FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
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Ryan White Part A Minority AIDS Initiative (MAI) Ad-Hoc Committee Meeting

Tuesday, September 10, 2024 - 9:30 – 11:30 AM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

Chair: Mark Schweizer • Vice Chair: Shawn Tinsley

Join the meeting now
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Meeting ID: 249 748 306 813
Passcode: Zvw54u

This meeting is audio and video recorded.

Quorum for this meeting is 4

DRAFT AGENDA

ORDER OF BUSINESS

I. Call to Order/Establishment of Quorum
   a. Welcome from the Chair
   b. Meeting Ground Rules
   c. Statement of Sunshine
   d. Introductions & Abstentions
II. Moment of Silence
III. ACTION: Approval of Agenda for September 10, 2024
IV. Public Comment
V. Discussion Items
   a. Action Item: Define the purpose of the MAI Ad Hoc Committee. **(Handouts A1, A2, A3)**
   b. Action Item: Receive expenditure/utilization report on current MAI services and funding to discuss and approve data request to be sent to the Part A Office. **(Handout B)**
VI. Unfinished Business: None.
VII. New Business: None.
VIII. Recipient Report
IX. Public Comment

X. Agenda Items for Next Meeting

a. TBD

XI. Next Meeting Date: TBD, at 9:30 a.m. Location: BRHPC and via Microsoft Teams Video Conference

XII. Announcements

XIII. 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.

Handout A 1

USING MAI FUNDS EFFECTIVELY: TAILORING SERVICES FOR LOCALLY IDENTIFIED SUBPOPULATIONS

This resource explains the history and goals of the Minority AIDS Initiative (MAI), describes allowable uses of MAI funds, offers sound practices for planning councils allocating MAI funds, identifies challenges, and gives examples of how planning councils have used MAI funds to support responsive, tailored services.

Resource Overview

Goals/Purpose of MAI funding
The Ryan White HIV/AIDS Program's (RWHAP) Minority AIDS Initiative (MAI) provides additional funding under 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 are used to fund core medical and support services that will improve access and reduce disparities in health outcomes for minority populations in metropolitan areas hardest hit by HIV/AIDS.

Populations of focus for MAI-funded services
RWHAP Part A jurisdictions are expected to identify specific minority subpopulations to focus on as they work to strengthen the local HIV service system. Planning councils use local data to identify population-based differences in linkage to care, retention in care, and viral suppression, as well as barriers to access for different groups. In identifying populations of focus, planning councils may go beyond race and ethnicity (e.g., all African Americans or all Latinos) to consider additional characteristics that affect service needs, such as gender/gender identity, sexual orientation, and age.

Types of services that can be supported with MAI funds
RWHAP Part A MAI funds should be used to support "population-tailored services" – specially designed, culturally responsive medical or support services that will improve treatment access and outcomes for the jurisdiction's particular minority subpopulations of focus. In addition, services supported with MAI funding should employ innovative approaches or interventions that address the unique needs of the different subpopulations of focus.

Separate allocation process for MAI funds
In priority setting and resource allocation (PSRA), planning councils are expected to separately allocate RWHAP Part A and MAI funds, and to report separately on priorities, allocations, expenditures, and number of clients served. A separate allocation process helps to ensure that MAI funds are used to implement tailored services or new service models that will improve access and treatment outcomes for the jurisdiction's identified subpopulations of focus.

Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations

Introduction

The Minority AIDS Initiative (MAI) provides funding through agencies within the Department of Health and Human Services (HHS) to reduce disparities in HIV access, treatment, care, and outcomes for racial and ethnic minorities. Under Part A of the Ryan White HIV/AIDS Program (RWHAP), the HIV/AIDS Bureau expects MAI funds to be used to support culturally-responsive core medical and related support services designed to address the unique barriers and challenges faced by disproportionately impacted racial and ethnic minority subpopulations as identified by each jurisdiction. It is not sufficient for MAI funds to be used to pay for services to racial and ethnic minorities. These services should be "population-tailored" so that they contribute to positive treatment outcomes, including increased levels of sustained viral suppression among subpopulations of focus.

This resource summarizes the history and purpose of MAI and then focuses on use of MAI funds under RWHAP Part A. It explains the continuing need for MAI, describes expectations for use of MAI funds, provides examples of MAI projects, identifies challenges, and describes the MAI-related roles of RWHAP Part A planning councils/planning bodies (PC/PBs). It is designed to help PC/PBs ensure that such funds improve HIV treatment outcomes and reduce HIV-related health disparities for racial and ethnic minorities.

History

In March of 1998, the Centers for Disease Control and Prevention (CDC) brought together a group of African American community leaders and service providers for a briefing that presented new surveillance data showing the extremely high and disproportionate rates of HIV infection among African Americans. The data led the leaders to declare a "state of emergency" in the African American community regarding HIV. They called upon the federal government to declare a public health state of emergency. Both the Congressional Black Caucus (CBC) and the President's Advisory Council on HIV/AIDS (PACHA) endorsed this action. In October 1998, President Bill Clinton described HIV as a "severe and ongoing health care crisis" in racial and ethnic minority communities and announced a new initiative to address it. Initially known as the CBC Initiative, it received FY 1999 funding of about $165 million, including newly appropriated and reprogrammed funds. The name later became the Minority AIDS Initiative (MAI) to reflect a broader focus on racial and ethnic minority communities, including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders.[1]

Congressional intent for use of MAI funds was specified in FY 2002:

> These funds are for activities that are designed to address the trends of the HIV/AIDS epidemic in communities of color based on the most recent estimated living AIDS cases, HIV infections and AIDS mortality among ethnic and racial minorities as reported by the Centers for Disease Control and Prevention.[2]

MAI implementation is decentralized, with funds going to various parts of the Department of Health and Human Services (HHS), including the Health Resources and Services Administration (HRSA), CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the Secretary. By FY 2004, MAI funds totaled about $400 million and were supporting over 50 separate projects in prevention, care and treatment, and research. Total MAI funding across the four agencies totaled about $416 million in FY 2011.

