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

Broward County HIV Health Services Planning Council Meeting

Tuesday, December 5, 2023 - 9:30 AM
Meeting at Broward Regional Health Planning Council and via WebEx Videoconference
Chair: Lorenzo Robertson • Vice Chair: Von Biggs
Join the meeting via phone: 1-408-418-9388 US Toll (access code: 132 007 3138)

This meeting is audio and video recorded.

Quorum for this meeting is 11

DRAFT AGENDA

ORDER OF BUSINESS

1. **CALL TO ORDER/ESTABLISHMENT OF QUORUM**
2. **WELCOME FROM THE CHAIR**

   Meeting Ground Rules

   Statement of Sunshine

   Introductions & Abstentions

   Moment of Silence

3. **PUBLIC COMMENT**
4. **ACTION:** Approval of Agenda for December 5, 2023
5. **ACTION:** Approval of Minutes from October 26, 2023 **(Handout A)**
6. **FEDERAL LEGISLATIVE REPORT**– Attorney Marty Cassini, Broward County Intergovernmental Affairs Office
7. **STANDARD COMMITTEE ITEMS**

   None

8. **CONSENT ITEMS**

   a) **Motion to reinstate Yusimir Arencibia (former HIVPC member) to the PWHA Recently Released from Jail or Prison or their representative seat.**

   Justification: Filling of HRSA-mandated seat for the HIV Planning Council.

   Proposed by: Chair, Membership Council Development Committee

9. **DISCUSSION ITEMS**

   a) **Reallocations/Sweeps**

   Reallocation/Sweeps from Core & Support Services

I. **Motion to reallocate $80,000 from AIDS Pharmaceutical Assistance for FY 2023-2024.**
Justification: Provider in the category is highly underutilized.
PROPOSED BY: Priority Setting & Resource Allocation Committee

II. **Motion to reallocate $22,706 from Medical Case Management – Disease Case Management for FY2023-2024.**
Justification: Provider in the category is highly underutilized.
PROPOSED BY: Priority Setting & Resource Allocation Committee

III. **Motion to reallocate $135,407 from Health Insurance Premium & Cost Sharing Assistance for FY2023-2024.**
Justification: Provider underutilized.
PROPOSED BY: Priority Setting & Resource Allocation Committee

IV. **Motion to reallocate $298,536 from Substance Abuse- Outpatient for FY2023-2024.**
Justification: Provider underutilized.
PROPOSED BY: Priority Setting & Resource Allocation Committee

V. **Motion to reallocate $201,000 from Non-Medical Case Management for FY2023-2024.**
Justification: Provider underutilized.
PROPOSED BY: Priority Setting & Resource Allocation Committee

Total Reallocation/Sweeps <u>from</u> Core & Support Services= ($737,649)

Reallocation/Sweeps <u>to</u> Core & Support Services

VI. **Motion to reallocate $476,088 to Outpatient Ambulatory Health Services for FY2023-2024.**
Justification: Underfunding among providers in the Category.
PROPOSED BY: Priority Setting & Resource Allocation Committee

VII. **Motion to reallocate $110,706 to AIDS Pharmaceutical Assistance for FY2023-2024.**
Justification: Underfunding among providers in the Category.
PROPOSED BY: Priority Setting & Resource Allocation Committee

VIII. **Motion to reallocate $51,855 to Medical Case Management – Case Management (Disease Case Management) for FY2023-2024.**
Justification: *Underfunding among providers in the Category.*
PROPOSED BY: Priority Setting & Resource Allocation Committee

IX. **Motion to reallocate $99,000 to Non-Medical Case Management for FY2023-2024.**
Justification: *Underfunding among providers in the Category.*
PROPOSED BY: Priority Setting & Resource Allocation Committee

Total Reallocation/Sweeps to Core & Support Services = $737,649

Reallocation/Sweeps from Minority AIDS Initiative (MAI) Core & Support Services

Funding Source for total Reallocation/Sweeps from MAI Core & Support Services: FY2023-2024 Carry Over Funds = $333,077

Reallocation/Sweeps <u>to</u> Minority AIDS Initiative (MAI)* Core & Support Services

X. **Motion to reallocate $171,500 to MAI Medical Case Management for FY2023-2024.**
Justification: Provider underfunded.
PROPOSED BY: Priority Setting & Resource Allocation Committee

XI. **Motion to reallocate $60,356 to MAI Substance Abuse- Outpatient for FY2023-2024.**
Justification: Provider underfunded.
PROPOSED BY: Priority Setting & Resource Allocation Committee

XII. **Motion to reallocate $101,221 to MAI Non-Medical Case Management (CIED) for FY2023-2024.**
Justification: Provider underfunded.
PROPOSED BY: Priority Setting & Resource Allocation Committee

Total Reallocation/Sweeps to MAI Core & Support Services = $333,077

b) Motion to approve the Food Services – Service Delivery Model (Handout B)

SDM Request for Approval Form (Handout B1)

Justification: The Food Services- Service Delivery Model was reviewed by the Systems of Care Committee during its November 2, 2023, meeting and approved by the Quality Management Committee during its November 20, 2023, meeting.

PROPOSED BY: Quality Management Committee

c) Motion to approve the Non-Medical Case Management – Service Delivery Model (Handout C)

SDM Request for Approval Form (Handout C1)

Justification: The Non-Medical Case Management - Service Delivery Model was reviewed by the Systems of Care Committee during its November 2, 2023, meeting and approved by the Quality Management Committee during its November 20, 2023, meeting.

PROPOSED BY: Quality Management Committee

d) Motion to approve the Medical Case Management – Service Delivery Model (Handout D)

SDM Request for Approval Form (Handout D1)

Justification: The Medical Case Management - Service Delivery Model was reviewed by the Systems of Care Committee during its November 2, 2023, meeting and approved by the Quality Management Committee during its November 20, 2023, meeting.

PROPOSED BY: Quality Management Committee

10. OLD BUSINESS

a) None

11. NEW BUSINESS

a) **Action Item:** FY2024-2025 HIVPC Chair/Vice Chair Nominee Q&A **(Handout E)**

12. COMMITTEE REPORTS

a. Community Empowerment Committee (CEC)
Chair: Shawn Jackson • Vice Chair: Irvin Wilson
November 7, 2023

i. **Work Plan Item Update/Status Summary:** Members discussed and planned their facilitated town hall listening session, “Stigma Smashers” January 31, 2024. Lastly, members continued discussing ideas for the 2024-2025 CEC Community Conversation.

ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** Continue planning their facilitated town hall listening session scheduled for January 31, 2024, and planning for the 2024-2025 CEC Community Conversations.
vii. **Next Meeting date:** December 5, 2023, at 3:00 PM at BRHPC and via WebEx Videoconference

b. System of Care Committee (SOC)
Chair: Jose Castillo • Vice Chair: Kendra Hayes
November 2, 2023

i. **Work Plan Item Update/Status Summary:** Committee members reviewed Service Delivery Models for Food Services, Non-Medical Case Management, Medical Case Management and provided recommendations to QMC.

ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** Continue reviewing Service Delivery Models.
vii. **Next Meeting date:** January 4, 2023, at 9:30 AM at BRHPC and via WebEx Videoconference

c. Membership/Council Development Committee (MCDC)
Chair: Vincent Foster • Vice Chair: Dr. Timothy Moragne
November 2023- No Meeting Held

i. **Work Plan Item Update/Status Summary:**

ii. **Data Requests:**
iii. **Rationale for Recommendations:**
iv. **Data Reports/ Data Review Updates:**
v. **Other Business Items:**
vi. **Agenda Items for Next Meeting:**
vii. **Next Meeting date:** January 11, 2023, at 9:30 AM at BRHPC and via WebEx Videoconference

d. Quality Management Committee (QMC)
Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore
November 20, 2023

i. **Work Plan Item Update/Status Summary:** Committee members reviewed and approved Service Delivery Models for Food Services, Non-Medical Case Management, Medical Case Management, with recommendations from the SOC Committee.

ii. **Data Requests:** None.
iii. **Rationale for Recommendations:** None.
iv. **Data Reports/ Data Review Updates:** None.
v. **Other Business Items:** None.
vi. **Agenda Items for Next Meeting:** Continue reviewing Service Delivery Models
vii. **Next Meeting date:** January 8, 2023, at 12:30 PM at BRHPC and via WebEx Videoconference

e. Executive Committee
Chair: Lorenzo Robertson • Vice Chair: Von Biggs

November 30, 2023
Work Plan Item Update/Status Summary:

i. **Work Plan Item Update/Status Summary:** Members discussed HIVPC retreat which will be held on February 22, 2024, replacing the regular HIVPC Meeting. In-person attendance is mandatory. Lastly, members discussed and agreed to add 'Data Requests' at the end of the agenda items for all committees.

ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** TBD
vii. **Next Meeting date:** January 18, 2024, at 12:45PM at BRHPC and via WebEx Videoconference

f. Priority Setting & Resource Allocation Committee (PSRA)
Chair: Brad Barnes • Vice Chair: Vacant
November 30, 2023

i. **Work Plan Item Update/Status Summary:** Committee members reviewed expenditure report and conducted the second round of reallocations/sweeps. Members discussed the Affordable Care Act Enrollment with the goal to develop an ACA Action Plan for FY 2024-2025. An update on the Administrative Mechanism Report was provided. The report will be presented to PSRA during the January meeting.

ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** ACA Action Plan, Workplans FY 2023 and FY 2024
vii. **Next Meeting date:** December 21, 2023, at 9:30 AM at BRHPC and via WebEx Videoconference

g. Ad-Hoc Term Limits
Chair: Brad Barnes • Vice Chair: Vacant
No Meeting Held

i. **Work Plan Item Update/Status Summary:**
ii. **Data Requests:**
iii. **Rationale for Recommendations:**
iv. **Data Reports/ Data Review Updates:**
v. **Other Business Items:**
vi. **Agenda Items for Next Meeting:**
vii. **Next Meeting date:** December 21, 2023, at 12:45 PM at BRHPC and via WebEx Videoconference

h. Ad-Hoc Nominations
Chair: Brad Barnes • Vice Chair: Vacant
November 2023- No Meeting Held

i. **Work Plan Item Update/Status Summary:**
ii. **Data Requests:**
iii. **Rationale for Recommendations:**
iv. **Data Reports/ Data Review Updates:**
v. **Other Business Items:**
vi. **Agenda Items for Next Meeting:**
vii. **Next Meeting date:** TBD

13. RECIPIENT REPORTS

- **a.** Part A **(Handout F)**
- **b.** Part B
- **c.** Part C
- **d.** Part D
- **e.** Part F
- **f.** HOPWA
- **g.** Prevention – Quarterly Update (April, July, October, January)

14. PUBLIC COMMENT

15. DATA REQUESTED

16. AGENDA ITEMS FOR NEXT MEETING

- **a.** Next Meeting Date: January 25, 2024, at 9:30 a.m. at BRHPC and via WebEx
- **b.** Agenda Items for next meeting: To Be Determined

17. ANNOUNCEMENTS

- **a. SAVE THE DATE: Thursday, February 22, 2024 – HIVPC Annual Retreat; 9 a.m. – 3:00 p.m.; Location to be Determined**

18. ADJOURNMENT

For a detailed discussion on any of the above items, please refer to the minutes available at:
HIV Planning Council Website

Please complete your 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.

December 2023

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 http://www.brhpc.org for updates.					
					December 1 World AIDS Day **South Florida AIDS Network Meeting (SFAN) 9:30AM**	2 **World AIDS Day Memorial Quilt 12:00PM-4:30PM**
3	4	5 Support Services Network Meeting 9:00 AM– 10:15 AM HIV Planning Council Meeting 9:30AM – 11:30AM Locations: BRHPC/Webex Community Empowerment Committee Meeting (CEC) 3:00PM– 5:00PM Location: BRHPC/WebEx	6	7	8 **Hanukkah** 	9
10	11	12	13 **Quality Network Meeting 9:00 AM – 10:15 AM**	14	15	16
17	18	19	20	21 Priority Setting & Resource Allocation Committee Meeting 9:30AM -12:30PM Ad-Hoc Term Limits Committee Meeting 12:45PM – 2:45PM	22	23
24	25 **Christmas Day** 	26 **Kwanzaa** 	27	28	29	

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.

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.

December 2023

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 http://www.brhpc.org 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:	Unless otherwise noted on the calendar, all meetings are held at:	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	Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020	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.	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.	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 A

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

Broward County HIV Health Services Planning Council Meeting

Thursday, October 26, 2023 - 9:30AM
Meeting at Ujima Men's Collective and via WebEx

DRAFT MINUTES

HIVPC Members Present: L. Robertson (HIVPC Chair), V. Biggs (HIVPC Vice-Chair), B. Barnes, R. Bhrangger, A. Cutright, V. Foster, T. Moragne, J. Castillo, J. Rodriguez, B. Fortune-Evans, I Wilson, R. Jimenez, K. Hayes, E. Dudelzak, B. Mester, J. Casseus, F. D'Amore, W. Marcoviche, D. Shamer, A. Machado

Members Absent: E. Davis, E. Dsouza, M. Schweizer, J. Wright, J. Wynn, S. Jackson - Tinsley,

Ryan White Part A Recipient Staff Present: T. Thompson, G. James, W. Cius, Q. Cowan, B. Miller, R. Honick, R. Pena

Planning Council Support Staff Present: G. Berkley-Martinez, M. Patel, N. Del Valle

Guests Present: S. Cook, K. Kirkland-Mobley, S. Webb, T. Bratcher, K. Bush, Kristine Atrigenio-Conway, M. Cassini

1. Call to Order, Welcome from the Chair & Public Record Requirements:

The HIVPC Chair called the meeting to order at 9:35 a.m. The HIVPC Chair welcomed all meeting attendees that were present. Attendees were notified that the HIVPC meeting is based on Florida's "Government-in-the-Sunshine Law" and 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. Introductions were made by committee members, Recipient staff, PCS/CQM staff, and guests by roll call, and a moment of silence was observed.

2. Public Comment:

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and services in Broward County. There were no public comments.

3. Meeting Approvals:

The approval for the agenda of the October 26, 2023, HIVPC meeting was proposed by V. Biggs, seconded by V. Foster, and passed unanimously. The approval for the minutes of the September 28, 2023 meeting was proposed by V. Foster, seconded by V. Biggs, and passed unanimously.

Motion #1: V. Biggs, on behalf of HIVPC, made a motion to approve the October 26, 2023, HIV Health Services Planning Council Agenda. The motion was seconded by V. Foster and adopted unanimously.

Motion #2: V. Foster, on behalf of HIVPC, made a motion to approve the September 28, 2023, HIV Health Services Planning Council Minutes. The motion was seconded by V. Biggs and passed unanimously.

4. Federal Legislative Report:

Marty Cassini, from the Broward County Intergovernmental Affairs Office, provided an update to the Federal Legislative Report which included the following:

- Kevin McCarthey has been removed as the speaker of the House of Representatives, and Mike Johnson of Louisiana is the new Speaker of the House of Representatives. Mike Johnson announced that he would like to see a funding resolution from the House of Representatives to extend to January 15, 2024 or to April 15, 2023.
- From the House of Representatives and Senate, there will be a three million dollar increase for the Ending the HIV Initiative, a 275 million dollar increase in homeless grants and a six billion dollar initiative for affordable housing.
- From HRSA, an amount of 223 million dollars will also be allocated toward upgrading the CDC's data management system which will help further identify and track individuals living with HIV/AIDS.

5. Consent Items:

Council members reviewed and approved the consent items. The motion was proposed by V. Biggs, seconded by B. Barnes, and passed unanimously.

