FORT LAUDERDALE/BROWARD EMA

BROWARD HIV HEALTH SERVICES PLANNING COUNCIL

AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS

200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020

(954) 561-9681 • FAX (954) 561-9685

Broward County HIV Health Services Planning Council Meeting

Thursday, April 25, 2024 - 9:30 AM

Meeting at Broward Regional Health Planning Council and Microsoft Teams

https://teams.microsoft.com/l/meetup-join/19%3ameeting_MTgzNDBjZmEtYzllOS00YzA4LThjMjktOGVjYTI2MTJmOGEz%40thread.v2/0?context=%7b%22Tid%22%3a%220dd42165-bf27-4e00-9f50-1f4dff8a73f8%22%2c%22Oid%22%3a%221bcbe6d6-8962-41e8-b7e5-3cd660df997c%22%7d

Meeting ID: 223 679 016 307 | Passcode: 9Af8tf

Or call in (audio only)

+1 561-437-3349 - Phone Conference ID: 869 406 955#

Chair: Lorenzo Robertson • Vice Chair: Von Biggs

This meeting is audio and video recorded.

Quorum for this meeting is 14

DRAFT AGENDA

ORDER OF BUSINESS

1. **CALL TO ORDER/ESTABLISHMENT OF QUORUM**

2. **WELCOME FROM THE CHAIR**
   a) Meeting Ground Rules
   b) Statement of Sunshine
   c) Introductions & Abstentions
   d) Moment of Silence

3. **PUBLIC COMMENT**

4. **ACTION:** Approval of Agenda for April 25, 2024

5. **ACTION:** Approval of Minutes from March 28, 2024 **(Handout A)**

6. **FEDERAL LEGISLATIVE REPORT**– Attorney Marty Cassini, Broward County Intergovernmental Affairs Office

7. **STANDARD COMMITTEE ITEMS:**
8. **CONSENT ITEMS**

Action Item: Review and approve the HIVPC membership application for Karen Creary.
Justification: Ms. Creary previously served as a member of the Planning Council and is a PWH who is committed to advocating for and serving the HIV/AIDS community by improving the quality of life of those affected and diagnosed. Ms. Creary's application was reviewed by MCDC and sent to HIVPC for approval.
Seat: Affected Communities/Unaffiliated Seat.
PROPOSED BY: Membership/Council Development Committee Chair

Action Item: Motion to approve the FY2023 Training Plan **(Handout B)**
Justification: The MCDC Committee approved the training plan during its April 11, 2024, meeting.
PROPOSED BY: Membership/Council Development Committee Chair

9. **OLD BUSINESS: None**
10. **NEW BUSINESS: None**
11. **DISCUSSION ITEMS:**

The Minority AIDS Initiative (MAI) Service Delivery Models (SDM) were reviewed by the Systems of Care Committee (SOC) during its April 4, 2024, meeting. SOC provided recommendations to the Quality Management Committee. Upon review, the SDMs were approved by the Quality Management Committee during its April 15, 2024, meeting.

a. **Motion to approve the Minority AIDS Initiative Substance Abuse - Outpatient –Service Delivery Model (Handout C)**
Justification: Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders.
PROPOSED BY: Quality Management Committee Chair

b. **Motion to approve the Minority AIDS Initiative Non-Medical Case Management –Service Delivery Model SDM (Handout D)**
Justification: *Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention of needed core medical and support services.*
PROPOSED BY: Quality Management Committee Chair

c. **Motion to approve the Minority AIDS Initiative Medical Case Management – Service Delivery Model SDM Request for Approval Form (Handout E)**
Justification: *Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum.*
PROPOSED BY: Quality Management Committee Chair

SDM Presentation Presented by Broward County Ryan White Part A Office (Handout F)

12. COMMITTEE REPORTS

a) **Community Empowerment Committee (CEC)**
Chair: Shawn Jackson • Vice Chair: Irvin Wilson

April 2, 2024 – No Meeting Held

i. **Work Plan Item Update/Status Summary:**
ii. **Data Requests:**
iii. **Rationale for Recommendations:**
iv. **Data Reports/ Data Review Updates:**
v. **Other Business Items:**
vi. **Agenda Items for Next Meeting:**
vii. **Next Meeting date:** May 7, 2024, at 3:00 PM at BRHPC and via Microsoft Teams Videoconference

b) **System of Care Committee (SOC)**
Chair: Jose Castillo • Vice Chair: Kendra Hayes
April 4, 2024

i. **Work Plan Item Update/Status Summary:** Committee Members reviewed the Substance Abuse Service Delivery Model (SDM), Non-Medical Case Management with Minority AIDS Initiative (MAI) SDM, and Medical Case Management MAI SDM and made recommendations, which were forwarded to the Quality Management Committee.
ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** Continue reviewing Service Delivery Models
    a. Health Insurance Continuation Program
    b. Integrated Primary Care and Behavioral Health (IPCBH)
    c. Universal SDM
    d. FY2023-2024 Needs Assessment Overview
    e. How Best to Meet the Need Review for FY2024-2025
vii. **Next Meeting date:** May 2, 2024, at 9:30 AM at BRHPC and via Microsoft Teams Videoconference

c) **Membership/Council Development Committee (MCDC)**
Chair: Vincent Foster • Vice Chair: Dr. Timothy Moragne
April 11, 2024

i. **Work Plan Item Update/Status Summary:** The committee members reviewed and approved Lemont Lewis' application, which was then forwarded to the Executive Committee. The members reviewed Karen Creary's application, accepted it pending her attendance at three committee meetings, and forwarded it to the HIVPC for approval. The

members reviewed and approved the HIVPC Member Recognition Program, the HIVPC Mentoring Program, the Membership Attendance for Mandatory Training/Meetings Policy, and the HIVPC Training and Presentation Plan.

ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None.
vi. **Agenda Items for Next Meeting:** To be determined.
vii. **Next Meeting date:** July 11, 2024, at 9:30 AM at BRHPC and via Microsoft Teams Videoconference

d) **Quality Management Committee (QMC)**
Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore
April 15, 2024

i. **Work Plan Item Update/Status Summary:** Committee Members reviewed and approved the Substance Abuse Service Delivery Model (SDM), Non-Medical Case Management with Minority AIDS Initiative (MAI) SDM, and Medical Case Management MAI SDM.
ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:** None
v. **Other Business Items:** None
vi. **Agenda Items for Next Meeting:** Continue reviewing SDMs
    a. Health Insurance Continuation Program
    b. Integrated Primary Care and Behavioral Health (IPCBH)
    c. Universal SDM
vii. **Next Meeting date:** May 20, 2024, at 12:30 PM at BRHPC and via Microsoft Teams Videoconference

di) **Executive Committee**
Chair: Lorenzo Robertson • Vice Chair: Von Biggs
April 18, 2024
Work Plan Item Update/Status Summary:

i. **Work Plan Item Update/Status Summary:**
The Executive Committee reviewed and approved the agenda for the April 25th HIVPC meeting and the May 2024 calendar. The MCDC Chair reported on the HIVPC membership roster, seat vacancies, and demographics to identify populations over or underrepresented on the Council. The MCDC Chair also updated the committee on the HIVPC Member Recognition Program, the HIVPC Mentoring Program, and the Membership Attendance for Mandatory Training/Meetings Policy.

ii. **Data Requests:** None
iii. **Rationale for Recommendations:** None
iv. **Data Reports/ Data Review Updates:**
v. **Other Business Items:** None

vii. **Agenda Items for Next Meeting:**
   a. Review and approve May 23, 2024, HIVPC Agenda, Meeting Materials, and Motions
   b. Review the June 2024 HIVPC Calendar

viii. **Next Meeting date:** May 16, 2024, at 12:45 PM at BRHPC and via Microsoft Teams Videoconference

f) **Priority Setting & Resource Allocation Committee (PSRA)**

Chair: Brad Barnes • Vice Chair: Vacant

April 2024 – Workshop Held

i. **Work Plan Item Update/Status Summary:**
Due to a lack of quorum, a workshop was held. Members tabled the Minutes from the March 21, 2024, meeting. The Ryan White Part A Office provided a Monthly Expenditure/Utilization Report—by service category. The committee agreed to an emergency meeting to discuss the Food Bank/Voucher Services. PCS staff will send out a Doodle Poll to schedule the meeting. Members discussed the Minority AIDS Initiative and a projected plan. The Chair reminded members about the April 24th Ryan White Services Listening Session at the AIDS Healthcare Foundation, from 3 to 5 PM.

ii. **Data Requests:** None.

iii. **Rationale for Recommendations:** None.

iv. **Data Reports/ Data Review Updates:** None.

