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

Committee Meeting Agenda: Part A Executive Committee
Date/Time: THURSDAY, December 5, 2013, 12:30 P.M. **Location:** BRHPC
Chair: KURYLA, S. **Vice-Chair**: GAMMELL, B.

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*

2. **APPROVALS:** 12-5-13 Executive Committee Agenda and 11-21-13 Meeting Minutes.

3. **STANDARD COMMITTEE ITEMS**
   a) Committee Chair Reports – Activities and Progress on Work Plans
   b) Discuss Healthcare Reform Update on HIVPC Agenda
   c) Approve 12-12-13 HIVPC Agenda
   d) Review January 2014 HIVPC Calendar

4. **UNFINISHED BUSINESS**

5. **MEETING ACTIVITIES / NEW BUSINESS**

Goal / Work Plan Objective #:	*Accomplishments*
Planning Council Retreat (WP Item 2.3)	Plan the annual Planning Council Retreat to ensure training and leadership. Discuss date, venue, and agenda items.
Assessment of the Administrative Mechanism (WP Item 5.6)	Review a summary of the FY13 Assessment of the Administrative Mechanism results, which were presented to the Priority Setting & Resource Allocation Committee. The purpose is to assure that funds are being contracted quickly and through an open process, and that providers are being paid in a timely manner. A survey will also be developed for HIVPC members to evaluate the effectiveness of the services offered in meeting identified needs.

6. **GRANTEE REPORTS**

7. **PUBLIC COMMENT**

8. **AGENDA ITEMS / TASKS FOR NEXT MEETING, 12:30 p.m. January 16, 2014**

Agenda Items / Tasks for next Meeting (Work Plan Item #)	*Party to Complete Task*	*Information requested (i.e. data, research, etc.)action to be taken, presentation, discussion, brainstorm etc.*
Planning Council Retreat (WP Item 2.3)	Exec, Staff, Grantee	Continue planning the annual Planning Council Retreat to ensure training and leadership.
Executive Committee (WP Item 4.2)	Exec, Staff, Grantee	Review and revise the Executive Committee's purpose, mission statement, Committee Work Plans, Policies & Procedures

9. **ANNOUNCEMENTS**

10. **ADJOURNMENT**

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

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

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

MEETING MINUTES
COMMITTEE: Part A Executive Committee
Date/Time: Thursday, November 21, 2013, 2:00 p.m. **Location:** BRHPC
KURYLA, S. **Part A Chair** GAMMELL, B. **Part A Vice Chair**

Attendance					
#	**Members**	**Present**	**Absent**		**Guests**
1	Kuryla, S. Chair (*Chair*)	**X**			Saiswick, K.
2	Gammel, B. (*Vice Chair*)	**X**			Wynn, J.
3	Taylor-Bennett, C.	**X**			
4	Reed, Y.		**X**		
5	Katz, H. B.	**X**			**Part A Grantee**
6	Grant, C.	**X**			Jones, L. (Part A)
	Quorum = 4	**5**	**1**		
	Spencer, W. (ex oficio)		**X**		**HIVPC Support Staff**
					Crawford, T.
					McEachrane, T.
					Rosiere, M.

1. CALL TO ORDER:

The Chair called the meeting to order at 2:10 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 support staff self-introductions were made.

A moment of silence was observed.

2. APPROVALS:

Motion #1	To approve today's meeting agenda with amendment		
Proposed by:	Tomlinson, K.	**Seconded by:**	Grant, C.
Action:	Passed Unanimously		

Motion #2	To approve meeting minutes of 10/17/13		
Proposed by:	Katz, H.B.	**Seconded by:**	Grant, C.
Action:	Passed Unanimously		

3. STANDARD COMMITTEE ITEMS

a) Committee Chair Reports – Activities and Progress on Work Plans

Priority Setting and Resource Allocation (PSRA): The PSRA Part A Co-Chair addressed the motions previously made by PSRA regarding Food Bank eligibility to help spend down bulk purchases. The Chair stated that the two motions passed during the meeting regarding modifications to food bank eligibility will need to be rescinded from the HIVPC agenda. The Chair requested that the members meet on December 11th vs. December 18th in order to revisit this issue prior to the December 12th HIVPC meeting in order for them to be approved in a timely manner. Staff will follow up with committee members to move the December meeting date.

Quality Management Committee (QMC): The QMC Chair expressed gratitude to committee members and support staff for their efforts in making a successful QMC Retreat, held on November 18th. The Chair

looks forward to implementing ideas regarding the evaluation process of quality measures. Additionally, it was announced that longstanding committee member, Marcel Martin, has resigned from her position due to scheduling difficulties.

Membership Council Development Committee (MCDC): The next meeting will take place at the Grantee's office for transportation purposes. The Committee will be working to improve the recruitment brochure to make it more visually appealing.

Ad-Hoc Nominating & By-Laws Committees: The voting system will be completely electronic. The By-Laws meeting packet will be sent to members today (November 21st) for review prior to the December 12th Planning Council meeting.

Executive Committee: The Chair announced that the Epilepsy Foundation would like to report to the Council on Navigator activities. This item will be included in the HIVPC agenda after the Federal Legislative Report.

b) Discuss Healthcare Reform Update on HIVPC Agenda
The SFAN Chair will report on updates as they are available at the December meeting.

c) Approve 12-12-13 HIVPC Agenda
The HIVPC agenda will be formally approved at the December 5th Part A Executive Committee meeting.

d) Review December 2013 HIVPC Calendar
Staff was requested to email members and interested parties of the Committee meetings taking place in December with an emphasis on the county ordinance regarding the attendance policy in red font.

4. UNFINISHED BUSINESS:
None

5. MEETING ACTIVITIES / NEW BUSINESS

Goal / Work Plan Objective #:	*Accomplishments*
Integrated HIV/AIDS Community Planning Webinar	Members viewed a webinar focusing on integrated HIV prevention and care planning efforts and approaches to joint planning bodies. Divisions of HIV/AIDS Prevention announcements were made. The Division is in the process of sending analysis of the Fiscal Year 2012-2014 Planning Council Comprehensive Plans. Grantees should expect a monthly monitoring call. Objective reviews of the Part A Grant Applications are set for December 9-11. It is highly probably that Grantees will receive partial awards (slated for March 1, 2014) due to the Continuing Resolution. Notification has been sent regarding the awards. The Core Medical services waiver provision has been posted as policy clarification notice 130. There has been a delay of 340B recertification of covered entities either currently or newly eligible to participate in the program until the first quarter of 2014. Following the announcements, the Los Angeles and Chicago EMAs presented on their experiences creating an integrated prevention and care planning body. There will be a webinar on December 3rd addressing new requirements from Part A and Part B Grantees involved with local pharmaceutical assistance programs. Staff was requested to send members a PowerPoint presentation of the webinar. The Part A Grantee gave an overview of the information regarding integration that was presented at the Urban Coalition for HIV/AIDS