The MAI program within the RWHAP was codified in Section 2693 of the 2006 reauthorization: "to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities."[3] The 2009 reauthorization called for synchronization of the schedules for MAI and the applications for each Part. MAI is a component of Part F, with funds allocated to each grant recipient on a formula basis. To receive an MAI grant, an entity must have received a grant under the relevant RWHAP Part. In FY 2021, MAI funding under Part A totaled almost $51.7 million.

Strategies and uses of MAI funds have changed over the years. For example, MAI was restructured in 2010, with the release of the National HIV/AIDS Strategy (NHAS). The intent remains unchanged: to reduce HIV-related disparities and improve outcomes for disproportionately impacted racial and ethnic minorities.

Allowable Uses of MAI Funds under RWHAP

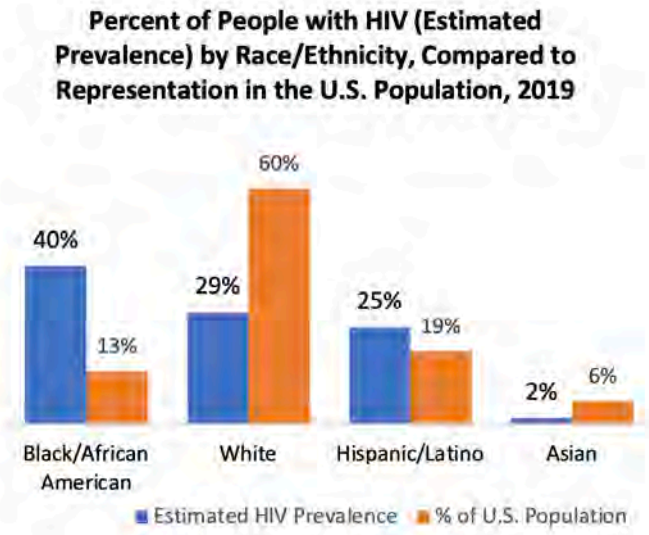
Several HHS agencies receive MAI funding, and each agency and each RWHAP Part uses funds differently. Use of funds under each RWHAP Part is summarized below. Expectations for other agencies are provided in Attachment A and may help PC/PBs in developing resource inventories covering other funding streams.

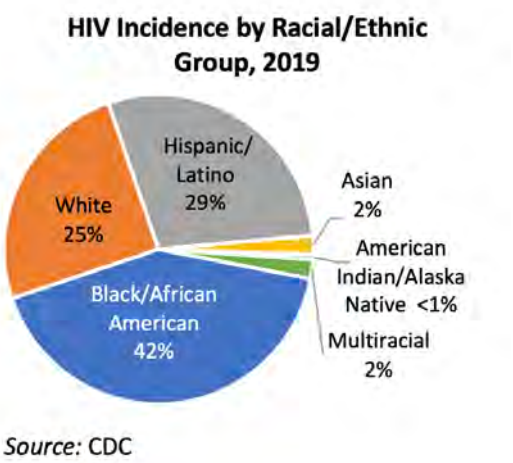
MAI funding under RWHAP is legislatively authorized, and the HIV/AIDS Bureau has specified allowable uses by Part: [4]

- **Part A:** for "core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS."
- **Part B:** to "fund outreach and education services designed to increase minority access to needed HIV/AIDS medications," including the AIDS Drug Assistance Program (ADAP). Part B recipients receive MAI funding only if they choose to request it and provide the required narrative in their application.
- **Part C:** for "the provision of culturally and linguistically appropriate care for racial and ethnic minority populations."
- **Part D:** for "eliminating racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care services for women, infants, children, and youth."
- **Part F:** for "increasing the training capacity of AIDS Education and Training Centers to expand the number of health care professionals with treatment expertise and knowledge about the most appropriate standards of HIV-related treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV."

Continuing Need

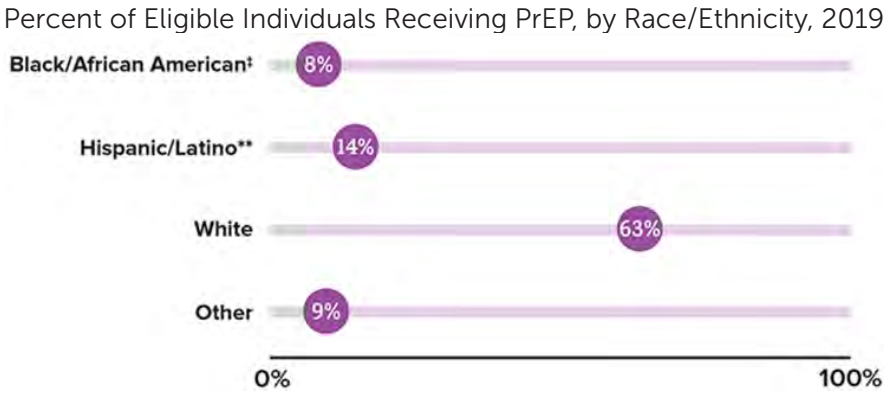
CDC data show that HIV-related racial and ethnic disparities remain – in new diagnoses, access to care including medications, viral suppression, and deaths. Three-fourths of new HIV diagnoses in the U.S. in 2018 and in 2019 were among racial and ethnic minorities. African Americans and Latinos together accounted for more than 70% -- 42% were African American and 29% Latino.[5]