v. **Other Business Items:** None.

vi. **Agenda Items for Next Meeting:**

vii. **Next Meeting date:** April 30, 2024, at 12:00 PM at BRHPC and via Microsoft Teams Videoconference

13. RECIPIENT REPORTS

a) Part A **(Handout G)**

b) Part B **(Handout H1, H2)**

c) Part C

d) Part D **(Handout I)**

e) Part F

f) HOPWA

g) Prevention – Quarterly Update (April, July, October, January)

14. DATA REQUEST(S)

15. PUBLIC COMMENT

16. AGENDA ITEMS FOR THE NEXT MEETING

a) Next Meeting Date: May 16, 2024, at 9:30 a.m. at BRHPC and via Microsoft Teams

b) Agenda Items for next meeting: To Be Determined

17. ANNOUNCEMENTS

a) PSRA Emergency Meeting; Tuesday, April 30th, 12:00 pm at BRHPC and via Microsoft Teams

b) HIVPC Partnership with the UJIMA Men's Collective Man Up Festival; Saturday, May 4th, 12:00 pm-6:00 pm

18. ADJOURNMENT

For a detailed discussion on any of the above items, please refer to the

minutes

available at:
HIV Planning Council Website

Please complete your meeting evaluation.
Three Guiding Principles of the Broward County HIV Health Services Planning Council

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

Vision: To ensure the delivery of high-quality, comprehensive HIV/AIDS services to low-income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high-quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: (1) Foster the substantive involvement of the HIV-affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care, (2) Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments, (3) Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

HANDOUT A

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

Broward County HIV Health Services Planning Council Meeting

Thursday March 28, 2024 - 9:30AM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

DRAFT MINUTES

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

Members Absent: V. Biggs (HIVPC Vice- Chair), E. Dsouza, J. Wright, J. Wynn, J. Casseus, D. Shamer

Ryan White Part A Recipient Staff Present: J. Roy, T. Thompson, G. James, B. Miller, R. Honick, R. Pena, C. Evans, A. Tareq, T. Currie, Q. Cowan,

Planning Council Support Staff Present: G. Berkley-Martinez, M. Patel, D. Liao, M. Lacroix

Guests Present: S. Cook, D. Monestime, Gaby, A. Ruby, K. Bush, B. Baker, M. Cassini, J. Hidalgo, J. Shirley

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

The HIVPC Chair called the meeting to order at 9:35 a.m. The HIVPC Chair welcomed all meeting attendees that were present. Attendees were notified that the HIVPC meeting is based on Florida's "Government-in-the-Sunshine Law" and meeting reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by committee members, Recipient staff, PCS/CQM staff, and guests by roll call, and a moment of silence was observed.

2. Public Comment:

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and services in Broward County. K. Hayes made a public comment by expressing to the Planning Council that all members must set aside their biases and work together for a shared purpose. B. Barnes noted that the Public Comment is meant for guests, not members.

3. Meeting Approvals:

The approval for the agenda of the March 28, 2024, HIVPC meeting was proposed by V. Foster, seconded by J. Castillio, and passed unanimously. The approval for the minutes of the January 25, 2024, meeting was proposed by M. Schweizer, seconded by B. Mester, and passed unanimously with an amendment by B. Barnes, that those who missed the Annual Retreat should be listed as absent.

Motion #1: V. Foster, on behalf of HIVPC, made a motion to approve the March 28, 2024, HIV Health Services Planning Council Agenda. The motion was seconded by J. Castillio and adopted unanimously.

Motion #2: M. Schweizer, on behalf of HIVPC, made a motion to approve the January 25, 2024, HIV Health Services Planning Council Minutes. The motion was seconded by B. Mester and passed unanimously.

4. Federal Legislative Report:

Attorney Marty Cassini, Broward County Intergovernmental Affairs Office conducted a report regarding several recent legislative actions passed by the county, state, and federal governments and that would affect the funding for Ryan White services.

5. Consent Items:

Motions made from the committee chairs under consent items were approved unanimously by the HIVPC.

a. **Motion to approve Yusimir Arencibia to join the Priority Setting and Resource Allocation Committee** – PROPOSED by: PSRA Committee Chair. Approved unanimously.
Justification: Ms. Arencibia is a current member of the HIV Health Services Planning Council and requested to join this committee. **Seat: Representatives of/or formerly incarcerated PWH.**
b. **Motion to approve the FY2024-2025 PSRA Work Plan and PSRA Process** – PROPOSED by: PSRA Committee Chair. Approved unanimously.
Justification: The Priority Setting and Resource Allocation Committee finalized and approved the work plan and timeline during its March 21, 2024, meeting.

6. Old Business:

None.

7. New Business:

Overview of the Broward HIVPC Accomplishments from March 1, 2023, through February 29, 2024, fiscal year

L. Robertson conducted an overview of accomplishments that members of the Planning Council achieved during FY2023-2024.

Evaluation Report HIVPC Retreat, February 22, 2024

M. Lacroix presented an evaluation report based on the responses of Planning Council members who attended the Annual Retreat on February 22, 2024, and completed a survey regarding their thoughts on the Retreat. J. Roy stated that the Ryan White Part A Office is willing to attend future meetings and retreats hosted by the Planning Council.

8. Discussion Items:

Motion to approve the Centralized Intake Eligibility Determination (CIED) Service Delivery Model

Justification: The CIED- Service Delivery Model was reviewed by the Systems of Care Committee during its March 7, 2024, meeting. SOC provided recommendations to the Quality Management Committee. The CIED SDM was reviewed and approved by the Quality Management Committee during its March 18, 2024, meeting.

Motion #4: QMC made the motion to approve the Centralized Intake Eligibility Determination (CIED) Service Delivery Model. The motion was seconded by J. Castillio and passed unanimously.

9. Committee Reports:

a. Community Empowerment Committee Workshop – March 5, 2024
Chair: Shawn Jackson Vice Chair: Irvin Wilson
The report stands.

S. Jackson explained the results of the "Stigma Smashers" event held on January 31, 2024 and discussed a CEC Marketing Proposal designed to create low-effort systems for staying consistent with social media posting, publicizing CEC events, promoting the HIVPC, press coverage, and event turnout of community members and decision-makers. CEC finalized outreach activities for FY2024-2025.

b. System of Care Committee – March 7, 2024
Chair: J. Castillo, Vice Chair: K. Hayes
The report stands.

J. Castillion explained that committee members reviewed the Service Delivery Model for CIED and made recommendations, which were forwarded to the Quality Management Committee.

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

d. Quality Management Committee – March 18, 2024
Chair: B. Fortune-Evans, Vice Chair: F. D'Amore
The report stands.

B. Fortune-Evans explained that committee members reviewed the Service Delivery Model for CIED and recommendations from the SOC Committee. The SDM was revised with a final update to the HIVPC. CQM

staff provided an update on revisions to the FY2024- 2025 Quality Improvement Toolkit, which will be shared with the members of the Quality Improvement Network to guide QI projects.

e. **Priority Setting & Resource Allocation Committee – March 21, 2024**
Chair: B. Barnes, Vice Chair: Vacant
The report stands.

f. **Executive Committee – December 2023: No Meeting Scheduled**
Chair: Lorenzo Robertson Vice Chair: V. Biggs
The report stands.

g. **Ad-Hoc By-Laws & MOU Committee, Ad-Hoc Nominations – December 2023: No Meeting Scheduled**
Chair: B. Barnes, Vice Chair: Vacant
The report stands.

B. Barnes explained that Committee members reviewed the expenditure/utilization report, discussed Broward County Taxonomy rate increase with possible impact on Ryan White reimbursement rates, and quarterly updates on clients moving into ACA, which will start in June 2024. Members reviewed the proposed FY2024-

2025 PSRA process timeline and annual workplan. Furthermore, members discussed the Affordable Care Act enrollment of the Ryan White Part A eligible clients. They received a historical overview of the Minority AIDS Initiative program from former PSRA Chair and HIVPC Vice Chair, Ms. Carla Taylor-Bennet, to start the discussion on the effectiveness of the current MAI program and service categories. The Chair discussed the purpose of the April 24th Ryan White Services Listening Session.

The committee members had three data requests during the last meeting.

- How many consumers are currently enrolled with ACA and how many are eligible for ACA.
- All Ryan White money spent on retention in care and viral load suppression broken down into groups (race, ethnicity, Wiki categories).
- Language of MAI funding and spending, to determine what it is intended and used for. What the language says from HRSA. What is allowable for service categories?

