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

Committee Meeting Agenda: Executive Committee
Date/Time: Tuesday, April 21, 2015, 9:30 a.m.-11:30 a.m. **Location:** Governmental Center GC-302
Chair: Vacant **Vice Chair**: Reed, Y.

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 4/21/15 Executive Committee Agenda and 3/17/15 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
4. **UNFINISHED BUSINESS:**
   a) HIVPC Retreat (WP Item 2.3) (Handout A)
   ACTION ITEM: Continue planning for the HIVPC retreat. Solidify the theme, additional parties to invite, and a date.
   b) Annual Evaluation (WP Item 3.6) (Handout B)
   ACTION ITEM: Review the annual evaluation of the HIVPC. Identify accomplishments and challenges, and actions to mitigate challenges in 2015.
   c) Committee Reflectiveness (Handout C)
   ACTION ITEM: Discuss the reflectiveness of each committee and determine steps to improve reflectiveness.
   d) Update Planning Documents (WP Item 5.2) (Handouts D-1 & D-2)
   ACTION ITEM: Review the Executive purpose, mission statement, and policies and procedures. Make necessary updates.
   e) PCS Quarterly Report (Handouts E-1 & E-2)
   ACTION ITEM: Review the PCS Quarterly Report for the 3rd and 4th quarters of FY 2014-2015.
5. **MEETING ACTIVITIES/NEW BUSINESS**

Agenda Items (Work Plan Item #)	*Action to be taken, presentation, discussion, brainstorm etc.*
HIVPC Chair	ACTION ITEM: Discuss the HIVPC Chair vacancy and next steps.
By-Laws Changes (Handout F)	ACTION ITEM: Review the proposed succession plan from By-Laws.
Monitor Comprehensive Plan (WP Item 1.2) (Handout G)	ACTION ITEM: Review committee activities to ensure the objectives of the Comprehensive Plan are met. Identify successes and challenges.
Evaluation Report (Handout H)	ACTION ITEM: Review the evaluation report and make recommendations for action based on analysis.
Meeting Evaluations (Handout I) (WP Item 3.5)	ACTION ITEM: Review meeting evaluations to assess effectiveness of Council and committee meetings, including meeting efficiency and effectiveness.
Training Schedule (Handout J) (WP Item 2.2)	ACTION ITEM: Determine a training schedule for MCDC & Executive quarterly trainings to avoid overlap. Ensure trainings focus on topics that inform on the 3 Guiding Principles.
Community Data Presentation	ACTION ITEM: Discuss the community data presentation, and how to present the data in a manner that is meaningful and effective.

6. **GRANTEE REPORTS**
7. **PUBLIC COMMENT**
8. **AGENDA ITEMS / TASKS FOR NEXT MEETING:** May 19, 2015, 9:30 a.m. **VENUE:** A-337

Agenda Items for next Meeting	*Responsible Party*	*Action to be taken, presentation, discussion, etc.*
SOC Recommendations for PSRA (WP Item 4.1)	*SOC, PSRA, Exec*	ACTION ITEM: Review the SOC recommendations about other funding sources for the PSRA process.

9. **ANNOUNCEMENTS**
10. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS
THREE GUIDING PRINCIPLES OF THE HIV 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: Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care
Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments
Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment

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

Meeting Minutes: Executive Committee
Date/Time: Tuesday, March 17, 2015, 9:30 a.m. **Location:** Governmental Center Annex, A337
Chair: Gammell, B. **Vice-Chair**: Reed, Y.

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	Gammell, B., *Chair*	**X**			Lewis, L.
2	Grant, C.	**X**			Radlauer, J.
3	Katz, H. B.	**X**			Ronik, M.
4	Lint, A.	**X**			Runkle, D.
5	Reed, Y., *Vice Chair*	**X**			
6	Sabatino, D.	**X**			**Grantee Staff**
7	Schweizer, M.	**X**			Degraffenreidt, S.
8	Siclari, R.	**X**			Green, W.E.
9	Spencer, W.	**X**			Jones, L.
10	Taylor-Bennett, C.	**X**			Vargas, J.
11	Tomlinson, K.	**X**			
12	Wilson, T.		**A**		**HIVPC Staff**
					Bente, A.
					Johnson, B.
	Quorum = 7	**11**			Sandler, C.

1. CALL TO ORDER

The Chair called the meeting to order at 9:45 a.m. and welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIV Planning Council (HIVPC) staff self-introductions were made. A moment of silence was observed.

2. APPROVALS

The following motions were made:

Motion #1: To approve today's meeting agenda with one amendment
Amendment: Move Collective Impact Training to meeting item #3.
Proposed by: Schweizer, M. **Seconded by:** Grant, C.
Action: Passed Unanimously

Motion #2: To approve meeting minutes of 2/17/15
Proposed by: Katz, H.B. **Seconded by:** Tomlinson, K.
Action: Passed Unanimously

3. COLLECTIVE IMPACT TRAINING (30 minutes)

Marci Ronik from the Ronik-Radluaer Group explained the various aspects that her organization is involved in and gave a Collective Impact (CI) training. CI increases health outcomes while incorporating results based accountability, a common agenda, establishing shared measurement, and key indicators, including hospitalization rates, retention in care, and best practices. She asked the committee to list key indicators for evaluation. Responses included national aggregate retention in care data, reasons for clients moving off the Ryan White system, national transgender data, education regarding the disease state, and medication adherence rates. Other CI aspects included mutually reinforcing activities, and continuous communication which produces extraordinary results.

4. STANDARD COMMITTEE ITEMS

a) Committee Chair Reports: The Chair asked that committee Chairs explain relevant documents contained in the HIVPC packet.

Priority Setting & Resource Allocation (PSRA) Committee: The PSRA Chair stated the committee has begun to review the FY 2014-2015 scorecards. The scorecards will now include demographics for clients that are not virally suppressed and not in care. The ad-Hoc Food Services Eligibility Committee is reviewing sustainable models including a medical need based model to improve health outcomes. The HIVPC Chair asked the PSRA Chair if the ad-Hoc Food Services Eligibility Committee Chair was ready to make a presentation regarding work that has taken place in the committee. The PSRA Chair stated that a presentation is not needed at this time.

Needs Assessment/Evaluation (NAE) Committee: The committee did not meet in March due to failure to meet quorum.

Quality Management Committee (QMC): The QMC Chair stated that five guests from community agencies attended the March meeting due to recruitment letters being sent. The committee reviewed data regarding those that are not meeting health outcomes by zip code. The QMC Chair explained that zip code data was not significant. She explained that black women are the predominant population that are not retained in care. The real goal of the committee is to ascertain the reason why this population continues to fall out of care. She explained that data regarding Hispanic and Caribbean populations was scarce and further data needs to be reviewed. The HIVPC Chair asked for the age ranges of black women not retained in care. The QMC Chair explained that those 24 years and older were primarily not retained in care.

Membership/Council Development Committee (MCDC): The MCDC Chair explained the next Welcome Brunch will take place on May 15, 2015 at Hispanic Unity. The committee approved the change in seat for the HIVPC Chair, and approved the new HIVPC membership applications. HIVPC staff explained the changes on the applications. The HIVPC Vice Chair asked if a member wants to become part of multiple committees, would they have to complete multiple applications. HIVPC staff explained that an interested party would only need to complete one application. The Grantee asked the reasons why certain demographic information is being ascertained in the application. HIVPC staff explained that this information is required by HRSA to be reflective of local populations and risk groups. The HIVPC Chair asked that these applications be sent back to the MCDC to review the applications. The PSRA Chair asked the Executive Committee make the changes in the current applications instead of sending them back to the MCDC. The MCDC Chair expressed his interest in having the Executive Committee make the changes to the applications. He stated that reflectiveness of the HIVPC is crucial. The Grantee asked which questions were required. HIVPC staff answered that age, gender, and special populations were required by HRSA. There was discussion regarding the question that asked about gender, especially for transgender members. The committee reviewed best practices. The following motion was made:

Motion #3: To ask gender on the HIVPC applications with a two-step approach
Proposed by: Spencer, W. **Seconded by:** Katz, H.B.
Action: Passed Unanimously

There was further discussion regarding race and ethnicity. There was discussion whether Haitian should be included in the application. The HIVPC Chair recommended that these applications be changed by the MCDC utilizing best practices.

There was further discussion regarding amending the HIVPC Chair's mandated seat due to his anticipated employment change. There was discussion that this item be addressed once his employment change occurs.

The PSRA Chair called a point of order as to whether adding a member to the ad-Hoc Food Services Eligibility Committee must be first approved by the PSRA Committee. The HIVPC Chair explained that the motion is at the discretion of the PSRA Chair. The PSRA Chair agreed to let the item be approved.

System of Care (SOC) Committee: The committee did not meet in February due to failure to meet quorum.

ad-Hoc By Laws Committee: The ad-Hoc By Laws Committee Chair explained the parking lot item #1-4 to be approved the by the HIVPC.

Community Empowerment Committee (CEC): The CEC Chair explained that the committee is still searching for a Vice Chair. The committee approved the community events survey, discussed Hot Topics discussions to take place at Broward House, Shadowood, and Memorial Hospital. CEC members will also be a part of the next MCDC Welcome Brunch

b) Discuss Healthcare Reform Update on HIVPC Agenda
This item will be covered in the Grantee's report.

c) Approve 3/26/15 HIVPC Meeting Materials and Motions (Handouts A-1 – A-6)
There was committee discussion regarding Public Comment. The HIVPC Chair stated that future public commentary will be limited to one minute and length will be up to the discretion of the HIVPC Chair. The Grantee stated that public comment at the last HIVPC meeting was unnecessary and lacked decorum. The PSRA Chair stated that public comment must be relevant to the items being discussed and recommended that public comment be eliminated in future HIVPC agendas. The SOC Chair stated that public comment should not be removed but rather be relevant to HIVPC items. The NAE Vice Chair stated that public comment cannot be removed as it is in the current HIVPC By-Laws, and the HIVPC Chair may impose time limits on those conducting giving public commentary. The HIVPC Vice Chair stated that public comment is the mechanism in which consumers voice their opinions regarding HIVPC services. The CEC Chair stated that public comment is important to let consumers and public voice their opinions. The committee decided to remove the first public comment section. There was discussion that public comment is up to the discretion of the HIVPC Chair, and can be stopped at any time.

d) Approve 3/26/15 HIVPC Agenda (Handout B)
The following motion was made:

Motion #4: To approve the March HIVPC agenda with the following amendments
Amendments: To withdrawal Consent Items # 1 & 3 and the first Public Comment Section
Proposed by: Spencer, W. **Seconded by:** Tomlinson, K.
Action: Passed Unanimously

5. UNFINISHED BUSINESS:

a) HIVPC Retreat (WP Item 2.3) (Handout D)
This item was tabled until the next meeting.

b) Annual Evaluation (WP Item 3.6) (Handout E)
This item was tabled until the next meeting.

c) Committee Reflectiveness (Handout F)
This item was tabled until the next meeting.

d) Update Planning Documents (WP Item 5.2) (Handouts G-1 & G-2)
This item was tabled until the next meeting.

e) PCS Quarterly Report (Handout H)
This item was tabled until the next meeting.

6. MEETING ACTIVITIES/NEW BUSINESS

a) Monitor Comprehensive Plan (WP Item 1.2) (Handout I)
This item was tabled until the next meeting.

b) Evaluation Report (Handout J)
This item was tabled until the next meeting.

c) Meeting Evaluations (WP Item 3.5) (Handout K)
This item was tabled until the next meeting.

d) Training Schedule (WP Item 2.2) (Handout L)
This item was tabled until the next meeting.

7. GRANTEE REPORT

As of March 1st, there is a new HRSA project officer Adeola Fawehinmi for Broward County. The Grantee presented the new CBS 4 media campaign, including the new video clip. The Grantee's office is currently wrapping up the fiscal year and the last provider invoice is due on April 15, 2015. The SOC Chair asked when budgets will be integrated in Provide Enterprise (PE). The Grantee stated that his office is currently being updated this mechanism in PE.

8. PUBLIC COMMENT

None.

9. AGENDA ITEMS / TASKS FOR NEXT MEETING: April 21, 2015, 12:30 p.m. VENUE: Room A-337

Agenda Items for next Meeting	*Responsible Party*	*Action to be taken, presentation, discussion, etc.*
HIVPC Retreat (WP Item 2.3)	*Exec*	ACTION ITEM: Continue planning for the HIVPC retreat. Solidify the theme, additional parties to invite, and a date.
Annual Evaluation (WP Item 3.6)	*Exec*	ACTION ITEM: Review the annual evaluation of the HIVPC. Identify accomplishments and challenges, and actions to mitigate challenges in 2015.
Committee Reflectiveness	*MCDC, Exec*	ACTION ITEM: Discuss the reflectiveness of each committee and determine steps to improve reflectiveness.
Update Planning Documents (WP Item 5.2)	*Exec*	ACTION ITEM: Review the Executive purpose, mission statement, and policies and procedures. Make necessary updates.
PCS Quarterly Report	*Exec*	ACTION ITEM: Review the PCS Quarterly Report for the 3rd quarter of FY 14-15.
Monitor Comprehensive Plan (WP Item 1.2)	*NAE, Exec*	ACTION ITEM: Review committee activities to ensure the objectives of the Comprehensive Plan are met. Identify successes and challenges.
Evaluation Report	*Exec*	ACTION ITEM: Review the evaluation report and make recommendations for action based on analysis.
Meeting Evaluations (WP Item 3.5)	*Exec*	ACTION ITEM: Review meeting evaluations to assess effectiveness of Council and committee meetings, including meeting efficiency and effectiveness.
Training Schedule (WP Item 2.2)	*MCDC, Exec*	ACTION ITEM: Determine a training schedule for MCDC & Executive quarterly trainings to avoid overlap. Ensure trainings focus on topics that inform on the 3 Guiding Principles.
Service Quality Outcomes (WP Item 3.3)	*QMC, Exec*	ACTION ITEM: Review service quality outcomes. Ensure outcomes are focused on the 3 Guiding Principles.

10. ANNOUNCEMENTS

None.

11. ADJOURNMENT

The meeting adjourned at 12:34 p.m.