	Prevention Services (UCHAPS) Conference. The Grantee noted that in both EMAs, the County runs both Prevention and Patient Care so administration is under the same umbrella. In Broward County, Prevention is coordinated through the state and Patient Care and Treatment through the County. Integrated bodies must meet both CDC grant requirements and Part A grant requirements. Integration can be done in multiple ways, including creating a committee or work group. The Grantee addressed concern regarding the Part A program's intention to merge the Prevention and Care and Treatment planning bodies. The Committee was informed that the goal is to have care and treatment and prevention bodies discuss the best way to integrate and devise ways to identify the steps to have this occur. It was noted that it is best that the EMA work toward integration now before it is officially mandated. The Grantee stated that there is need for a seamless process and a comprehensive, meaningful plan to accomplish the overarching goal of viral load suppression for PLWHA. The Committee continued to have a robust discussion to express their concerns about moving forward with integrating prevention with care and treatment. Members also discussed how the Ryan White program will look with the full implementation of the ACA; members mentioned that the system will need to be switched since the first priority is to get PLWHA into care. The idea of treatment is prevention will now be paramount in order to maintain the health of PLWHA. There will also be a need to move toward data integration. Members requested to continue to have this conversation at the Joint Executive retreat in order to strategize ways to bring these bodies together as well as the data needs for each body. SFAN members initiated discussion about issues regarding the lack of information distributed about the Prevention Council. The need for open and honest conversation with all parties as well as transparent meetings was stressed.
Planning Council Retreat (WP Item 2.3)	Emily Gantz-McKay will be invited to attend the Retreat. It was noted that once the details for the Joint Executive retreat are identified, information for the Planning Council retreat will also be identified.
December Meeting	The Committee decided that the December Part A Executive Committee meeting is needed and it will be held on December 5th at 12:30 p.m.

Members discussed the evolution of the Broward Community Planning Partnership (BCPP). It was noted that guidelines come from the CDC. Ultimately, integration ensues that services are cohesive and non-duplicative to help achieve success with the treatment cascade. The Joint Planning Part B Co-Chair expressed concern regarding the implementation of the Comprehensive Plan that meets CDC and HRSA requirements. Ideally, Patient Care and Treatment and Prevention will be responsible for their respective requirements, but both will submit under a collaborative effort. Unlike the HIV Planning Council, the jurisdictional Prevention body is not required to develop a Comprehensive Plan.

Members discussed collaborating with Prevention on service categories to create a seamless system of care. The Grantee noted that receiving state information will be a point of discussion with Prevention.

Members discussed efforts to improve partnership between both bodies, which includes consistent sharing of data and information (i.e. PROACT reports) not previously provided. Members emphasized the importance of Parts A & B and Prevention meeting together in order to come up with a joint plan. One member mentioned that they

would like a formal invitation from Prevention so that they can ensure both bodies are on the same page for collaboration purposes. It was also mentioned that discussion should stop taking place at the Grantee level and be held as a joint body to coordinate an integrated plan.

One member expressed concern regarding the merging of committees and lack of communication between both bodies. Members discussed the historical relationship between BCPP and HIVPC. The HIVPC Chair suggested that Prevention meet with HIVPC to clarify BCPP strategies and meeting notifications.

The Joint Planning Part B Co-Chair requested that Staff ask Prevention for a schedule of upcoming BCPP meetings. The Committee requested that Staff email members a link to the Jurisdictional Prevention Plan 2012-2016. The Chair of SFAN stated that he will scan and email staff a "snap shot" summary and activity list regarding Prevention activities. The HIVPC Vice Chair suggested holding discussions with Prevention at the Joint Executive Retreat in January. The Quality Management Committee (QMC) Chair recounted the Prevention Boot Camp held in October. Prevention strategies were presented with special attention given to Men who have sex with men (MSM) outreach efforts.

The HIVPC Vice Chair requested that invitations be sent to Ms. Gantz-McKay and possibly Prevention representatives to attend the Joint Executive Retreat in January. Staff will coordinate conference calls between Ms. Gantz-McKay, the Joint Planning Co-Chairs, and Prevention Director, Evelyn Ullah. Staff mentioned that Ms. Gantz-McKay needs to speak with all the Part A Committee Chairs, either by phone or in person, since she is doing the review of the Comprehensive Plan. Staff then asked which Committee Chairs were available to meet with Ms. Gantz-McKay the day of the Joint Planning Coordination meeting. It was also requested that staff send an invitation to the Prevention Grantee and the Prevention Executive team to attend the Joint Planning Coordination meeting on December 9th.

The Part B Co-Chair of Joint Planning inquired about the local Crosswalk conducted between the Part A Grantee and Evelyn Ullah, the Prevention Grantee. A report on the Crosswalk was requested from the Part A Grantee in preparation for the Joint Coordination meeting on December 9th in order to identify gaps. It was also requested that this information reflect the conversations held between the Part A and Prevention Grantees.

In addition, Ms. Gantz-McKay will receive a copy of the Part A Executive Committee minutes for review prior to the December 9th Joint Planning Coordination meeting in order to convey an honest landscape of issues surrounding integration.

Members discussed the Prevention Boot Camp summary prepared by support staff. The HIVPC Vice Chair requested a report from the Prevention Grantee of the second day's integration group activities conducted at the Prevention Boot Camp.

6. GRANTEE REPORTS:

a) Part A

None

7. PUBLIC COMMENT:

None

8. AGENDA ITEMS / TASKS FOR NEXT MEETING, 12:30 p.m. December 5, 2013 Venue: BRHPC

Agenda Items / Tasks for next Meeting (Work Plan Item #)	*Party to Complete Task*	*Information requested (i.e. data, research, etc.)action to be taken, presentation, discussion, brainstorm etc.*

9. ANNOUNCEMENTS:

None

10. ADJOURNMENT

Without objection the meeting was adjourned at 4:10 p.m.