10. Recipient's Report:

a. **Part A:** The Recipient Part A Office provided updates on Ryan White Part A Needs Assessment, Service Delivery Models, Services Report (RSR), and Contracting Updates.
b. **Part B:** Recipient provided a written report with Part B's expenditures for February 2024 and the ADAP Quarterly Report with Outcomes.
c. **Part C:** No Report
d. **Part D**: The Part D Representative provided a general report which included

the current number of enrolled HIV positive patients and the overall viral suppression rate.

e. **Part F:** No Report.
f. **HOPWA:** No Report.
g. **Prevention:** Quarterly Update (April, July, October, January)

11. Data Request(s):

B. Mester: How many people were certified and recertified during FY2022-2023, FY2023-2024, FY2024-2025? How many were recertified totally, how many through NOAs, workload, and how that has changed over time.

12. Public Comment:

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

13. Agenda Items for Next Meeting:

a. The next HIVPC meeting will be held on April 25, 2024, at 9:30 a.m. **Location:** Broward Regional Health Planning Council and Virtual through Microsoft Teams
b. Agenda Items for next meeting: **To Be Determined**

14. Announcements:

- PSRA/CEC Listening Tour on RW Part A Services (Handout I)
- S. Jackson: HIV Possible and SOS Broward in partnership with community partners, first annual second quarter events. Step N Mingle.
- K. Hayes: Transgender Visibility Day Events hosted by Transinclusive.
- K. Hayes: Taking Action Together Summit, Texas Conference. Biomedical Certificate and Biomedical Conference.
- L. Robertson: Ujima Men's Collective: Man Up in the Park

15. Adjournment:

There being no further business, the meeting was adjourned at 11:23 p.m.

HIVPC Attendance for CY 2024

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

Legend:

1 - present	N - newly appointed
A - absent	Z - resigned
E - excused	C - canceled
NQA - no quorum absent	W - warning letter
NQX - no quorum present	R - removal letter
CX - canceled due to quorum	

HANDOUT B

HIVPC Training & Presentation Plan

March 1, 2024-February 28, 2025

For more information: Contact hivpc@brhpc.org; (954) 561-9681 Ext. 1343/1244

Purpose: The PC/PB is responsible for providing updated training as needed to ensure that members understand their roles, responsibilities, and expectations for participation, how work is undertaken, and how formal decisions are made. *(RW Part A Manual, 2023)*

Determine Topics → Outline Training Goal → Contact Appropriate Parties → Schedule & Plan → Provide Training to HIVPC

FY 2024-2025 Training & Presentation Topics

☐	As Needed	**Post Orientation for New Members:** Understand the purpose and scope of the Ryan White HIV/AIDS Program (RWHAP); legislative roles and responsibilities of a Part A Planning Council (PC); Differentiate PC and recipient roles; the importance of data-based decision-making; committee structure and operations of the PC; and expectations for individual PC members.
☐	May 2024	**PSRA Process:** The PCS Staff will conduct a presentation about the Priority Setting and Resource Allocation (PSRA) process for the HIVPC. The PSRA committee ranks services and allocates Ryan White Part A Funds. (See detailed Professional development on the Part A Planning Cycle) **Trainer: PCS Staff**
☐	June, July, August 2024	**Professional Development:** • Overview of the RWHAP Part A Annual Planning Cycle: Participating in Your First Planning Cycle • Working Together: Effective Committee and PC/PB Meetings • Maintaining and Improving a System of Care
☐	February 2025	**Robert's Rules of Order Overview:** A presentation on Robert's Rules to detail the parliamentary procedure utilized by the HIV Planning Council to conduct efficient meetings. **Trainer: To be Determined**

Note: Training Topics are subject to change based on current issues.

HANDOUT C

GET CARE
BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Substance Abuse – Outpatient
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under the Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder.
  - Outpatient drug-free treatment and counseling
  - Medication-assisted therapy.
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group that is considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

Race/Ethnicity categories:

- Hispanic or Latino
- White (non-Hispanic)
- Black or African American (Non-Hispanic)
- Asian (non-Hispanic)
- American Indian or Alaska Native (Non-Hispanic)
- Native Hawaiian or Other Pacific Islander (Non-Hispanic)
- Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds underrepresented:

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

• American Indian or Alaska Native
• Black or African American
• Native Hawaiian or Other Pacific Islander
• Hispanic (all races)

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds Substance Abuse – Outpatient services are medical or other treatment and/or counseling services provided to clients to address substance use disorders (SUDs) (i.e. recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or impairment in physical, social or occupational functioning). These services will be provided by appropriately credentialed and/or licensed treatment professionals. Substance Abuse – Outpatient services include psychological assessment and evaluation, drug testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments, outpatient day treatment, intensive day/night treatment, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate to improve adherence to treatment and improve client health outcomes.

Population of focus for MAI:

- Individuals of a racial or ethnic minority group as defined by the U.S. Department of Health and Human Services (DHHS) & Health Resources and Services Administration (HRSA).

II. Key Service Components & Activities

In addition to the Substance Abuse – Outpatient Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Substance Abuse – Outpatient services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

All MAI funded programs are expected to adhere by the above service standards.

Outpatient Care

Outpatient substance abuse care treats ameliorate negative symptoms from SUDs and restores effective functioning in persons diagnosed with substance-use dependency or addiction. Outpatient care is appropriate as an initial level of care for clients with less severe disorders, in early stages of change (as a "step down" from more intensive services), or stable and ongoing

[2] FLA. STAT. § 394.

monitoring or disease management. Outpatient care is provided less than nine hours weekly.

Intensive Outpatient Services
Intensive outpatient services provide essential addiction education and treatment to clients with SUDs and have gradations of intensity. At a minimum, intensive outpatient services provide a support system including medical, psychologic, psychiatric, laboratory, and toxicology services within 24 hours via telehealth or within 72 hours in-person. Intensive outpatient services are provided from 9 – 19 hours weekly.

Day Treatment
Day treatment services differ from intensive outpatient services in the intensity of clinical services that are directly provided. Day treatment is appropriate for clients who are living with unstable medical and psychiatric conditions. Day treatment, at a minimum, meets the same treatment goals as described in *Intensive Outpatient Services*, with psychiatric and other medical consultation services available within eight hours via telehealth or within 48 hours in-person. Day treatment services must be continuously provided at a minimum from 9:00 a.m. until 10 p.m. during a single 24-hour period.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in designated Human Services Software System (HSSS).
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HSSS. 2.1.2. Data obtained from the MAI Annual Report.

IV. Assessment and Treatment Plan

Assessment
During the first encounter with a client, the provider must establish a provisional diagnosis and treatment plan goal. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HSSS within 30 calendar days of the first encounter with a client and be reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[3]

[3] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

For MAI programs, the assessment must identify opportunities for improvement on access to care and disparities in health outcomes.

Treatment Plan

Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client. Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if the client is under 18 years of age)
- Dated signature of a licensed provider
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identify the client's readiness to transition to a new level of care or out of care)

For MAI programs, the treatment plan must address potential barriers to access and reduce disparities in health outcomes.

Treatment Plan Review

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of

discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed practitioner and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Substance Abuse – Outpatient Service Delivery Standards

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within 30 calendar days of the first encounter.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HSSS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed practitioner and client in the designated HSSS.
4. Provider conducts a formal treatment plan review at least every six months.	4.1. Updated treatment plan with signature and date of licensed practitioner and client in the designated HSSS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made toward treatment plan goals in the designated HSSS.
6. All client communication is documented in the client file and includes a date, length of time spent with the client, the person(s) included in the encounter, a summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the designated HSSS.

Standard	Measure
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HSSS.
8. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	8.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcome within each minority population and/or subpopulation.

HANDOUT D

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Non-Medical Case Management
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

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

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

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

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group that is considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

Race/Ethnicity categories:

- Hispanic or Latino
- White (non-Hispanic)
- Black or African American (Non-Hispanic)
- Asian (non-Hispanic)

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

• American Indian or Alaska Native (Non-Hispanic)
• Native Hawaiian or Other Pacific Islander (Non-Hispanic)
• Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds underrepresented:

• American Indian or Alaska Native
• Black or African American
• Native Hawaiian or Other Pacific Islander
• Hispanic (all races)

Local Definition

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

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

Population of focus for MAI:

- Individuals of a racial or ethnic minority group as defined by the U.S. Department of Health and Human Services (DHHS) & Health Resources and Services Administration (HRSA).

II. Key Service Components and Activities

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

All MAI funded programs are expected to adhere by the above service standards.