In 2019, rates of HIV infection were 8.1 times as high among African Americans, 3.6 times as high among Hispanics/Latinos, and 1.9 times as high among American Indians/Alaska Natives as among White non-Hispanics.[6]

Contributing to the rate of new infections, racial and ethnic minorities are less likely than White Americans to use Pre-Exposure Prophylaxis (PrEP). As the figure below shows, while nearly two-thirds of eligible White Americans receive PrEP, the proportion is under 15% for racial and ethnic minorities.[7]



New HIV infections declined by 8% overall between 2015 and 2019, but there was no decline among African Americans. They are still less likely than White Americans to be virally suppressed within six months of diagnosis or to have sustained viral suppression. Death rates are falling for all groups but remain highest among African Americans, who accounted for 43% of HIV-related deaths in 2019.[8]

MAI under RWHAP Part A

Applications and Funding

The amount of MAI funding awarded each RWHAP Part A jurisdiction is calculated annually based on "the number of people with HIV and AIDS who are minorities in a jurisdiction"[9] and their proportion of all minorities with HIV in Part A service areas. In the FY 2022 RWHAP Part A Notice of Funding Opportunity (NOFO), MAI allocations by jurisdiction ranged from about $150,000 to $8.6 million. Jurisdictions are expected to separately allocate RWHAP Part A and Part A MAI funds, and to report separately on priorities, allocations, expenditures, and number of unduplicated clients served with MAI funds.

Applicants prepare an MAI narrative as part of the RWHAP Part A application. Focusing on identified "minority subpopulations of focus" (groups that are "disproportionately affected by HIV, as a result of specific needs"), applicants describe "how MAI services will be implemented to address the needs" of each identified subpopulation of focus, and how the planned MAI services "may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities" among those subpopulations.[10]

HIV/AIDS Bureau Expectations

All RWHAP Part A funds serve racial and ethnic minority subpopulations, who are a majority of RWHAP clients – 73.6% in 2020.[11] Part A MAI funds should support "population-tailored services" – specially designed, culturally appropriate services that improve treatment access and outcomes for the jurisdiction's particular minority populations of focus. As stated in the FY 2022 RWHAP Part A NOFO:

> "MAI funds must be used to deliver ***services designed to address the unique barriers and challenges faced by hard-to-reach, disproportionately impacted individuals*** within the EMA/TGA"(Eligible Metropolitan Area/Transitional Grant Area) [Emphasis added] [p 21]

> "MAI services must be consistent with the epidemiologic data and the identified need, and be ***culturally appropriate***. Furthermore, effective MAI service provision should ***employ the use of population-tailored, innovative approaches or interventions*** by specifically addressing the unique needs of MAI subpopulations most disproportionately impacted by HIV. Similar to the other components of RWHAP Part A, the goal of the MAI is ***viral suppression*** among ***identified minority subpopulations***. [Emphasis added] [p 23]

RWHAP Part A jurisdictions are expected to identify specific minority subpopulations to focus on. They can design MAI services for both broadly and narrowly defined subpopulations. Recent RWHAP Part A NOFOs have asked applicants to identify three subpopulations of focus in the Demonstrated Need section, and these are typically, though not always, the populations of focus for MAI. One large EMA simply notes "Blacks and Hispanics." Another has identified the following subpopulations: MSM of color aged 18-29, MSM of color aged 30 and older, and transgender women of color. Following are some other examples of groups identified for MAI services: African immigrants, Asian Americans, recently diagnosed Latinos, Black women of childbearing age, transgender Latinas, African American women living in outlying counties, immigrants who have dropped out of care, and African American men over age 55. The choices typically reflect the local epidemic, needs assessment findings, HIV care continuum data, and client outcomes data.

Inappropriate Use of MAI Funds under RWHAP Part A

Some Part A jurisdictions have used Part A MAI funds to support any core medical-related and support services delivered to people with HIV who are racial or ethnic minorities. For example, one TGA described how it used to put funds into service categories based on overall need, and direct providers to charge racial and ethnic minority clients receiving those services to MAI instead of regular Part A. This approach is not considered acceptable, since it does not involve designing or refining services to meet subpopulation needs.

Examples of MAI Activities in RWHAP Part A EMAs/TGAs

Following are examples of strategies and activities supported with RWHAP Part A MAI funds. Many involve use of peers – people from similar backgrounds to the individuals they serve, often people with HIV who have direct lived experience with the local system of HIV care – and/or other provider staff of the same racial/ethnic background as the subpopulations of focus.

- ***Tailored Early Intervention Services (EIS).*** MAI funds have been used to implement a variety of EIS models. For example:
  - One jurisdiction hired personnel from its subpopulations of focus to work with testing sites, linking individuals with a new HIV diagnosis to care and providing support for the first 3-6 months following linkage. They help ensure that these individuals feel fully connected to their medical provider and know how to request other services when needed.
  - Another used peers to locate people with HIV who had been diagnosed at least six months before but were not in care, and linked or re-linked them to services, accompanying them to the first few medical, case management, and other HIV-related appointments.

- ***Specialized case management.*** Jurisdictions have tailored case management models and strategies for specific racial and ethnic subpopulations. Some examples:
  - A TGA initiated strength-based Case Management for African American women.
  - Several jurisdictions added peers as "case management assistants" who provide navigation and treatment adherence services for clients who need extra support either long- or short-term.
  - Another jurisdiction assigned bilingual non-medical case managers to Spanish-dominant Latinos, with a focus on helping clients obtain the full range of needed services, apply for entitlements or other financial assistance, and identify non-RWHAP services to address other aspects of their lives that affect treatment outcomes, such as job training and placement.
- ***Culturally competent navigation services.*** Navigators, often linked to case managers and matched to subpopulations of focus in race/ethnicity, gender/gender identity, sexual orientation, and/or age, support linkage to care, retention and treatment adherence, and re-engagement in care. Services are intensive but time limited.