Executive Committee Attendance 2015

Count	Meeting Month:	Jan	Feb	Mar
	Meeting Date:	6	17	17
1	Gammell, B, *Chair*	X	X	X
2	Grant, C.	X	X	X
3	Katz, H.B.	X	X	X
4	Lint, A.	A	X	X
5	Reed, Y., *Vice Chair*	A	X	X
6	Sabatino, D.	X	X	X
7	Schweizer, M.	X	X	X
8	Sicalari, R.	X	X	X
9	Spencer, W.	X	X	X
10	Taylor-Bennett, C.	X	X	X
11	Tomlinson, K.	X	A	X
12	Wilson, T.	X	A	A
	Quorum = 7	10	10	11

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

HANDOUT A

2015 RETREAT OF HIV PLANNING COUNCIL

Proposed Date: August 3-7, 2015
Proposed Location: Oak Ridge Hall at Tree Tops Park, 3900 Southwest 100th Ave Davie, FL
Oak Hammock Hall at Long Key Natural Area, 3501 S.W. 130th Ave., Davie, FL

Integrated HIVPC & BCHPPC Meeting: 9:30 a.m. – 12:30 p.m.
Hold integrated meeting with the HIVPC and Broward County HIV Prevention Planning Council (BCHPPC). Share data and information in preparation for the integrated Comprehensive Plan.

Integrated Retreat: 1:00 – 4:00 p.m.
Proposed Theme & Training Topic
Integrated Prevention and Care Comprehensive Plan: Focusing the retreat on the integrated Prevention and Care Comprehensive Plan will help prepare the HIVPC for the integrated plan that is due in 2016.

Additional Parties to Invite

a. Emily Gantz-McKay: Ms. Gantz McKay may be available for further Technical Assistance (TA) on the integrated Prevention and Care Comprehensive Plan that will be due in 2016.
b. BCHPPC: If the retreat is focused on the integrated Comprehensive Plan, the committee may want to consider inviting the Prevention Planning Council. The committee may want to limit the retreat to the Executive Committees if both the HIVPC and the BCHPPC will be present.
c. Houston EMA: Invite Houston EMA staff and/or Planning Council members, and Houston Prevention program members to discuss their experiences with integrating planning efforts

HIVPC 2014 ACCOMPLISHMENTS & CHALLENGES

Accomplishments:

- Based on a successful sweeps process, the EMA requested carryover for less than 1% (approximately 0.3%) of total grant funds for FY 2013-2014
- Implementing two new service categories, HICP and Medical Disease Case Management, in response to changes in the health care landscape. Close to 100 clients have been enrolled in ACA Marketplace plans, and a Medical Disease Case Management Work Group is in the process of developing a service delivery model
- Exceeding the mandated 33% rule for HIVPC consumer membership: at the end of 2014, unaffiliated consumers made up 38% of the HIVPC
- Making progress along the HIV care continuum by increasing the number of clients who are prescribed ART (89% to 92%) and virally suppressed (71% to 73%) between FY 2013-2014 and FY 2014, year to date
- Increasing visibility in the community by holding multiple committee meetings and community events throughout Broward County. As a result of these community meetings and events, HIVPC committees added two new members, and six new HIVPC applications were received
- Increasing opportunities for consumers to participate in training and advocacy events: in 2014, the CEC wrote a letter of support to HRSA, had two consumer members apply for scholarships to AIDSWatch 2015, had a consumer member attend the United States Conference on AIDS, and six consumer members attend the NQC's Training Consumers on Quality conference. Based on attendance at the NQC training, one consumer is on track to join the HIVPC's QMC

Challenges:

- Planning for the unknowns of the ACA implementation, such as the actual cost of enrollment into insurance plans, deductibles, and co-pays and the actions of other payers
- Filling empty mandated seats on the HIVPC with numerous employment changes and restructuring of agencies that are responsible for carrying out programs affiliated with mandated seats. The committees of the HIVPC also encountered some difficulties ensuring committees were reflective of the epidemic and all had adequate consumer membership

- Developing marketing techniques and new ways to reach out to target audiences for HIVPC membership and outreach in the community

Evaluation

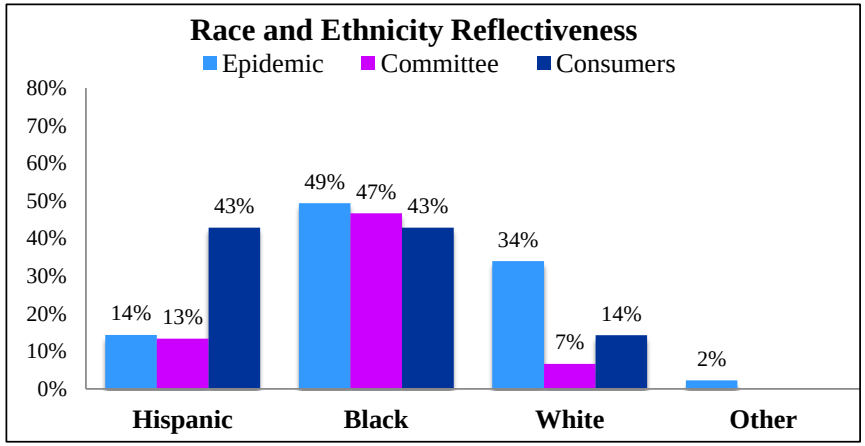
The HIVPC will continue to capitalize on its accomplishments in 2015 by continuing such work as communicating with other community stakeholders in preparation for 2016's integrated Comprehensive Plan, holding events and meeting in the community to increase the HIVPC's visibility, and engaging consumer members in advocacy and training opportunities. The HIVPC will also make efforts to make progress on some of its challenges by undertaking such work as convening work groups and ad-Hoc committees to update or develop service delivery models, increasing education for HIVPC and committee members to ensure understanding of key HIVPC processes, and working with outside organizations to fill as many of the vacant mandated seats as possible.

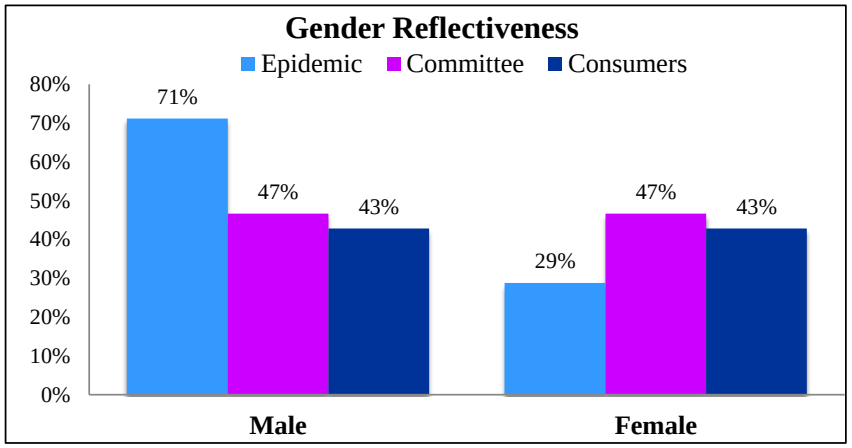
Committee Recommendations for 2015:

1. _____
2. _____
3. _____

HANDOUT C

Community Empowerment Committee (CEC) Reflectiveness Report
Through March 2015



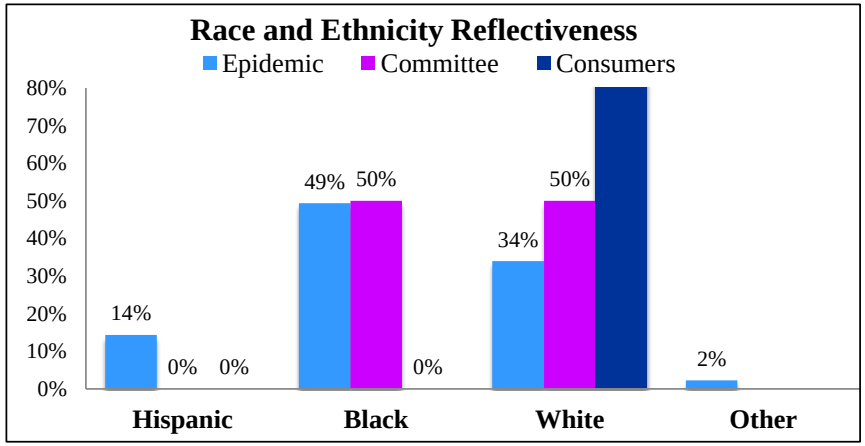


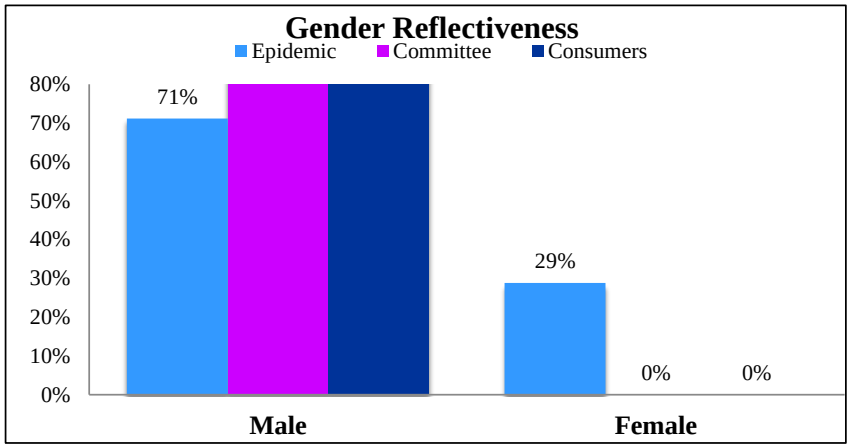
Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	7	47%	3	43%	**-25%**
Female	4,973	29%	7	47%	3	43%	**18%**
Transgender	-	-	0	0%	1	14%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	2	13%	3	43%	-1%
Black	8,521	49%	7	47%	3	43%	-3%
White	5,856	34%	1	7%	1	14%	**-27%**
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**15**		**7**		

Current Members	**15**
% of Members That Are Unaffiliated Consumers	**47%**

HANDOUT C

Membership/Council Development Committee (MCDC) Reflectiveness Report
Through March 2015



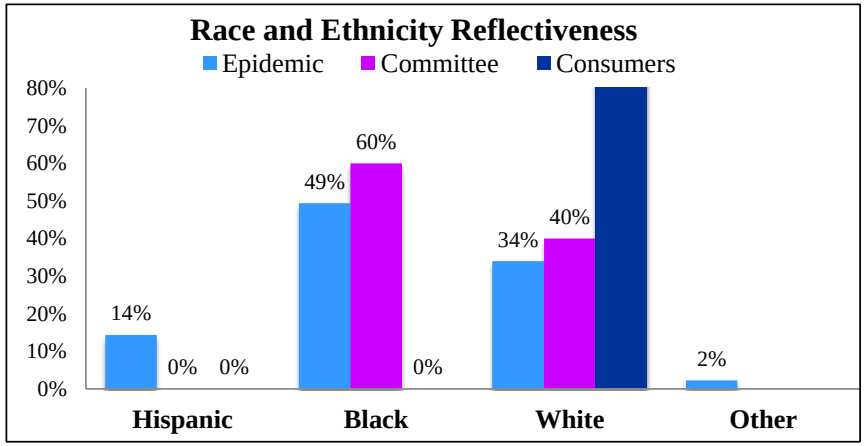


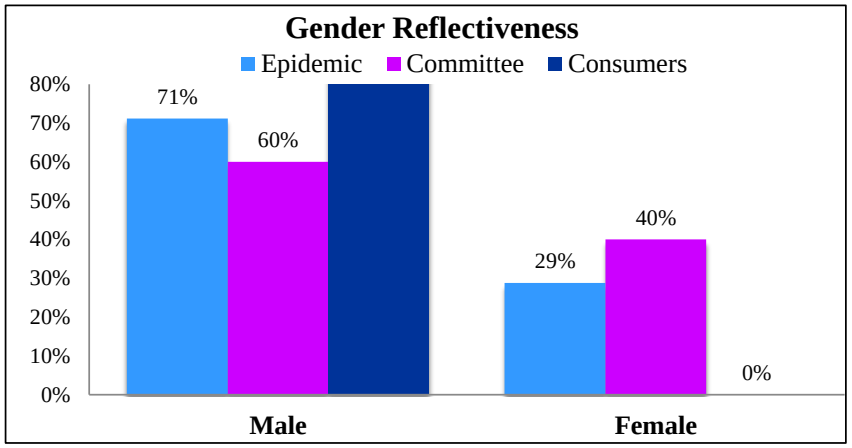
Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	4	100%	1	100%	**29%**
Female	4,973	29%	0	0%	0	0%	**-29%**
Transgender	-	-	0	0%	0	0%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	0	0%	0	0%	**-14%**
Black	8,521	49%	2	50%	0	0%	1%
White	5,856	34%	2	50%	1	100%	**16%**
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**4**		**1**		

Current Members	**4**
% of Members That Are Unaffiliated Consumers	**25%**

HANDOUT C

Needs Assessment/Evaluation (NAE) Committee Reflectiveness Report
Through March 2015



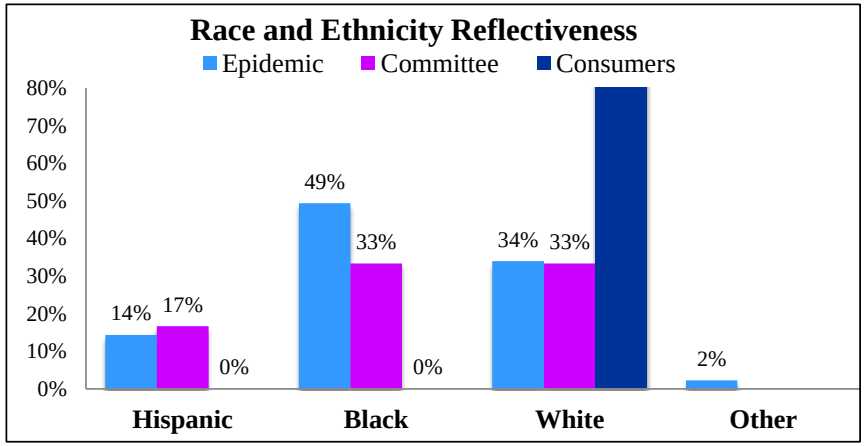


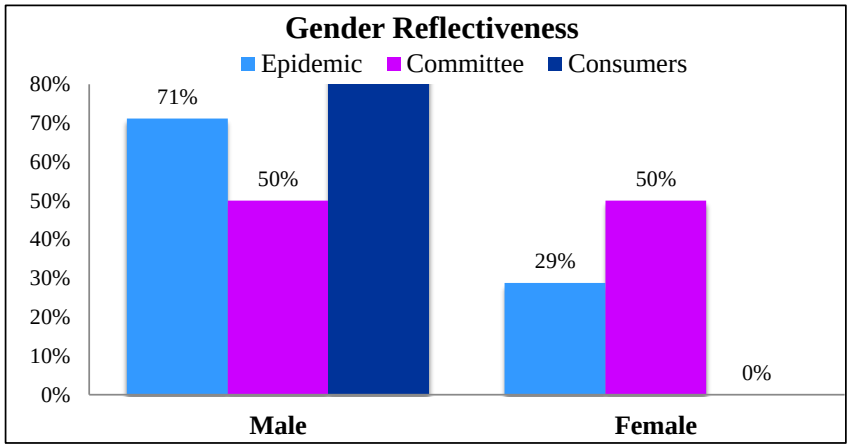
Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	3	60%	1	100%	**-11%**
Female	4,973	29%	2	40%	0	0%	**11%**
Transgender	-	-	0	0%	0	0%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	0	0%	0	0%	**-14%**
Black	8,521	49%	3	60%	0	0%	**11%**
White	5,856	34%	2	40%	1	100%	6%
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**5**		**1**		