- Approve to instate Alondra Machado and Jason Wynn to the Priority Setting and Resource Allocation Committee

- Approve the appointment of Irving Wilson to the Representatives of/or formerly incarcerated PWH Seat.
    - **Justification:** Filling of HRSA mandated seat for HIV Planning Council.

- Approve the appointment of Jose Castillo to the Social Service Representative/Provider Seat.
    - **Justification**: Filling of HRSA mandated seat for HIV Planning Council.

- Approve the 2024 - 2025 PSRA Timeline
    - As proposed by the PSRA Chair

Motion #3: V. Biggs, on behalf of HIVPC, made a motion to approve the consent items. The motion was seconded by B. Barnes and passed unanimously.

6. Discussion Items:

Council members reviewed draft marketing materials compiled by the PCS.

7. Old Business:

None.

8. New Business:

None.

9. Committee Reports:

a. Community Empowerment Committee –September 5, 2023
Vice Chair: I. Wilson
The report stands.

b. System of Care Committee – September 7, 2023
Chair: J. Castillo, Vice Chair: K. Hayes
The report stands.

c. Membership/Council Development Committee – September 2023: No Meeting Scheduled
Chair: V. Foster, Vice Chair: T. Moragne
The report stands.

d. Quality Management Committee – September 18, 2023:
Chair: B. Fortune-Evans, Vice Chair: F. D'Amore
The report stands.

e. Priority Setting & Resource Allocation Committee – September 2023- No Meeting Held
Chair: B. Barnes, Vice Chair: Vacant
The report stands with the following updates:

- At the six-month period, the Planning Council is approximately at 50% of allocation spent for the fiscal year.
- At the November PSRA meeting, the Planning Council will be having sweeps.

f. Executive Committee – September 21, 2023
Vice Chair: V. Biggs
The report stands.

g. Ad-Hoc By-Laws & MOU Committee, Ad-Hoc Nominations – September 21, 2023

Chair: B. Barnes, Vice Chair: Vacant
The report stands with the following updates:

- The By-Laws committee will be meeting in November to have voting in December.
- For the December HIV Planning Council Meeting, there will be a Q &A session for the nominees running for Chair and V. Chair

10. Recipient's Report:

a. Part A: The Part A Recipient provided a presentation informing the council of updates the follow areas:
- Medical Nutrition Therapy RFP Application Process
- Status of Service Delivery Models that are under review by the Part A Office
- Strategies to increasing enrollment into Affordable Care Act.
- EHE Housing & Care Support Services

b. Part B: Recipient provided a written report with Part B's expenditures for August 2023 and the ADAP Report for September 2023 is as follows:
- the total number of enrolled clients were 5,800,
- the ADAP enrollment and re-enrollment was 118, 59 new clients
- the total number for viral suppression from the past six months was 4,904

c. Part C: The Part C Representative provided a general report which included that they served 280 patients, 14 patients enrolled into Test and Treat Program. Some continuing challenges include affordable housing, lack of employment for undocumented patients.

d. Part D: The Part D Representative provided a general report which included that they enrolled 598 HIV positive patients. The overall viral suppression rate is 85%.

e. Part F: There was no Part F report for this meeting.

f. HOPWA: There was no HOPWA report for this meeting.

g. Prevention: K. Kirkland-Mobley – prevention report as stands for July to September 2023

11. Public Comment:

The Public Comment portion of the meeting provides the public an opportunity to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and services in Broward County. There were no public comments.

12. Agenda Items for Next Meeting:

a. The next HIVPC meeting will be held on December 5, 2023, at 9:30 a.m. **Location:** Broward Regional Health Planning Council and Virtual through WebEx
b. Agenda Items for next meeting: **To Be Determined**

13. Announcements:

a. V. Biggs – announced that vaccines would be available at The Eagle from

6 to 9pm on 10/26/23.

14. Adjournment:

There being no further business, the meeting was adjourned at 10:49 a.m.

HIVPC Attendance for CY 2023

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	26	23	23	27	25	22	27	24	28	26			
0	1	1	1	Barnes, B.	A	X	X	X	X	C	X	X	X	X			
1	1	0	2	Bhrangger, R.	X	X	X	X	X	C	X	X	X	X			
0	1	2	3	Biggs, V., V.Chair	X	X	A	X	A	C	X	X	X	X			
0	0	0	4	Cutright, A.	X	X	X	X	X	C	X	X	X	X			
0	0	0	5	Fortune-Evans, B.	X	X	X	E	X	C	X	E	X	X			
0	0	0	6	Foster, V.	X	X	X	X	X	C	X	X	X	X			
			7	Machado, A.									N, A	X			
1	1	0	8	Marcoviche, W.	X	X	X	X	X	C	X	E	X	X			
0	0	1	9	Moragne, T.	X	X	X	X	X	C	X	A	X	X			
0	1	0	10	Robertson, L., Chair	X	X	X	X	X	C	X	X	X	X			
0	0	0	11	Rodriguez, J.	X	X	X	X	X	C	X	X	X	X			
0	0	3	12	Ruffner, A.	A	X	X	A	X	C	A	X	X	Z- Resigned			
0	0	3	13	Schweizer, M.			X	A	X	C	X	A	X	A			
0	0	0	14	Wilson, I.	X	X	X	X	X	C	X	X	X	X			
0	1	1	15	Jackson-Tinsley, S.	X	X	X	X	X	C	X	X	X	A			
0	1	1	16	Castillo, J.	X	X	X	A	X	C	X	X	X	X			
0	0	3	17	Dsouza, E.	X	X	X	A	X	C	X	A	X	A			
0	0	1	18	Jimenez, R.	X	A	X	X	X	C	X	X	X	X			
			19	Mester, B.				N, X	X	C	A	X	X	X			
			20	Hayes, K.				N, X	X	C	X	X	X	X			
			21	Dudelzak, E.				N, X	E	C	X	X	X	X			
			22	Wright, J.				N, A	A	C	A	A	X	A			
0	0	6	23	Casseus, J.	A	A	A	X	A	C	A	A	X	X			
			24	Davis, E.									N, X	A			
			25	D'Amore, F.									N, X	X			
			26	Wynn, J.									N, X	A			
			27	Shamer, D.									N, X	X			
2	7			Quorum = 12	14	13	16	16	18		18	15	26	20			
9%	30%																

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	R - removal letter
CX - canceled due to quorum	

HANDOUT B

BROWARD COUNTY
RYAN WHITE PART A PROGRAM
Food Services
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Food bank/home delivered meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist.

Unallowable costs also include household appliances, pet foods, and other non-essential products.

Local Definition

Food Services provides nutritious and well-balanced food options to a client's nutritional intake and offer the client choice in selecting food items that support health needs (e.g. nutritional deficiencies, metabolic conditions). The provision of food services may be in the form of food bank or food vouchers.

Food Bank services are provided at a central distribution center that warehouses and provides nutritious groceries for clients. **Food Voucher** services are provided in the form of a certificate/gift card for a grocery store, allowing clients to purchase nutritious food. Clients receiving food vouchers must be able to shop for and prepare their meals. Lottery tickets, alcohol, and tobacco products cannot be purchased with food vouchers.

Food Service Units by Federal Poverty Level (FPL):

1. Clients eligible for Food Services within the **0%-200% FPL** are allotted **two (2) units** per month, whether from Food Bank or Food Voucher services.
2. Clients eligible for Food Services within the **201%-300% FPL** are allotted **one (1) unit** per month, whether from Food Bank or Food Voucher services.

II. Key Service Components and Activities

In addition to the Food Services Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Food Services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category, including state and local health codes. Additionally, providers must provide services in accordance with the USDA Dietary Guidelines and standards of Dietitians in AIDS Care and the American Dietetic Association.