Part A Executive Attendance CY: 2013

Member	1/10/13	2/21/13	3/21/13	4/18/13	5/16/13	6/18/13	7/18/13	9/19/13	10/17/13	11/21/13
Kuryla, S., *(Chair)*	1	1	1	1	A	1	1	1	A	1
Gammell, B, *(V. Chair)*	1	1	1	1	1	1	1	1	1	1
Reed, Y.	*Appointed 10/16/13*								1	A
Taylor-Bennett, C.	1	1	1	1	1	1	1	A	1	1
Grant, C.	1	A	1	1	1	1	1	1	1	1
Katz, H. Bradley	1	1	1	1	1	1	1	1	1	1
Will Spencer *(ex oficio)*	A	1	1	1	1	1	A	1	1	A
Quorum =4	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

ASSESSMENT OF THE ADMINISTRATIVE MECHANISM PRESENTATION SUMMARY: 11.20.13

PRESENTATION SUMMARY

- The Monthly Invoice Tracking for March 2013 - September 2013 was provided.
- In March, it took an average of 42 days for reimbursement; by September, processing time had been reduced to 16 days.
- The average processing time was 28 days from March to September; 9 days for Administrative processing and 18 days for Accounting.
- Recent turnover in the Accounting department has aided in reducing the processing time significantly.
- Invoices are first submitted to Contracts where it is reviewed for mistakes, then transferred to Billing where fiscal issues are noted usually within 24 hours.
- Incorrect invoices are sent back to the provider for correction. Providers then re-submit the invoice.
- Previously, the processing time began the day the invoice was initially received.
- The date the invoice is received has been modified in accordance with the Prompt Payment Act; processing time now begins once an invoice free of errors and corrections (a “clean” invoice) is submitted.
- Cleans invoices are usually approved within 24 hours then submitted to Accounting.
- There was a quicker accounting processing time in September due to the fiscal year ending in September 30th.
- The monthly invoice processing trends represent calendar days versus business days.
- Providers generally resubmit invoices within 24 hours of notification.

MEMBER INQUIRIES

- Members inquired about documentation of the time it takes for a provider to receive notice of the incorrect invoice; follow-up for invoice delays are documented internally.
- Members questioned the accuracy and fairness of including the time between receiving the initial incorrect invoice to receiving the correct invoice into the overall processing time.

COMMITTEE RECOMMENDATIONS

The Priority Setting & Resource Allocation Committee provided the following feedback:

- The average number of days it takes an incorrect invoice to be corrected and resubmitted should be included in the reporting. The Committee felt it would be helpful to know the time period from which the invoice was initially accepted until it was corrected in order to process.
- The Grantee should track the amount of days in business days versus calendar days.

2013-14 Work Plan Calendar for Executive Committees

	March	April	May	June	July	Aug
Exec	1 Request data from other funders 1 (Joint) Progress on NHAS goals	1 Review By-Laws changes	1 Mentoring plan 2 Review By-Laws Changes	1 ACA Discussion 2 Comp Plan annual review	1 FY14 Allocations 1 (Joint) Progress on NHAS goals	1 EIIHA data & strategy 2 Pick Nominat. Comm. 3 Mentoring Plan
Joint Exec		X		X		X

	Sep	Oct	Nov	Dec	Jan	Feb	2014/15
Exec	1 Link to care plan 1 (Joint) Progress on NHAS goals 2 Sweeps 3 Meet BCHD prevention team 4 HIVPC training survey	1 HIV Self Assessment Survey 2 Review Community Events 3 Appove FY13 Client Survey	1 Retreat planning 2 Self Assessment Survey 1 (Joint) Progress on NHAS goals	Assessment of Administrative Mechanism	1 Review new Committee Work Plans 2 Appv retreat plans 1 (Joint) Progress on NHAS goals	1 Update P&P, Mission Statement 2 Annual Evaluation	1 Create timeline for 2015-18 Comp Plan
Joint Exec		X		X		X	

Broward County HIV Health Services Planning Council FY2013-14 **Executive Committee Work Plan**

Objective 1. Maintain a Comprehensive Plan for the Organization and Delivery of HIV Services in Broward County	Responsible	Outcome	Start	Due	Progress
1.1 Annually review and update Comprehensive Plan to ensure continued appropriateness	Joint Executive	Plan meets EMA needs	6/13	6/13	Complete
1.2 Monitor activities of standing and ad Hoc Committees to ensure objectives of Comp Plan are met	Executive Committees	EMA goals addressed	Each meeting	Each meeting	Recurring
Objective 2. Capacity/Leadership Development For Planning Council Members and Applicants					
2.1 Review Mentoring Plan	MCDC, Exec, HIVPC	Educated HIVPC	8/13	8/13	Complete
2.2 Review results of Council training survey to recommend training sessions	MCDC, Exec, Staff	Educated HIVPC	9/13	10/13	Identified
2.3 Plan Annual Planning Council Retreat	Exec, Staff, Grantee	PC training, leadership	11/13	1/14	In process
2.4 Appoint Nominating Committee Chair. Hold Council leadership Elections.	Exec, Staff, HIVPC	PC leadership	8/13	2/14	Chair appointed
2.5 Assess effectiveness of Council, Committee meetings (Meeting Evaluation Reports)	Executive; (Data: Staff)	Develop leadership	2/14	2/14	
Objective 3. Planning Council Operations					
3.1 Monitor adherence to Planning Council attendance policy	Exec, MCDC, Staff	Comply with policy	Monthly	Monthly	Recurring
3.2 Organize and approve Planning Council meeting agenda every month	Executive, Staff	Efficient meetings	Monthly	Monthly	Recurring
3.3 Review, forward to HIVPC removal-for-cause recommendations from Membership	Exec, MCDC, Staff	Comply with policy	As needed	As needed	
3.4 Review and revise HIVPC grievance process	Executive, JCCR, Staff	Grievances resolved	4/13	8/13	Revision complete
3.5 Assess JCCR community educational sessions	Executive, JCCR, Staff	Strong consumer input	10/13	10/13	Complete
3.6 Review service quality outcomes	Exec, QM, Staff	High-quality services	As needed	As needed	Complete
3.7 Annual Evaluation	All Committees, Staff	Improved process	2/14	2/14	
Objective 4. Review and Revise Executive Committee Policies and Procedures					
4.1 Review recommended changes to By-Laws	Exec, By-Laws, Staff	Improved By-Laws	4/13	12/13	In process
4.2 Review Executive purpose, mission statement, Committee Work Plans, P & P	Executive, Staff	Updated policies	1/14	2/14	
4.3 Conduct mini-Retreat for Joint Executive	Joint Executive	Develop Leadership	As needed	As needed	
4.4 Review reports from Committee chairs on accomplishing work plan items	Exec, Chairs, Staff	Meet goals of NHAS	Monthly	Monthly	Recurring
Objective 5. Coordination of Funding Streams; Analyze Service Capacity and Infrastructure Needs					
5.1 Develop collaborative relationships with funding sources for PLWHA in Broward: a. Encourage grantees and agencies on PC to submit data on funding and utilization b. Strengthen coordination with federal, state, other funders. Request their data c. Develop linkages between care and prevention. Meet with prevention yearly.	Joint Executive	Efficient services, ensure RW is payer of last resort	As needed	As needed	
5.2 Mobilize providers, community to report data on Community Viral Load	JPC, Exec, Staff	Improved prevention	As needed	As needed	
5.3 Meet bi-monthly with Part B to ensure coordination of funders and policies	Joint Executive	Improved efficiency	Bimonthly	Bimonthly	Recurring
5.4 Review plans for FY13 Client Survey to inform PSRA process	Exec, JPC, Staff	Consumer feedback	10/13	10/13	Recurring
5.5 Review and revise EIIHA Strategy	JPC, Exec, Staff, DOH	Improved EIIHA effort	8/13	8/13	Complete
5.6 HIVPC Self-Assessment Survey. Complete Assessment of Administrative Mechanism	PSRA, Exec, Staff	Efficient services	12/13	12/13	Pending
5.7 Review recommended FY14/15 Allocations	PSRA, Exec	Service funding	7/13	7/13	Complete
5.8 Review recommended FY13/14 reallocations (Sweeps)	PSRA, Exec	Service funding	9/13	9/13	Complete