Current Members	**5**
% of Members That Are Unaffiliated Consumers	**20%**

HANDOUT C

Quality Management Committee (QMC) Reflectiveness Report
Through March 2015



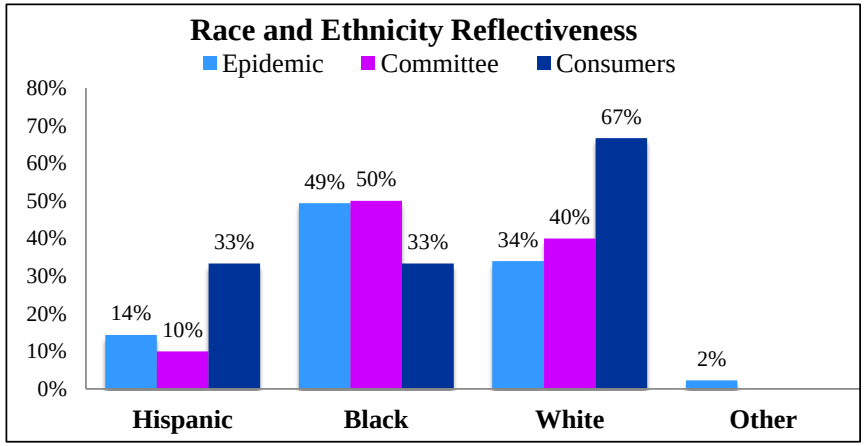


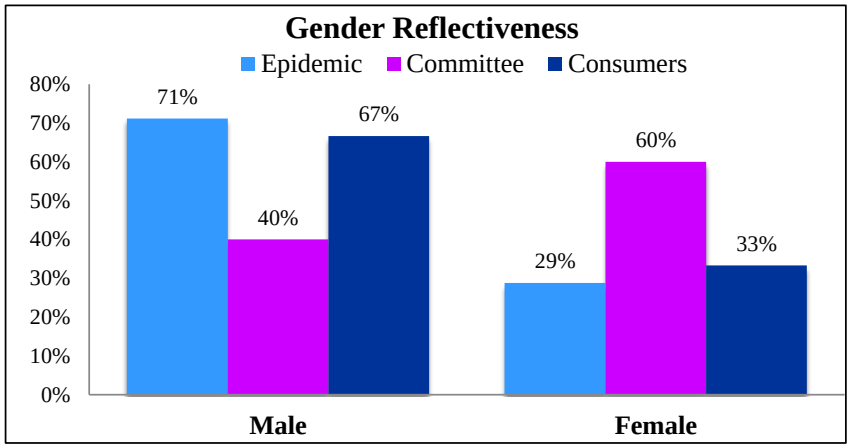
Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	3	50%	2	100%	**-21%**
Female	4,973	29%	3	50%	0	0%	**21%**
Transgender	-	-	0	0%	0	0%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	1	17%	0	0%	2%
Black	8,521	49%	2	33%	0	0%	**-16%**
White	5,856	34%	2	33%	2	100%	-1%
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**6**		**2**		

Current Members	**6**
% of Members That Are Unaffiliated Consumers	33%

HANDOUT C

Priority Setting & Resource Allocation Committee (PSRA) Reflectiveness Report
Through March 2015



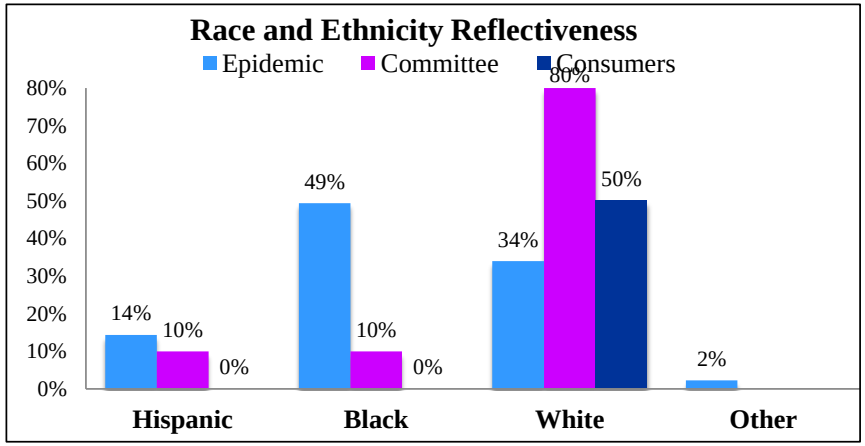


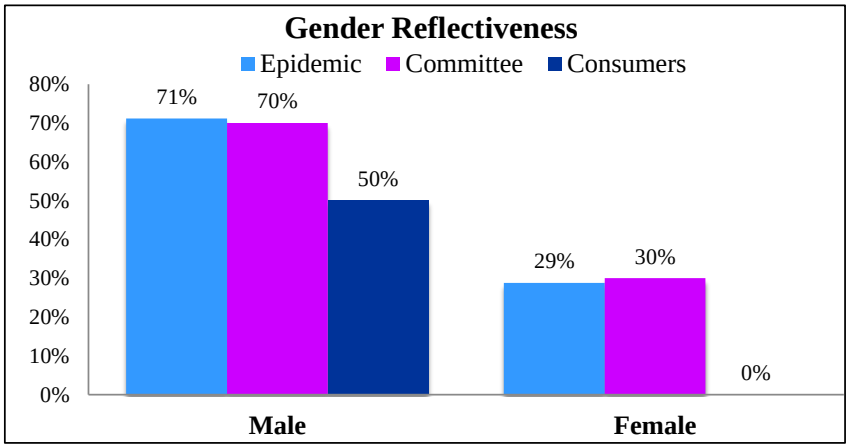
Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	4	40%	2	67%	**-31%**
Female	4,973	29%	6	60%	1	33%	**31%**
Transgender	-	-	0	0%	0	0%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	1	10%	1	33%	-4%
Black	8,521	49%	5	50%	1	33%	1%
White	5,856	34%	4	40%	2	67%	6%
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**10**		**3**		

Current Members	**10**
% of Members That Are Unaffiliated Consumers	**30%**

HANDOUT C

System of Care (SOC) Committee Reflectiveness Report
Through March 2015



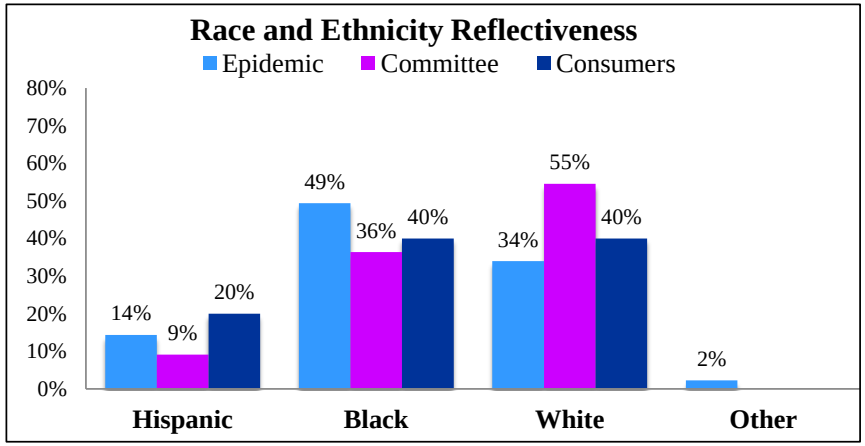


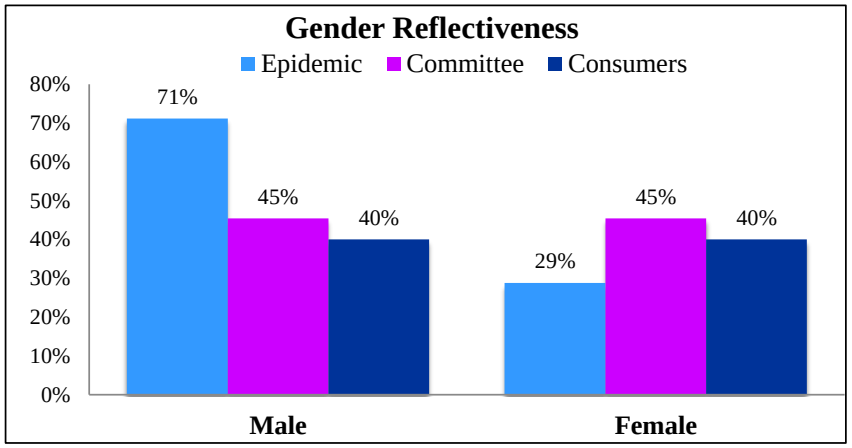
Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	7	70%	1	50%	-1%
Female	4,973	29%	3	30%	0	0%	1%
Transgender	-	-	0	0%	0	0%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	1	10%	0	0%	-4%
Black	8,521	49%	1	10%	0	0%	**-39%**
White	5,856	34%	8	80%	1	50%	**46%**
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**10**		**2**		

Current Members	**10**
% of Members That Are Unaffiliated Consumers	**20%**

HANDOUT C

Executive Committee Reflectiveness Report
Through March 2015





Gender	Epidemic		Committee		Consumers		% Difference
Male	12,275	71%	5	45%	2	40%	**-26%**
Female	4,973	29%	5	45%	2	40%	**17%**
Transgender	-	-	1	9%	1	20%	-
Race	**Epidemic**		**Committee**		**Consumers**		**% Difference**
Hispanic	2,476	14%	1	9%	1	20%	-5%
Black	8,521	49%	4	36%	2	40%	-13%
White	5,856	34%	6	55%	2	40%	**21%**
Other	395	2%	0	0%	0	0%	-2%
Total	**17,248**		**11**		**5**		

Current Members	**11**
% of Members That Are Unaffiliated Consumers	**36%**

EXECUTIVE COMMITTEE
Policies and Procedures

Policies

The Committee shall have responsibility for oversight of the planning activities established in the comprehensive plan and development and oversight of committee work plans to address comprehensive planning goals and objectives.

The membership of the Executive Committee shall consist of the Broward County HIV Health Services Planning Council (Council) Chair, the Council Vice-Chair and the Chairs and Vice Chairs of each of the Standing Committees. Immediate past Council Chair (if the past Chair is currently a member of the Council) will serve as an ex-officio member of the Committee.

The Executive Committee may meet between regular Council meetings as needed, on an emergency basis, to conduct business of the Council (excluding priority-setting and allocation decisions). The Executive Committee shall:

- Set the agenda for Council meetings.
- Address Conflict of Interest issues.
- ~~Oversee the planning activities established in the Comprehensive Plan.~~
- Develop and oversee committee work plans which address comprehensive planning goals and objectives.
- Review Membership/Council Development Committee Attendance report to identify Council members not in compliance with attendance requirements.
- Review Committee recommendations to determine whether the items should be referred to the appropriate Committee.
- Ratify Membership/Council Development Committee recommendations for removal for cause.

The Committee shall be authorized to formulate Council policy, review all concerns, and make recommendations to the full Council regarding unresolved grievance issues as stated in the Council's Grievance Policy.

Procedures

Conflict of Interest

The Committee shall be authorized to formulate Council policy, review all concerns, and make recommendations to the full Council regarding conflict of interest issues.

Comprehensive Plan:

~~The Executive Committee shall be responsible for developing and maintaining a Comprehensive HIV/AIDS Plan.~~

The Committee shall have responsibility to develop and maintain a comprehensive plan for the organization and delivery of HIV health and support services that:

- Incorporates information from the needs assessment, continuous quality improvement activities, evaluation studies, etc.;
- Includes a strategy to coordinate the provision of services with programs for HIV prevention (including outreach and early intervention) and the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for substance abuse);
- establishes mechanisms to ensure participation in Statewide Coordinated Statement of Need (SCSN) activities to encourage CARE Act programs to address key HIV/AIDS care issues and enhance coordination;
- coordinates with Federal grantees that provide HIV-related services; and,
- Includes discrete goals and timetables.

The Committee will invite representatives from other planning bodies **and other community stakeholders** to participate in the preparation of all planning documents, coordinate and collaborate the funding available for services to HIV infected individuals.

The Committee will encourage a cooperative, non-duplicative relationship amongst all providers of HIV/AIDS services.

The Committee will ensure participation in SCSN activities.

The Committee shall develop work plans for HIVPC committees to respond to the goals and objectives of the Comprehensive Plan and oversee/manage accomplishment of work plan activities.

Council Meeting Agenda:
The Committee (or in the absence of Executive Meeting action, ~~the Council's Planner/Coordinator~~**Planning Council Support (PCS) staff**) shall prepare an agenda for full Council meetings.