- ***Clusters of coordinated services.*** Sometimes MAI funds support a group of linked and coordinated services for the same group of clients. For example, one jurisdiction has used MAI funds to support a cluster of linked and coordinated core medical-related and support services designed to meet the needs of Latino and African immigrants.

MAI funds support a combination of outpatient ambulatory health services, medical case management, mental health services, medical transportation, outreach services, psychosocial support services, and linguistic services that support interpreters where providers are unable to hire bilingual staff.

- ***Services to address social determinants.*** MAI funds can be used for support services that address various social determinants of health and contribute to HIV-related disparities. For example, one jurisdiction's needs assessment highlighted racially-based disparities in housing and access to non-medical services, from childcare to nutritional support. To respond, it allocated MAI funds to housing and to non-medical case management, to help clients access needed services beyond HIV care.

PC/PB MAI-related Roles

Part A planning councils/planning bodies (PC/PBs) have many roles related to MAI. For example:

- ***Needs assessment:*** Epidemiologic and HIV care continuum data can identify population-based differences in linkage to care, retention in care, adherence to treatments, and viral suppression. Surveys, focus groups, or special needs assessment studies can collect and analyze data about service barriers by race and ethnicity, and identify disproportionately affected subpopulations. This can be a multi-step process, as described in the box.

Using Needs Assessment in MAI Planning

Step 1: Survey people with HIV, asking about their experience with services and barriers to care, and collecting demographic data; if possible, use trained peers to maximize response rates and obtain frank responses.

Step 2: Analyze findings by race/ethnicity and identify racial and ethnic populations with the greatest barriers to care.

Step 3: Do additional analyses of the same survey data by subpopulations defined by multiple characteristics, including race/ethnicity, age, gender, sexual orientation, and/or other locally-defined factors – for example, African American MSM under 30; limited-English-proficient Latinx immigrants; recently incarcerated African American men; African American women experiencing homelessness. Determine which subpopulations appear to face the greatest barriers and HIV-related disparities.

Step 4: The following year, do specialized needs assessment – e.g., focus groups, analysis of service utilization data, review of Clinical Quality Management data -- that looks at these identified subpopulations, to better understand barriers they face and strategies that can help overcome them.

Step 5: Use this information to inform MAI priority setting and resource allocation.

- ***Integrated planning:*** Integrated HIV prevention and care planning provides an opportunity to document the need for improving viral suppression or other service outcomes for particular racial/ethnic subpopulations, and to lay out objectives and tasks for refining services to address those subpopulation-specific needs.

- ***Care strategies:*** The PC/PB can work with the recipient to identify or refine service strategies or develop innovative service models to help overcome barriers to care and improve treatment outcomes for identified racial/ethnic subpopulations.

- ***Priority setting and resource allocation (PSRA):*** PC/PBs are responsible for setting service priorities and allocating resources, including MAI funds, to prioritized service categories. The expectation is for separately allocating Part A and Part A MAI funds to serve subpopulations of focus and implement tailored services or new service models that the data indicate are most needed to improve their treatment outcomes.

- ***Directives:*** As a part of PSRA, PC/PBs can provide directives to the recipient on how best to meet each priority. Once a new service model or strategy is identified or developed, a directive may call for testing it with a specific subpopulation. The recipient then uses the directive in contracting for services. The box below provides an example of such a process.

Using Allocations and Directives to Improve Subpopulation Treatment Outcomes

Available data show that Latinas with HIV in your jurisdiction have high rates of viral suppression when retained in care but are less likely than other subpopulations to be linked to care promptly after diagnosis and much more likely to drop out of care in the first few months after linkage. A special study including focus groups found that this subpopulation includes many recent immigrants with limited English proficiency and identified two key problems: (1) current EIS staff do not speak Spanish; and (2) none of the current medical providers focus on women, and the only one with Spanish-speaking medical personnel is overbooked and has not been accepting new patients for almost two years. The PC/PB and recipient agree on the need for tailored services and cost out some options. The PC/PB allocates MAI funds to EIS, OAHS, and Language Services, and adopts two directives. One calls for a coordinated pilot project including a Latina-focused, peer-based EIS project to link newly diagnosed and out-of-care Latinas to care and provide support for up to six months and support more Spanish-speaking medical personnel. The second requires all medical providers without bilingual staff to use trained interpreter/navigators. The recipient uses the model, allocations, and directives in putting out a Request for Proposals (RFP) to implement the new model. The recipient also redesigns Language Services under MAI to involve trained interpreter/navigators. Careful monitoring and evaluation of linkage, retention in care, and viral suppression data are planned, as well as a Spanish-language client satisfaction study for Latinas.

Challenges in Using MAI Funds Effectively

PC/PBs have identified a number of challenges in developing and implementing MAI projects that can demonstrate success. They include the following:

- ***Amount of MAI funding.*** MAI funding for Part A jurisdictions for FY 2021 ranged from about $146,000 to $8.6 million. The median amount was about $554,000, but seven

jurisdictions received less than $300,000, and nine others less than $400,000. Smaller allocations make it harder for PC/PBs to support potentially effective strategies for multiple minority subpopulations. Some smaller jurisdictions may need to focus on one or two disproportionately impacted subpopulations.