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

Provision of Food Bank Services
Providers of Food Bank services must maintain a list of available foods for clients to select their weekly food provisions and document the foods selected by the client at each distribution. Menu and food choice development must occur under the direction of a licensed health professional to ensure food packages contain a variety of nutritious foods, align with the nutritional needs of the client, and are culturally/ethnically appropriate, when possible. Providers must ensure that the client's food selections are in the food pick-up/delivery package. Clients must confirm receipt of all food distributions as evidenced by the client signature and date of pick up.

Provision of Food Voucher Services
Providers of Food Voucher services must develop and implement policies and procedures for receiving, distributing, and tracking the food voucher inventory. Policies and procedures must ensure that no prohibited items are purchased, purchases support the client's nutritional needs, and no cash is exchanged between the vendor and the client. Food vouchers must clearly state that the use of food vouchers to purchase alcohol, tobacco, lottery, and non-food products is prohibited. Providers must document client acceptance and understanding of the Food Voucher Policy, as evidenced by client signature, in the designated HIV Human Services Support Services (HSSS).

Food vouchers must be tracked using a voucher identification number. Clients must return receipts showing purchases made with the numbered food voucher distributed to them. Providers must confirm the purchases made with the food voucher guidelines before another voucher is issued. The provider must implement a corrective action for clients who purchase ineligible items. Corrective actions may include warnings and suspension from the Food Voucher Program. Providers must document food vouchers distributed to each client by identification number and returned receipts in the designated HIV HSSS.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Supports access to client retention and care.	1.1. 80% of clients are retained in primary medical care.	1.1.1. Client appointment record in designated HIV HSSS.
2. Supports viral suppression.	2.1. 90% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	2.1.1. Client viral load test result in designated HIV HSSS. 2.1.2. Client prescription of ART documented in designated HIV HSSS.

IV. Standards for Service Delivery

Table 2. Food Services Standards for Service Delivery

Standard	Measure
1. Client confirms current medication list and provides updates as needed to the provider.	1.1. The medication list is documented in the designated HIV HSSS.
2. Foods selected by clients align with their health and wellness needs and are culturally/ethnically appropriate, when possible.	2.1. Receipt of food distribution with client signature and date in the designated HIV HSSS.
3. Clients confirm receipt of all food distributions as evidenced by the client signature and date of pick up.	3.1. Receipt of food distribution with client signature and date in the designated HIV HSSS.
4. Clients demonstrate acceptance and understanding of the Food Voucher Policy prior to receiving Food Voucher services.	4.1. Food Voucher Policy signed and dated by the client in the designated HIV HSSS.
5. Clients utilize food vouchers to purchase foods that support the client's nutritional needs.	5.1. Receipt showing purchases made with the numbered food voucher in the designated HIV HSSS.
6. Providers confirm purchases made with food vouchers meet set guidelines before another voucher is issued.	6.1. Receipt showing purchases made with the numbered food voucher in the designated HIV HSSS.

HANDOUT B1

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	11/20/23
Service Delivery Model	Food Services
Status	Revision to Food Service Model

Background/summary of service delivery model:

Food Services provide a nutritious and well-balanced food supplement to a client's nutritional intake and offer the client choice in selecting menu options that support health needs (e.g., nutritional deficiencies, metabolic conditions). The provision of food services may be in the form of a food bank or food vouchers. Food Bank services are provided at a central distribution center that warehouses and provides nutritious groceries for clients. Food Voucher services are provided in the form of a certificate/gift card for a grocery store, allowing clients to purchase nutritious food. Clients receiving food vouchers must be able to shop for and prepare their meals. Alcohol and tobacco products cannot be purchased with food vouchers.

Provision of Food Bank Services

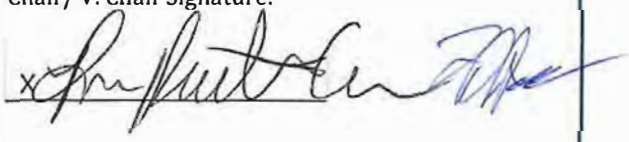
Providers of Food Bank services must maintain a list of available foods for clients to select their weekly food provisions and document the foods selected by the client at each distribution. Menu and food choice development must occur under the direction of a qualified professional to ensure food packages contain a variety of nutritious foods, align with the nutritional needs of the client, and are culturally/ethnically appropriate, when possible.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

- Per HRSA Guidelines, the nutritional assessment is no longer billable under the food service category. Therefore, that requirement was removed.
- By changing the Outcomes and Indicators for this service category, providers will be able to measure how they can support access to client retention in care and viral suppression.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision	Reason(s) for denial:
☒ Approved ☐ Denied Chair/ V. Chair Signature: x  Date:	

HIV Planning Council:

Service Delivery Model Request for Approval Decision	Reason(s) for denial:
☐ Approved ☐ Denied Chair/ V. Chair Signature: X _____ Date:	

HANDOUT C

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Non-Medical Case Management
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services.

NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities for this service category include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Local Definition

NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services).

The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer

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

to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Peer Counseling
Peer counseling is a required component of NMCM services. It is recommended that providers of NMCM services utilize at least 30% of all NMCM personnel funds provided under the Ryan White Part A program for Peer Counseling services.

Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression
- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals
- Facilitating peer counselor-led client support groups

II. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Supports access to client retention and care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Human Services Support Services (HSSS).
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV HSSS.
2. Supports viral suppression.	2.1. 90% of clients on ART for more than six months will have a viral load less than 200 copies/ml.	2.1.1. Client viral load test result in designated HIV HSSS. 2.1.2. Client prescription of ART documented in the designated HIV HSSS.

III. Assessment and Action Plan

Assessment
Providers must conduct an assessment of the client's service needs including a review of medical, financial, social, emotional, resources, and other needs within three sessions of the initial visit. The

assessment must be documented using the "Client Assessment" form in the designated HIV HSSS and include, at minimum, the following components:

- STI/HIV Health Literacy Assessment, including U=U (undetectable equals untransmittable), knowledge of HIV and STI testing, prevention, and treatment
- Barriers to accessing primary medical care medication adherence and other service needs
- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Education and guidance to support a successful transition to an Affordable Care Act (ACA) Insurance, Medicare, and Medicaid
- Support service needs, including advice and assistance in obtaining medical, social, community, legal assistance, finances/benefits, support groups, food bank, vocational, and transportation
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal Violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

Relevant Areas of Concern

Following the completion of the assessment or reassessment, the designated HIV HSSS generates a list of the clients "Relevant Areas of Concern." Providers must utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan

Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals. The action plan must be documented in the designated HIV HSSS and contain, at minimum, the following components:

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)

- Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
- Specified interventions to achieve the goal statement
- Date goals are established
- Target date for goal completion

All completed action plans must be reviewed, signed, and dated by Case Management supervisors.

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, 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, NMCM 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

Action Plan Review

An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

IV. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV HSSS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.

Standard	Measure
4. 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. 4.4. Confidentiality releases in client file/designated HIV HSSS.
5. Case managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates and service delivery.	5.1. 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 (501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
6. Peer Counselors will participate in professional development activities that focus on HIV/AIDS/STI updates and service delivery.	6.1. Peer Counselors 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

Standard	Measure
	and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (501); code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: peer counseling trainings, mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
7. Case Management supervisors review a 5% sample of open client action plans each month to identify opportunities for improvement.	7.1. Open action plans in the designated HIV HSSS. 7.2. Documentation of monthly reviews and identified opportunities for improvement.
8. Completed action plans are reviewed by Case Management supervisors.	8.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV HSSS.
9. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	9.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV HSSS.
10. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	10.1. Closed cases include documentation stating the reason for closure and a closure summary. 10.2. Supervisor signs off on closure summary indicating approval. 10.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 10.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.