The meeting agenda for the Council shall be based upon the following:

- Each committee chair, the grantee, and Council support staff will inform the Committee (or ~~Council Planner/Coordinator~~**PCS staff**) of committee recommendations and other actions to be presented for the Council's approval.
- Motions passed by Committees may be sponsored by the Chair of the Committee on behalf of the committee and annotated on the Council Agenda as sponsored by the Committee. Individual members of the Council may also request that action items be placed upon the agenda by providing them in writing to ~~the Council Planner/Coordinator~~**PCS staff** prior to the Executive Committee meeting.
- Members of the public who wish to bring matters before the Council for consideration must obtain sponsorship of the item by a member of the Council. Requesters of all Council actions will also provide appropriate back-up documentation to explain the action being requested.
- The Executive Committee may refer proposed actions to the appropriate committee to examine and make a recommendation prior to presenting the matter to the Council for action.
- Proposed motions requiring the Council's vote shall be listed on the agenda which is sent out to members prior to the Council meeting.
- At the Executive Committee's discretion, the back-up documentation will be labeled and distributed with the Council's agenda.
- At the discretion of the Council Chair, action items requested at the Council meeting not on the published agenda may be deferred to the old business or new business portion of the agenda, or until the next Council meeting, or may be assigned to an appropriate committee for recommendation.
- **The ordinary Council agenda shall include: Call to Order, Welcome and Self-introductions (includes explanation of Ground Rules, Sunshine Law and HIV self- disclosure), Moment of Silence, Excused Absences and Appointment of Alternates, Adoption of Agenda, Approval of Minutes, Consent Items, (no discussion required), Discussion Items (discussion required), Committee Reports, Grantee and Other Reports (including, but not limited to Part A , Part B, Part C, Part D, Part F, HOPWA, Prevention, etc.), Old/New Business, Public Comment, Announcements, Next Meeting Date, Agenda Items for the Next Meeting, Adjournment. The Executive Committee may order agenda items for the efficient and effective administration of the Council's business.**
- ~~The ordinary order of the Council's agenda shall be: 1, welcomes and introductions (including explanation of Government in the Sunshine Requirements for meeting attendees regarding attendees choice to disclose HIV status as disclosure in HIV Planning Council and/or Committee meetings would then become a matter of public record); 2, adoption of agenda; 3. approval of minutes; 4, moment of silence; 5, review meeting ground rules; 6. public comment; 7. action items, consent (no discussion required); 8, action items, regular (discussion required); 9, discussion items; 10, grantee report; 11, program support report; 12, committee reports; 13, legislative update; 14, old business; 15, new business; 16 public input; 17, announcements; 18, next meeting date, adjournment. The Executive Committee may re-order these items for particular meetings if necessary for the efficient~~

~~and effective administration of the Council's business.~~

- The Executive Committee (or Council Chair in the absence of Executive Committee action) will determine the order of decision action items.
- The Executive Committee will establish time limits for each agenda item for each meeting. The Chair may use discretion to impose time limits on each speaker, to be consistently applied. Upon expiration of the time for discussion of a particular action item, the Chair shall close the debate and call for a vote. A person who has spoken once on a pending matter may not speak again on that matter until all others requesting the floor have been recognized.

Grievances

The Executive Committee (Committee) will provide a clearinghouse and facilitate resolution of grievances in an open, inclusive, non-discriminatory and impartial manner. Pre-dispute activities (such as publicly announcing all Broward County HIV Health Services Planning Council (Council), and Committee meetings, encouraging participation and feedback from members of the community at all Council, and Committee meetings, establishment of policies for attendance-related expense reimbursement for the infected community, development and distribution of outreach materials, including Grievance and Membership flyers, offering technical assistance, and informing the public of decision making procedures) have been enacted which assist in preventing potential grievances. The Committee is responsible for ensuring that consumer groups, affected individuals with direct interest, service providers, and Council members are aware of and have access to operating procedures available to address grievances. The Committee operates in accordance with applicable State and County conflict of interest statutes and ordinances.

The Committee will address grievances by individuals, community groups, council members and Part A providers eligible to receive Ryan White Part A funding which have been adversely affected by any actions of the Council involving the following: the needs assessment process, the comprehensive planning process, the priority setting process (including language regarding how best to meet such priorities), the clinical outcome/cost effectiveness determination process and allocation (as well as any possible reallocation) of funds to service categories process. For a grievance to be eligible for consideration, deviation from established, written processes or policies must be stated within the claim. All appeals from an initial action must be filed within two weeks of any decision, deviation or incident, and all resolutions or remedies are meant to apply prospectively. To avoid conflict of interest, grievances relative to the process used to select Part A service providers shall be in accordance with the Broward County Administrative Code.

Broward County HIV Health Services Planning Council

Vision Statement

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 Statement

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:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

HANDOUT E-1

Quarterly Planning and Evaluation Report

FY 2014-2015 Third Quarter Report: September 1-November 30, 2014

Prepared by Broward Regional Health Planning Council

200 Oakwood Lane, Ste 100
Hollywood, FL 33020

p. 954-561-9681
f. 954-561-9685

hivpc@brhpc.org
www.brhpc.org

Summary: FY 2014-2015 Third Quarter

The fiscal year (FY) 2014-2015 third quarter ran from September 1, 2014 until November 30, 2014. In the third quarter, the HIV Planning Council (HIVPC) began using new work plans that were focused on three guiding principles. The three guiding principles were developed at the recommendation of a consultant who determined that the Broward Eligible Metropolitan Area (EMA) had so much data available to it, that it sometimes had difficulty focusing its activities.

What are the three guiding principles?

The three guiding principles of the HIVPC are:

1. Linkage to care
2. Retention in care
3. Viral load suppression

How were the three guiding principles developed?

The three guiding principles were developed to reflect the National HIV/AIDS Strategy (NHAS) and the HIV Care Continuum. In 2010, the White House released NHAS. The four goals of NHAS were to reduce new infections, increase access to care and improve health outcomes for PLWHA, to decrease HIV-related health disparities and inequities, and to achieve a more coordinated response to the epidemic. The HIV Care Continuum was developed subsequently to NHAS, as a tool to be used to analyze the progress being made on NHAS goals. The HIV Care Continuum is most often shown as a bar graph made up of five bars (see Figure 1) showing the following percentages for people living in the United States: diagnosed with HIV, linked to care, retained in care, prescribed Antiretroviral Therapy (ART), and virally suppressed.

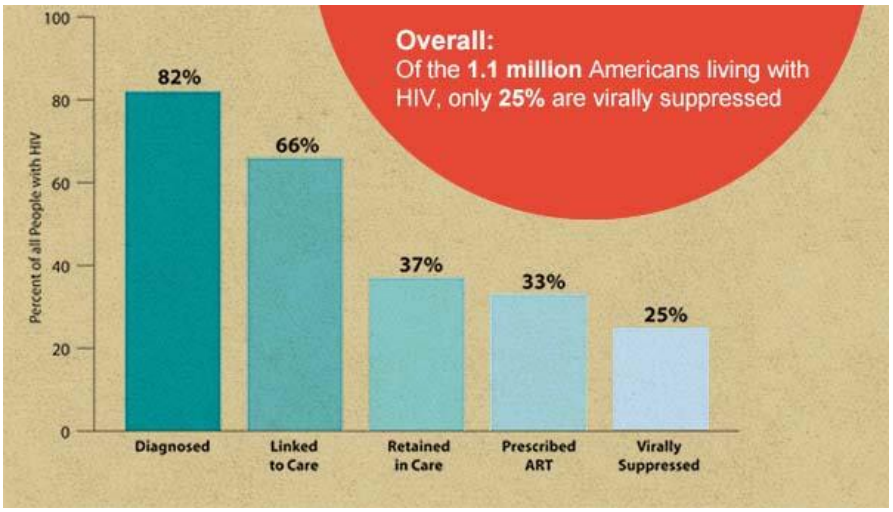


Figure 1. The HIV Care Continuum for the United States. Source: AIDS.gov

Of the five bars, the HIVPC felt that the three bars the HIVPC could have the most impact on were linkage to care, retention in care, and viral load suppression. The work of local prevention programs is predominantly focused on diagnosing HIV, and once an individual enters care, being prescribed ART is largely automatic. The HIV Care Continuum for Broward,

which compares people living with HIV and AIDS (PLWHA) in Broward to Part A clients, is shown as Figure 2 below. Unfortunately, PLWHA tend to drop off at each stage of the continuum. In Broward, this occurs especially between the linked to care stage and the retained in care stage. While 87% of people diagnosed with HIV in Broward are linked to care, only 52% are retained in care. According to Florida Department of Health (FLDOH) data, only 37% of diagnosed individuals living with HIV/AIDS in Broward achieved viral load suppression in 2013. The care continuum data strongly indicates that there is room for improvement across all stages of the continuum.

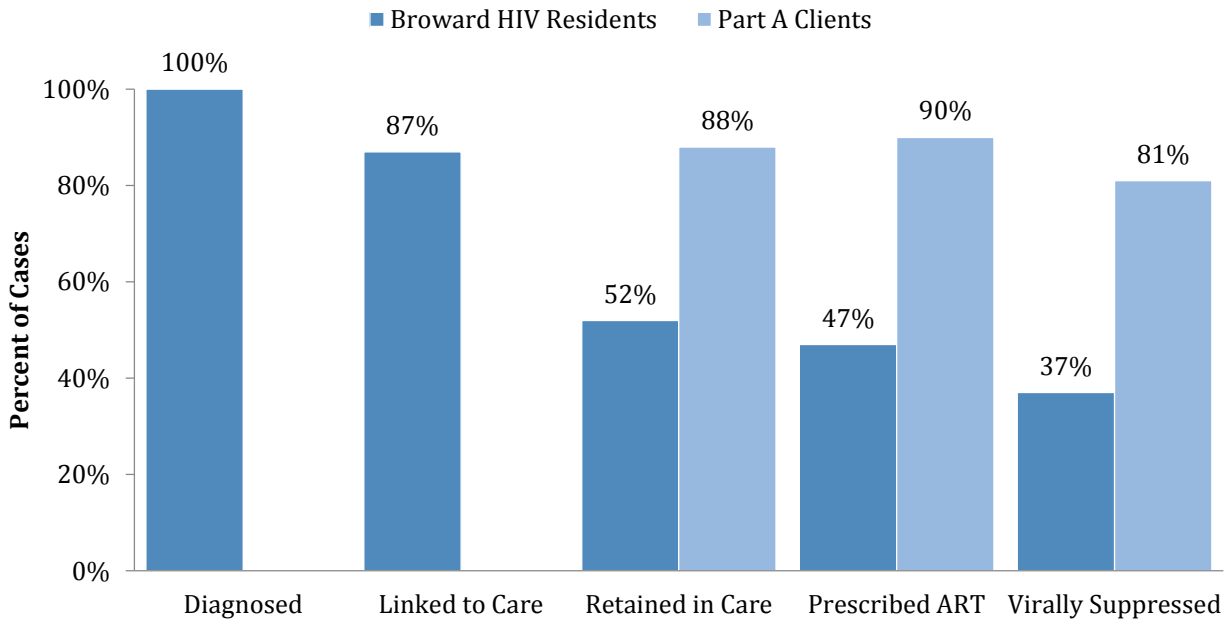


Figure 2. Outcomes along the HIV Care Continuum, Broward County Compared to the Broward EMA, FY 2013

Why are the three guiding principles important?

The Broward EMA's current Comprehensive Plan goals were developed to reflect the goals of NHAS and the HIV Care Continuum, and all of the committee work plans were developed using activities outlined in the Comprehensive Plan. The focusing HIVPC activities on the three guiding principles, the HIVPC can identify where gaps may exist in connecting individuals living with HIV to quality care and treatment. System improvements and service enhancements can be implemented to better support individuals as they move through the continuum of care. These efforts can help break the cycle of HIV transmission, reduce new infections, and improve the health of people living with HIV.

How are the three guiding principles being addressed?

The work plans are designed to relate activities of the HIVPC and committees to the three guiding principles and outcomes along the care continuum. For example, the Needs

Assessment & Evaluation (NAE) Committee is tasked with developing questions for the annual client survey to identify barriers to being retained in care or virally suppressed. The System of Care (SOC) Committee works to determine gaps in the Broward continuum of HIV services for linking clients to care after their initial HIV diagnosis. The Quality Management (QM) Committee ensures high quality HIV medical care and support services by identifying and monitoring client and system-based performance measures for linkage, retention, and viral load suppression. The Quality Improvement (QI) Networks also examine the HIV care continuum to assess where improvements in services are needed and target them accordingly. This report documents HIVPC activities that were conducted during the third quarter and how these activities help make progress on the HIVPC's goals and the three guiding principles.

Priority Setting & Resource Allocation (PSRA)

The reallocation of grant funds is conducted at least twice each fiscal year to ensure the effective and efficient use of grant funds and to meet priority needs. The first round of reallocations (hereafter referred to as sweeps) for FY 2014-2015 was conducted in November. During the sweeps process, providers are allowed to request additional funds or return funds that they anticipate will not be used. Requests for additional funding are reviewed by the Grantee to determine if requests are appropriate and will contribute to linking clients to care, retaining clients in care, or achieving viral load suppression.

The PSRA committee also reviews expenditure and utilization data, and takes into account emerging issues that may impact the reallocation of funds. In November, the PSRA committee had to take into account several issues that could impact the EMA. Historically, Outpatient Ambulatory Medical Care (OAMC) has been the largest funded, if not the most important service category. Funding OAMC appropriately so all clients have access to primary medical care is imperative to achieving outcomes related to retention in care and viral load suppression. As the EMA adjusts to a changing health care landscape and the impacts of implementing the Affordable Care Act (ACA), OAMC may cease to be the most important and largest funded service category. As clients move onto ACA Marketplace plans, services such as case management may become increasingly important to linking and retaining clients in care. Case managers are most often the personnel charged with enrolling clients in Marketplace plans, explaining to clients how a plan works, and following up with clients to make sure they are able to navigate the differences of having insurance compared to being a traditional Part A client.

The PSRA committee also had to account for dwindling funds for food services. Food services provides Part A clients with food in the form of a food box or food voucher. Ensuring the clients have adequate sources of food is important, since many clients on ART must take food when they take their medications. This could have an impact on viral load suppression for

those clients. Clients who do not have access to food and therefore cannot take their medication would be less likely to be virally suppressed.