Peer Counseling

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

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

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

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Supports access to client retention and care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Human Services Support Services (HSSS). 1.1.2. Data obtained from the MAI Annual Report.
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV HSSS.
2. Supports viral suppression.	2.1. 90% of clients on ART for more than six months will have a viral load less than 200 copies/ml.	2.1.1. Client viral load test result in designated HIV HSSS. 2.1.2. Client prescription of ART documented in the designated HIV HSSS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's service needs including a review of medical, financial, social, emotional, resources, and other needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV HSSS and include, at minimum, the following components:

- STI/HIV Health Literacy Assessment, including U=U (undetectable equals untransmittable), knowledge of HIV and STI testing, prevention, and treatment
- Barriers to accessing primary medical care medication adherence and other service needs
- Medical information, including overall health, laboratory results, and prescribed medication regimen

- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Education and guidance to support a successful transition to an Affordable Care Act (ACA) Insurance, Medicare, and Medicaid
- Support service needs, including advice and assistance in obtaining medical, social, community, legal assistance, finances/benefits, support groups, food bank, vocational, and transportation
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal Violence

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

For MAI programs, the reassessment must identify opportunities for improvement on access to care and disparities in health outcomes.

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

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

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)
    - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
    - Specified interventions to achieve the goal statement
    - Date goals are established
    - Target date for goal completion

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

Progress Notes
Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress including, assistance provided, and communication with clients in the designated HIV HSSS, including phone calls, mail, face-to-face, and electronic communication. Additionally, providers are responsible for checking and verifying lab reports (ensuring correct lab value entry, trending viral load, and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up.

On a monthly basis, Case Management supervisors must review a 5% sample of open client action plans to identify opportunities for improvement. To ensure a high quality of progress notes, NMCM must write effectively to include:

- Protected privacy of the client
- Detailed and organized notes documenting activities. All activities must be documented in the client file.
- Facts about your encounter with the client
- The purpose and clear observations of the client interaction
- Describe next steps, including, the purpose and/or goal for the next encounter

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

For MAI programs, the action plan must address potential barriers to access and reduce disparities in health outcomes.

V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV HSSS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
4. All client records/files will be neatly maintained and organized.	4.1. All client records will contain at a minimum the following documentation: brief intake, current notice of

Standard	Measure
	eligibility, confidentiality forms (if applicable), case closure (if applicable), and other documentation an agency deemed appropriate in the designated HIV HSSS. 4.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 4.3. Progress notes in the client file/designated HIV HSSS. 4.4. Confidentiality releases in client file/designated HIV HSSS.
5. Case managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates and service delivery.	5.1. Case managers will receive, within 6 months of hire, the following required training : annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
6. Peer Counselors will participate in professional development activities that focus on HIV/AIDS/STI updates and service delivery.	6.1. Peer Counselors will receive, within 6 months of hire, the following required training: annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and

Standard	Measure
	HOPWA programs); basic and advanced information on HIV/AIDS (501); code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: peer counseling trainings, mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
7. Case Management supervisors review a 5% sample of open client action plans each month to identify opportunities for improvement.	7.1. Open action plans in the designated HIV HSSS. 7.2. Documentation of monthly reviews and identified opportunities for improvement.
8. Completed action plans are reviewed by Case Management supervisors.	8.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV HSSS.
9. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	9.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV HSSS.
10. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	10.1. Closed cases include documentation stating the reason for closure and a closure summary. 10.2. Supervisor signs off on closure summary indicating approval. 10.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 10.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
11. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	11.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth.

Standard	Measure
	• Client-level outcome within each minority population and/or subpopulation.

HANDOUT E

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Medical Case Management
Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

Approved by HIVPC on 12/5/2023

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I. Service Definitions

HRSA Definition[1]

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities undertaken in this service category may be provided by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication), as well as activities taken on behalf of the client (e.g., multidisciplinary case conferences, referrals to other personnel or agencies).

Key activities include:

- Initial assessment of service needs
- Develop a comprehensive, Individualized Care Plan (ICP)
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ICP
- Re-evaluate the ICP plan at least every six months, with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of service utilization

In addition to providing the medically oriented activities above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. Such programs may include Florida Medicaid Managed Care Organizations (MCOs), Medicare Part D, Florida AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's Patient Assistance Programs (PAPs), other state or local healthcare and supportive services, and insurance plans through the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), Marketplaces/Exchanges.

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group that is considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

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

Race/Ethnicity categories:

- Hispanic or Latino
- White (non-Hispanic)
- Black or African American (Non-Hispanic)
- Asian (non-Hispanic)
- American Indian or Alaska Native (Non-Hispanic)
- Native Hawaiian or Other Pacific Islander (Non-Hispanic)
- Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds underrepresented:

- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Hispanic (all races)

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds the Medical Case Management and provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications stemming from co-morbid chronic disease conditions. MCM includes assessment of client needs, development of a coordinated plan of care, and care coordination. Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments
- Coordinating essential medical and support services and making referrals when indicated
- Providing adherence counseling to treatment regimens and healthcare and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

Population of focus for MAI:

- Individuals of a racial or ethnic minority group as defined by the U.S. Department of Health and Human Services (DHHS) & Health Resources and Services Administration (HRSA).

II. Key Service Components and Activities

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

comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

All MAI funded programs are expected to adhere by the above service standards.

Coordination of Medical and Healthcare Improvement Services
Providers must ensure coordination of medical and healthcare improvement services to support clients in meeting their ICP goals and maintaining their engagement in care. Case coordination and case conferencing includes communication, information sharing, and collaboration that occurs regularly with case management and other providers serving the client within and between agencies in the community. Coordination includes, but is not limited to:

- Managing HIV and co-morbid condition (chronic and acute) treatments
- Communicating with the client's primary care and behavioral health providers and other service providers to support client adherence, understanding, motivation, access to services and optimal engagement in care to include case coordination and case conferencing activities
- Coordinating medical and support service use within the RWHAP system of care, addressing barriers to obtaining services, and linking the client to services
- Coordinating specialty medical services outside the RWHAP system of care
- Coordinating with prescribing medical providers to prioritize HIV treatment, ARV adherence, and goal setting for other medical conditions, including but not limited to, diabetes, chronic renal failure, chronic obstructive pulmonary disease, cardiovascular conditions, neurocognitive disorders, and cancer

Case conferences include multi-disciplinary service providers, including providers within the agency and those from other agencies when possible and relevant. Case conferences must be face-to-face or via conference call and must be held at routine intervals or during significant care changes or transitions. High acuity levels established by the Acuity Scale informs the frequency of case conferences. The client and their family members, significant others, or designated caregiver(s) should also be included in case conferences when possible and appropriate. These activities must be recorded in the client's progress notes in the designated HIV Human Services Support Services (HSSS). Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals
- Resolve conflicts or strategize solutions

Adherence Counseling to Support Medical Care and Treatment
MCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions

- Documenting all adherence counseling activities in the designated HIV HSSS

Client-Centered Education and Training on HIV Self-Management
MCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression
- Retention in HIV and primary medical care, including health promotion activities
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning
- Recognizing the signs of stress, distress, anxiety, and depression and strategies to access emotional support services
- Adequate nutrition, regular exercise, and the benefits of stress reduction and self-care.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicator(s)	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one (1) or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV HSSS. 1.1.2. Data obtained from the MAI Annual Report.
	1.2. 90% of clients are retained in primary medical care.	1.1.3. Client appointment record in designated HIV HSSS.

IV. Assessment and Individual Care Plan

Comprehensive Health Assessment (CHA)
MCMs must assess client needs by conducting a CHA within 14 days of the client's initial visit. The CHA must be completed within the designated HIV HSSS. The CHA is used to evaluate each client's access to medical care, health status, health maintenance, health knowledge, treatment adherence, behavioral health needs, and environment. Assessment findings are used to inform the acuity scale component.

Progress Notes
Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress including,

assistance provided, and communication with clients in the designated HIV HSSS, including phone calls, mail, face-to-face, and electronic communication. Additionally, providers are responsible for checking and verifying lab reports (ensuring correct lab value entry, trending viral load, and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up.

On a monthly basis, Case Management supervisors must review a 5% sample of open client action plans to identify opportunities for improvement. To ensure a high quality of progress notes, MCM must write effectively to include:

- Protected privacy of the client
- Detailed and organized notes documenting activities. All activities must be documented in the client file.
- Facts about your encounter with the client
- The purpose and clear observations of the client interaction
- Describe next steps, including, the purpose and/or goal for the next encounter

Acuity Scale

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. MCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

Table 2: Acuity Scale Scoring and MCM Management Levels

Management Level	Points	Health Status/ Medical Condition	Client Contact Frequency	Chart Review Frequency
Self-Management	24-34 Points	Medically stable without need of MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up at least once every six months for reassessment	Once every six months
Basic Management	35-49 Points	Medically stable with minimal MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months	Every 3 months
Moderate Management	50-73 Points	At risk of becoming medically unstable without MCM assistance including documented detectable viral load or risk for viremia	Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month	Every 3 months

Intensive Management	74-96 Points	Medically unstable and in need of comprehensive MCM assistance with an accompanying detectable viral load	Face-to-face at least once a month with phone contact weekly	Monthly

Reassessment
Reassessments provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous timeframe of activities. Providers must reevaluate the client's unmet needs and related barriers by conducting reassessments every six months after completion of the initial assessment, or sooner if the client's circumstances change significantly. Reassessment findings are used to update the ICP.