HANDOUT C1

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	11/20/23
Service Delivery Model	Non-Medical Case Management
Status	Revision to NMCM Model

Background/summary of service delivery model:

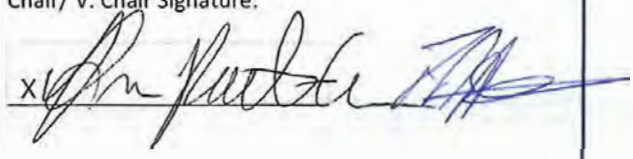
Non-Medical Case Management (NMCM) services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing client's medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

- By changing the Outcomes and Indicators for this service category, providers will be able to measure how they can support access to client retention in care and viral suppression.
- In this Service Delivery Model, additional language was included to improve tracking and monitoring of client activities, client documentation and progress notes, and ensure linkage to care.
- Additional training standards were added to ensure adequate training for providers to equip them with professional development activities that foster a continual learning environment.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision	Reason(s) for denial:
☒ Approved ☐ Denied Chair/ V. Chair Signature: X  Date:	

HIV Planning Council:

Service Delivery Model Request for Approval Decision	Reason(s) for denial:
☐ Approved ☐ Denied Chair/ V. Chair Signature: X Date:	

HANDOUT D

BROWARD COUNTY
RYAN WHITE PART A PROGRAM
Medical Case Management
Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

Last Revised by HIVPC on 3/25/2021

Table of Contents

I. Service Definitions

HRSA Definition[1]

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).

Key activities include:

- Initial assessment of service needs
- Develop a comprehensive, Individualized Care Plan (ICP)
- 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
- 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.

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) funds the Disease Case Management (DCM) model of MCM. DCM 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. DCM 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

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

- 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.

II. Key Service Components and Activities

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

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 engagement in care. 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:

- Managing 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 specialty medical services outside the RWHAP system of care
- Coordinating with prescribing medical providers 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. 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 (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
- Resolve conflicts or strategize solutions

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:

- 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

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
- Retention in HIV and primary medical care, including health promotion activities
- 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.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicator(s)	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one (1) or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV HSSS.
	1.2. 90% of clients are retained in primary medical care.	1.1.2. Client appointment record in designated HIV HSSS.

IV. Assessment and Individual Care Plan

Comprehensive Health Assessment (CHA)

MCMs must assess client needs by conducting a CHA within 14 days of the client's initial visit. 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. 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, 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, NMCM 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. DCMs 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 2: Acuity Scale Scoring and DCM 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 DCM 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 DCM	Face-to-face or telehealth visual follow-	Every 3 months

		assistance and is virally suppressed	up every six months with a minimum of 1 phone contact every 3 months	
Moderate Management	50-73 Points	At risk of becoming medically unstable without DCM 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 3 months
Intensive Management	74-96 Points	Medically unstable and in need of comprehensive DCM 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 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 authorized family member. 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.

V. Standards for Service Delivery

Table 3. MCM Standards for Service Delivery

Standard	Measure
1. Provider completes a CHA with each client within 14 days of their initial visit.	1.1. Completed CHA in the designated HIV HSSS.

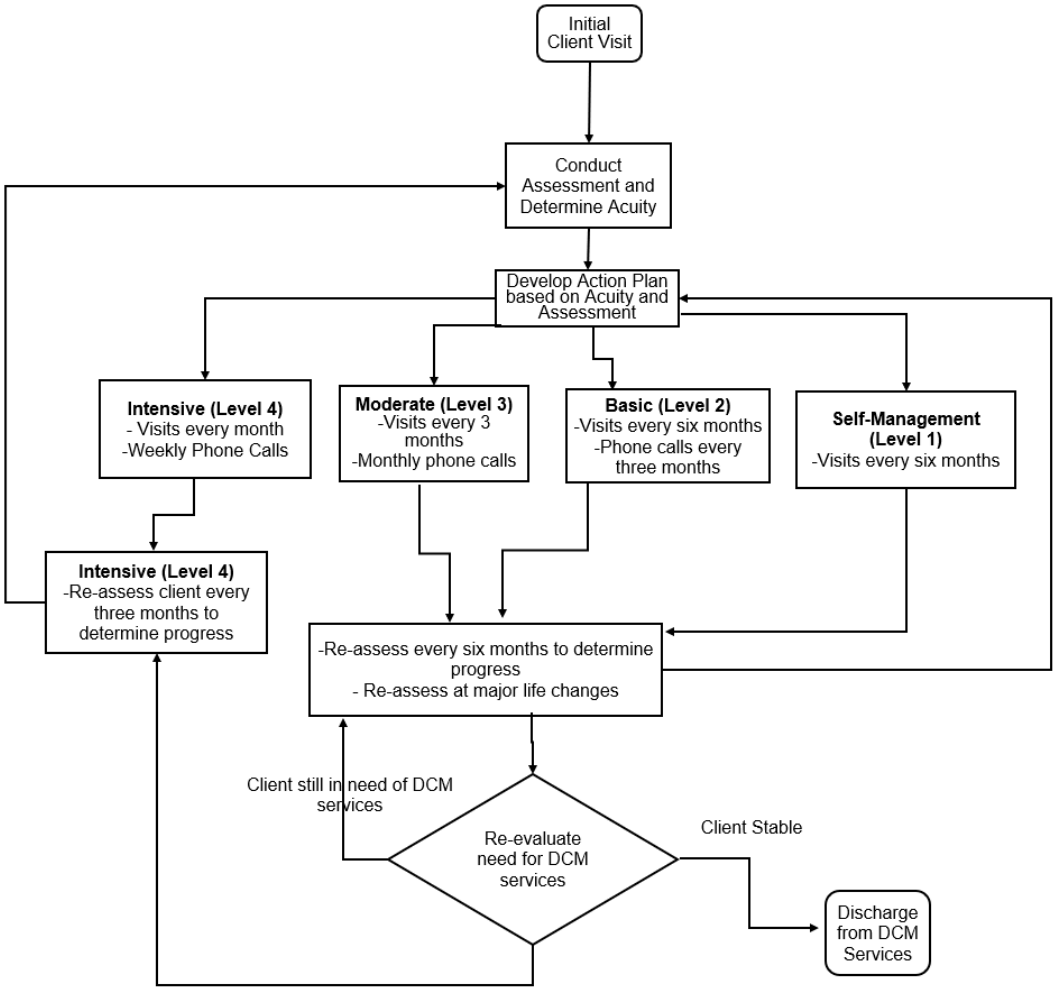
Standard	Measure
2. Provider develops an ICP with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client.	2.1. ICP signed and dated by the provider and client in the designated HIV HSSS.
3. Provider completes a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change.	3.1. Completed CHA in the designated HIV HSSS. 3.2. Progress notes in the designated HIV HSSS.
4. All client records/files will be neatly maintained and organized.	1.1. 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. 1.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 1.3. Progress notes in the client file/designated HIV HSSS. 4.1. Confidentiality releases in client file/designated HIV HSSS.
5. Medical Case Managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates and service delivery.	1.4. 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 (501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation,

Standard	Measure
	documentation, AETC Medical Case Management training, local resources.
6. 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	6.1. Evidence of timely case conferencing with key providers is found in the client's records through case note documentation in the designated HIV HSSS.
7. Client health needs are assessed and reassessed using the Acuity Scale as outlined in *Appendix A.*	7.1. Acuity Scale completed and scored in the designated HIV HSSS.
8. Client has contact with the provider at the frequency specified by client's management level as detailed in *Appendix A.*	8.1. Documentation of client communication in the designated HIV HSSS.
9. Provider conducts healthcare monitoring as specified by the ICP.	9.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
10. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	10.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
11. Provider conducts adherence counseling to support treatment regimens and medical care.	11.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
12. 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.	12.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV HSSS.
13. Provider follows up with clients within two business days of the client's requested communication.	13.1. Documentation of client communication in the designated HIV HSSS.
14. Provider conducts medical 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 2.*	14.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV HSSS.
15. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 2.*	15.1. Documentation of client case management conference in the designated HIV HSSS.
16. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	1.5. Closed cases include documentation stating the reason for closure and a closure summary. 1.6. Supervisor signs off on closure summary

Standard	Measure
	indicating approval. 1.7. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 16.1. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.