A total of $1,016,055 was redistributed among service categories in November. Service categories receiving additional funds included OAMC and Minority AIDS Initiative (MAI) OAMC, pharmacy, case management, mental health, substance abuse, and food services. Service categories that returned funds included dental, medical case (disease) management, Health Insurance Continuation Program (HICP), and legal services. A large amount of funds was swept from both disease management and HICP in order to provide funds for food services. Both disease management and HICP had large sums of money available because they were newly funded service categories for FY 2014-2015 that had not been fully implemented. The Grantee also contributed $60,000 from available administrative funds to help provide funds for food services. Table 1 below shows all of the sweeps that were approved by the HIVPC in November:

SERVICE CATEGORY	Recommended TO	Recommended FROM
OAMC	$423,000	$321,315
MAI OAMC	$22,000	$0
Pharmaceuticals	$38,464	$8,000
Dental	$0	$38,464
Case Management	$78,445	$17,306
MAI Case Management	$0	$7,000
Disease Management	$0	$401,970
Mental Health	$18,590	$12,000
MAI Mental Health	$0	$15,000
Substance Abuse	$14,000	$0
Food Bank	$200,000	$0
Food Voucher	$221,556	$0
HICP	$0	$125,000
Legal Assistance	$0	$10,000
Unallocated Grant Funds		$60,000
Total Part A Funds	**$994,055**	**$994,055**
Total MAI Funds	**$22,000**	**$22,000**
Total Funds	**$1,016,055**	**$1,016,055**

Table 1. FY 2014-2015 Reallocations, Part 1

Outreach Report

The Community Empowerment Committee (CEC) strives to hold at least one meeting each quarter in the community in order to promote the HIVPC and provide outreach and education to community members. The CEC held its September meeting at Fusion in Wilton Manors. Fusion is an organization funded by FLDOH in Broward County (FLDOH-BC) that provides a safe space for gay and bisexual men to meet and learn. Fusion also works closely with the transgender population, which made the location a great choice for the meeting leading up to the CEC's *Transgender 101* event. When the CEC holds meetings in the community, interested parties from the venue are always invited to attend and participate in the meeting, and the committee always leaves HIVPC promotional materials for interested parties to spur interest in becoming involved with the HIVPC. Holding meetings in the community also allows the HIVPC to be more visible to community members who may be unfamiliar with the work of the Council, and also allows members the opportunity to educate community members about living with HIV and how and where to access services.

The two events sponsored by the HIVPC during the third quarter were the CEC's *Transgender 101* event and the Membership/Council Development Committee's (MCDC) Quarterly Welcome Brunch. The CEC's *Transgender 101* event was created to educate the community about the issues and challenges faced by the transgender community. Arianna Lint, the CEC Vice Chair and SunServe's Director of Transgender Services presented to attendees about various issues faced by the transgender population. Benjamin Di'Costa, the Youth and Transgender HIV/STD intervention and prevention specialist from Latinos Salud, presented to attendees on how HIV/AIDS affects the transgender community.

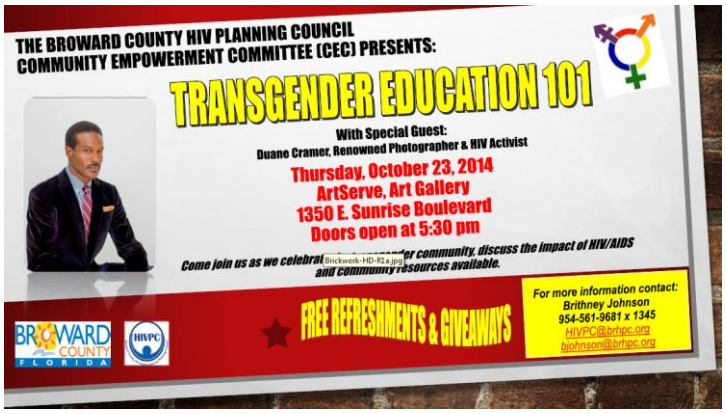


Figure 3. Transgender 101 flyer

Event attendees also participated in an icebreaker titled 'Stand-Up, Sit-Down' which was adapted to have an emphasis on lesbian, gay, bisexual, and transgender (LGBT) issues. A CEC member acted as the facilitator for the icebreaker. All participants were asked to stand, and to sit only if the facilitator read a statement that they agreed with. The facilitator read several statements such as "You identify as a feminist" and "You are a man and you wear jewelry." The facilitator continued reading statements until most of the participants were sitting. The facilitator noted that all of the statements were actual reasons given by perpetrators who have targeted LGBT people. Attendees also had an opportunity to meet renowned photographer and HIV activist Duane Cramer. Mr. Cramer shared his story with attendees and took photographs of participants.

The MCDC's Welcome Brunch is designed to promote the HIVPC and its committees to interested parties and community members. Attendees were educated about the importance of the HIVPC, as well as ensuring that their voice is heard when planning for Ryan White Part A services. The Welcome Brunch in November was well attended by the community, including five community agencies that provide HIV-related services throughout Broward County. The HIVPC received four applications from interested parties as a result of the Welcome Brunch. Future plans for the quarterly Welcome Brunch include holding the event at other community venues and targeting populations that are underrepresented on the HIVPC.

Training and Development Summary

The HIVPC's Executive Committee and MCDC determine quarterly trainings for HIVPC members, so members are well educated and informed about emerging issues. Training topics are focused on strategies and information that will inform the HIVPC about making progress towards the three guiding principles. The third quarter training occurred at the November HIVPC meeting and focused on the System of Care Committee (SOC), the HIVPC's newest standing committee. The SOC Chair presented the training, discussing the background of the committee and why it was formed and some of its roles and responsibilities.

The committee was formed after a recommendation from a consultant to have a committee whose responsibility would be to look at entire system in Broward County. Looking at the entire system will help identify any service gaps or needs in Broward, particularly linkage gaps, and the committee can make recommendations about how to address the gaps and needs. The committee will serve as a filter for data for several other committees, such as PSRA and the Quality Management Committee (QMC), and the committee will also receive information from other committees, such as the Needs Assessment/Evaluation Committee (NAE). Tasks assigned to the committee on the 18 month work plan include reviewing client health outcomes by payer and along the HIV Care Continuum, analyzing available funding in Broward County for all services, and developing language for How Best to Meet the Need (HBTMTN).

The SOC Chair encouraged interested parties to join the committee, noting that the committee could use more insight from consumers and experts in the HIV field. SOC committee meetings are held on the fourth Friday of every month at 9:30 a.m. at the Ryan White Part A Program Office.

Community Empowerment Committee (CEC) Survey Summary

The CEC's 18 month work plan includes the development of a survey to analyze the effectiveness of each community meeting or event. This survey will be distributed while the

event is taking place in an effort to attain full participant feedback. Surveying attendees about the event venue, time, or topic will aid the CEC in planning future events that best suit the community. The committee is still in the development stage of the survey, which is included on CEC's January meeting agenda for final review and approval.

Meeting Evaluation Summary

Meeting evaluations are distributed at all committee meetings to collect feedback about the effectiveness and efficiency of meetings. Evaluation respondents have the opportunity to identify themselves, or to complete the evaluation anonymously. The meeting evaluation consists of the following nine questions:

1. The meeting place was a good working environment.
2. The agenda was clear and was supported by the necessary documents.
3. The Chair guided the meeting effectively.
4. All Council/committee members were prepared to participate in the agenda.
5. Reports were clear and contained needed information.
6. Next steps for future tasks were identified and responsibility was assigned.
7. The agenda was followed without spending too much time on non-agenda items.
8. It was possible to express my opinion if I wanted to.
9. Meeting participants conducted themselves appropriately.

Respondents can answer "Yes" or "Needs Improvement" and can also leave comments or suggestions for each statement. Historically, return rates for meeting evaluations have been low. Measures have been implemented to improve return rates, such as a verbal reminder at the end of meetings and a written reminder at the bottom of each agenda. Despite these efforts, meeting evaluation return rates remain low. From July to December 2014, the highest average rate of return for a standing committee was 57%. The rates of return for most other standing committees were much lower, ranging from 9% to 43%. As such, responses may not be truly representative of meeting attendees.

The majority of meeting evaluations received have "Yes" checked for all of the statements, but some evaluations do indicate "Needs Improvement." Statement four, "All Council/committee members were prepared to participate in the agenda" was the statement most frequently indicated as needing improvement, but had almost no comments about the issues that may have arisen or how to improve. Comments were most frequently left for statement nine, "Meeting participants conducted themselves appropriately" and statement three, "The Chair guided the meeting effectively." Comments for statement nine indicated that side conversations in meetings can be a distraction, and meeting participants may comment on topics that are irrelevant. Comments for statement three noted that while some chairs are able to guide the agenda and committee discussion effectively, other chairs are perceived as being overzealous and in control of the discussion, rather than guiding it.

Other comments suggest that meeting agendas need to be streamlined so the work is not overwhelming for the two hour time frame, and to take more care to clearly explain agenda items and discussion topics when guests or new members are present.

Epidemiology

Understanding epidemiology and analyzing data to determine its impact on a system has become increasingly important. The Broward EMA uses epidemiology and surveillance data provided by FLDOH to track trends and changes in Broward may impact the types of services needed or how services are delivered. Two basic data points are especially vital: prevalence and incidence. Prevalence and incidence both measure HIV, but have important differences:

- **Prevalence** measures the *total* number of living cases of HIV and AIDS as of the date specified. Prevalence can be expressed as a number (for example, 8,362 living HIV cases through calendar year 2013) or as a proportion (for example, 475.4 living HIV cases per 100,000 population).
- **Incidence** measures *new* cases of HIV and AIDS during a specific period of time. Incidence can also be expressed as a number (for example, 498 new AIDS cases during calendar year 2013) or as a proportion (for example, 28.3 AIDS cases per 100,000 population).

Measures of incidence and prevalence can also be broken down by subpopulations to track trends for target populations or MAI populations. Being able to see the data by subpopulation is important for making progress on Care Continuum outcomes; although 81% of Part A clients were virally suppressed in FY 2013, there may be certain subpopulations with lower rates of viral suppression. In order to increase the rate of viral suppression for all clients, improvements must be made in the viral load suppression rates for subpopulations. The most recent complete incidence and prevalence data for Broward are shown in the tables below.

	HIV				AIDS			
	2012	2013	2014	%Δ (2012-14)	2012	2013	2014	%Δ (2012-14)
White	214	298	175	**-18%**	72	119	99	**38%**
Black	326	453	418	**28%**	224	288	247	**10%**
Hispanic	116	178	381	**228%**	54	63	42	**-22%**
Other	11	10	19	**73%**	7	10	15	**114%**
Total	667	939	993	**49%**	357	480	403	**13%**

Table 2. HIV and AIDS Incidence in Broward County, 2012-2014

	2012	% of total	2013	% of total
Race/Ethnicity				
White	5,677	34.1%	5,856	34.0%
Black	8,233	49.5%	8,521	49.4%
Hispanic	2,331	14.0%	2,476	14.4%
Other/Unknown	391	2.4%	398	2.2%
Gender				
Male	11,772	70.8%	12,275	71.2%
Female	4,860	29.2%	4,973	28.8%
Age				
<13 years	39	0.2%	34	0.2%
13 - 24 years	560	3.4%	552	3.2%
25 - 44 years	5,573	33.5%	5,562	32.3%
45 - 60 years	8,388	50.4%	8,745	50.7%
60+ years	2,072	12.5%	2,355	13.7%
Exposure Category				
Men who have sex with men (MSM)	8,030	48.3%	8,468	49.1%
Injection drug users (IDU)	1,225	7.4%	1,241	7.2%
MSM IDU	474	2.8%	474	2.7%
Heterosexuals	6,630	39.9%	6,794	
Other/Unknown	273	1.6%	271	
Total	**16,632**	**100%**	**17,248**	**100%**

Table 3. HIV and AIDS Prevalence in Broward County, 2012-2013

HANDOUT E-2

Quarterly Planning and Evaluation Report

FY 2014-2015 Fourth Quarter Report: December 1, 2014-February 28, 2015

Prepared by Broward Regional Health Planning Council

200 Oakwood Lane, Ste 100
Hollywood, FL 33020

p. 954-561-9681
f. 954-561-9685

hivpc@brhpc.org
www.brhpc.org

Summary: FY 2014-2015 Fourth Quarter

The fiscal year (FY) 2014-2015 fourth quarter ran from December 1, 2014 until February 28, 2015. In the fourth quarter, the HIV Planning Council (HIVPC) continued using new work plans that were focused on three guiding principles. The three guiding principles were developed at the recommendation of a consultant who determined that the Broward Eligible Metropolitan Area (EMA) had so much data available to it, that it sometimes had difficulty focusing its activities.

What are the three guiding principles?

The three guiding principles of the HIVPC are:

1. Linkage to care
2. Retention in care
3. Viral load suppression

How were the three guiding principles developed?

The three guiding principles were developed to reflect the National HIV/AIDS Strategy (NHAS) and the HIV Care Continuum. In 2010, the White House released NHAS. The four goals of NHAS were to reduce new infections, increase access to care and improve health outcomes for PLWHA, to decrease HIV-related health disparities and inequities, and to achieve a more coordinated response to the epidemic. The HIV Care Continuum was developed subsequently to NHAS, as a tool to be used to analyze the progress being made on NHAS goals. The HIV Care Continuum is most often shown as a bar graph made up of five bars (see Figure 1 below) showing the following percentages for people living in the United States: diagnosed with HIV, linked to care, retained in care, prescribed Antiretroviral Therapy (ART), and virally suppressed.

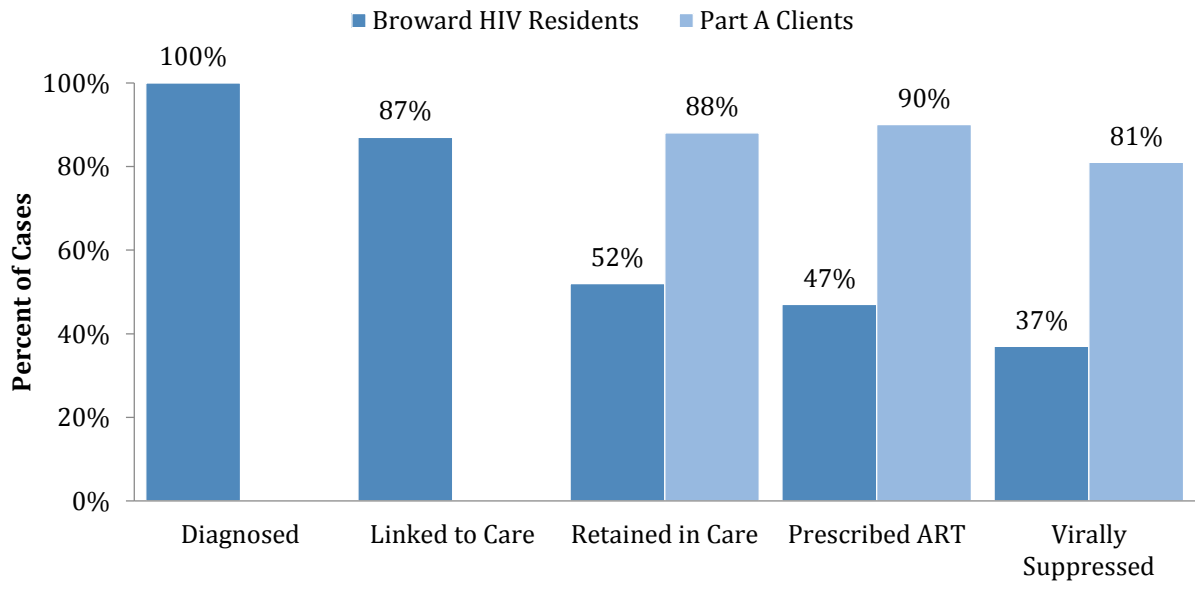


Figure 1. Outcomes along the HIV Care Continuum, Broward County Compared to the Broward EMA, FY 2013

Of the five bars, the HIVPC felt that the three bars the HIVPC could have the most impact on were linkage to care, retention in care, and viral load suppression. The work of local prevention programs is predominantly focused on diagnosing HIV, and once an individual enters care, being prescribed ART is largely automatic. The HIV Care Continuum for Broward, which compares people living with HIV and AIDS (PLWHA) in Broward to Part A clients, is shown as Figure 2 below. Unfortunately, PLWHA tend to drop off at each stage of the continuum. In Broward, this occurs especially between the linked to care stage and the retained in care stage. While 87% of people diagnosed with HIV in Broward are linked to care, only 52% are retained in care. According to Florida Department of Health (FLDOH) data, only 37% of diagnosed individuals living with HIV/AIDS in Broward achieved viral load suppression in 2013. The care continuum data strongly indicates that there is room for improvement across all stages of the continuum.