- ***Demonstrating increased viral suppression.*** Jurisdictions are expected to demonstrate that MAI funds are contributing to improved health outcomes, with a focus on viral suppression. This can be challenging with some strategies. For example, an MAI EIS project that focuses on getting people into care – and hands them off to case managers after the first few medical visits – may find it hard to demonstrate increased viral suppression for the clients served by that initiative. It may, however, be able to demonstrate that clients from that subpopulation have high rates of viral suppression if they are retained in care, and to show that their model increases retention in care.

- ***Lack of PC/PB familiarity with MAI expectations.*** Jurisdictions, including their PC/PBs, vary in their knowledge of the history and development of MAI and its intended use to help address HIV-related disparities. They may need a better understanding of HIV/AIDS Bureau expectations and assistance in establishing processes to meet these expectations through a combination of priority setting, resource allocation, directives, and service design.

- ***Knowledge and experience in designing tailored projects.*** Some jurisdictions have been providing subpopulation-tailored services for many years. Others have far less experience in designing services for specific groups – or may need to focus on a different subpopulation due to changing epidemiologic trends. Review of completed Special Projects of National Significance (SPNS) initiatives can help increase PC/PB familiarity with models and strategies that have been effective with specific subpopulations.

- ***Staffing.*** Racial and ethnic minority staff play an extremely important role in providing culturally and linguistically appropriate services. Some PC/PBs have used directives to encourage hiring of staff from disproportionately impacted subpopulations, but providers may find that a variety of factors – such as limits on salaries and benefits combined with challenging jobs – make it hard to compete successfully for minority social workers, mental health counselors, and other professional staff. Providers in one TGA said that young professionals often stay only a year or two, then use their experience to move on to higher-paid, less-demanding positions.

- ***Providers.*** In the early days of MAI, a key focus was providing capacity-building services to enable minority-focused providers with strong program skills but limited federal funding experience to compete for MAI funds and meet federal subrecipient management requirements. This has become less common. Many jurisdictions have been funding the same group of providers for a long time. PC/PBs can use directives to encourage efforts to broaden the provider network, and recipients can encourage new applicants. However, the number of minority-focused providers varies considerably by jurisdiction. EHE funding has encouraged community health center engagement, and some jurisdictions have used EHE funds to support additional providers and try new approaches.

Sound Practices for PC/PBs in Using MAI Funds

- ***Understand MAI purposes and HIV/AIDS Bureau expectations.*** This requires including MAI in new member orientation and/or as a topic for a mini-training session during a PC/PB meeting. The appropriate PC/PB committee should receive and review any new guidance or clarifications provided to the recipient, including findings from a comprehensive site visit or changes in the Notice of Funding Opportunity NOFO) instructions for preparing the MAI narrative in the Part A application. Many PC/PBs provide refresher sessions at the beginning of the PSRA process; MAI should be a part of such discussions.

- ***Regularly collect, receive, and review MAI-relevant data.*** This includes analyzing and reviewing available epi, client utilization, outcomes, and needs assessment data (usually provided by the recipient) by race and ethnicity, with special attention to HIV care continuum data for Part A clients. The PC/PB should work with the recipient to identify subpopulations that have lower rates of viral suppression, as well as longer delays between testing and linkage to care, lower retention rates or less frequent doctor visits, and lower rates of adherence to medications, using a combination of quantitative and qualitative data.

- ***Participate in discussions about the jurisdiction's subpopulations of focus.*** The needs assessment section of the Part A application typically asks each EMA or TGA to identify three disproportionately affected subpopulations of focus, based on local data. In identifying these subpopulations, it is usually best to go beyond race and ethnicity (e.g., all African Americans or all Latinos) to consider additional characteristics that affect service needs, such as gender/gender identity, sexual orientation, and age. Local data may indicate that other characteristics may also be important. For example, the jurisdiction may have a large subpopulation of people with HIV who are immigrants that speak primarily a language other than English (like Spanish) or come from a particular country (like Haiti). In a jurisdiction that includes urban, suburban, and rural areas, place of residence within the EMA or TGA may be important. A jurisdiction may identify subpopulations based on multiple characteristics, like young African American MSM aged 13-34, transgender Latinas, Haitian immigrants with limited English proficiency, recently incarcerated African American men, or Latinas living in the outlying counties.

- ***Engage people from your subpopulations of focus in developing service models.*** In addition to PC/PB members, input to design of MAI service strategies can be obtained through "roundtables" that focus on particular subpopulations, task forces or work groups, and community listening sessions. For example, one PC/PB obtained specific service model recommendations from an African American Task Force of people with lived experience. Another held listening sessions with disproportionately impacted subpopulations (e.g., Latino immigrants and aging/older African American adults with HIV) as a basis for service design or redesign.

- ***Have a process in place to guide the allocation of MAI funds.*** MAI allocations should be done separately from other Part A allocations, and with some different considerations. Since non-MAI Part A funds already support many people of color with HIV, MAI funds can be focused on a limited number of service categories that require special strategies

to better serve a specific subpopulation. Often the appropriate PC/PB committee (e.g., Care Strategy) works closely with the recipient to ensure the availability of information needed to make such decisions. For example, the PC/PB's process may call for identifying service categories that need to be tailored to better serve identified subpopulations. This may require allocations to more than one service category (for example, EIS and medical case management to improve linkage and retention, or non-medical case management and housing to address homelessness and food insecurity); development of directives; and consultation with the recipient to estimate the cost for implementing a new or refined service model. Having a clearly defined process helps ensure an efficient, data-driven process.

- ***Ask for and review progress and outcomes data on MAI services.*** MAI requires evaluation of outcomes. Regular – perhaps twice annual – review and discussion of such data enable the PC/PB to consider what service categories and strategies should continue to receive support and whether refinements or new models are needed.