For MAI programs, the reassessment must identify opportunities for improvement on access to care and disparities in health outcomes.

Individual Care Plan (ICP)
Providers must develop an ICP within 30 days of completing the initial client visit. MCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The MCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. MCMs must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV HSSS.

For MAI programs, The ICP must address potential barriers to access and reduce disparities in health outcomes.

V. Standards for Service Delivery

Table 3. MCM Standards for Service Delivery

Standard	Measure
1. Provider completes a CHA with each client within 14 days of their initial visit.	1.1. Completed CHA in the designated HIV HSSS.
2. Provider develops an ICP with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client.	2.1. ICP signed and dated by the provider and client in the designated HIV HSSS.

Standard	Measure
3. Provider completes a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change.	3.1. Completed CHA in the designated HIV HSSS. 3.2. Progress notes in the designated HIV HSSS.
4. All client records/files will be neatly maintained and organized.	4.1. All client records will contain at a minimum the following documentation: brief intake, current notice of eligibility, confidentiality forms (if applicable), case closure (if applicable), and other documentation an agency deemed appropriate in the designated HIV HSSS. 4.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 4.3. Progress notes in the client file/designated HIV HSSS. 4.4. Confidentiality releases in client file/designated HIV HSSS.
5. Medical Case Managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates and service delivery.	5.1. Medical Case Managers will receive, within 6 months of hire, the following required training : annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (500 and 501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
6. As needed, case managers routinely coordinate all necessary services along the continuum of care, including	6.1. Evidence of timely case conferencing with key providers is found in the client's records through case note

Standard	Measure
institutional and community-based, medical, and non-medical, social and support services	documentation in the designated HIV HSSS.
7. Client health needs are assessed and reassessed using the Acuity Scale as outlined in *Appendix A.*	7.1. Acuity Scale completed and scored in the designated HIV HSSS.
8. Client has contact with the provider at the frequency specified by client's management level as detailed in *Appendix A*.	8.1. Documentation of client communication in the designated HIV HSSS.
9. Provider conducts healthcare monitoring as specified by the ICP.	9.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
10. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	10.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
11. Provider conducts adherence counseling to support treatment regimens and medical care.	11.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
12. Assistance provided to client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client.	12.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV HSSS.
13. Provider follows up with clients within two business days of the client's requested communication.	13.1. Documentation of client communication in the designated HIV HSSS.
14. Provider conducts medical chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in *Table 2.*	14.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV HSSS.
15. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 2.*	15.1. Documentation of client case management conference in the designated HIV HSSS.
16. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	16.1. Closed cases include documentation stating the reason for closure and a closure summary. 16.2. Supervisor signs off on closure summary indicating approval. 16.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff.

Standard	Measure
	16.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
17. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care and outcomes.	17.

17 Establish and maintain a system that tracks and reports the following for MAI Services:

Funds expended.

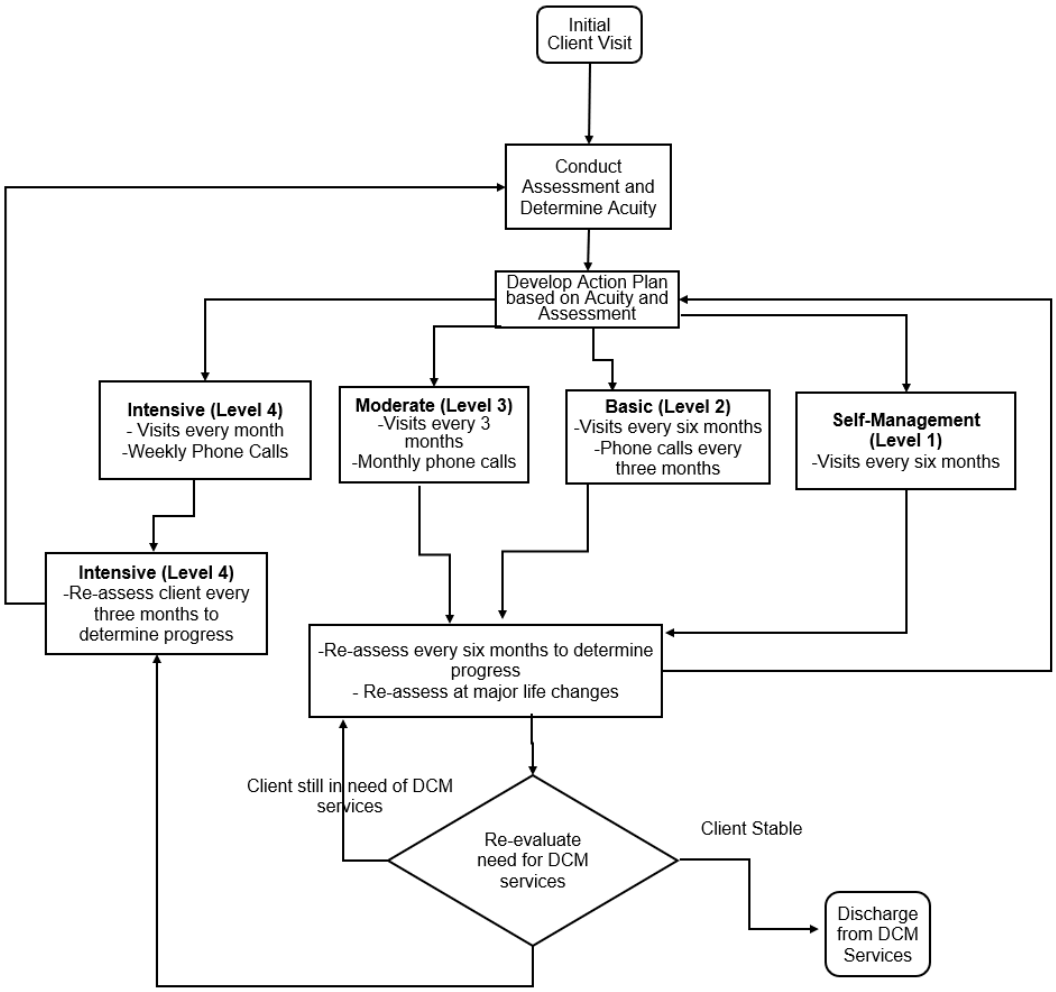
Number of clients served.

Units of service provided overall by race/ethnicity, women, infants, children, and youth.

Client-level outcome within each minority population and/or subpopulation.

VI. Appendix A

The Medical Case Management Assessment Model



HANDOUT F

SDM
Presentation

Presented by Broward County
Ryan White Part A Office

Fiscal Year 2023-2024

Medical Case Management

Non-Medical Case Management

Substance Abuse Outpatient

MAI

- The Minority AIDS Initiative (MAI) was created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. It provides new funding to strengthen organizational capacity and expand HIV-related services in minority communities. This began a new initiative and the culmination of a community-based advocacy campaign that began more than six months earlier in Atlanta, Georgia.

- The MAI's principal goals are to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and reduce HIV-related health disparities.

Racial & Ethnic Group

HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

Race/Ethnicity categories:

- Hispanic or Latino
- White (Non-Hispanic)
- Black or African-American (Non-Hispanic)
- Asian (Non-Hispanic)
- American Indian or Alaska Native (Non-Hispanic)
- Native Hawaiian or Other Pacific Islander (Non-Hispanic)
- Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, the Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds as underrepresented:

- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Hispanic (all races)

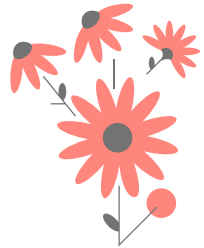
Target Population

- Individuals who are of a racial or ethnic minority group, as defined by the U.S. Department of Health and Human Services (DHHS) and the Health Resources and Services Administration (HRSA).

HRSA Guidelines

- MAI improves access to HIV care and health outcomes for disproportionately affected racial and ethnic minority populations. The MAI was codified in 2006 and provides additional funding under the RWHAP Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

- Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas most affected by HIV/AIDS.