VI. Appendix A

The Medical Case Management Assessment Model



HANDOUT D1

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	11/20/23
Service Delivery Model	Medical Case Management
Status	Revision to MCM Model

Background/summary of service delivery model:

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).

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

- To stay within HRSA guidelines, the name of the Service Delivery Model was changed from "Disease Case Management" to "Medical Case Management."
- In this Service Delivery Model, additional language was included to improve tracking and monitoring of client activities, client documentation and progress notes, and ensure linkage to care.
- Additional training standards were added to ensure adequate training for providers to equip them with professional development activities that foster a continual learning environment.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision	Reason(s) for denial:
X Approved ☐ Denied Chair/ V. Chair Signature: X _____ Date: _____	

HIV Planning Council:

Service Delivery Model Request for Approval Decision	Reason(s) for denial:
☐ Approved ☐ Denied Chair/ V. Chair Signature: X _____ Date: _____	

NOMINEE QUESTIONNAIRE

HANDOUT E

Please return your questionnaire to HIVPC staff by [TBD].

Candidate Name: Von Biggs

Office Sought: Vice Chair

Affiliation: None

Please state your affiliation as an employee, consultant, or board member with Ryan White Part A, if any.

Please answer each question as concisely as possible, using the space provided.

Leadership

Please describe your leadership style and how you might engage Council members and facilitate the meting process.

My leadership style is characterized by a constant drive for progress. Although we operate within the parameters of a planning body, I believe in seeking avenues for enhancement and community involvement. As a consumer within the Ryan White system, I emphasize the importance of not merely rubber-stamping agenda items for the sake of expediency. Instead, my approach is centered on active engagement, open discussion, and the pursuit of genuine solutions to address the substantive issues we face.

Membership

How will you go about ensuring Council membership is compliant and reflective of the demographics of the HIV/AIDS epidemic in Broward County?

Ensuring council membership alignment is a commitment rooted in my passion for community engagement. Some of the existing council members are a testament to my active involvement in the community. Regular discussions about membership are integrated into my personal outreach efforts within the community. This ongoing dialogue is essential to maintaining a council that is compliant and truly reflective of the Broward County EMA.

Relationships, Community, & Outreach

What will your strategies be to improve the relationship between the Council and the Broward County HIV/AIDS Community?

My strategy involves reinforcing community engagement and outreach, integral aspects of my involvement. Actively participating in panel discussions and focus groups, I strive to convene diverse voices at the table for meaningful dialogue. Recognizing the limitations faced by our planning body and its partnership with the county, I aim to address this by advocating for more impactful measures. My goal is to push boundaries and empower community consumers, ensuring they feel they have a genuine voice in shaping equitable healthcare outcomes in Broward County.

Health Disparity

What initiatives should the Planning Council focus on to eliminate health disparities and improve access to services?

See Last page... list is too long!

NOMINEE QUESTIONNAIRE

Please return your questionnaire to HIVPC staff by [TBD].

Conflict of Interest

If elected, how will you avoid conflict of interest, real or perceived, while exercising your duties of office and that of your personal and professional life?

If elected, I am committed to actively managing and mitigating any potential conflicts of interest, whether perceived or real, in the execution of my duties both within office and in my professional and personal life.As a dedicated advocate for the LGBTQIA+ and HIV community, I understand that my role may involve navigating conflicts. With the responsibility of representing over 8,000 individuals living with HIV/AIDS, I recognize the gravity of the task at hand and am committed to addressing conflicts judiciously and with tact.

My approach is characterized by thorough research and a commitment to ensuring that any issue brought forward is well-founded. While I am unapologetically disruptive in advocating for the community, I understand the importance of handling conflicts with care and professionalism.

As Vice Chair, my primary role is to support the Chair and bring a unique perspective to the planning body. I acknowledge the need for transparency and will work diligently to balance my advocacy efforts with the expectations and responsibilities of my position. My unwavering commitment to pushing boundaries and expectations is a fundamental aspect of my approach, and I will continue to uphold these principles while navigating any potential conflicts that may arise.

Advocacy

What current issues impacting the HIV/AIDS community would you like the Council to address?

Along with previous Health Disparity answers, It's crucial for the planning council to regularly reassess and adapt its priorities based on the evolving needs of the community and the changing landscape of HIV/AIDS. Local input, ongoing community engagement, and collaboration with healthcare providers and advocacy groups are essential for effectively addressing these issues. We are not currently engaged with providers from a planning body perspective.

Communications

How would you communicate to the community about the possibility of the upcoming changes that could impact their Ryan White Part A Services?

Enhancing communication is a priority for Ryan White Part A, particularly in the areas of community newsletters, provider communications, social media, and email/text campaigns. We have identified a need to improve the timeliness of our promotions and information dissemination to the community. Establishing genuine partnerships with providers is essential to effectively relay information to consumers receiving services. Consideration is given to implementing signed acknowledgments of any changes, ensuring a more informed and engaged community.

Outlook

How will you help the HIVPC achieve the goals of the Broward County Integrated HIV Prevention and Care Plan, and the Ending the HIV Epidemic pillars? *(The goals are to increase access to care, improve health outcomes, reduce HIV-related health disparities; and reduce the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030, for an estimated 250,000 total HIV infections averted.)*

NOMINEE QUESTIONNAIRE

Please return your questionnaire to HIVPC staff by [TBD].

To support the HIV Planning Council (HIVPC) in achieving the goals outlined in the Broward County Integrated HIV Prevention and Care Plan and contributing to the broader initiative of ending the HIV epidemic, consider the following actions:

Regularly update yourself on the Broward County Integrated HIV Prevention and Care Plan, as well as broader national and international strategies for ending the HIV epidemic. Knowledge is key to effective advocacy.

Attend HIVPC meetings regularly to stay engaged with ongoing discussions, initiatives, and priorities.Contribute actively during meetings by insights, experiences, and suggestions related to the goals of the plan.

Advocate for the implementation of evidence-based strategies outlined in the plan within your community.
Engage in community outreach efforts to raise awareness about HIV prevention, testing, and care services.

Foster collaboration wicommunity organizations, healthcare providers, and advocacy groups to strengthen the local response to HIV.
Actively participate in or support community events and initiatives related to HIV prevention and care.

Educate yourself and others about HIV prevention methods, the importance of regular testing, and the availability of care services.
Use your knowledge to dispel myths and reduce stigma surrounding HIV/AIDS.

Explore opportunities for resource mobilization to support HIV prevention and care initiatives.
Advocate for increased funding and resources to address the specific needs outlined in the plan.

Advocate for strong partnerships between the HIVPC and healthcare providers to ensure seamless communication and implementation of care strategies.
Support initiatives that facilitate the exchange of information between providers and the council.

Collaborate in monitoring and evaluating the progress of the plan's goals.
Advocate for the use of data to inform decision-making and identify areas that require additional attention or resources.

Engage in dvocacy efforts to support policies that align with the goals of the Broward County plan and the broader initiative to end the HIV epidemic.
Communicate with policymakers to ensure they are aware of the challenges and opportunities related to HIV prevention and care.

Advocate for cultural competency in all aspects of HIV prevention and care, recognizing the diverse needs of the community.
Promote training and education programs to enhance cultural sensitivity within the healthcare system.

Provide constructive feedback on communication processes within the HIVPC.
Advocate for improvements in communication channels, ensuring timely and effective dissemination of information.
Remember that your active engagement, advocacy, and collaboration with various stakeholders are crucial to the success of the HIVPC and the broader initiative to end the

To eliminate health disparities and enhance access to services, the planning council should consider implementing the following initiatives: Some of these we do, but need to do better. We need to pull our Broward County Resources together to be the most effective.

Community Education and Outreach:

Develop and implement educational campaigns to raise awareness about HIV/AIDS, prevention methods, and available services.

Conduct outreach programs to disseminate information in diverse communities, addressing cultural and linguistic barriers.