Why are the three guiding principles important?

The Broward EMA's current Comprehensive Plan goals were developed to reflect the goals of NHAS and the HIV Care Continuum, and all of the committee work plans were developed using activities outlined in the Comprehensive Plan. The focusing HIVPC activities on the three guiding principles, the HIVPC can identify where gaps may exist in connecting individuals living with HIV to quality care and treatment. System improvements and service enhancements can be implemented to better support individuals as they move through the continuum of care. These efforts can help break the cycle of HIV transmission, reduce new infections, and improve the health of people living with HIV.

How are the three guiding principles being addressed?

The work plans are designed to relate activities of the HIVPC and committees to the three guiding principles and outcomes along the care continuum. For example, the Needs Assessment & Evaluation (NAE) Committee is tasked with developing questions for the annual client survey to identify barriers to being retained in care or virally suppressed. The System of Care (SOC) Committee works to determine gaps in the Broward continuum of HIV services for linking clients to care after their initial HIV diagnosis. The Quality Management (QM) Committee ensures high quality HIV medical care and support services by identifying and monitoring client and system-based performance measures for linkage, retention, and viral load suppression. The Quality Improvement (QI) Networks also examine the HIV care continuum to assess where improvements in services are needed and target them accordingly. This report documents HIVPC activities that were conducted during the third quarter and how these activities help make progress on the HIVPC's goals and the three guiding principles.

Priority Setting & Resource Allocation (PSRA)

During the fourth quarter, several activities were completed that will have an impact on progress on the three guiding principles. In January, the second round of reallocations (also referred to as sweeps) for FY 2014-2015 was conducted. The reallocation of grant funds is conducted at least twice each fiscal year to ensure the effective and efficient use of grant funds and to meet priority needs. During the sweeps process, providers are allowed to request additional funds or return funds that they anticipate will not be used. Requests for additional funding are reviewed by the Grantee to determine if requests are appropriate and will contribute to linking clients to care, retaining clients in care, or achieving viral load suppression. The PSRA committee also reviews expenditure and utilization data, and takes into account emerging issues that may impact the reallocation of funds.

In January, the biggest issue affecting the reallocation of funds was the enrollment of Part A clients into Marketplace insurance plans. Based on recommendations from the Health Resources and Services Administration (HRSA), the Broward EMA strongly encouraged clients to enroll in Marketplace insurance plans. Enrolling eligible clients in insurance helps ensure that clients are retained in care by having access to primary medical care and antiretrovirals, as well as other supportive medical services and medications that make it easier for clients to stay in care. Enrolling clients in insurance plans that pay for a variety of health services costs less than the Part A program paying for those services directly. The savings from enrolling clients in insurance can be used to pay for other Part A support services not covered by insurance, such as food services or medical transportation, that can also help keep clients retained in care and adherent to their medication. Ultimately, access to medical care and support services that help with retention and adherence should help clients achieve viral load suppression. Additional funds were also swept to case management services, to account for the additional hours many case managers were spending with clients to enroll them in insurance.

Table 1 below shows all of the sweeps that were approved by the HIVPC in January:

SERVICE CATEGORY	Recommended TO	Recommended FROM	Variance
Outpatient Ambulatory Medical Care	$174,000	($324,800)	($150,800)
Pharmaceuticals	$14,700	$0	$14,700
Case Management	$119,060	($7,479)	$111,581
Mental Health	$0	($15,000)	($15,000)
Substance Abuse	$0	($5,350)	($5,350)
Food Bank	$20,000	$0	$20,000
Food Voucher	$0	($20,000)	($20,000)
Total Funds	**$327,760**	**($372,629)**	**($44,869)**

Table 1. FY 2014-2015 Reallocations, Part 2

Preparation for the FY 2016-2017 PSRA process also started in January. Changes were made to the way the PSRA process is being approached; previously a large amount of data would be presented and reviewed at one time, and the PSRA Committee would have the task of reviewing and analyzing the data, and making decisions based on the data over the span of one to two meetings. Conducting the PSRA process this way was somewhat overwhelming, and in January, the PSRA Committee decided to slow down the process by committing to a monthly review of utilization and expenditure data, service categories, and other important data elements, such as unmet need and the Early Identification of Individuals with HIV/AIDS (EIIHA). Service category scorecards are also being restructured to look at the clients who are not achieving health outcomes in each service, rather than the clients who are achieving. A narrative that further explains trends for each service category will accompany the scorecards.

Outreach Report

The HIVPC conducts outreach through the work of several committees, in particular the Community Empowerment Committee (CEC). The CEC strives to hold at least one meeting each quarter in the community in order to promote the HIVPC and provide outreach and education to community members. Beginning in April 2015, the committee will hold meetings at various Part A agencies; not only does the committee hope to bring in new participants by meeting clients where they are, the committee is also working to educate themselves on the services offered at each agency. All the meetings held at the Part A agencies will include a presentation by the agency's staff to inform the committee about the services offered there, and how clients can access those services. Keeping CEC members informed of available services is a key element of the CEC's role as the education arm of the HIVPC in the community.

In addition to meetings at Part A agencies, the CEC is also in the process of planning for a June event focused on educating the community about Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). PrEP and PEP are hot button topics in the community, and the CEC is committed to ensuring that the community has access to valuable, unbiased information about what PrEP and PEP are, who they can be used by, how they should be used, and when they should be used. Keeping the community informed about hot button issues can help ensure that clients are educated about the care that is available to them, and may help engage and retain them in care.

The Membership/Council Development Committee (MCDC) continues to hold Welcome Brunches. The MCDC's Welcome Brunch is designed to promote the HIVPC and its committees to interested parties and community members. Attendees are educated about the roles and the responsibilities of the HIVPC, how to become involved with the HIVPC and its committees, and what the benefits of membership are. The committee has opted to hold them less frequently than quarterly, in order to give adequate preparation and planning

time for each brunch. Welcome Brunches are now targeted to specific populations under represented on the HIVPC, or highly affected by the HIV/AIDS epidemic in Broward. The MCDC is reaching these populations, by holding brunches at community partnership organizations that target the populations, and in conjunction with a holiday or event that resonates with the target population. For example, the committee plans to hold a Cinco de Mayo themed event at a Hispanic/Latino-focused community organization in early May. By meeting clients and consumers where they are, the committee hopes to reach new people that are not currently involved in the HIVPC.

Training and Development Summary

The HIVPC's Executive Committee and MCDC determine quarterly trainings for HIVPC members, so members are well educated and informed about emerging issues. Training topics are focused on strategies and information that will inform the HIVPC about making progress towards the three guiding principles. The fourth quarter training occurred at the February HIVPC meeting and focused on How Best to Meet the Need (HBTMTN), an integral piece of the PSRA process.

HBTMTN are a set of directives to the Grantee from the HIVPC that are used to give direction to providers about where services should be located, who the services should be targeted to, and how services are to be delivered. HBTMTN is developed using data sources such as epidemiology, U.S. Census Data, and the needs assessment. These data sources provide information about the hardest hit populations (who services should be targeted to), where populations live (where to target services), and the barriers they face (how to deliver services). Although the HIVPC is ultimately responsible for developing priorities and allocations, which includes HBTMTN, the System of Care Committee (SOC) has been assigned the task of developing HBTMTN. In order for the HIVPC to approve the language for HBTMTN, it is imperative that its importance and the role it plays in service delivery in understood by all HIVPC members. The HBTMTN power point that was presented to the HIVPC is included at the end of this report.

Community Empowerment Committee (CEC) Survey Summary

The CEC's 18 month work plan includes the development of a survey to analyze the effectiveness of each community meeting or event. This survey will be distributed while the event is taking place in an effort to attain full participant feedback. The survey was developed in conjunction with the committee and staff, and was approved by the CEC at its February meeting. Rather than using the survey to gain feedback about the event itself, the committee felt the survey should be used to gain information about who the people are that are attending events (clients, providers, community stakeholders), whether they are recipients of Part A services, and if they are in need of care that they are currently not receiving. Gaining this kind of feedback will give the HIVPC data about community

members that come to events, but may not be involved in the HIVPC. Data about what kind of services are needed, and the kinds of marketing techniques that are successful in bringing clients to an event rather than providers to an event can be helpful to the HIVPC in planning for services, and developing HBTMTN.

Meeting Evaluation Summary

Meeting evaluations are distributed at all committee meetings to collect feedback about the effectiveness and efficiency of meetings. Evaluation respondents have the opportunity to identify themselves, or to complete the evaluation anonymously. The meeting evaluation consists of the following nine questions:

1. The meeting place was a good working environment.
2. The agenda was clear and was supported by the necessary documents.
3. The Chair guided the meeting effectively.
4. All Council/committee members were prepared to participate in the agenda.
5. Reports were clear and contained needed information.
6. Next steps for future tasks were identified and responsibility was assigned.
7. The agenda was followed without spending too much time on non-agenda items.
8. It was possible to express my opinion if I wanted to.
9. Meeting participants conducted themselves appropriately.

Respondents can answer "Yes" or "Needs Improvement" and can also leave comments or suggestions for each statement. Historically, return rates for meeting evaluations have been low. Measures have been implemented to improve return rates, such as a verbal reminder at the end of meetings and a written reminder at the bottom of each agenda. Despite these efforts, meeting evaluation return rates remain low. For the fourth quarter of the 2014-2015 fiscal year (December – February), From January to December 2014, the highest average rate of return for a standing committee was 80%. The rates of return for most other standing committees were much lower, ranging from 0% to 59%. As such, responses may not be truly representative of meeting attendees.

The majority of meeting evaluations received have "Yes" checked for all of the statements, but some evaluations do indicate "Needs Improvement." Statement five, "Reports were clear and contained needed information" was the statement most frequently indicated as needing improvement. Responses indicated that meeting materials could be improved to be better understood, and more time may need to be spent on reviewing materials to help committee members understand their purpose.

Epidemiology

Understanding epidemiology and analyzing data to determine its impact on a system has become increasingly important. The Broward EMA uses epidemiology and surveillance data provided by FLDOH to track trends and changes in Broward may impact the types of services needed or how services are delivered. Risk factors play an especially important role when measuring the HIV epidemic:

- **Risk factors** are the characteristics or exposures of an individual that increase the likelihood of contracting HIV.

Risk factors tracked by the FLDOH and the Part A program include hemophilia, heterosexual sex, injecting drug user (IDU), men who have sex with men (MSM), and perinatal infection. Risk factors are used to measure how people contract HIV, and can help target prevention programs, such as clean needle exchange programs. Understanding the risk factors associated with the epidemic in Broward can also help when planning for services. For example, knowing that a large number of Part A clients were most likely infected with HIV through the IDU risk factor may indicate the need for robust substance abuse services. The breakdown of Broward's HIV/AIDS epidemic by exposure category is shown in Table 2 below:

	2012	% of total	2013	% of total
Exposure Category				
Men who have sex with men (MSM)	8,030	48.3%	8,468	49.1%
Injection drug users (IDU)	1,225	7.4%	1,241	7.2%
MSM IDU	474	2.8%	474	2.7%
Heterosexuals	6,630	39.9%	6,794	39.4%
Other/Unknown	273	1.6%	271	1.6%
Total	**16,632**	**100%**	**17,248**	**100%**

Table 2. HIV and AIDS Prevalence in Broward County, 2012-2013

HANDOUT E-2

HOW BEST TO MEET THE NEED

HIVPC Training – February 26, 2015

WHAT IS IT?

How best to meet the need is a set of directives

from the HIVPC → *to* the Grantee

about how best to meet service priorities.

HANDOUT E-2

WHAT IS IT? (CONTINUED)

How best to meet the need may include directives about

where services should be,

who the services should be targeted to,

or **how** services are delivered.

WHY IS IT IMPORTANT?

These directives are important because they help target funding and services to be as effective as possible.

The directives are also entered into provider contracts so providers understand what is expected of them.

HANDOUT E-2

WHEN IS IT DEVELOPED?

How best to meet the need is developed as part of the

Priority Setting and Resource Allocation (PSRA)

process.

HOW IS IT DEVELOPED?

Directives are developed using data sources such as epidemiology, the U.S. Census, and the needs assessment.

These data sources provide information about the hardest hit populations (*who* to target), where they live (*where* to target services), and barriers they face (*how* to provide services).

HANDOUT E-2

WHO IS RESPONSIBLE FOR IT?

Ultimately, the HIVPC is responsible.

But, it is a System of Care Committee (SOC) work plan item to develop the directives.

QUESTIONS?

BY-LAWS PARKING LOT ITEMS				
No.	**Proposal**	**By-Laws Location**	**Stated Reason**	**Recommendation**
5	Update the succession plan for HIVPC Chair and Vice Chair to include information about who takes on the roles and responsibilities of the Chair/Vice Chair in the event of a vacancy.	Article VI, Section 8	The By-Laws indicate who should Chair a meeting if the Chair or Vice Chair is not present, but there is no mention of who should take over the roles and responsibilities of the Chair or Vice Chair in the interim between a resignation and an election.	

SECTION 8: LINE OF SUCCESSION

A. In the event the Chair and the Vice Chair do not attend the Council Meeting and neither the Chair nor the Vice Chair has notified the Council that they are not attending the Council Meeting, the immediate past chair, if present and a member of the Council, shall chair the meeting.