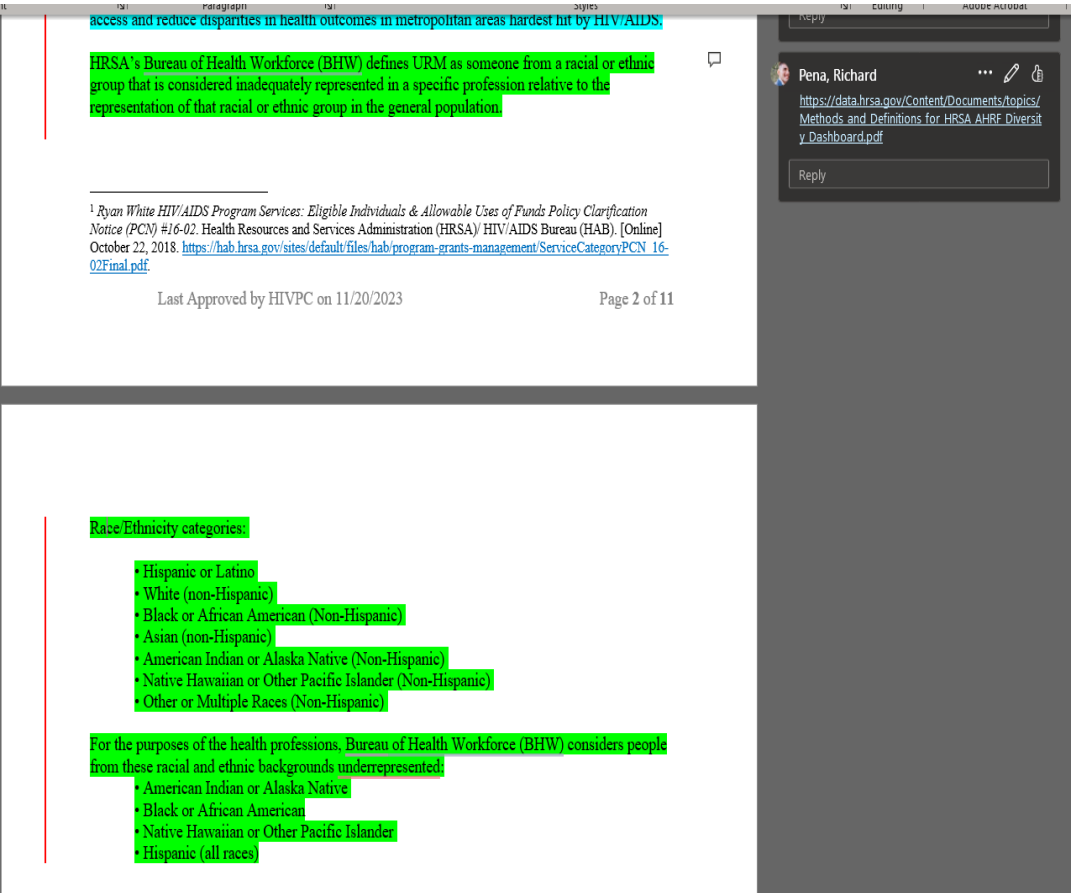
Reporting

- **The language in the HRSA Part A Manual states the MAI Annual Report documents how RWHAP A MAI funds were used during the grant year to reach and serve priority populations, the viral suppression rates of MAI populations, and achieved outcomes.**

SDM Changes

- **The current SDM changes to Medical Case Management, Non-Medical Case Management, and Substance Abuse Outpatient are only additions to language about MAI; please note that the SDM changes for MAI do not subtract any current language in the prior approved SDM.**

SDM Changes



access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

HRSA's Bureau of Health Workforce (BHW) defines URM as someone from a racial or ethnic group that is considered inadequately represented in a specific profession relative to the representation of that racial or ethnic group in the general population.

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

Last Approved by HIVPC on 11/20/2023 Page 2 of 11

Pena, Richard

https://data.hrsa.gov/Content/Documents/topics/Methods and Definitions for HRSA AHRF Diversity Dashboard.pdf

Reply

Race/Ethnicity categories:

- Hispanic or Latino
- White (non-Hispanic)
- Black or African American (Non-Hispanic)
- Asian (non-Hispanic)
- American Indian or Alaska Native (Non-Hispanic)
- Native Hawaiian or Other Pacific Islander (Non-Hispanic)
- Other or Multiple Races (Non-Hispanic)

For the purposes of the health professions, Bureau of Health Workforce (BHW) considers people from these racial and ethnic backgrounds underrepresented:

- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Hispanic (all races)

Addition of Racial and Ethnic group definition as defined by HRSA

SDM Changes

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds the Medical Case Management and provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications stemming from co-morbid chronic disease conditions. MCM includes assessment of client needs, development of a coordinated plan of care, and care coordination. Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments
- Coordinating essential medical and support services and making referrals when indicated
- Providing adherence counseling to treatment regimens and healthcare and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

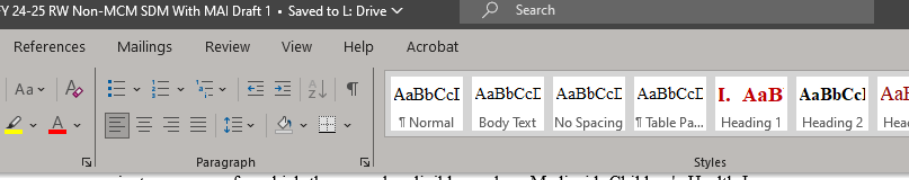
Population of focus for MAI:

- Individuals of a racial or ethnic minority group as defined by the U.S. Department of Health and Human Services (DHHS) & Health Resources and Services Administration (HRSA).

II. Key Service Components and Activities

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

Addition of Local Definition for population of focus.



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

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

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

Local Definition

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

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

SDM Changes

Including the MAI initiative purpose under Part A as defined by HRSA would be feasible. I was unsure where this definition would best be suited for placement.

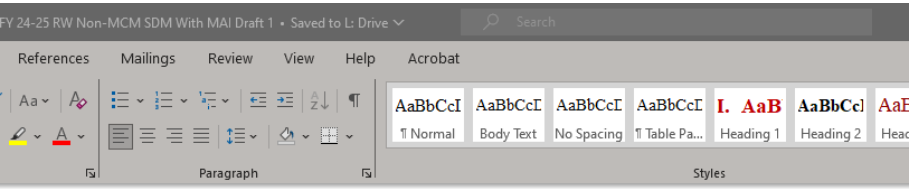
Fulton County EMA includes MAI language in its service delivery models for services that offer MAI and the core service.

https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

Additionally, the Miami-Dade EMA & the Palm Beach EMA use the same format.

https://www.miamidade.gov/grants/library/ryanwhite/service-delivery-section-III-mcm-standards.pdf

https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf



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

II. Key Service Components and Activities

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

All MAI funded programs are expected to adhere by the above service standards.

Peer Counseling

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

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

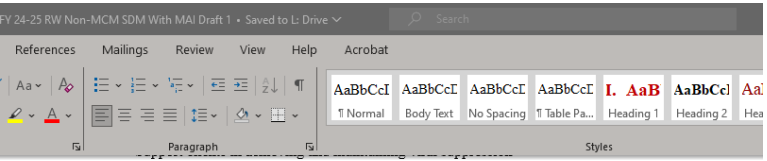
- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression
- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification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

SDM Changes

The Fulton County EMA includes this language to ensure that MAI-funded programs adhere to the Universal SDM and fulfill the MAI's expectations.

https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

SDM Changes



- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals
- Facilitating peer counselor-led client support groups

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

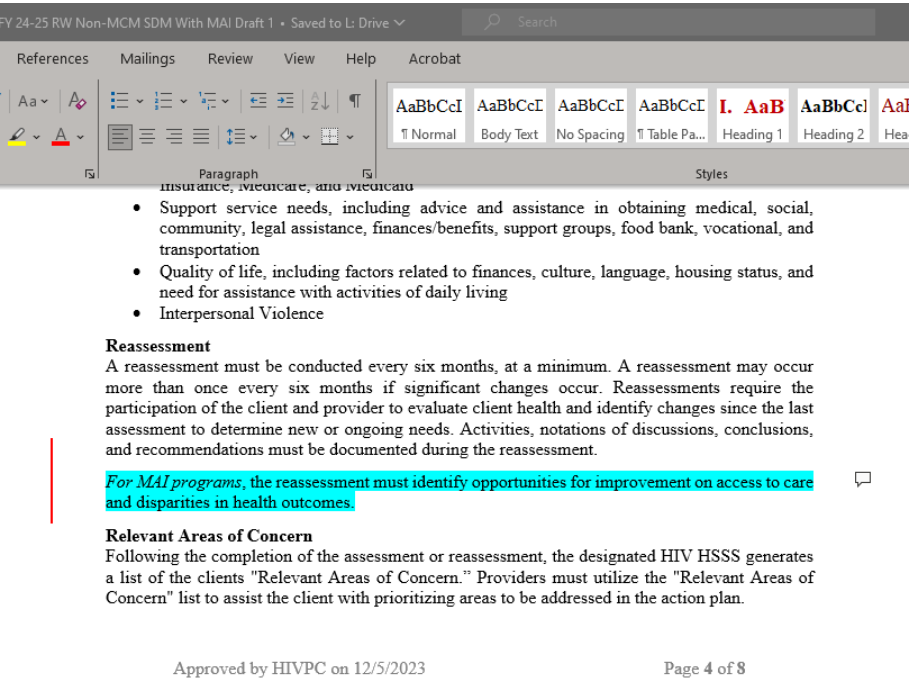
Outcomes	Indicators	Measure
1. Supports access to client retention and care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Human Services Support Services (HSSS). 1.1.2. Data obtained from the MAI Annual Report.
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV HSSS.