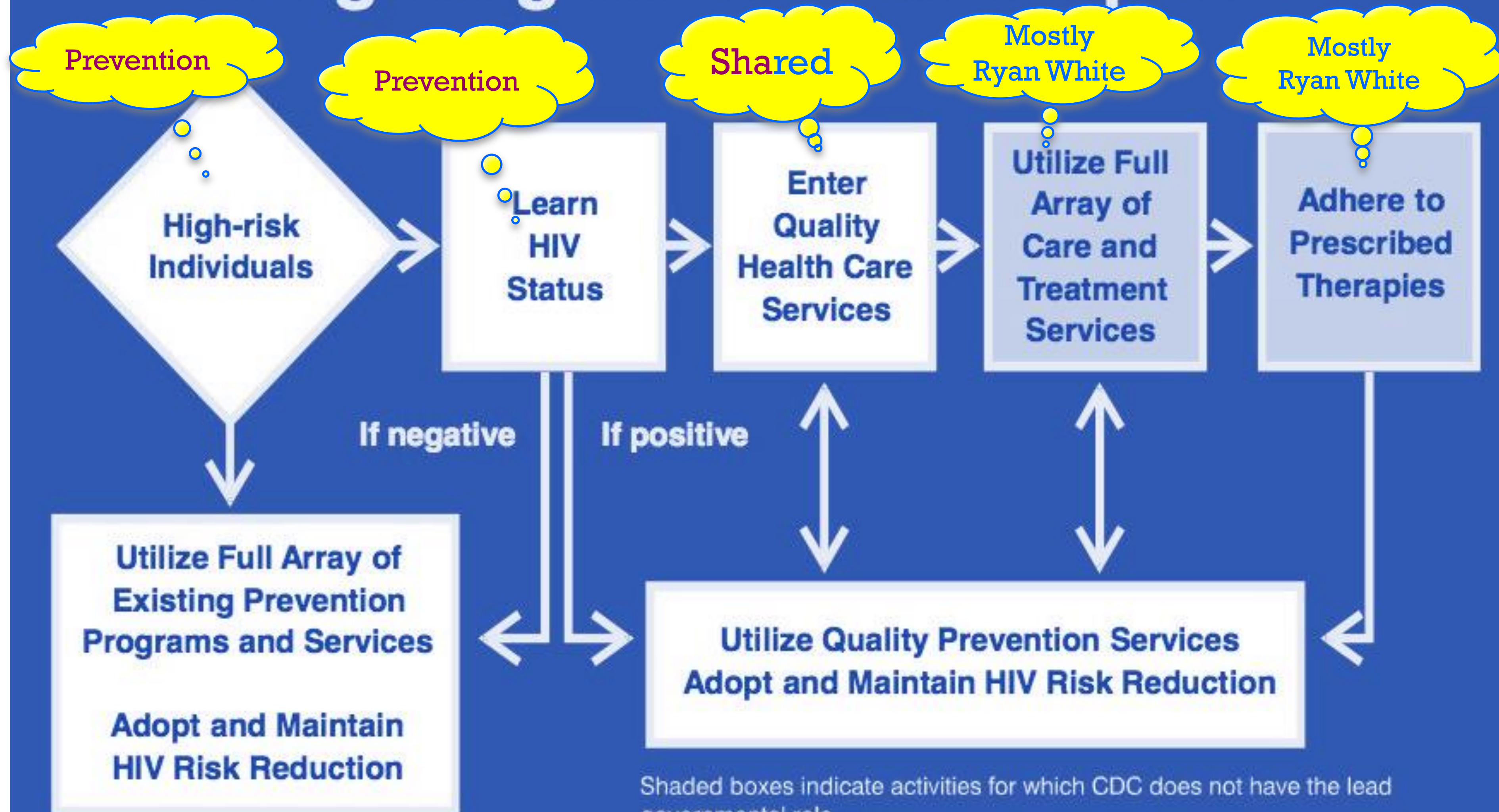
Integrating Prevention and Treatment

Broward County Jurisdictional Prevention Plan
Broward HIV Health Services Comprehensive Plan

Silvana Baner, Early Intervention Administrator
HIV Prevention Program, FDOH in Broward County
Michele Rosiere, Division Director
Broward Regional Health Planning Council

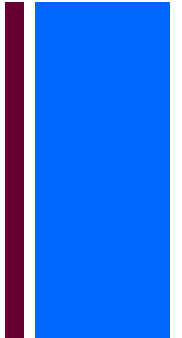
+ Prevention is Treatment Video

Blueprint for a Sero-status Approach to Fighting the HIV/AIDS Epidemic



Shaded boxes indicate activities for which CDC does not have the lead governmental role.

