BROWARD HIV HEALTH SERVICES PLANNING COUNCIL

PSRA Data Workshops
Day 3

Wednesday, May 20, 2026
10:00AM to 4:00PM

Broward Regional Health Planning Council (BRHPC)

FORT LAUDERDALE/BROWARD EMA

BROWARD HIV HEALTH SERVICES PLANNING COUNCIL

A BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS

200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020

(954) 561-9681 • FAX (954) 561-9685

Priority Setting & Resource Allocation Committee Meeting Agenda

Wednesday, May 20, 2026 – 10:00 AM

Click Here to Join Priority Setting and Resource Allocation Committee Meeting

Meeting ID: 251 437 066 890 59

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Phone conference ID: 703 542 346#

Chair: Brad Barnes • Vice Chair: Dr. Mark Schweizer

This meeting is audio and video recorded.

ORDER OF BUSINESS

I. Call to Order

II. Welcome from the Chair:
- **a.** Meeting Ground Rules
- **b.** Statement of Sunshine
- **c.** Introductions & Abstentions
- **d.** Moment of Silence

III. Public Comment

IV. **ACTION ITEM:** Approval of Agenda for May 20, 2026

V. **ACTION ITEM:** Approval of Minutes from April 9, 2026, *tabled till June 18, PSRA Meeting*

VI. Standard Committee Items

- **a.** Ryan White Part A Office: Overall FY24-25 Allocations Expenditure/Utilization Report – by service category: *Recipient Representative (10 minutes)* **(Handout A)**

VII. New Business:
- **a. Action Item:** Priority Setting Resource Allocation Members Ranking of All Services; *PCS Support Staff* **(Handout B)**
- **b. Action Item:** How Best to Meet the Need; *PCS Support Staff* **(Handout C)**
- **c. Action Item:** Service Categories Funding/Justification Service Categories Not Funding; *Recipient Office* **(Handout D)**
- **d. Action Item:** Funding Allocation 2027-2028 by Service Category; *PSRA Chair*
- **e. Discussion:** Integrated Plan/Priority Setting Committee Workplan; *PSRA Chair* **(Handout E)**
- **f. Discussion:** PSRA/EHE Retreat; *PSRA Chair*

VIII. Public Comment

IX. Recipient Report

X. **Next Meeting Dates:**

a. Regular PSRA Meeting: June 18, 2026, 9:30AM to 12:30PM. Location: Microsoft Teams and BRHPC

b. Agenda Items for Next Meeting:

- FY2026 Reallocation/Sweeps – Cycle One
- AIDS Drug Assistance Program (ADAP) Updates

XI. Announcements

XII. 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.

May 2026

Broward HIV Health Services Planning Council Calendar

All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Please contact support staff at **hivpc@brhpc.org** or **(954) 561-9681 ext. 1244/1343**. Visit **HIV Health Service Planning Council** for updates.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2 
3	4	Community Empowerment Committee (CEC) 3:00PM - 5:00PM 5	6	System of Care Meeting (SOC) 9:30AM - 11:30AM 7	8	9
 10	11	12	13	Local Pharmacy Asisstance Committee (LPAC) 2:00PM - 4:00PM 14	Integrated Planning Work Group (IP) 11:30AM - 2:30PM 15	16
17	PSRA Data Presentation Workshop Day 1 10:00AM - 4:00PM 18 	PSRA Data Presentation Workshop Day 2 10:00AM - 4:00PM 19	PSRA Data Presentation Workshop Day 3 10:00AM - 4:00PM 20 Quality Network Meeting (CQM) 10:00AM - 11:15AM In-Person	Executive Committee Meeting 12:45PM - 2:45PM 21	22	23
24	 25 BRHPC Office Closed	26	27	HIV Planning Council Meeting 9:30AM to 11:30AM 28	Medical Case Management Meeting (CQM) 2:30PM - 3:45PM 29 Integrated Planning Work Group (IP) 9:30AM - 12:30PM	 30
31						

Broward Regional Health Planning Council (BRHPC):
200 Oakwood Lane, Suite #100, Hollywood, FL 33020
Links are active and lead to meetings or Awareness Day Information. **Information is subject to change.**

Meetings in **RED** are canceled. Meetings in **BLUE** are for the HIV Planning Council Committees. Meetings in **GREEN** are for the Provider Network. Holidays and meetings outside of the HIV Planning Council are in **BLACK**.