- ***Maintain ongoing collaboration with the recipient.*** The PC/PB and recipient share responsibility for establishing and maintaining a comprehensive, culturally appropriate system of care and for the many tasks to accomplish that. For example, the PC/PB is responsible for PSRA including directives; the recipient contracts for services. Year-round cooperation on MAI-related tasks – e.g., sharing of epi and client data, discussion of service needs and barriers for specific subpopulations, review of Quality Management findings, agreement on strategies to refine and improve viral suppression -- is necessary for maintaining a system of care that meets the needs of all people with HIV, including disproportionately impacted racial and ethnic minorities.

Putting It All Together: A Comprehensive Scenario

The scenario that follows describes a process that can be used by a PC/PB for identifying a subpopulation in need of MAI funds, learning more about their needs and service barriers, and working with the recipient to design, implement, and evaluate an appropriate strategy or service model.

Tailoring Services to Improve Subpopulation Treatment Outcomes

Two years ago, an analysis of HIV care continuum data by subpopulation showed that young African American MSM aged 13-29 in your jurisdiction had the lowest rate of viral suppression among identified subgroups. Overall, 67% of people diagnosed with HIV had achieved viral suppression, compared with 57% of young African American men. To better understand the situation, the PC/PB and recipient analyzed RWHAP Part A client data on viral suppression and found that overall viral suppression among clients was much higher at 88%, but the rate for African American MSM aged 13-29 was 79%. Further analysis of service utilization and Clinical Quality Management (CQM) data found that members of this subpopulation were also less likely to see a medical provider regularly or to adhere to prescribed medications. Young African American MSM were noted as a subpopulation of

focus in the Part A application that year.
Last year, your PC/PB did a survey of people with HIV as part of its needs assessment and analyzed the data by race/ethnicity, risk factor, gender, and age. The survey explored barriers to care and found that young African American MSM were especially likely to report unstable housing, incomes below the poverty level, frequent periods of unemployment, and lack of health insurance.

A special study as part of the needs assessment this past winter, including focus groups with young African American MSM and with key informants (several of them peers) who work with this subpopulation, confirmed these findings and identified some issues with the local system of care. They included the following: few African American medical personnel or case managers, some provider facilities where these clients didn't feel comfortable due to their age and race, and not enough use of peers with similar life experiences. Those living outside the central city found it especially difficult to access culturally appropriate care, with the only medical provider facility nearby described as "not welcoming." Getting into town to another provider was challenging given the distance and the lack of evening and weekend hours. Many clients were unaware that they could receive transportation assistance for medical appointments.

Based on the available data, the PC/PB asked the Care Strategy Committee to work with the recipient to identify service strategies to improve retention in care and viral suppression in this subpopulation, develop a directive if needed, and provide advice on resource allocations.

The Committee held a roundtable with people from the focus subpopulation and several provider staff to discuss how to address the identified barriers, and also explored approaches used in other jurisdictions for improving treatment adherence and viral suppression. They identified an EMA and a TGA that reported improved outcomes through a combination of tailored medical services from providers that have African American and relatively young staff, along with the use of peer navigators/case management assistants who help ensure that new clients are aware of available medical and support services and assist them for about six months by providing information, referrals, and adherence counseling. The Committee and recipient studied and refined the model and estimated the cost of implementation. The Committee drafted a directive calling for testing the model by at least one medical provider that would either provide case management directly or work with a medical case management provider able to use peer navigator assistants.

To support the model, the PC/PB allocated MAI funds to OAHS and medical case management and approved the directive. The recipient used the model, allocations, and directive in putting out a Request for Proposals (RFP), and eventually selected two providers to implement the model, one in the central city, the other in an outlying county. Careful monitoring and evaluation of service utilization, retention in care, viral suppression, and client satisfaction were arranged.

Attachment A:
Uses of Minority AIDS Initiative Funds by Agencies Other than the HRSA HIV/AIDS Bureau

SAMHSA: MAI funds are used for activities including:

- Service Integration to "help reduce the co-occurring epidemics of HIV, Hepatitis, and mental health disorders through accessible, evidence-based, culturally appropriate mental and co-occurring disorder treatment that is integrated with HIV primary care and prevention services" and focuses on racial and ethnic minorities living with or at risk for HIV and/or hepatitis.[12]
- Substance Use Disorder Treatment to "increase engagement in care for racial and ethnic underrepresented individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for, or are living with, HIV/AIDS and receive HIV/AIDS services/treatment."[13]

CDC: MAI funds support various prevention activities tailored to specific racial and ethnic groups, and for the Minority HIV/AIDS Research Initiative (MARI), which helps to build capacity for HIV epidemiologic and prevention research among mostly African American and Hispanic/Latino communities and investigators.[14]

Office of the Secretary: Managed by the Office of Infectious Disease Policy (OIDP) as what is now the Minority HIV/AIDS Fund, resources are used to improve "prevention, care, and treatment for racial and ethnic minorities across federal programs through innovation, systems change, and strategic partnerships and collaboration,"[15] and to "reduce HIV-related disparities among racial/ethnic minority populations."[16] Funds are distributed to up to 10 other HHS agencies, which award the grants. Projects are aligned with National HIV/AIDS Strategy (NHAS) priorities, including cross-agency collaboration. Some Minority HIV/AIDS Fund resources help support Ending the HIV Epidemic (EHE).

Other HHS agencies: Some MAI funds from the Minority HIV/AIDS Fund are provided to other HHS agencies.

References

[1] Regina Aragon and Jennifer Kates, "The Minority AIDS Initiative," Policy Brief, Kaiser Family Foundation, June 2004; https://www.kff.org/racial-equity-and-health-policy/issue-brief/policy-brief-minority-aids-initiative/

[2] FY 2002 Labor and Health and Human Services, and Education appropriations report language for the MAI; quoted in Aragon and Kates, *Ibid.*

[3] Section 2693(b)(2)(A) of the Public Health Service Act.