NHAS Goals and Indicators



#1 Reduce the number of people who become infected with HIV

- Lead efforts to lower the number of new infections by 25%
- Reduce the HIV transmission rate by 30%
- Increase the number of people who know their serostatus to 90%

#2 Increase access to care and improve health outcomes for PLWHA

- Increase to 85% # of newly diagnosed who receive clinical care w/in 3 months of diagnosis
- Increase to 80% the proportion of Ryan White clients in continuous care
- Increase the number of PLWHA in permanent housing to 86%

#3 Reduce HIV-related health disparities

- Increase access to prevention and care services
- Increase the number of gay and bisexual men, Blacks, and Latinos who have an undetectable viral load by 20%

+ NHAS Goal 1: Reducing New HIV Infections

Lower Number of Annual Infections by 25%

BCHD Prevention Objectives and Activities

Increase number of HIV tests conducted in healthcare settings by 5% each year

- Collaborate with 6 hospitals to provide ED testing as part of routine medical care
- Collaborate with 12 primary care providers to provide testing as routine care
- Meet with hospital EDs, administrators and providers on importance of routine testing
- Provide TA and physician tool kits to enhance provider skills in implementation of HIV testing as part of routine medical care

Increase number of tests conducted in non-healthcare settings by 5% each year

- Fund 6 targeted HIV testing initiatives
- Provide TA to enhance skills in implementing targeted testing and social network strategies
- Provide training on HIV testing technologies
- Encourage contracted agencies to provide expanded hours and days for testing

+ NHAS Goal 1: Reducing New HIV Infections

Decrease HIV transmission rate by 30%

BCHD Prevention Objectives and Activities

Reduce to zero the number of pediatric HIV transmission cases

Educate OB/GYNs, labor/delivery hospitals & birthing centers to comply w/ FL Statutes & standards

Increase HIV testing awareness during 3rd trimester among pregnant women

Expand HIV Perinatal Provider Network capabilities with strategies to reduce transmissions

Conduct annual perinatal symposium in collaboration with FLAETC

Promote Walgreen's voucher program and other resources for HAART regimens

Distribute perinatal toolkits for OB/GYN providers

Conduct HIV clinical/prevention grand rounds at two birthing hospitals each year

Ensure 80% receiving positive result are linked to medical care w/in 90 days of receiving result*

Assess local capacity to cross-match databases

Ensure 95% of People who received positive result are linked to partner services*

Require HIP contracted agencies to refer all positives upon diagnosis to partner services

DIS will locate partners, advise of their exposure, offer onsite testing and refer to PROACT

** Refers to DOH registered test sites only*

+ NHAS Goal 1: Reducing New HIV Infections

Increase # of PLWH who know their status by 10%

BCHD Prevention Objectives and Activities

Ensure >/=95% testing positive receive their results*

Ensure >/=75% testing negative receive results and offered counseling or referred to prevention services*

- Provide HIV prevention counseling, testing, referrals and linkage in high HIV prevalence community settings
- Promote HIV testing in ED, correctional facilities, mental health/substance abuse treatment centers and CHCs
- Review policies, procedures and QA protocols to make recommendations and stream line testing procedures

** Refers to DOH registered test sites only*

NHAS Goal 1: Reducing New HIV Infections

Increase condoms distributed to PLWHA and those at highest risk by 15% each year

BCHD Prevention Objectives and Activities

Establish 10 condom distribution centers and 100 drop sites reaching >/=10,000 people annually at highest risk and PLWHA in high morbidity areas

Identify public & private condom distribution partners.

Increase accessibility, acceptability, and education of barrier methods in healthcare and non-healthcare settings

Design/implement condom use Knowledge, Attitudes, Beliefs & Behaviors online assessment

Distribute 16,000,000 condoms, 450,000 lubricants, and 96,000 female condoms

Conduct quarterly condom distribution to public and private partners

Monitor activities and provide technical assistance services

Integrate condom distribution with community interventions to promote risk reduction
Support and participate in national HIV observance events, i.e. National Condom Week

Include condom distribution center, drop sites and other info on Broward>AIDS web site

Design, launch and promote the Broward>AIDS web site

Coordinate with HIP contracted agencies to serve areas

Design search engine capabilities for the public to find locations for free condoms

+ NHAS Goal 1: Reducing New HIV Infections

Expand prevention with HIV Positive Individuals

Ryan White Part A Quality Management and QI Networks

- Educate patients about risk reduction and encourage safer-sex practices
- Become familiar with prevention offered at CBOs so that patients' referrals are properly matched according to specific patient risks
- Identify women who wish to become pregnant; provide preconception counseling; refer pregnant women for early prenatal care
- Screen for, diagnose, and treat other STIs
- Ensure substance abuse and mental health screening and referrals to treatment
- Promote adherence to ART treatment to ensure maximal viral suppression and reduced transmission risk
- Implement AETC Prevention with Positives trainings
- Continue AETC Operation HOPEFUL pilot to assist risk assessments

NHAS Goal 2: Increase Access to Care and Improve Health Outcomes

Establish seamless system to immediately link PLWHA to continuous/coordinated quality care

Ryan White QMC, QI Networks Objectives and Activities

Facilitate linkages to care (including coordination in health and social services settings

Implement Ryan White/Prevention Grantees Collaborative Work Group to Ensure Seamless Care System

- Design client flow processes to ensure seamless system from test sites to Part A OAMC engagement
- Define and provide training regarding linkage roles and responsibilities
- Design and/or modify reporting and MIS to track HIV+ individuals receiving their diagnosis at confidential testing sites to LTC, and engagement and retention in OAMC
- Develop aggregate reports regarding key processes, performance measures and outcomes

Ensure the following strategies are incorporated into Outreach through SDM revisions and training

- Mobilize Part A-funded outreach workers to provide services at CDC and FDOH tests sites
- Ensure motivational techniques to engage newly diagnosed and encourage immediate care
- Ensure orientation about available services, and eligibility documentation assistance
- Compute OAMC engagement >/= 3 month rates following HIV+ test and long-term retention

Utilize engagement reports to identify areas of improvement. Reports include sub-analyses to assess EIIHA strategy impact on rates of racial, ethnic, and sexual minorities, and WICY

- Apply quality management (QM) methods to identify areas of improvement and modify processes
- Compute time from initial HIV+ test to the first OAMC visit with a physician; Engagement and retention in OAMC in the first year following initial HIV testing; Tailor Linkage and retention methods to unique needs of racial, ethnic, and sexual minority men and women
- Develop QIPs by Outreach QI Network to design, test, and implement the new LTC model

NHAS Goal 2: Increase Access To Care and Improve Health Outcomes

Support PLWHA with co-occurring conditions and challenges to meet basic needs, such as housing

Ryan White PSRA, QMC, QI Networks Objectives and Activities

Enhance client assessment tools and measurement of health outcomes

- Develop tools to measure impact of all Part A Services on client level health outcomes
- Program revised client level outcomes in PE MIS
- Monitor the impact of non-medical services on retention in medical care
- Integrate the 2 core group 1 VL performance measures into PE system and SDMs

Provide MCM and clinical services that contribute to improving health outcomes

- Ensure Part A/MAI service allocations are sufficient to serve all eligible PLWHA
- Develop QIP's based on review of HAB Measures
- Analyze client level data to develop strategies to improve retention
- Develop a baseline measure of client Health Literacy levels

Increase access to non-medical services as critical elements of an effective HIV care continuum:

Including CIED, Food bank/vouchers, Legal services and Outreach

Provide housing assistance and other services that enable access and adhere to treatment