May 2026

Broward HIV Health Services Planning Council Calendar

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TODOS ESTAN BIENVENIDOS!	ALL ARE WELCOME!	BON VINI!
A menos que se anote de forma diferente en el calendario, todas las reuniones se realizarán en: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Para confirmar información acerca de la reunión de Consejo de Planeación HIV, o confirmar la reserva de servicios especiales tales como: Traducción Inglés a Español o a Criollo (Haitiano), servicios para discapacitados en visión o audición, por favor llame con 48 horas de antelación para que puedan hacerse los arreglos necesarios.	Unless otherwise noted on the calendar, all meetings are held at: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 To confirm HIV Planning Council meeting information, or reserve special needs services such as Translation from English to Spanish or Creole, or are hearing or visually impaired, please call 48 hours in advance so that arrangements can be made for you.	Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fét: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Pou konfime enfòmasyon ou resevwa sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyol; oswa, si ou gen pwoblèm wè oswa tande, rele 48 tè alavans pou yo ka fè aranjman pou ou.

HIVPC Committee Descriptions

HIV Health Services Planning Council (HIVPC): Continuously monitors, evaluates, and improves the quality of HIV care for Ryan White Part A and MAI-funded patients.

Executive Committee (EXEC): Oversees the HIV Integrated Prevention and Care Plan, work of HIVPC committees, recommendations, and grievance resolution. Sets HIVPC agendas, manages conflicts of interes, and review attendance.

Priority Setting and Resource Allocation Committee (PSRA): Recommends priorities and allocates Ryan White Part A funds based on data review. Develops, monitors, and refines eligibility, service definitions, and strategies to meet community needs.

Quality Management Committee (QMC): Ensures high-quality HIV care by developing outcomes and indicators. Oversees standards of care, evaluates programs, assesses client satisfaction, and training.

Membership/Council Development Committee (MCDC): Recruits and screens applicants to ensure the Council meets demographic requirements. Provides recommendations, orientation, training for new members.

Community Empowerment Committee (CEC): Engages in community outreach to Ryan White Part A consumers to inform them about opportunities to participate in the HIV Planning Council and provide input.

System of Care Committee (SOC): Evaluates the system of care and the impact of policies on people living with HIV in Broward County. Plans and coordinates care across diverse groups to improve access and reduce disparities.

Handout A

Ft. Lauderdale/Broward EMA
Ryan White Part A and MAI
FY 25-26 Allocations

	Service Category	Contract/ Allotted Amount	Expended Amount As of FEB Invoice	Expended %	Unduplicated Clients Served	Average Cost Per Client	Unexpended Amount	Average Monthly Expenditures	FY 2025-26 Projected Expenditures	Provider Unspent Billables
Core Medical Services	Ambulatory- Integrated Primary Care and Behavioral Health Services (7)	5,537,990	5,482,758	99%	3134	$1,749.44	55,232	456,896	5,482,758	301,627
	AIDS Pharmaceutical Assistance (3)	4,652	2,779	60%	5	$555.87	1,873	232	2,779	-
	Oral Health Care Routine (4)	2,404,053	2,399,204	100%	2256	$1,216.71	4,849	199,934	2,399,204	113,375
	Specialty (1)	346,964	345,692	100%			1,272	28,808	345,692	-
	Medical Case Management Disease Case Management (9)	900,478	878,845	98%	539	$1,630.51	21,633	73,237	878,845	166,895
	Mental Health- Trauma-Informed (4)	124,000	123,387	100%	84	$1,468.89	613	10,282	123,387	1,812
	Health Insurance Premium & Cost Sharing Assistance	619,465	619,439	100%	1318	$469.98	26	51,620	619,439	-
	Medical Nutrition Therapy (1)	250,000	246,628	99%	285	$865.36	3,372	20,552	246,628	-
	Substance Abuse-Outpatient (1)	185,684	185,683	100%	35	$5,305.22	1	15,474	185,683	59,609
Support Services	Non-Medical Case Management Centralized Intake and Eligibility Determination (1)	416,454	416,442	100%	4408	$94.47	12	34,704	416,442	75,968
	Non-Medical Case Management Case Management (10)	1,433,684	1,433,554	100%	2820	$508.35	130	119,463	1,433,554	441,817
	Food Services Food Bank (2)	620,000	606,976	98%	1544	$393.12	13,024	50,581	606,976	-
	Food Voucher (3)	33,186	33,109	100%	289	$114.56	77	2,759	33,109	-
	Legal Assistance (1)	129,151	129,138	100%	80	$1,614.22	13	10,761	129,138	-
	Emergency Financial Assistance (3)	194,872	167,010	86%	133	$1,255.71	27,862	13,917	167,010	-
	Total Part A Funds	**13,200,633**	**13,070,643**	**99%**			**129,990**	**1,089,220**	**13,070,643**	**1,161,103**
	*** Some of the providers have not billed for month of FEB 2025**									

