpatient ambulatory medical care, medical case management, mental health and substance abuse services specifically designed for the Part A MAI populations. To improve access to and retention in care, the MAI program will utilize a patient centered medical home model. Intensive coordination and direct intervention will be provided by the care teams to improve HIV treatment adherence, medical education and the patient's ability to effectively navigate the healthcare system.

To enter the MAI program, unsuppressed clients in the priority populations will be screened for eligibility. If clients choose to enter the program they will have their care coordinated across providers so as to receive streamlined services. Each participant will receive a baseline needs assessment within the first month of entering the MAI program, and must be screened for both MH and SA. The client will be referred to the appropriate services, and referring provider will document their follow-up with confirmation by the receiving provider. Each MAI participant will have an MAI MCM, who will conduct quarterly evaluations of client progress based on the issues documented in the client's needs assessment and individualized treatment plan. The MAI MCM will develop and maintain a care plan that teaches the client where, when and how to access all health services to assist clients with attaining self-sufficiency. Updates on the client's needs assessment will be communicated and coordinated with shared outcomes between providers in the client's Patient Care Team.

Patient Care Team members will receive annual training to further educate on advancement of developmental, behavioral, medical, psychiatric and social service needs for the targeted MAI populations. Scheduling staff will maintain on-demand medical appointment slots to accommodate clients, including those who are employed or have other scheduling barriers. Based on preference of the client, providers will send at least two reminders within two weeks prior to the appointment via text message or email in addition to contact by phone. The model will utilize trained and certified peers to assist with linkage/referrals, engagement and retention in services.

Newly enrolled MAI clients will take a survey to assess their baseline needs, gaps and barriers to care. To ensure the implementation of high quality services, MAI clients will participate in an annual Part A MAI Needs Assessment activity (survey, focus group, community forum, etc.). The comprehensive Part A MAI Needs Assessment will at minimum include: clients' demographics, barriers to care, service gaps, and satisfaction with received services. Upon completion of the MAI program, clients will participate in a completion evaluation of the program.

HANDOUT A

MAI PROGRAM CLIENT OUTCOMES

In the first 18 months, the client should achieve the following outcomes in each enrolled service:

MAI OAMC

- Maintained medication adherence for >95%
- Maintained a suppressed viral load for at least nine consecutive months
- Demonstrated improvement with other clinical criteria (decreased hospitalization, other medical conditions stabilized, no new opportunistic infection diagnoses)
- Resolved 60% of major issues in the needs assessments
- Kept 85% of all scheduled medical appointments

MAI MCM

- Resolved 60% of major issues in the needs assessments
- Demonstrate the ability to navigate the health care system
- Developed a sense of self-sufficiency
    - Kept 85% of all scheduled medical and social services appointments
    - Established tools and resources to assist with being able to keep appointments in the future
    - Obtained and maintained needed services (housing, entitlements, benefits, medical, social, etc.)

MAI MH

- Documented improvement in client's symptoms associated with primary metal health diagnosis
- Kept 85% of all scheduled service appointments

MAI SA

- Documented improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis
- Kept 85% of all scheduled service appointments

HANDOUT B

TARGET POPULATION FOR BROWARD MAI PROGRAMS

FY2015-2016 Broward Ryan White Part A Clients					
	Viral Load Status				
Black or African American, 18-38	**Unsuppressed VL**	**% of Total**	**Suppressed VL**	**% of Total**	**Grand Total**
Heterosexual Female	98	34.63%	183	64.66%	283
Heterosexual Male	40	26.67%	109	72.67%	150
Heterosexual Total	**138**	**31.87%**	**292**	**67.44%**	**433**
MSM	97	23.21%	319	76.32%	418
Black 18-38 Total	**235**	**27.61%**	**611**	**71.8%**	**851**

* Exclusions- Black Part A clients 18-38 with Unknown Viral Load (n=5)

FY2015-2016 Broward Ryan White Part A Clients					
	Viral Load Status				
Black or African American, All Aged	**Unsuppressed VL**	**% of Total**	**Suppressed VL**	**% of Total**	**Grand Total**
Heterosexual Female	294	19.12%	1,234	80.23%	1,538
Heterosexual Male	237	19.30%	987	80.37%	1,228
Heterosexual Total	**531**	**19.20%**	**2,221**	**30.30%**	**2,766**
MSM	159	18.82%	680	80.47%	845
Black All Aged Total	**690**	**19.11%**	**2,901**	**80.34%**	**3,611**

* Exclusions- Black Part A clients with Unknown Viral Load (n=20)