- Continue to provide joint MCM trainings to Ryan White and HOPWA case managers
- Review utilization of SOAR in assisting HOPWA clients access benefits, thereby reducing the financial burden on HOPWA and opening housing slots for clients with no income
- Identify barriers to care related to supportive services and develop QIP's to address barriers

NHAS Goal 2: Increase Access to Care and Improve Health Outcomes

Ryan White QMC, QI Networks Objectives and Activities

Ensure all eligible HIV-positive persons have access to antiretroviral therapy

- Create a system to obtain real time information for all ADAP clients
- Ensure linkage to PAP – Educate MCMs, pharmacists, and Part A clinicians on changes to PAP requirements and eligibility guidelines to ensure that barrier to access to ART are addressed; Continue to monitor changing PAP guidelines through the Medical Network ensure clinicians' recommendations for additions to Part A Formulary are brought before LPAC for consideration
- Continue to provide emergency ART through Part A and other community resources to ensure clients do not experience interruption in treatment; Educate MCMs, pharmacists, and Part A clinicians about the availability of emergency ART
- Ensure MCMs/clinicians discuss importance of ADAP 6-month recertification w/ patients

Ensure PLWHA who start therapy are maintained on regimen, per HHS guidelines

- Increase the percentage of clients with a viral load <200 by monitoring NQC viral load suppression and developing strategies to improve suppression rates

Evaluation Measures: HAB and NQC Viral Load suppression measures

NHAS Goal 2: Increase Access to Care and Improve Health Outcomes

Increase proportion of newly diagnosed and lost-to-care patients linked to care within three months by 10% each year

BCHD Prevention Objectives and Activities

80% of clients referred to PROACT linked to medical care within 90 days of referral

80% or more of PROACT active cases stay in HIV care

45% of PROACT active cases achieve an undetectable viral load

- Monitor utilization of PROACT services
- Conduct outreach and community education on importance of linkage and maintenance to care and treatment
- Provide education to community and providers on comprehensive HIV treatment and care
- Conduct clinician outreach project to disseminate guidelines

80% of HIV+ clients linked to clinical care w/in 3 months at HIP agencies

- Monitor HIP contracted agencies on a quarterly basis
- Provide technical assistance

NHAS Goal 3: Reduce HIV-Related Health Disparities and Inequities

Reduce HIV related mortality in communities at high risk by 10%

BCHD Prevention Objectives and Activities

Increase the number of gay and bisexual men, Blacks and Latinos accessing testing for viral hepatitis, sexually transmitted infections (STIs) and HIV by 25% in clinical settings.

- Develop pilot program of private physician network offering integrated rapid testing and Hepatitis screening among gay/bisexual men, Blacks and Latinos.
- Conduct education/testing events each year that screen for both HIV and Hepatitis C in conjunction with medical providers and community-based organizations among gay and bisexual men, Blacks, Latinos, and ages 45 to 65.

Train 50 medical providers and contracted HIP medical providers to engage patients in discussions on sexual health and disclosure.

- Provide trainings for medical providers.
- Fund medical providers to implement evidence-based programming

NHAS 3: Reduce HIV-Related Health Disparities and Inequities

Reduce HIV related mortality in communities at high risk by 10%

Ryan White Part A QMC Objectives and Activities

Ensure high-risk groups have access to regular viral load and CD4 tests

- Ensure access to high quality HIV-related OAMC including regular VL and CD4 tests
- Improve retention in HIV Primary Care
- Ensure OAMC meets or exceed HHS guidelines as measured by HAB Measures
- Apply HAB measurement model to QI Networks
- Conduct PM quality assessment to ensure data are accurate and meet goals
- Develop QIPs to address data quality/reporting issues and performance deficiencies
- Review progress annually; identify remediation steps and key action steps

Measure Ryan White Part A program viral load as a measure of program quality

- Assess reliability of estimate based on proportion of cases with known viral load
- Ensure OAMC and MCM electronically document VL and CD4 at least every 6 months
- Require VL/CD4 documentation for recertification for those not in Part A OAMC
- Assess Ryan White viral load data for accuracy, completeness and quality
- Develop a QIP for improving incomplete or inaccurate Ryan White data
- Measure undetectable viral load baselines Part A program and subpopulation

NHAS 3: Reduce HIV-Related Health Disparities and Inequities

Reduce stigma and discrimination against PLWHA

Ryan White Part A QMC Objectives and Activities

Engage communities to affirm support for people living with HIV

- HIVPC planning efforts, materials and events will "Engage communities and affirm PLWHA support"

Promote public leadership of people living with HIV.

- Promote public leadership of PLWHA through actively recruiting PLWHA to serve as HIVPC members and council leadership positions; training; and disseminating national opportunities

NHAS Goal 3: Reduce HIV-Related Health Disparities and Inequities

Reduce stigma and discrimination against PLWHA

BCHD Prevention Objectives and Activities

Identify and coordinate 2 social marketing and media campaigns focused on HIP

- Identify marketing strategies that address role of stigma and barriers to HIV prevention behaviors
- Support culturally sensitive and linguistically appropriate social marketing and media campaigns
- Collaborate with local businesses through Business Response to AIDS and Labor Response to AIDS

Recruit and train 50 Black, Latino, MSM and Transgender leaders and stakeholders to promote HIP

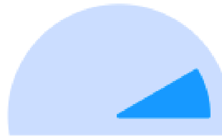
- Build capacity of community leaders to address disparities with HIP strategies, through training & TA

Include condom distribution centers, drop sites and information on Broward>AIDS website

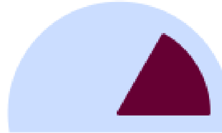
- Design, launch and promote the Broward>AIDS web site.
- Coordinate with the HIP contracted agencies to serve areas.
- Design search engine capabilities for the public to find locations for free condoms.
- Focus messaging on stigma and discrimination against people living with HIV

Full Engagement In HIV Medical Care

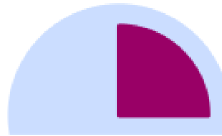
Unaware of HIV Status
Never Tested Or Never Received Results



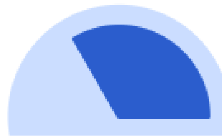
Knows HIV Status
But Not Referred to Medical Care
Or Did Not Keep Referral