	Service Category	Contract/ Allotted Amount	Expended Amount As of FEB Invoice	Expended %	Unduplicated Clients Served	Average Cost Per Client	Unexpended Amount	Average Monthly Expenditures	FY 2025-26 Projected Expenditures	Provider Unspent Billables
Core Medical Services	MAI Ambulatory (1)	1,000	625	62%	1		375	52	625	-
	MAI Mental Health (1)	82,469	68,813	83%	26	$2,646.65	13,656	5,734	68,813	-
	MAI Substance Abuse-Outpatient (1)	461,318	454,443	99%	67	$6,782.73	6,875	37,870	454,443	-
Support Services	MAI Non-Medical Case Management Case Management (4)	274,967	274,413	100%	414	$662.83	554	22,868	274,413	95,310
	MAI Non-Medical Case Management Centralized Intake and Eligibility Determination (1)	541,431	541,424	100%	5253	$103.07	7	45,119	541,424	57,006
	Total MAI Funds	**1,361,185**	**1,339,718**	**98%**			**21,467**	**111,643**	**1,339,718**	**152,316**
	*** Some of the providers have not billed for month of FEB 2025**									
	*** Carryover amount of $254,837 included in calculations.**									
	Total Part A and MAI Funding	**14,561,818**	**14,410,361**	**99%**			**151,457**	**1,200,863**	**14,410,361**	**1,313,419**

Handout B

Report for FY 2027-2028 PSRA Ranking Survey

Response Counts

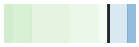
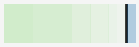
Completion Rate:	**100%**	
	Complete	14

Totals: 14

Value	Percent	Responses
Barnes, Brad	7.1%	1
Biggs, Von	7.1%	1
Castillo, Jose	7.1%	1
D'Amore, Franchesca	7.1%	1
Hafley, Shalisa	7.1%	1
Jimenez, Rafael	7.1%	1
Jones, Leonard	7.1%	1
Mester, Brad	7.1%	1
Patterson, Matthew	7.1%	1
Robertson, Lorenzo	7.1%	1
Rodriguez, Joshua	7.1%	1
Schickowski, Kara	7.1%	1
Schweizer, Mark	7.1%	1
Tinsley, Shawn	7.1%	1

Totals: 14

2. CORE SERVICES. Listed below are the core services that meet the federal government's requirements for Part A funds. Please rank the services in their order of importance to Broward residents living with HIV. The score of 1 is given to the most important service, while the score of 13 is the lowest important service. Do not give two services the same rank.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
AIDS Pharmaceutical Assistance (Local)	1		161	14
Outpatient/Ambulatory Health Services (OAHS)	2		154	14
Health Insurance Premium and Cost Sharing (HICP)	3		153	14
Medical Case Management (Disease)	4		127	14
Oral Health Care (Dental) [Routine & Specialty Care)	5		125	14
AIDS Drugs Assistance Program Treatments (ADAP)	6		119	13
Mental Health Services	7		100	14
Substance Abuse- Outpatient	8		83	14
Early Intervention Services (EIS)	9		69	14
Medical Nutrition Therapy	10		51	14
Home and Community-Based Health Services	11		48	14
Home Health Care	12		45	14
Hospice	13		26	14

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Non-Medical Case Management	1		205	14
Food Bank/Home-Delivered Meals	2		198	14
Medical Transportation Services	3		185	14
Housing	4		181	14
Emergency Financial Assistance	5		174	13
Legal Services	6		147	14
Referral for Health Care and Support Services	7		126	14
Substance Abuse- Residential	8		121	14
Psychosocial Support	9		106	14
Outreach	10		104	14
Health Education/Risk Reduction	11		102	13
Linguistics Services (Interpretation and Translation)	12		99	13
Child Care	13		90	12
Rehabilitation Services	14		86	14
Respite Care	15		67	14
Other Professional Services	16		65	14
Permanency Planning	17		63	14