Access to Testing and Early Diagnosis:

Support initiatives that provide widespread access to HIV testing, promoting regular screenings for early detection.

Collaborate with healthcare providers and community organizations to ensure testing services are readily available and stigma-free.

Culturally Competent Healthcare Services:

Advocate for culturally competent healthcare services that address the unique needs of diverse populations.

Promote training for healthcare professionals to ensure sensitivity to cultural differences in providing care.

Telemedicine and Technology Integration:

Explore and implement telemedicine options to enhance access to healthcare services, especially in underserved or remote areas.

Leverage technology for virtual support groups, counseling, and educational resources.

Affordable and Inclusive Healthcare Policies:

Advocate for policies that improve healthcare affordability and inclusivity, ensuring that financial barriers do not hinder access to necessary services.

Work towards eliminating discrimination in healthcare settings and policies.

Youth and School-Based Programs:

Implement educational programs in schools to raise awareness about HIV prevention and safe practices.

Provide resources and support for youth-focused initiatives that address the unique challenges faced by younger populations.

Collaboration with Community-Based Organizations:

Strengthen partnerships with community-based organizations to leverage their expertise and outreach capabilities.

Support grassroots initiatives that directly engage with affected communities and tailor services to their specific needs.

Mental Health Support:

Advocate for increased access to mental health services, recognizing the mental health challenges often associated with living with HIV/AIDS.

Promote destigmatization of mental health issues within the community.

Peer Support and Mentorship Programs:

Establish peer support programs to connect individuals living with HIV/AIDS, fostering a sense of community and shared experience.

Implement mentorship programs to guide and support newly diagnosed individuals through their healthcare journey.

Data Collection and Analysis:

Collect and analyze data on health disparities within the community to inform targeted interventions.

Use data-driven insights to identify areas with the greatest need and allocate resources accordingly.

Legal Support and Advocacy:

Provide legal support to individuals facing discrimination or barriers to healthcare access.

Advocate for policies that protect the rights of individuals living with HIV/AIDS and ensure equitable treatment.

By focusing on these initiatives, the planning council can contribute significantly to eliminating health disparities and improving access to essential services for individuals affected by HIV/AIDS.

NOMINEE QUESTIONNAIRE

Please return your questionnaire to HIVPC staff by [TBD].

Candidate Name: Lorenzo Robertson

Office Sought: Broward County HIV Health Services Planning Council Chair

Affiliation: No Affiliation

Please state your affiliation as an employee, consultant, or board member with Ryan White Part A, if any.

Please answer each question as concisely as possible, using the space provided.

Leadership

Please describe your leadership style and how you might engage Council members and facilitate the meeting process.

My personal and professional style is to act in accordance with the protocols of the organization. As the chair, I prefer to have a very engaging involvement with the members and the organization's leadership. As the Chair, I will facilitate meetings following Robert's Rules of Order to the best of my knowledge and ability. I think since we are primarily dealing with other adults, we all will conduct ourselves with respect and decorum during our meetings. I will, if need be, make sure that the members will respect each other and the process during our meetings. I don't feel that as the Chair of the Council, I need to act as a parent to naughty children. I think we all act with civility and respect during our meetings, there will be no need for any heavy-handed leadership for the Chair.

Membership

How will you go about ensuring Council membership is compliant and reflective of the demographics of the HIV/AIDS epidemic in Broward County?

Ensuring compliance and reflection of the epidemic in Broward County has been a challenge for decades. I will do my best to work cohesively with the Membership Chair to explore innovative methods of recruiting and retaining new members reflecting the Broward County HIV epidemic. I am not sure if at this time we can make significant changes to the reflectiveness of the Council, but I can continue to request the membership assistance to seek out members from their social, sexual, and professional contacts to join the council because their voices are needed at the table for compliance and reflectiveness, but also for service needed that may not have been brought to the forefront.

Relationships, Community, & Outreach

What will your strategies be to improve the relationship between the Council and the Broward County HIV/AIDS Community?

I think was have very strong relationships with eh Broward County HIV/AIDS Community. I am personally a member of BCHHPPC and SFAN. I think we can only continue to create

environments to facilitate conversations to ensure that we are all doing our part to serve the citizens of Broward County, those living with HIV/AIDS, and those at risk of acquiring HIV. We can start to have reports from the other planning bodies to have a clear perspective of the work they are conducting in their respective realms. Continue to invite the other planning bodies to our meetings and attend their meetings as well. I think one of the best action items for a council is to have a better understanding of what services are available through the other planning bodies. I feel we are all doing similar work with specific nuanced differences specifically around our funding and how those funds are disseminated. The BCHHSPC needs to be more visible in the community to create an environment where more people want to know more about the council.

Health Disparity

What initiatives should the Planning Council focus on to eliminate health disparities and improve access to services?

These are areas where we rely on our committees, Quality Management, and Systems of Care. Health Disparity is a huge issue around the country and a daunting task to undertake. I feel if we continue to create opportunities for community members to learn more about the council and the importance of their voice to receive service. We have done an amazing job with our community conversations, but we can do more. If we begin to explore other vendor opportunities outside of the traditional HIV/AIDS realm, we can start to educate other community members and also provide referral options for people who may not have an understanding that there is an entity to assist with needed services for people living with HIV/AIDS. We may want to explore addressing stigma, racial discrimination, sexism, and other isms impacting people living with HIV. Many of these strategies may fall outside the scope of duty for the council, but I think that if we don't start to work outside the line we will continue to encounter the same issues we've encountered for decades.

Conflict of Interest

If elected, how will you avoid conflict of interest, real or perceived, while exercising your duties of office and that of your personal and professional life?

I am a very transparent person, but if there is a perceived conflict of interest, I will address the issue head-on to ensure that there is no perception of impropriety. I pride myself on being a person of integrity and fairness. I will not do anything that will compromise my position as the Chair. I will do my due diligence to conflicts and impropriety outside of the realm of the Chair and to keep the best interest of the people we pledge to serve and provide care at the forefront of my leadership of the Broward County HIV Health Services Planning Council.

NOMINEE QUESTIONNAIRE

Please return your questionnaire to HIVPC staff by [TBD].

Advocacy

What current issues impacting the HIV/AIDS community would you like the Council to address?

There are a myriad of issues impacting our HIV/AIDS community, but one of the biggest concerns for me is the divisiveness within our HIV/AIDS community. We have to start to address HIV/AIDS as a disease impacting all people regardless of race, sexual orientation, immigrant status, or gender. I realize and understand the issues within the HIV/AIDS community come down to dollars and cents, but until we start to unite and work collaboratively to powers that be (funders) will continue to pit us against each that one group's HIV/AIDS is more important that another groups. Until we start to see HIV/AIDS as a human condition, the division will become cavernous. We need to start bridging the gap between all of us living with HIV.

Communications

How would you communicate to the community about the possibility of the upcoming changes that could impact their Ryan White Part A Services?

My biggest fear is that we will continue to divide ourselves and lose the war because of our small battles within our HIV/AIDS community. I would like to speak to the community about the importance of Ryan White Services in our community. We must make sure that our community members are not only registered to vote, but that exercise their right to vote. Our HIV/AIDS community needs to have a better understanding of our elected officials and how vote to either protect the health and wellbeing of their constituents or how they vote to be detrimental to our wellbeing. We also need to be very vigilant in connecting with other groups, entities, and organizations in our community because we all need to work as a united front to address issues and have clear thought processes about what our elected officials have done that reflects their care for those living with HIV/AIDS. I will also let our HIV/AIDS community know that the Ryan White Services are not a given and they are up for renewal, we have continually received flat funding, meaning, in theory, we are getting a funding cut because we are expected to do more with the same amount of funding. The client numbers have increased, but our funding remains stagnant. I would share that type of information with our community.