Not In HIV Primary Medical Care
May Receive Other Medical Care

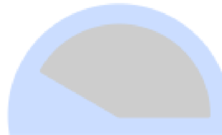


Entered HIV Medical Care
But Dropped Out
Lost to Follow-up

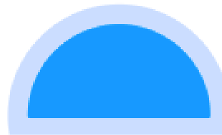


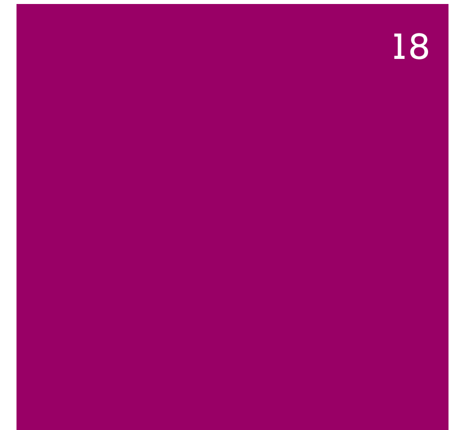
+

In and Out of HIV Medical Care
(Infrequent User)



Fully Engaged In HIV
Primary Medical Care





Collaboration Efforts with Other EMAs

Broward County HIV Health Services Planning Council

Palm Beach HIV Care Council

Retreat Wrap Up

“Crosswalk” of CDC & HRSA Planning Requirements & Expectations	
HIV Prevention	**Ryan White – Part A**
Funder	
CDC	HRSA’s HIV/AIDS Bureau (HAB)
Grantee	
Health department (HD) - State, local (8 cities) or territorial	Chief Elected Official (CEO); CEO typically delegates responsibility to a local government agency, most often the Health Department
Jurisdiction	
State, territory or city	Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA)
Planning Body	
HIV Planning Group (HGP) - state, regional, or local	Planning Council
Planning Body - Primary Function	
To inform the development or update of the health department’s Jurisdictional HIV Prevention Plan that will contribute to the reduction of HIV infection in the jurisdiction	To carry out planning and determine the allocation of Ryan White Part A funds within the EMA or TGA to provide a continuum of care that meets the most critical service needs of eligible people living with HIV/AIDS, including traditionally underserved populations, to get people linked to and retained in care and achieve positive health outcomes
Establishment of Planning Body	
Health Department	Chief Elected Official (CEO)
Grantee - Planning Body Relationship	
Separate roles and mutual goals	Separate and shared roles and mutual goals; Planning Council is an independent body that reports to the Chief Elected Official (CEO) and works closely with the grantee
Functions, Roles, and Responsibilities – Planning Body	
How Functions are Determined	
Specified in the HIV Planning Guidance from CDC; grantee may clarify and add functions	Specified in Ryan White legislation and further clarified through guidance from HAB; CEO may add functions
Primary Roles and Responsibilities as Specified in Guidance or Legislation	
Partner with the health department to address how the jurisdiction can collaborate to accomplish the activities set forth in the health department FOA PS12-1201 – includes participation in stakeholder identification, a results-oriented engagement process, and Jurisdictional HIV Prevention Plan development, implementation, and	Conduct planning, decide how to use Part A funds, and work to ensure a system of care that effectively serves all eligible people living with HIV/AIDS in the EMA or TGA.

<table>
<tr><td>monitoring</td><td></td></tr>
<tr><td colspan="2">Other Roles as Specified in Guidance or Legislation</td></tr>
<tr><td>Elect the community co-chair</td><td>Develop and implement policies and procedures for planning council operations, including membership, discussions and decision making, open meeting processes, grievance procedures related to funding decisions, conflict of interest), and input from the community</td></tr>
<tr><td>Ensure membership structure achieves community and key stakeholder representation (parity and inclusion)</td><td>Assess service needs and gaps</td></tr>
<tr><td>Ensure information is presented in a clear and comprehensive manner</td><td>Develop a comprehensive plan for the organization and delivery of HIV services that is compatible with existing State and local plans (currently updated at least every 3 years)</td></tr>
<tr><td>Inform the development or update of the Jurisdictional HIV Prevention Plan(s), which includes:
• A description of existing resources for HIV prevention services, care, and treatment, including key features of the prevention services, interventions, and/or strategies being used or delivered in the jurisdiction
• Needs assessment (e.g., resources, infrastructure, and service delivery)
• Gaps to be addressed and rationale for selection
• Prevention activities and strategies to be implemented
• Scalability of activities to achieve high-impact HIV prevention results and responsible agency/group to carry out the activities (e.g., Prevention Unit, Ryan White funded agencies, and Housing Opportunities for People With AIDS)
• Relevant timelines</td><td>Establish priorities for the allocation of funds; includes:
• Setting priorities among core medical and support service categories
• Allocating resources to service categories
• Providing guidance (directives) to the grantee on how best to meet these priorities
• Approving any reallocation of fund across service categories during the program year</td></tr>
<tr><td>Submit a letter of concurrence, concurrence with reservations, or non-concurrence with the Plan</td><td>Help ensure coordination with other Ryan White programs and other HIV-related services</td></tr>
<tr><td rowspan="3">Help to monitor the Plan; this involves:
• Working with the HD on monitoring the results from the engagement activities and strategies to ensure that they are in alignment with the Plan and the goals set forth in the National HIV/AIDS Strategy (NHAS)
• Reviewing the engagement process and</td><td>Assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the EMA/TGA</td></tr>
<tr><td>Evaluate the effectiveness of funded services (optional)</td></tr>
<tr><td>Develop standards of care for funded service categories (used by grantee in monitoring and</td></tr>
</table>

strategies to ensure that they meet the needs of the Plan • Continually assessing key stakeholder involvement and ensuring that the Plan is updated when needed • In collaboration with the HD, reviewing and submitting all monitoring documentation required by the HIV Planning Guidance	quality management) – *recommended but not required by legislation*
Shared Planning Responsibilities – Planning Body and Grantee	
Determine the most effective strategies for input into the Jurisdictional HIV Prevention Plan and engagement process	Assess needs *[Planning Council plays lead role]*
Monitor or assess the HIV planning group process to ensure that it meets the objectives of the Guidance	Develop a comprehensive plan *[Planning Council plays lead role]*
Ensure that HIV prevention efforts are guided by High-Impact Prevention activities	Ensure coordination with other Ryan White programs and other HIV-related services *[Planning Council plays supporting role]*
Planning-Related Responsibilities – Grantee	
Create and maintain one HPG per jurisdiction that meets the objectives, activities, and principles of the HIV Planning Guidance	Make staff available at Planning Council and committee meetings to provide reports and expertise
Appoint a State/Jurisdictional Co-Chair	Carry out procurement that distributes funds according to Planning Council priorities and allocations
Implement the engagement process and the Jurisdictional HIV Prevention Plan with assistance from the HPG	Carry out contract monitoring, using the National Monitoring Standards and local standards *[usually includes use of standards of care developed by the Planning Council]*
Develop the Jurisdictional HIV Prevention Plan with input from the HPG and the engagement process	Carry out and manage Clinical Quality Management *[Planning Council usually develops standards of care that are used in Quality Management]*
Keep the HPG informed of other planning processes in the jurisdiction related to HIV care, treatment, and mental health and substance abuse services (such as Ryan White Planning Councils and SAMHSA planning activities) to ensure collaboration between the HPG and the other entities	Reallocate funds as needed to ensure that funds are used appropriately and are fully expended, obtaining Planning Council approval for reallocation across service categories
Provide the HPG with information on federal, state, and local public health services (STD, TB, hepatitis, mental health, etc.) for high-risk populations identified in the	Evaluate services using HRSA/HAB performance indicators, Early Identification of Individuals with HIV/AIDS (EIIHA), treatment cascade, and other measures of service