Handout C

Broward County Ryan White Part A
HIV Health Services Planning Council
"HOW BEST TO MEET THE NEEDS/PRIORITIES LANGUAGE"
Recommendations by the System of Care Committee to the
Priority Setting Resource Allocation Committee for FY 2027-2028
Approved during the *05/07/2026* SOC Meeting
***Note = New recommended needs/priorities language is in blue**

Recommendations At-A-Glance

All Services

1. Annual SDM Training and Documentation
2. Peer Specialist Resource Webpage and Feedback Platform
3. Training Plans and Continuing Education Requirements

Outpatient Ambulatory Health Services (OAHS) /Integrated Primary Care and Behavioral Health

1. Develop a Collaborative Specialty Care Support System
2. Strengthen Documentation of Oral Health Counseling

Health Insurance Continuation Program

1. HICP Infrastructure for ACA Premium Assistance

Sources: *HIV Needs Assessment FY2025; Listening Sessions (April, August, and October 2025); HIV Planning Council changes related to ADAP updates (April 9, 2026).*

Coding: <u>underscored</u> type are additions

ALL SERVICES

Recommended Language

Recommendations for FY2027-2028

Workforce Development

1. Annual SDM Training and Documentation

- Conduct an annual online Service Delivery Model (SDM) training review for all providers.
- Maintain records of training completion at each subrecipient site.
- Ensure all providers have a comprehensive understanding of the applicable SDM.

2. Peer Specialist Resource Webpage and Feedback Platform

- Develop a Broward RW Part A EMA webpage dedicated to Peer Specialists in HIV.
- Include:
  - Certification resources
  - Links to continuing education opportunities
  - A comment and feedback option
- Share collected feedback with the Clinical Quality Management (CQM) team.
- Use this platform to capture Peer Specialists perspectives.

3. Training Plans and Continuing Education Requirements

- Ensure all subrecipient agencies maintain a documented training plan for new service providers covering each service offered to Broward RW Part A clients.
- Require all RW Part A service providers to complete annual continuing education (CE) related to HIV treatment and care.
- Determine total CE hours through collaboration between:
  - RW Part A Recipient staff
  - AIDS Education and Training Center (AETC)

Previous Recommendations (2026-2027)	**Recipient Response** **Recommendations for FY2026-2027** **Status as of 05.04.2026**
1. Address higher viral loads among various demographic groups, including individuals of Black/African Americans, Haitian descent, and Youth/adolescents (18-28 yrs old)	1. The Recipient Office began including individuals with high viral loads in monthly calls, providing a list of those identified as having elevated levels. Additionally, discussions on viral suppression were prioritized during provider monitoring. As of the end of the year, the overall Viral Suppression rate stands at 90%.
2. Increase on-demand telehealth* adoption and training for clients and licensed health care providers, including NMCM/MCM. **Telehealth Note:* *1. Standardized telehealth means delivering virtual care in a consistent, regulated, and*	2. Telehealth was always available to providers, particularly around NMCM/MCM, as well as IPCBH and Mental Health. We did remind providers that it's an allowable way to render services.

high-quality way across providers so patients receive safe and effective care no matter where or how they access services.
2. Telehealth allows case managers to stay connected through virtual appointments (video or phone), to support treatment adherence, coordinate care, and monitor clients more efficiently, especially for those who may have difficulty accessing in-person services.

3. Increase consumer utilization of patient portals

4. Require Peer Specialists to attend quarterly Support Network meetings with salary reimbursement for participation

5. Standardize job descriptions for Peer Specialists and increase the number of employed Peer Specialists.

6. Track MCM turnover rates in the RW Part A system of care and suggest interventions to improve MCM retention.

7. The Recipient office should regularly provide updates in the form of data and reports to show evidence of executing HBTMTN recommendations.

8. Consider establishing an on-demand healthcare team to meet the needs of urgent licensed medical healthcare providers, MCM, NMCM, Behavioral Health, and Peer client needs.

9. Develop a planned collaborative process for RWPA licensed health care providers' access to subspecialty care services.