According to the HRSA website's official guidelines for MAI programs. The MAI annual report documents how RWHAP A MAI funds were used during the grant year to reach and serve priority populations, the viral suppression rates of MAI populations, and the outcomes achieved.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Please note from the previous links to other EMA SDMs that additional outcomes are not created for MAI-funded programs. It appears that the current outcomes for each service that includes MAI are expanded to include the goals of MAI. Additionally, I found a Henry J. Kaiser Family Foundation resource highlighting possible complications when creating too many restrictions for MAI.

https://www.kff.org/wp-content/uploads/2013/01/minority-aids-initiative-policy-brief.pdf



SDM Changes

According to the HRSA guidelines for MAI programs, Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas most affected by HIV/AIDS.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

For MAI programs, the action plan must address potential barriers to access and reduce disparities in health outcomes.

V. Standards for Service Delivery

findings are used to update the ICP.

For MAI programs, the reassessment must identify opportunities for improvement on access to care and disparities in health outcomes.

Individual Care Plan (ICP)
Providers must develop an ICP within 30 days of completing the initial client visit. MCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The MCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. MCMs

must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

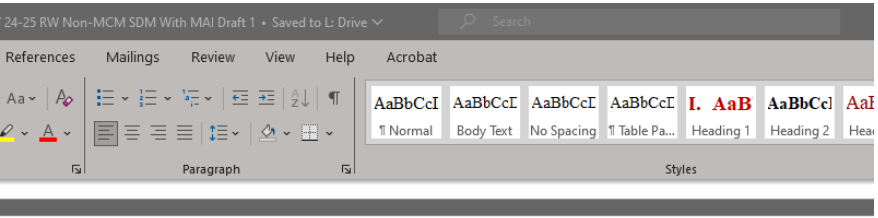
Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV HSSS.

For MAI programs, The ICP must address potential barriers to access and reduce disparities in health outcomes.

V. Standards for Service Delivery

SDM Changes

This Language was included to expand upon Action Plans, Reassessments, & Individual Care Plans to reflect MAI goals.



SDM Changes

Standard	Measure
within three business days of meeting with the client.	
10. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	10.1. Closed cases include documentation stating the reason for closure and a closure summary. 10.2. Supervisor signs off on closure summary indicating approval. 10.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 10.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
11. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	11.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcome within each minority population and/or subpopulation.

- **The Palm Beach EMA includes the National Standards for MAI in their SDM format.**

- **https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf**

Resources

1) Aragón, R., & Kates , J. (2004, June). The minority aids initiative. The Minority AIDS Initiative. https://www.kff.org/wp-content/uploads/2013/01/minority-aids-initiative-policy-brief.pdf

2) Data definitions for HRSA health workforce diversity ... Data Definitions for HRSA Health Workforce Diversity Dashboard. (2017). https://data.hrsa.gov/Content/Documents/topics/Methods_and_Definitions_for_HRSA_AHRF_Diversity_Dashboard.pdf

3) Department for HIV Elimination, Quality Management Staff, & Metropolitan Atlanta HIV Health Services Planning Council, Quality Management Committee The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) provides funding for Ryan White DHE Services in the A. (2024). Ryan White project. Ryan White Project. https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

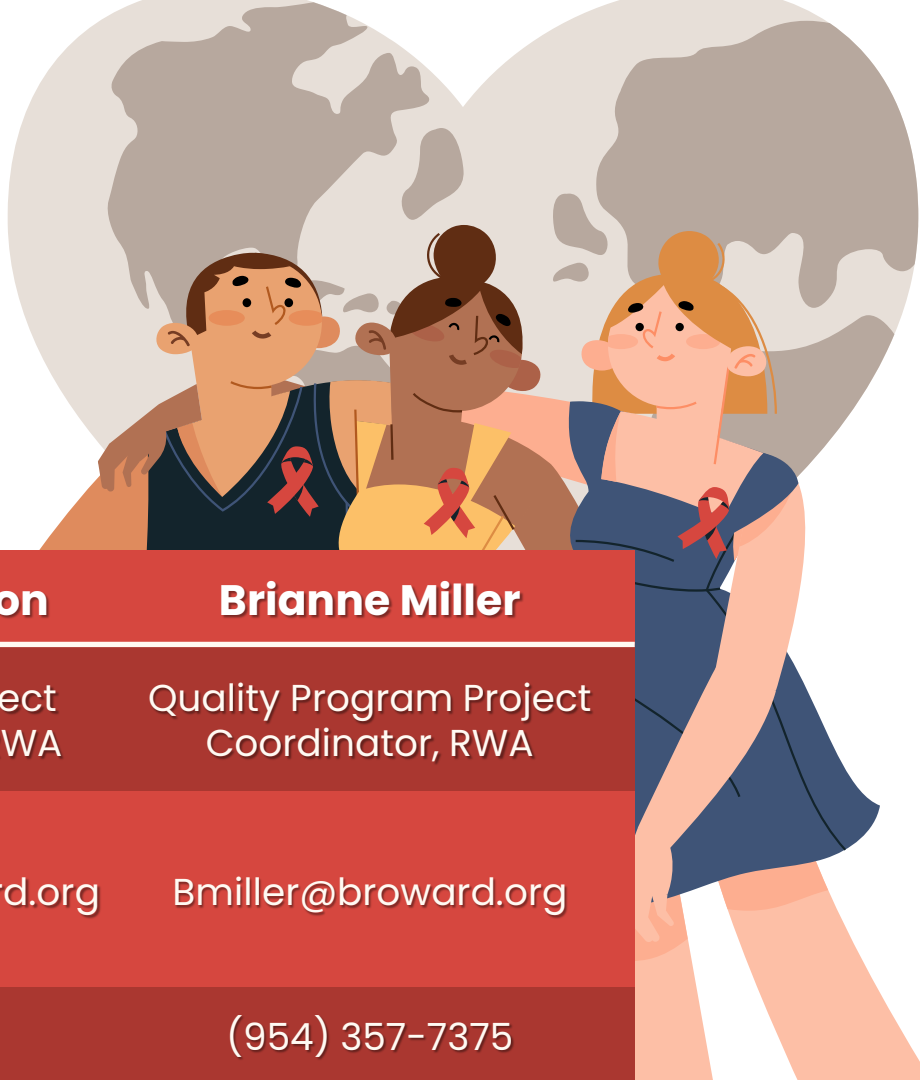
4) Miami Dade County Ryan White Program. (2018, April 30). Medical Case Management (MCM) standards - Miami-Dade ... Miami Dade County Medical Case Management Standards of Service. https://www.miamidade.gov/grants/library/ryanwhite/service-delivery-section-III-mcm-standards.pdf

5) Palm Beach County HIV Elimination Services. (2024, March 1). RYAN WHITE PART A/MAI PROGRAM MANUAL Community Services Department Board of County Commissioners Palm Beach County. Discover Palm Beach County. https://discover.pbcgov.org/carecouncil/PDF/PBC_RWHAP_Manual_GY21.pdf

6) U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau. (2023, March). Part A manual - Ryan White HIV/AIDS Program - HRSA. Ryan White HIV/AIDS Program Part A Manual. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

THANKS!

Do you have any questions?



Richard Pena	Timothy Thompson	Brianne Miller
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(954) 357-5393	(954) 357-7811	(954) 357-7375

HANDOUT G

BROWARD COUNTY FLORIDA

Ryan White Part A

Administrative Update

Notice of Award

- We are projected to receive the final notice of award by mid-May.
- Providers are currently invoicing for FY 24-25.