Jurisdiction’s HIV Prevention Plan	outcomes and cost effectiveness and provide findings to the Planning Council for use in planning and decision making
Ensure that HPGs have access to current HIV prevention information and analyses of data which may have potential implications for HIV prevention in the jurisdiction	Provide information to the Planning Council to support its required planning tasks, such as: • Epidemiologic data • Client utilization data • Data on service costs • Quality Management findings by service category • Evaluation findings
Provide the HPG with information on the application and its relationship to accomplishing the goals set forth by the Division of HIV/AIDS Prevention and NHAS	
Allocate, administer, and coordinate other HIV public funds (federal, state, and local) to maximize the impact of interventions to prevent HIV transmission and reduce HIV-associated morbidity and mortality	
Provide regular updates to the HPG on successes and barriers encountered in implementing the engagement process and HIV prevention services described in the Jurisdictional HIV Prevention Plan	
Determine the amount of planning funds necessary to support HIV planning, including meetings and other means for obtaining key stakeholder or community input, facilitation of member involvement, capacity development, technical assistance from outside experts, and representation of the HPG at necessary jurisdictional or national planning meetings. HDs should discuss planning funds with their CDC project officer	
Document the engagement with other relevant federal planning processes, especially HRSA, SAMHSA and HUD	
Planning Body Membership - Nomination and Selection Process	
Nomination through an open process	All members required to go through a clearly defined open nominations process
Selected based on criteria developed and applied jointly by the health department and the planning group	Candidates recommended by the Planning Council to the CEO based on legislatively-mandated categories to ensure appropriate

	representation and addresses diversity in factors such as race/ethnicity, gender, and age to meet requirement that both the full Planning Council and the unaligned consumer members be reflective of the epidemic in the EMA or TGA
	Nominees vetted and members appointed by the CEO
Planning Body - Membership Composition	
Jointly, HPG and Health Department develop and apply criteria for selecting HPG members, placing special emphasis on identifying representatives of at-risk, affected, HIV-positive, and socioeconomically marginalized populations	Legislation specifies membership categories and requirements; CEO further determines membership size and composition when establishing the Planning Council and may review proposed changes in Bylaws
	At least 33% of members required to be unaffiliated consumers – not employees, consultants, or board members of a Part A-funded provider
Guided by PIR: • Parity: ability of HIV planning group members to equally participate and carry out planning tasks or duties • Inclusion: meaningful involvement of members in the process, with an active role in making decisions • Representation: representation of varying races and ethnicities, genders, sexual orientations, ages, plus characteristics such as educational backgrounds, professions, and expertise	Membership expected to be representative and reflective: • Reflectiveness: overall membership and consumer members expected to reflect the local epidemic in such factors as race, ethnicity, and age • Representation: membership that includes individuals filling all the membership categories that are stated in the legislation)
Voting and non-voting members	Voting membership specified in legislation; CEO may add non-voting members
Program Guidance identifies membership categories, including: • Social services • PLWHA • Behavioral/social scientists • Epidemiologists • HIV clinical care provider • Faith community • Business/labor • Community Health Center • Substance abuse • Health department (HIV, STD, TB, and Hep)	Legislatively mandated membership categories, including: • Health-care providers, including federally qualified health centers • Community-based organizations serving affected populations and AIDS service organizations • Social-service providers (including housing and homeless-services providers) • Mental-health providers • Substance-abuse providers • Local public health agencies • Hospital planning agencies or health-care planning agencies

• Interventions specialist • Local education agencies/academic institutions • Mental health • Homeless services • Corrections • HOPWA	• Affected communities, including individuals with HIV disease or AIDS, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and historically underserved groups and subpopulations • Non-elected community leaders • State Medicaid agency • State agency administering the Part B program • Ryan White grantees under Part C and Part D (If there is no Part D grantee in the EMA or TGA, representatives of organizations in the EMA with a history of serving children, youth, and families living with HIV) • Grantees under other Federal HIV programs (including HIV prevention programs) • Formerly incarcerated PLWHA or their representatives
Planning Body Leadership	
• Usually two Co-Chairs: ▪ Community co-chair elected by the planning body membership in accordance with its policies and procedures ▪ Grantee co-chair selected by the Health Department • Co-chairs lead the meetings, conduct activities between meetings, and call special meetings as necessary.	• Planning Council determines leadership structure and roles with CEO approval • Legislation does not permit an employee of the grantee to be the sole chair of a Planning Council
Policies and Procedures	
• HPG and Health Department share responsibility for developing policies and procedures that address membership, roles, and decision making; includes planning body composition, roles and responsibilities, conflict of interest, and conflict resolution • Guidance indicates that "flexibility is offered regarding potential operational modes of planning, such as the number of HPG members, frequency of meetings, meeting participation, and various strategies for expanded stakeholder and community engagement"	Planning Council bylaws expected to include: • Mission of the planning council • Member terms and how members are selected (open nominations process). • Duties of members • Officers and their duties • How meetings are announced and run, including how decisions are made • What committees the planning council has and how they operate • Conflict of interest • Grievance procedures • Code of Conduct for members

	• How the bylaws can be amended
Bylaws or protocols should : • Define roles and responsibilities of Health Department and HPG • Contain reasonable term limits for HPG membership and appointment of co-chairs (and committees if needed) • Be reviewed annually	
Planning Body Support	
Prevention Planning Coordinator (PPC) [though this is not a requirement], usually a Health Department employee or contractor; Coordinator is not a voting member of the HPG	Planning Council support, including cost of hiring staff, is a part of the Grantee's administrative budget of up to 10% of total grant
Support costs for HPG activities are part of the Health Department's prevention budget	Planning Council and grantee decide together the amount of funds to be spent on Planning Council support
Funds are managed by the Health Department	Planning Council develops its own budget and monitors expenses (usually with help from its staff), but must meet Ryan White and municipal rules regarding use of funds