B. In the absence of the immediate past chair the Council meeting may be chaired by Committee Chairs, in the following order:

1. Chair of Priority Setting and Resource Allocation
2. Chair of Membership/Council Development
3. Chair of Needs Assessment/Evaluation
4. Chair of Community Empowerment
5. Chair of Quality Management
6. Chair of System of Care

C. In the event of a vacancy of the Planning Council Chair or Vice Chair position, the duties of the Chair or Vice Chair will be assumed by the immediate past chair. If the immediate past chair is no longer a member of the Planning Council, duties will be assumed in the following order:

1. **A past Planning Council Chair**
2. **Chair of Needs Assessment/Evaluation**
3. **Chair of Community Empowerment**
4. **Chair of Priority Setting and Resource Allocation**
5. **Chair of Quality Management**
6. **Chair of System of Care**
7. **Chair of Membership/Council Development**

Duties will be assumed upon the Chair or Vice Chair vacancy, until the vacancy is filled by a special election as outlined in Article V, Section 2C.

Broward County 2012-2015 Comprehensive Plan Master Chart					
Goals, Objectives, Tasks, & Activities	**Responsibility**	**Timeline**	**Performance/Outcome Measures**	**Progress as of 1/31/2014**	**Notes**
Broward EMA Goal: Improve health, reduce HIV transmission, and reduce community viral load • Improved access to and retention in HIV care for target populations[1] • Timely entry into HIV care • Prevention of vulnerable clients from dropping out of care					
NHAS Goal 1 - Reduce the number of people who become infected with HIV By 2015: 1. Lead efforts to lower the number of new infections by 25% 2. Reduce the HIV transmission rate by 30% 3. Increase the number of people who know their serostatus from 79% to 90%					Very difficult to measure/ estimate at a regional level
Objective 1.5 Expand prevention with HIV- positive individuals	Ryan White Part A Quality Management and QI Networks				

[1] A number of different but overlapping target populations are identified in the comprehensive plan. The primary target population for the NHAS and EIIHA is individuals unaware of their status, defined as: "any individual who has not been tested for HIV in the past 12 months, or any individual who has not been informed of their HIV test result (HIV positive or HIV negative), or any HIV positive individual who has not been informed of their confirmatory HIV test result," while "Secondary target populations include individuals aware of HIV status but not in care, individuals receiving medical care but not HIV care, individuals lost to follow-up, and sporadic users of HIV care" (p 91). HRSA identified the following target populations in the most recent Comprehensive Plan Guidance: Adolescents, Homeless, IDU, and Transgender. Task 1.1.1 of the work plan lists gay/bisexual men, transgenders, Blacks, Latinos, and substance users. The comprehensive plan also lists five emerging populations with special needs (p 94): Homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM.

Broward County 2012-2015 Comprehensive Plan Master Chart					
Goals, Objectives, Tasks, & Activities	**Responsibility**	**Timeline**	**Performance/Outcome Measures**	**Progress as of 1/31/2014**	**Notes**
1.5.1 Expand prevention with HIV+ individuals for avoidance of transmitting HIV to others 1. Educate and counsel patients about risk reduction and encourage safer-sex practices 2. Continue AETC Operation HOPEFUL pilot to assist risk and prevention assessments with patients 3. Implement AETC Prevention with Positives trainings (Core Medical QI Networks) 4. Identify available prevention with positives services and document in client services inventory 5. Become familiar with the prevention interventions that are offered at community-based organizations (CBOs) so that patients' referrals to these interventions are properly matched according to specific patient risks 6. Promote adherence to ART treatment to ensure maximal viral suppression and reduce transmission risk 7. Identify women who wish to become pregnant and provide preconception counseling 8. Refer HIV-infected pregnant women for early prenatal care and antiretroviral therapy (ART) 9. Screen for, diagnose, and treat other	Part A Grantee, Integrated Care and Prevention Coordination (ICPC) Work Group, Quality Management Committee (QMC), QI Networks	FY 2012-2013	• Percent of Part A clients who received HIV risk counseling within the measurement year • Percent of clients on ARVs assessed and counseled for adherence 2 or more times in measurement year • Documentation of training provided for MCM, Mental Health Provider Networks • Percent of MCM clients who receive treatment adherence counseling • Percent of adult clients who had a test for syphilis performed in the measurement year • Percent of clients at risk of STIs who had a test for chlamydia in the measurement year • Number of women in Part A care who received family planning counseling in the measurement year • Number of women who indicated during the measurement year that they wished to become pregnant; percent of these	1-3: HOPEFUL (uses flash cards to provide points for discussion and contracting for change) • Successfully piloted with physicians and Medical Case Managers (MCMs); challenge for physicians identified: it is hard to do counseling in the 15 minutes allocated to each patient • Want to continue use of HOPEFUL, focusing on MCMs or non-physician clinical staff 3: Training: some providers attended CDC boot camp; AETC training has not yet occurred 4-5: Inventory to be prepared as first task of the new ICPC Work Group 6-11: QI networks working to ensure full implementation of these tasks/standards	ICPC not established – this task may need to be moved to the Needs Assessment/Evaluation Committee (NAE), System of Care Committee (SOC), or QMC. Community Empowerment Committee (CEC) may want to consider having 'Hot Topic' presentations or community events focused on prevention for positives. **NAE Recommendation: Responsibility of Integrated**

Broward County 2012-2015 Comprehensive Plan Master Chart					
Goals, Objectives, Tasks, & Activities	**Responsibility**	**Timeline**	**Performance/Outcome Measures**	**Progress as of 1/31/2014**	**Notes**
STIs 10. Ensure substance abuse screening and make appropriate referrals to treatment 11. Ensure mental health screening and make referrals to treatment			women who received preconception counseling • Percent of HIV-infected pregnant women in care who were referred for and received early prenatal care and ART • Percent of clients at risk of STIs who had a test for gonorrhea in the measurement year • Percent of clients with Hepatitis B or C infection who received alcohol counseling in measurement year • Percent of new clients with HIV infection who have had a mental health screening • Percent of new clients screened for substance abuse (alcohol & drugs) in measurement year		**Comprehensive Plan Work Group**

EVALUATION REPORT

In 2014, the HIVPC developed and implemented a number of surveys to evaluate processes and areas for improvement. Surveys included:

- Committee Chair Assessment
- PSRA Self-Assessment
- Community Event Surveys (Transgender 101, Welcome Brunch, Mini Retreat)
- HIVPC Self-Assessment Survey
- MCDC Barriers to HIVPC & Committee Participation

Committee Chair Assessment

The Committee Chair Assessment was developed after Vice Chairs were added to each committee. In addition to opening leadership opportunities on the HIVPC's committees to community stakeholders, Vice Chair positions presented an opportunity for leadership development, so that there are leaders ready and willing to take on more responsibility should a committee Chair resign. The Committee Chair Assessment was developed in the Executive Committee and was distributed via email to all committee members. The survey asked about member demographics (how long they had served on the committee, if the respondent was a Part A consumer), organizational matters (if the Chair follows the policies and procedures, or encourages open communication), leadership (if the Chair creates a culture of respect and high morale), and personal characteristics (if the Chair is respectful of other opinions, and if the Chair encourages individual member growth).

Twenty eight committee members responded to the survey, and responses were overall positive, with 56% of respondents rating the performance of their Chair as excellent. Almost all Chairs were evaluated positively for organizational matters and personal characteristics, but some committee members did not agree with their Chair's leadership or communication style. Most respondents served on two committees and 40% of respondents had served on a committee for five or more years. There was strong feedback from consumers - 70% of respondents reported being a consumer of Part A services - and also strong feedback from HIVPC members. Of the twenty eight responses received, twenty five were also HIVPC members.

The largest number of evaluations were received for the CEC Chair, which is also the largest committee. This was followed by the PSRA Committee, and the QMC. The only committee Chair

not evaluated was the SOC Chair, since the SOC was a brand new committee, and members had not been to enough meetings to fairly evaluate the Chair. There were few differences in response by Chair; no respondents strongly disagreed with any of the survey statements, and there were very few that disagreed with a survey statement.

There were no responses received that indicated Chairs did not follow the HIVPC by-laws or committee's policies and procedures, but only 52% of respondents strongly agreed that their Chair follows the HIVPC by-laws and only 56% strongly agreed that the Chair follows the committee's Policies & Procedures. Communication between the Chairs and their committees was strong: 56% of respondents strongly agree that their Chair kept the committee up to date on important matters relating to the HIVPC, 52% strongly agreed that their Chair works effectively with committee members to complete work plan objectives, and 63% strongly agreed that their Chair encourages open communication among members.

Approximately half of respondents agreed that Chairs communicated a clear direction for their committees and encouraged an environment supportive of individual initiatives. Fifteen percent of respondents, however, reported being neutral or unsure that the Chair encouraged an environment that rewarded teamwork within the committee. Chairs were reported as creating a climate of respect and high morale for the committee, and for representing a positive image of the committee.

PSRA Self-Assessment

The PSRA Process Self-Assessment Survey was distributed to HIVPC and PSRA members in July 2014, following the completion of the PSRA process for FY 2015-2016. The survey was comprised of 10 questions and asked for member understanding of the purpose, process, and data sources. Respondents reported that they understood the purpose of the PSRA process, however, not all respondents understood the details of the PSRA process or data sources. Half of respondents reported being an HIVPC or PSRA member for 5-10 years, and 92% of respondents reported their knowledge of the PSRA process had increased a lot since becoming a member. Length of membership did not seem to have a large impact on responses, especially given the small number of respondents. Respondents who reported being an HIVPC or PSRA member for three to five years, however, were more likely to respond to a question with "I mostly understand" or "I understand some" in comparison to other lengths of membership.

While survey respondents overwhelmingly understood the purpose of the PSRA process (92%) only 75% reported completely understanding the process (Figure 1). Respondents were asked to answer questions about their understanding of important data sources, and responses were a little disheartening. As shown in Table 1, cost data was the data source least understood by respondents, with only 64% of respondents completely understanding the data. Additionally, only 75% of respondents reported completely understanding needs assessment and service utilization data.

		I COMPLETELY UNDERSTAND	I MOSTLY UNDERSTAND	I UNDERSTAND SOME
Needs assessment	n	9	2	1
	%	75.0%	16.7%	8.3%
Service utilization	n	9	2	1
	%	75.0%	16.7%	8.3%
Cost data	n	7	3	1
	%	63.6%	27.3%	9.1%
Priority setting	n	10	1	1
	%	83.3%	8.3%	8.3%
Resource allocation	n	10	1	1
	%	83.3%	8.3%	8.3%
Conflict of interest	n	8	2	1
	%	72.7%	18.2%	9.1%
Data used to create rankings	n	10	1	1
	%	83.3%	8.3%	8.3%

Table 1. Respondents were asked to indicate their understanding of the data sources

Only two-thirds of respondents reported completely understanding service category definitions, meaning a third of respondents either mostly understood or only understood some of the service category definitions. A quarter of respondents did not completely understand how each service category was ranked, nor did they understand why all of the service categories were ranked for FY 2015. Seventy five percent of respondents said they completely understood how allocations were made, which is surprising given that only 64% of respondents indicated understanding cost data.

Upon review of the survey findings, the PSRA committee decided to put measure in to place to improve understanding of the priority setting and resource allocation process. In 2015, the committee plans to spend a portion of each meeting reviewing a data source, which will include an explanation of where the data comes from, how it is used, and why it is important to the prioritization or allocation of funds. The Grantee's office will also provide the committee with a

monthly snapshot of expenditures and utilization for each service category, in order to help the committee better understand cost data, and to note expenditure trends before sweeps.

Transgender 101

The CEC held a community event at Art Serve in October 2014 titled Transgender 101, the purpose of which was to raise awareness of transgender issues, especially for transgender individuals who are HIV positive. A brief, nine question survey was distributed to participants to gain feedback about the event and what the community would like to see in the future. Responses were received by approximately 40% of attendees and were overwhelmingly positive. Ninety one percent of respondents rated the event as good or very good, noted that the event provided them with helpful resources, and would be willing to attend a similar event in the future.

Forty five percent of survey respondents were Part A clients, and respondents were mostly not affiliated with an agency (82% of respondents). Attendees largely heard about the event through word of mouth (90%), followed by seeing a flyer for the event (30%). All respondents agreed the event was held at a convenient location, but made suggestions that other events be held in Wilton Manors or at a Broward County library.

The CEC is in the process of developing a final survey to be used at all of its community events. The survey should be finalized in early 2015.

Welcome Brunch

The MCDC held two welcome brunches in 2014, one in July and one in November. Very few evaluations were received following the July welcome brunch, but close to half of attendees filled out an evaluation following the November brunch. Responses for completed evaluations were largely positive. Respondents felt that the event was easily accessible and well guided, and that the icebreaker and member testimonials were effective. Approximately 22% of respondents felt neutrally about whether HIVPC functions and duties were explained clearly and concisely; the MCDC may want to consider spending more time explaining the roles and responsibilities of the HIVPC in the future.

Mini Retreat

A brief, five question evaluation was sent to mini retreat attendees in the week following the retreat. Questions were asked about the event location, date and time, and the benefits of attending the mini retreat. A total of nine responses were received, although close to fifty people attended the event. Of the responses received, one respondent indicated that they were not able to attend the mini retreat due to a scheduling conflict. The remaining eight respondents were able to attend the retreat. Responses about the location were split, with half of respondents saying the location was excellent, and half rating the location average or good. Comments indicated that the location was difficult to find. A majority of respondents rated the time as good and said the mini retreat was beneficial to them. Based on the success of the mini retreat in December, the HIVPC plans to hold another mini retreat in the late summer of 2015.

HIVPC Self-Assessment

The HIVPC Self-Assessment was a three party survey distributed to HIVPC members over the course of three months in 2014. The parts were distributed to HIVPC members via email (part one in September, part two in October, and part three in November) and iPads were also available at HIVPC meetings to encourage additional responses. Of the three parts, part one had the most responses (about 57% of HIVPC members), part two had slightly less (43% of HIVPC members), and part three had very few responses (17% of HIVPC members).

Part one asked respondents questions about the HIVPC mission statement, work plans, and representation and diversity of HIVPC members. Respondents were tremendously aware that the HIVPC had a mission statement (92% of respondents reported knowing the HIVPC had a mission statement), but 30% of respondents were unaware of what the mission statement says. Some respondents knew where the mission statement could be found, identifying the training and orientation packet for new members (46%) and the HIVPC's written documents (39%) as the two most likely places to find the mission statement. Interestingly, although less than three quarters of respondents knew the text of the mission statement, 46% of respondents felt the mission statement influenced major decisions of the HIVPC a lot.