Service Delivery Models

- We have three SDMs left that will be introduced in May; IPCBH, HICP, & Universal.

- Once the SDMs pass the end of May, the Recipient office will tidy up any outstanding changes & proceed to submit to the RFP process.

Legislative Changes

- HB 0975 – Changes to Background Screenings

I. Effective July 1, 2024, adds 8 offenses to the statutory list of 52 offenses that can disqualify a person from employment in certain regulated professions if he or she has been the subject of certain legal actions regarding such offenses;

II. Effective July 1, 2024, revise the provisions under which an agency head may provide an exemption from a disqualification of employment in certain regulated professions;

III. Requires that effective July 1, 2025, background checks conducted for 24 types of health care practitioners must include fingerprint screening by the Florida Department of Law Enforcement for prospective licensure applicants and practitioners licensed before July 1, 2025, when they renew their licenses after that date. Under prior law, these practitioner types were not required to undergo fingerprint screening before licensure.

Legislative Changes

- HB 1451

I. The bill prohibits a county or municipality from accepting as identification an identification card or document issued by an entity that knowingly issues the card or document to individuals who are not lawfully present in the United States. These identification cards are commonly called community ID cards. The prohibition does not apply to documentation issued by, or on behalf of, the Federal Government.
II. It has not been signed by the governor yet. If signed, it would go into effect on July 1st, 2024.

Questions?

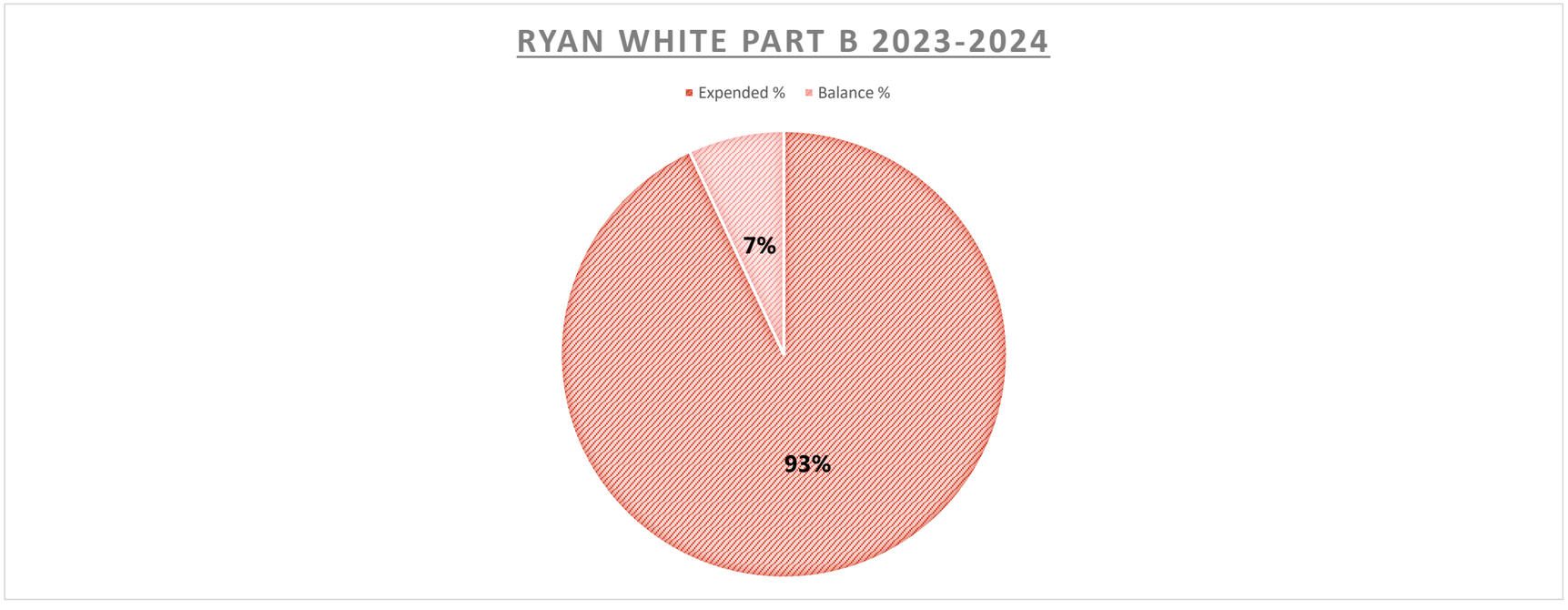
HANDOUT H1

Ryan White Part B

PTC24: April 1, 2023 to March 31, 2024

Expenditures for February 2024

Service Category	Allocation	February 2024	Expended to Date	Expended %	Balance %	Balance
Administrative Services	$ 85,825	$ -	$ 85,825	100%	0%	**$ -**
Health Insurance Premium/Cost Sharing	$ 190,324	$ 18,273	$ 163,370	86%	14%	**$ 26,953.77**
Home & Community Based Health	$ 9,000	$ -	$ 6,440	72%	28%	**$ 2,560.40**
Medical Nutritional Therapy	$ 30,000	$ 2,392	$ 20,823	69%	31%	**$ 9,176.70**
Emergency Financial Assistance	$ 223,520	$ 33,522	$ 221,553	99%	1%	**$ 1,967.38**
Home Delivered Meals	$ 3,000	$ 1,386	$ 2,741	91%	9%	**$ 259.50**
Medical Transportation	$ 95,476	$ 4,900	$ 89,720	94%	6%	**$ 5,755.56**
Non-Medical Case Management	$ 346,770	$ 17,008	$ 343,131	99%	1%	**$ 3,639.04**
Referral for Health Care/Support Services	$ 56,126	$ 18,335	$ 44,540	79%	21%	**$ 11,585.75**
Residential Substance Abuse	$ 62,217	$ 9,900	$ 53,135	85%	15%	**$ 9,082.00**
Clinical Quality Management	$ 58,096	$ 8,461	$ 48,512	84%	16%	**$ 9,584.02**
Planning and Evaluation	$ 1,575	$ -	$ 1,575	100%	0%	**$ 0.35**
TOTALS	**$ 1,161,929**	**$ 114,177**	**$ 1,081,365**	**93%**	**7%**	**$ 80,564.47**



HANDOUT H2

ADAP REPORT March 2024

Enrollment March 2024

Total Enrolled March 2024	5,694
ADAP Enrollments and Re-enrollments processed	826
New Clients	63
Assessments completed using RWPA NOE	124

Viral Suppression March 2024

Total Virally Suppressed at 6 months	4,708
Percentage of Virally Suppressed	93.3%
% Uninsured Virally Suppressed at 6 months	88.75%
% Insured Virally Suppressed at 6 months	96.61%

No Show Report March 2024

No Show Report	32%

HANDOUT I

Ryan White Part D Report

Children's Diagnostic & Treatment Center (CDTC)

Comprehensive Family AIDS Program (CFAP)

- Total # of affected clients provided an HIV RWHAP support service- 1527
- Total Number of HIV Positive Individuals <u>enrolled in Program</u> - **602**
  - Total Number of HIV Exposed – Indeterminate Individuals between the ages of 0 - 24 months old **-63**
  - Total number of HIV Positive Individuals enrolled in Program break down-**Women-553 Children-6 Youth-43**
- HIV positive individuals **<u>enrolled in medical care at CDTC/Outside Provider</u>** – **602**

  (318 CDTC, 284 Outside provider) Over all Viral Suppression 88%
- HIV positive individuals who **<u>attended medical care</u>** as of **<u>1/1/2024- Current Date</u>** - **297**

- <u>New Referrals as of **1/1/2024- Current Date**</u>
  - Infants (HIV exposed) - 3
  - Children (3 – 11) - **0**
  - Adolescent (12 -24) – 0
  - Adult (25 +) - 7
  - **Total** – 10
- Total Pregnancies (previously known and new) – 24 (21 previously known/ 3new)

4/4/2024

HIV HEALTH SERVICES PLANNING COUNCIL
MEETING GROUND RULES

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

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

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

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

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

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

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

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

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

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

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

Revised 7/24/14

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

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

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

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

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

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

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

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

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

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

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

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

Revised 7/24/14

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV
RÈGLEMAN RANKONT-YO

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

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

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

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

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

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

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

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

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

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

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

Acronym List

ACA: The Patient Protection and Affordable Care Act 2010

ADAP: AIDS Drugs Assistance Program

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BISS: Benefit Insurance Support Service

BMSM: Black Men Who Have Sex with Men

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CM: Case Management

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

DCM: Disease Case Management

DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

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

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

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

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SA: Substance Abuse

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

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

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

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

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

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