[4] HRSA Ryan White HIV/AIDS Program, About the Program, Program Parts & Initiatives, Part F: Minority AIDS Initiative, at https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-minority-aids-initiative.

[5] CDC, "HIV in the United States by Race/Ethnicity: HIV Diagnoses," 2019 data, https://www.cdc.gov/hiv/group/racialethnic/other-races/diagnoses.html.

[6] HIV.gov, What Is the Impact of HIV on Racial and Ethnic Minorities in the U.S.?" 2019 data, accessed from website October 2022, https://www.hiv.gov/hiv-basics/overview/data-and-trends/impact-on-racial-and-ethnic-minorities.

[7] CDC, "HIV In the United States by Race/Ethnicity: PrEP Coverage," accessed from website October 2022, https://www.cdc.gov/hiv/group/racialethnic/other-races/prep-coverage.html.

[8] KFF, "The HIV/AIDS Epidemic in the United States: The Basics," https://www.kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states-the-basics, based on data from Centers for Disease Control and Prevention, *HIV Surveillance Report, 2019*; vol.32, May 2021; http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

[9] Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program Notice of Funding Opportunity, Fiscal Year 2022, p 8; see https://www.hrsa.gov/grants/find-funding/HRSA-22-018.

[10] *Ibid,* p 24.

[11] HRSA, "Clients Served by the Ryan White HIV/AIDS Program 2020: Overview 2020," released December 2021; https://ryanwhite.hrsa.gov/data/reports.

[12] See, for example, SAMHSA Notice of Funding Opportunity No. SM-22-005, Minority AIDS Initiative – Service Integration, announced February 24, 2022; https://www.samhsa.gov/grants/grant-announcements/sm-22-005.

[13] See, for example, SAMHSA Notice of Funding Opportunity No. TI-22-004, Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS, announced February 28, 2022; https://www.samhsa.gov/grants/grant-announcements/ti-22-004.

[14] "What CDC is Doing," CDC website; https://www.cdc.gov/hiv/group/racialethnic/other-races/cdc-efforts.html.

[15] "Minority HIV/AIDS Fund Activities," HIV.gov; https://www.hiv.gov/federal-response/smaif/current-activities.

[16] Ronald O. Valdiserri and Timothy P. Harrison, "The Evolution of the Secretary's Minority AIDS Initiative Fund: The US Department of Health and Human Services Responds to the National HIV/AIDS Strategy," *Public Health Report: 2018 Nov-Dec: 133*(2 Suppl): 3S-5S; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6262522/

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Handout A2

MEETING AGENDA

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

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

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

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

Goal/Work Plan Objective #:	*Accomplishments*

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

PLEASE COMPLETE YOUR MEETING EVALUATIONS

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

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

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MEETING MINUTES

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

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

1. CALL TO ORDER:

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

2. APPROVALS:

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

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

3. STANDARD COMMITTEE ITEMS:

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

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

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

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

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

4. UNFINISHED BUSINESS:

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

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

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

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

5. NEW BUSINESS

a. MAI –

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

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

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

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

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

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

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

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

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

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

6. GRANTEE REPORT

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

7. PUBLIC COMMENT

None

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

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

9. ANNOUNCEMENTS

None.

10. ADJOURNMENT

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

PSRA Attendance CY 2016

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

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

Legend:

X - present

A - absent

E - excused

NQA - no quorum absent

NQX - no quorum present

N - newly appointed

Z - removed

C - cancelled

W - warning letter

R - removal letter

TARGET POPULATION FOR BROWARD MAI PROGRAMS

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

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

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

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

October 17, 2016

An Open Letter to the PSRA Committee,

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

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

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

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

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

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

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

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

-Carla

HANDOUT A

MAI PROGRAM CLIENT OUTCOMES

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

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

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

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

MAI PROGRAM CLIENT OUTCOMES

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

MAI OAMC

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

MAI MCM

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

MAI MH

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

MAI SA

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

Ft. Lauderdale/Broward EMA
Ryan White Part A and MAI
FY 24-25 Allocations

Handout A3

	Service Category	Contract/ Allotted Amount	Expended Amount As of MAY Invoice	Expended %	Unduplicated Clients Served	Unexpended Amount	Average Monthly Expenditures	FY 2024-25 Projected Expenditures	Provider Unspent Billables	Potential Unexpended Dollars	Providers' Request	Providers' Return	Recommended Sweep To	Recommended Sweep From	Grantee Recommended Sweep Amount	Funding Allocation Recommendation
Core Medical Services	Ambulatory- Integrated Primary Care and Behavioral Health Services (6)	5,253,767	1,279,775	24%	2182	3,973,992	426,592	5,119,100	-	134,667	653,493	(345,760)	467,132	(345,760)	121,372	5,375,139
	AIDS Pharmaceutical Assistance (2)	349,916	20	0%	5	349,896	7	79	-	349,837	-	(287,916)		(287,916)	(287,916)	(62,000)
	Oral Health Care Routine (4)	1,910,475	502,637	26%	1518	1,407,838	167,546	2,010,549	-	(100,074)	205,408	(107,000)	157,729	(370,000)	(212,271)	1,698,204
	Specialty (1)	736,489	157,386	21%		579,103	52,462	629,543	-	106,946	-	(107,000)	-	(107,000)	(107,000)	629,489
	Medical Case Management Disease Case Management (5)	512,117	155,539	30%	361	356,578	51,846	622,155	-	(110,038)	311,202	-	184,819	(48,000)	136,819	648,936
	Mental Health- Trauma-Informed (2)	159,939	27,294	17%	67	132,645	9,098	109,175	-	50,764	-	-	-	(20,000)	(20,000)	139,939
	Health Insurance Premium & Cost Sharing Assistance	779,279	99,055	13%	457	680,224	33,018	396,220	-	383,059	-	(136,279)	-	(136,279)	(136,279)	643,000
	Medical Nutrition Therapy (1)	300,000	-	0%		300,000	-	-	-	300,000	-	-	-	-	-	300,000
	Substance Abuse-Outpatient (1)	337,498	5,885	2%	5	331,613	1,962	23,539	-	313,959	-	-	-	(200,000)	(200,000)	137,498
Support Services	Non-Medical Case Management Centralized Intake and Eligibility Determination (1)	349,378	103,421	30%	1594	245,957	34,474	413,684	-	(64,306)	-	-	-	-	-	349,378
	Non-Medical Case Management Case Management (7)	1,239,359	362,693	29%	1724	876,666	120,898	1,450,773	-	(211,414)	537,237	-	335,775	(115,000)	220,775	1,460,134
	Food Services Food Bank (1)	700,000	481,586	69%	1663	218,415	160,529	1,926,342	-	(1,226,342)	375,000	-	234,375	-	234,375	934,375
	Food Voucher (1)	82,586	82,566	100%	713	20	27,522	330,264	-	(247,678)	245,000	-	153,125	-	153,125	235,711
	Legal Assistance (1)	129,151	34,534	27%	59	94,617	11,511	138,136	-	(8,985)	-	-	-	-	-	129,151
	Emergency Financial Assistance (2)	115,872	61,962	53%	73	53,910	20,654	247,848	-	(131,976)	107,128	-	97,000	-	97,000	212,872
	Total Part A Funds	**12,955,826**	**3,354,352**	**26%**		**9,601,474**	**1,118,117**	**13,417,407**	**-**	**(461,581)**	**2,434,468**	**(983,955)**	**1,629,955**	**(1,629,955)**		**12,955,826**
	*** Some of the providers have not billed for month of MAY 2024.**															

	Service Category	Contract/ Allotted Amount	Expended Amount As of MAY Invoice	Expended %	Unduplicated Clients Served	Unexpended Amount	Average Monthly Expenditures	FY 2024-25 Projected Expenditures	Provider Unspent Billables	Potential Unexpended Dollars	Providers' Request	Providers' Return	Recommended Sweep To	Recommended Sweep From	Grantee Recommended Sweep Amount	Funding Allocation Recommendation
Core Medical Services	MAI Ambulatory (1)	-	-			-	-	-	-	0	-	-	-	-	-	-
	MAI Medical Case Management (2)	93,212	70,551	76%	184	22,661	23,517	282,204	-	(188,992)	97,827	-	48,000	-	48,000	141,212
	MAI Mental Health (1)	62,469	7,943	13%	18	54,526	2,648	31,771	-	30,698	-	-	-	-	-	62,469
	MAI Substance Abuse-Outpatient (1)	400,000	22,144	6%	11	377,856	7,381	88,577	-	311,423	-	-	-	(48,000)	(48,000)	352,000
Support Services	MAI Non-Medical Case Management Centralized Intake and Eligibility Determination (1)	524,066	250,383	48%	3040	273,683	83,461	1,001,532	-	(477,466)	-	-	-	-	-	524,066
	Total MAI Funds	**1,079,747**	**351,021**	**33%**		**728,726**	**117,007**	**1,404,084**	**-**	**(324,337)**	**97,827**	**-**	**48,000**	**(48,000)**	**-**	**1,079,747**
	*** Some of the providers have not billed for month of MAY 2024.**															
	Total Part A and MAI Funding	**14,035,573**	**3,705,373**	**26%**		**10,330,200**	**1,235,124**	**14,821,491**	**-**	**(785,918)**	**2,532,295**	**(983,955)**	**1,677,955**	**(1,677,955)**		**14,035,573**

Handout B

HIV PLANNING COUNCIL & COMMITTEES
Data Request Form

Date of Data Request: _____

Data Requested Approved by:

- ☐ HIV Health Services Planning Council
- ☐ Community Empowerment Committee
- ☐ Executive Committee
- ☐ Membership Council Development Committee
- ☐ Priority Setting Resource Allocation Committee
- ☐ Quality Management Committee
- ☐ System of Care Committee
- ☑ MAI Ad-Hoc Committee

List of Data Requested: M. Schweizer requests to know how other EMA's such as, Palm Beach and Miami-Dade, are utilizing their MAI funding; what service categories are being funded and the amount allocated to each; and a copy of the SDM's for each service category funded with MAI (draft copy is acceptable). Latest Monthly Expenditure/Utilization Report for MAI.

Date Data is Due: _____

Data Request submitted to:

☐ Clinical Quality Management Team ☑ Ryan White Part A Recipient Office

Signature,

_____

- ❑ **HIV Planning Council Chair or Vice Chair**
- ❑ **Committee Chair or Vice Chair**

HIV HEALTH SERVICES PLANNING COUNCIL
MEETING GROUND RULES

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

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

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

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

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

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

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

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

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

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

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

Revised 7/24/14

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

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

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

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

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

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

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

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

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

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

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

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

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV
RÈGLEMAN RANKONT-YO

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

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

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

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

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

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

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

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

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

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

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

Acronym List

ACA: The Patient Protection and Affordable Care Act 2010

ADAP: AIDS Drugs Assistance Program

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BISS: Benefit Insurance Support Service

BMSM: Black Men Who Have Sex with Men

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CM: Case Management

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

DCM: Disease Case Management

DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

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

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

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

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SA: Substance Abuse

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

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

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

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

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

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