Respondents were much more aware of the work plans used to conduct activities. Ninety two percent of respondents were aware of the work plans, and 85% felt the work plans set adequate goals and objectives, provided specific activities for completion, and could be used to monitor

the HIVPC's effectiveness. Slightly over three quarters of respondents (77%) agreed that the work plans contained reasonable timelines and 92% agreed that work plans identified the responsible party of each activity. Respondents also largely understood the process for becoming an HIVPC member, and the procedures that are followed to approve an applicant for the HIVPC. Although respondents were well aware of the process and procedures for adding new members, respondents were not as aware of written policies for adding new HIVPC members. The HIVPC by-laws and policies and procedures were both cited by 69% of respondents as including the policy, but only 31% cited the Local Procedures Manual. Around three quarter (77%) knew of a written policy with criteria for HIVPC membership, but less than two thirds (62%) of respondents reported being aware of written job descriptions for members, and 15% of respondents indicated there were no written procedures at all for the application process.

Part two asked questions about the PSRA process and the needs assessment, and responses were similar to responses for the PSRA self-assessment. Less than three quarter of respondents (70%) identified that priorities are set annually, although all respondents were aware that allocations are set annually, with adjustments made as necessary throughout the fiscal year. Similar to the PSRA self-assessment responses, respondents to part two of the HIVPC self-assessment were aware of how and why the PSRA process was conducted; data sources used to make decisions were less familiar with respondents, particularly cost effectiveness data (only 70% of respondents identified that it was used as part of the PSRA process).

Both the needs assessment and Comprehensive Plan were less understood by respondents than the PSRA process. When asked which committee was responsible for the needs assessment, no committee emerged as a clear leader. Though it is true that all committees contributed to all HIVPC processes in some part, respondents clearly identified the PSRA committee as the lead committee for the PSRA process. Subsequent questions about the needs assessment indicate that respondents are not well aware of the methodology used in the needs assessment, or how the needs assessment is implemented. More clarity and education may be necessary about the methods used to conduct the needs assessment and the persons responsible for implementing the needs assessment. Respondents also had difficulty understanding the needs assessment report; only 50% of respondents agreed that it was easy to understand, and only 50% agreed that the report addressed the need for further study.

Part three was focused on the Comprehensive Plan and the continuum of services in Broward County. With only 17% of HIVPC members responding to part three of the self-assessment, it is difficult to say whether or not responses are significant and representative of HIVPC members as

a whole. Similarly to the needs assessment, confusion existed among respondents about which committee was responsible for the Comprehensive Plan. Half of respondents cited the Executive Committee as the responsible committee, and only 25% of respondents cited the NAE. This may be due in part to the changing of work plan activities over the past several years, which included the changing of most of the Comprehensive Plan responsibilities from the Executive Committee to the NAE. All respondents were are that the Comprehensive Plan contained goals and objectives, and respondents were familiar with the contents of the Plan, but 25% of respondents were unsure if the Plan is being implemented as intended and 25% of respondent were unaware if the Plan assigned responsibility for activities or if there was a mechanism to monitor the plan. Questions about the continuum of services in Broward indicated a good understanding among respondents about core services, the coordination of services, and the announcement of available services to the community.

Barriers to HIVPC & Committee Participation

The MCDC developed a survey to determine barriers that HIVPC and committee members face in participating. The survey was distributed throughout the month of March 2015. 36 responses were received, a third of which were from consumers. The majority of respondents were HIVPC and committee members (77%), and none of the respondents who reported only being committee members were consumers.

Overall, the greatest barrier to attending meetings was employment (cited by 34% of respondents). Of respondents indicating employment as a barrier, only 23% were consumers. The greatest barrier for consumers was transportation; this barrier was not cited by non-consumers. Half of respondents citing transportation as a barrier said reimbursement for transportation would help and 43% said a bus pass would help.

Suggested changes to help retain members focused largely on time and attendance or quorum requirements. 22% of respondents indicated changes to the times of meetings could help retain members, including shortening meetings, condensing or combining meetings, and keeping meetings focused on the agenda. 17% of respondents indicated changes were needed to attendance or quorum rules. Overall, time issues were mentioned in 16 comments, and location issues were mentioned in 5 comments; two of the comments about location were made by consumers. There were also several comments about increasing community involvement and reaching out to new community partners and interested parties.

The MCDC plans to revise the survey to be distributed at events and Welcome Brunches, to gain perspective about barriers from interested parties who may want to join, but have been unable to.

HANDOUT I

Committee Meeting Evaluation Report – January-March 2015

HIV Planning Council and committee meeting attendees (members and guests) are asked to complete a meeting evaluation following each meeting.

Participants can check **Yes** or **Needs Improvement** to the following Evaluation Statements:

1. The meeting place was a good working environment.
2. The agenda was clear and was supported by the necessary documents.
3. The chair guided the meeting effectively.
4. All Council/Committee members were prepared to participate in the agenda.
5. Reports were clear and contained needed information.
6. Next steps for future tasks were identified and responsibility was assigned.
7. The agenda was followed without spending too much time on non-agenda items.
8. It was possible to express my opinion if I wanted to.
9. Meeting participants conducted themselves appropriately.

Additional space is provided for comments.

Responses to statements are 100% "Yes" unless otherwise indicated. Needs Improvement = NI. No Response = NR.

COMMUNITY EMPOWERMENT COMMITTEE (CEC)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 6, 2015	14/15 (93%)	#1	NR (1)	Focus more on time than the committee members understandingrf
		#2	NR (1)	
		#3	NR (2)	
		#4	NI (1), NR(1)	Who order the pizza it bad? Bad veggies spoil! Nasty!
		#5	NR (2)	
		#6	NR (1)	
		#7	NR (1)	
		#8	NR (1)	
		#9	NR (1)	
February 3, 2015	0/14 (0%)	None.		None.
March 3, 2015	8/9 (89%)	#4	NI (1),	Started Late

MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE (MCDC)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 8, 2015	5/5 (100%)	None.	None.
February 5, 2015	3/5 (60%)	None.	None.
March 5, 2015	0/5 (0 %)	None.	None.

NEEDS ASSESSMENT/EVALUATION COMMITTEE (NAE)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 12, 2015	4/8 (50%)	None.	None.
No February Meeting			
No March Meeting			

Evaluation Statements

1. The Meeting place was a good working environment.
2. Clear agenda supported by necessary documents.
3. Chair guided meeting effectively.
4. Members were prepared to participate in agenda.
5. Reports were clear and contained needed information.
6. Future tasks were identified; responsibility assigned.
7. Agenda was well followed.
8. It was possible to express my opinion.
9. Meeting participants conducted themselves appropriately.

HANDOUT I

Committee Meeting Evaluation Report – January-March 2015

PRIORITY SETTING AND RESOURCE ALLOCATION COMMITTEE (PSRA)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 21, 2015	0/12 (0%)	None.		No comments.
February 18, 2015	0/10 (0%)	None.		No comments.
March 18, 2015	1/10 (0%)	None.		"Clamp down on cross talk!"

QUALITY MANAGEMENT COMMITTEE (QMC)

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 26, 2015	3/6 (50%)	None.		No comments.
February 23, 2015	4/6 (67%)	#5	NI (5)	Data tables could be made easier to read & understand.
			NI (5)	Statistics needed more clarification.
		#6	NI (6)	Break down info more in data.
March 16, 2015	11/11 (100%)	#3	NI (2)	Helpful if chair helped to guide "topic" or "input" a bit more "It seems the meeting got off track on several occasions"
		#7	NI (2)	Agenda appeared looser @ meeting—too much time on "off shoots" agenda items appeared to get lost at times. "Better Facilitiation"
		#8	NI (2)	"Give members adequate time to make their points w/out cutting them off"
		#9	NI (1)	

SYSTEM OF CARE COMMITTEE (SOC)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
No January Meeting			
No February meeting			
March 27, 2015	2/15 (13%)		Training was very good. Cross talking.

EXECUTIVE COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 6, 2015	6/9 (66%)	#3	NI (1)	"Spent too much time on some items, very long meeting"
		#5	NR (1)	
		#6	NI (1)	"sometimes we procrastinate"
		#7	NI (1)	
February 17, 2015	0/10 (0%)	None.		No comments.
March 17, 2015	1/15 (7%)	None.		Training was very good.

Evaluation Statements

1. The Meeting place was a good working environment.
2. Clear agenda supported by necessary documents.
3. Chair guided meeting effectively.
4. Members were prepared to participate in agenda.
5. Reports were clear and contained needed information.
6. Future tasks were identified; responsibility assigned.
7. Agenda was well followed.
8. It was possible to express my opinion.
9. Meeting participants conducted themselves appropriately.

HANDOUT I

Committee Meeting Evaluation Report – January-March 2015

HIV PLANNING COUNCIL

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
January 22, 2015	9/26 (35%)	#1	NR (1)	"Aesthetic & Spacious"
		#2	NR (1)	"Great visual board & audio as well"
		#3	NR (1)	"Reported well their plan & goal on committee's activities"
		#4	NR (1)	
		#5	NR (1)	
		#6	NR (1)	
		#7	NI (1)	
		#8	NR (1)	
		#9	NR (1)	"Very Professional"
February 26, 2015	0/28 (0%)	None.		No comments.
March 26, 2015	9/31 (29%)	None.		No comments.

AD-HOC LOCAL PHARMACY ADVISORY COMMITTEE (LPAC)

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
No January meeting			
No February Meeting			
March 12, 2015	3/3 (100%)	None.	No comments.

EXPLORATORY SUB COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
March 18, 2015	3/7 (43%)	None.	No comments.

AD-HOC FOOD SERVICES ELIGIBILITY COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT		COMMENTS
No January Meeting				
No February Meeting				
March 10, 2015	2/4 (50%)	#9	NR (1)	No comments.

AD-HOC NOMINATING COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 8, 2015	3/4 (75%)	None.	No comments.

AD-HOC BY-LAWS COMMITTEE

DATE	RESPONSES/ ATTENDEES	STATEMENT	COMMENTS
January 14, 2015	2/4 (50%)	None.	No comments.
February 11, 2015	3/4 (75%)	None.	No comments.
No March Meeting			

Evaluation Statements

1. The Meeting place was a good working environment.
2. Clear agenda supported by necessary documents.
3. Chair guided meeting effectively.
4. Members were prepared to participate in agenda.
5. Reports were clear and contained needed information.
6. Future tasks were identified; responsibility assigned.
7. Agenda was well followed.
8. It was possible to express my opinion.
9. Meeting participants conducted themselves appropriately.

FY 2014-16 HIVPC Trainings

Past

Comprehensive Plan (March 2014): (Ryan White legislation and implementation process)
Update of the 2012-2015 Comprehensive Plan for the Broward Part A program was developed by EGM Consulting, LLC (EGMC). The update was designed to provide a mid-term review and assessment of task completion and progress towards comprehensive plan goals and objectives, and to recommend updates in the work plan as needed.

Priority Setting and Resource Allocation (PSRA) Process (May 2014): (Specific skills related to particular planning and related tasks)
The Priority Setting and Resource Allocation (PSRA) Committee Chair conducted a brief presentation about the priority setting process. The process begins with the collection of data and a data presentation to the PSRA committee. The PSRA Chair reviewed the data presentation given by consultant Emily Gantz-McKay; Ms. Gantz-McKay was responsible for analyzing the data from the Needs Assessment, which included a client survey, a provider survey, and focus groups. Utilization and financial data from Part A, as well as other Ryan White parts and other community funders was used to create scorecards.

HIV Prevention Planning Council Presentation (May 2014): (Specific skills related to particular planning and related tasks)
Christopher Bates, a member of the Florida Department of Health in Broward County gave a presentation on the structure of Broward County's HIV Prevention Council. The council is broken into four teams and six advisory groups. The full council is comprised of approximately 15-21 members, with two appointed seats. One of the appointed seats belongs to the Broward County school district and the other is a research seat; the Council felt these were critical elements that needed to be a part of the Council.

System of Care Committee training (November 2014): (Service delivery system and provider profiles)
This training will allow the System of Care (SOC) committee Chair to discuss the main functions of the committee. This training will include: unmet need research, identifying gaps in care, and evaluation of community needs.

National Quality Center: Training of Consumers on Quality (TCQ) (January 2015): (Importance and sources of data)
This training will increase the number of consumers actively participating in local quality management committees or regional quality improvement activities. The rigorous TCQ Program includes extensive pre-work activities and a 2-day face-to-face TCQ session.

How Best to Meet the Need language and how it impacts services (February 2015): (Importance and sources of data)
The Ryan White legislation gives Planning Councils the responsibility not only to set priorities, but also to establish how best to meet those priorities. This training will highlight the legislative provision which includes establishing a role for the Planning Council in guiding the Grantee in identifying the types of organizations and service delivery mechanisms that best meet each service priority established by the Council (e.g.,

outpatient clinics, community-based organizations that serve affected populations and historically underserved communities).

Future

HIVPC Reflectiveness and Mandated Seats (May 2015): (Specific skills related to particular planning and related tasks)
This training will focus on HIVPC membership requirements, reflectiveness, and mandated membership categories.

Minority AIDS Initiative (MAI) Funds (June 2015): (Specific skills related to particular planning and related tasks)
This training will provide an overview of MAI funding, what it is, and how it works in the broader context of Ryan White Part A funding. It will also discuss the realities of MAI funding (it is less than 10% of total funds), the difficulties in developing specialized programming with the small amount of funds available, and how MAI funds work in Broward.

HIV Biomedical Interventions (June 2015): (Specific skills related to particular planning and related tasks)
This training will focus on current HIV biomedical medical interventions. This training will explore interventions such as Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), both utilized to prevent HIV infection.

Affordable Care Act Update (August 2015): (Ryan White legislation and implementation process)
Prior to the start of enrollment, this training will provide an update to the Affordable Care Act (ACA) and Health Insurance Marketplace. This training will include: an overview of the ACA marketplace, and Florida specific resources, and consumer feedback.

2016 Comprehensive Plan with Prevention (August 2015): (Ryan White legislation and implementation process)
Beginning in 2016, Ryan White Part A and Prevention will be responsible for a joint comprehensive plan. This training will include strategies to form an effective collaboration between the HIVPC and Broward County's HIV Prevention Council.

Self-Assessment Findings (February 2016): (Specific skills related to particular planning and related tasks)
Evaluation data from the HIVPC Self-Assessments will be presented. Self-Assessment findings will provide training opportunities that will benefit all committees as well as the HIVPC.