Outlook

How will you help the HIVPC achieve the goals of the Broward County Integrated HIV Prevention and Care Plan, and the Ending the HIV Epidemic pillars? *(The goals are to increase access to care, improve health outcomes, reduce HIV-related health disparities; and reduce the number of new HIV infections in the United*

NOMINEE QUESTIONNAIRE

Please return your questionnaire to HIVPC staff by [TBD].

States by 75 percent by 2025, and then by at least 90 percent by 2030, for an estimated 250,000 total HIV infections averted.)

As a member of the Broward County Integrated HIV Prevention and Care Plan workgroup, I will attend meetings and provide my perspective on how the integrated plan is progressing and what we can do to implement change to correct the direction of the integrated workgroup. However, some of the issues with the plan are embedded in the initial structure and design of the plan. There are many groups not included in the plan's conceptualization and implementation which are impediments to the success of the plan. I will continue to be a member of the integrated workgroup and provide my thoughts and views on the process.

HANDOUT F

BROWARD COUNTY FLORIDA

Ryan White Part A

Administrative Update

Affordable Care Act (ACA)

- Training has been provided to the case managers from American Exchange.
- Recipients' office is monitoring enrollment through monthly calls with providers & PE enrollment tracking.
- Recipients' office has sent out flyers from BRHPC, Information regarding PE, & items providers may have in their office to spread the word about ACA.

Ryan White Part A Service Delivery Model Updates

- We are currently going through all the SDMs, With 3 that have gone through the process with more to come in January
- We are adding SDMs for MAI To better differentiate between MAI and Part A services

Questions?

HIV HEALTH SERVICES PLANNING COUNCIL
MEETING GROUND RULES

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

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

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

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

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

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

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

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

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

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

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

Revised 7/24/14

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

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

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

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

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

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

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

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

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

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

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

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

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV
RÈGLEMAN RANKONT-YO

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

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

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

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

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

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

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

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

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

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

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

Acronym List

ACA: The Patient Protection and Affordable Care Act 2010

ADAP: AIDS Drugs Assistance Program

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BISS: Benefit Insurance Support Service

BMSM: Black Men Who Have Sex with Men

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CM: Case Management

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

DCM: Disease Case Management

DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
HAB: HIV/AIDS Bureau
HHS: U.S. Department of Health and Human Services
HICP: Health Insurance Continuation Program
HIV: Human Immunodeficiency Virus
HIVPC: Broward County HIV Planning Council
HMSM: Hispanic Men who have Sex with Men
HOPWA: Housing Opportunities for People with AIDS
HRSA: Health Resources and Service Administration
HUD: U.S Department of Housing and Urban Development
IW: Integrated Workgroup
IDU: Intravenous Drug User
JLP: Jail Linkage Program
LPAP: Local AIDS Pharmaceutical Assistance Program
MAI: Minority AIDS Initiative
MCDC: Membership/Council Development Committee
MCM: Medical Case Management
MH: Mental Health
MNT: Medical Nutrition Therapy
MOU: Memorandum of Understanding
MSM: Men Who Have Sex with Men
NBHD: North Broward Hospital District (Broward Health)
NGA: Notice of Grant Award
NHAS: National HIV/AIDS Strategy
NOFO: Notice of Funding Opportunity
nPEP: Non-Occupational Post Exposure Prophylaxis
NSU: Nova Southeastern University
OAHS: Outpatient Ambulatory Health Services
OHC: Oral Health Care
PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

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

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SA: Substance Abuse

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

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

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

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

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

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

HIVPC ATTENDANCE POLICIES

BROWARD COUNTY CODE OF ORDINANCES
CHAPTER 1, ARTICLE XII. BOARDS, AUTHORITIES AND AGENCIES GENERALLY

GENERAL REQUIREMENT AND POLICIES

Sec. 1-233. Terms of appointees to Broward County agencies, authorities, boards, committees, commissions, councils, and task forces; quorum

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Removal based on Attendance

1. Board meetings on a quarterly or less frequent basis: Members will be removed after two (2) consecutive unexcused absences or missing two (2) properly noticed meetings in one (1) calendar year.
2. Board meetings more frequently than quarterly: Members will be removed after three (3) consecutive unexcused absences or missing for (4) properly noticed meetings in one (1) calendar year.

Excused Absences

Require written notice to the chair of the board prior to the meeting (when practicable). The chair of the board shall determine whether the absence meets the criteria for an excused absence. Members may be excused **ONLY** for the following reasons:

1. Member performing an authorized alternative activity relating to outside advisory board business that directly conflicts with the properly noticed meeting;
2. Death of an immediate family member (spouse, father, mother, stepparent, in loco parentis, child, or stepchild domiciled in member's household);
3. Death of member's domestic partner;
4. Member's hospitalization;
5. Member summoned for jury duty; or
6. Member is issued a subpoena by a court of competent jurisdiction.

Non-excused absences

1. Out of town business.
2. Doing business or attending a meeting for member's company.
3. Attending another meeting as an elected official.
4. Car problems.

Requirements of Appointment

Any advisory board appointee who fails to meet the requirements of his or her appointment, including residency, if required to live in the district, is automatically disqualified, and his or her appointment shall immediately cease and be deemed vacant.

Quorum Rules

Once a quorum has been established by members physically present at a meeting, members who are not physically present may attend and participate in such meeting by telephone.

Appointees shall notify the board coordinator *at least two (2) business days prior* to the scheduled meeting date as to whether they will or will not attend the meeting. This will allow the cancellation of a meeting due to a lack of quorum prior to the actual meeting date.

If a board member does not confirm to the board coordinator that he or she will be present, at least 2 days prior to the meeting, he or she will be marked absent where such failure results in the meeting being cancelled for lack of quorum.

HIVPC ATTENDANCE POLICIES

If a meeting is **scheduled and a sufficient number of members to constitute a quorum CONFIRMED** that they will be physically present at the meeting:

- Members present will be marked as attending.
- Members who telephone in, will be marked as attending.
- Members not present will be marked absent.
- Members, who did not confirm they were attending and attend, will be marked present.

If a meeting is **scheduled and a sufficient number of members to have quorum DID NOT CONFIRM** that they will be physically present at the meeting, **THE MEETING WILL BE CANCELLED PRIOR TO THE MEETING DATE**:

- Members who intended to telephone in, will be marked absent.
- Members, who did not confirm that they were attending, will be marked absent.
- Members who confirmed they would be attending will be marked *present* and it will be noted on the attendance sheet that the meeting was cancelled.

If a meeting is **scheduled and sufficient number of members to constitute a quorum CONFIRMED** that they will be physically present at the meeting, **BUT QUORUM WAS NOT PRESENT AT THE MEETING, THE MEETING WILL BE CANCELLED**:

- Members present will be marked as attending but it will be noted that the meeting was cancelled.
- Members not present will be marked absent.
- Members, who telephone in, will be absent.
- Members, who did not confirm that they were attending, and attend, will be marked present.
- Members who did not confirm that they were attending, and do not attend, will be marked absent.

(Ord. No. 79-36, § 1, 6-20-79; Ord. No. 89-19, § 1, 5-9-89; Ord. No. 92-4, § 1, 3-10-92; Ord. No. 92-13, § 1, 5-12-92; Ord. No. 92-46, § 1, 11-10-92; Ord. No. 95-18, § 1, 4-11-95; Ord. No. 1999-06, § 1, 2-23-99; Ord. No. 2001-01, § 1, 1-9-01; Ord. No. 2001-10, § 1, 3-27-01; Ord. No. 2002-10, § 1, 3-18-02; Ord. No. 2003-21, § 1, 6-10-03; Ord. No. 2005-01, § 1, 1-11-05; Ord. No. 2005-16, § 1, 6-28-05; Ord. No. 2006-17, § 1, 6-13-06; Ord. No. 2008-36, § 1, 9-9-08; Ord. No. 2009-39, § 1, 6-23-09; Ord. No. 2012-30, § 1, 10-23-12; Ord. No. 2014-08, § 1, 02-25-14)

End of Packet