10. Partner with Broward 211 to provide education on RWPA and EHE services in Broward County and to provide RWPA contracted entities with education on 211 Broward services

3. The recipient office has no control over whether individuals utilize patient portals. To our knowledge, most medical providers offer some form of patient portal.

4. We cannot require specific staff titles to attend network meetings; we do make network meetings mandatory for providers, and it is up to the agency who they send. To that end, a fair number of peer specialists attend EHE's support network meetings and capacity-building sessions.

5. We cannot standardize a job description; we only have requirements in our taxonomy and or SDM

6. We did not get an opportunity to track the turnover rate; it has been an internal discussion

7. We did provide data updates, albeit not specific to these recommendations.

8. Monetary cost is too high, and it is unable to be established at this time.

9. Ultimately, contractually, it is up to the providers to establish MOUs for their services.

10. 211 has information available, but any outreach and education would require a contractual obligation with 211, which currently does not exist.

Recommendations for FY2025-2026

1. Verify the accuracy of client data entered into the HIV Human Services Software System (Provide Enterprise).
2. When an alert is noted in the HIV Human Services Software System (HSSS) (Provide Enterprise - PE), proof of documented action must be recorded in the HIV/ MIS
3. When an alert is noted in the HIV Human Services Software System (HSSS) (Provide Enterprise - PE), proof of documented action must be recorded in the HIV/ MIS

Recipient Response
Recommendations for FY2025-2026
Status as of 04.28.2025

1. This is a requirement in the Universal SDM; providers were given ample notification during the last monitoring cycle. Failure to maintain up-to-date, accurate information in PE during the FY25-26 Monitoring cycle will result in corrective action plans (CAPs).
2. This item was pursued; however, it is not possible to program it within PE. The Recipient office would have to pay to make it possible, and currently, there are conflicting priorities in the Statement of Works.
3. Same issue as number two (2). However, we can reapproach this recommendation.

Recommendations FY2024 and Previous Years

1. Develop a formal client orientation program that includes a visual tour and access procedures explained by a Community Health Worker or Peer when they are linked to treatment. (2021-2022 Broward County HIV Community Needs Assessment).
2. Develop and ensure that all Part A Providers receive Educational Tools that support a more caring and culturally competent workforce (2021-2022 Broward County HIV Community Needs Assessment and CEC Community Conversations).
3. Ensure collaboration and knowledge sharing between Providers and Peers in delivering HIV treatment and care (2021-2022 Broward County HIV Community Needs Assessment).
4. Increase after-hours/ non-traditional hours across all services to ensure clients have access to care (CEC)
5. Ensure Part A Providers document collaborative agreements with all other organizations within their continuum of care, and across systems to help clients address all their needs.
6. Maintain client satisfaction with services by offering regular feedback opportunities, including surveys or focus groups, conducting annual customer service training for staff, and providing follow-up when necessary.
7. Develop collaborative agreements with treatment adherence programs and

Recipient Response
Recommendations for FY2024 and Previous Years
Status as of 04.28.2025

1. The Recipient office is working on a client resource guide, but a video production for a visual tour may not be feasible at this moment.
2. At the time, the county was actively supporting cultural competency initiatives; however, these efforts have now been indefinitely tabled.
3. The Recipient Office funds Peer Counseling as a service category under EHE. Peer counseling was always allowable under case management.
4. Providers are required to offer after-hours services, though the required number of hours remains unchanged.
5. Providers are required to establish MOUs for service, though it is not currently a requirement to share with the Recipient office
6. The Recipient Office and the HIVPC conduct surveys, listening sessions, and focus groups.
7. Subrecipients coordinate and collaborate with Disease Intervention

other key points of entry to facilitate rapid eligibility determination for the newly diagnosed and for clients who have fallen out of care.	Specialists through the Broward County Health Department.
8. Enhance the emphasis on adherence and retention in medical care, inclusive of sub-populations not achieving viral load suppression, including but not limited to: a. Black heterosexual men and women b. Black men who have sex with men (MSM) 18-38 years of age	8. We established disparities in care back in 2019/2020 and contracted with an MAI NMCM provider to facilitate services. Retention in Care (RIC) has been steadily increasing amongst vulnerable populations
9. Integrate care collaboration with members of the client's service providers.	9. Case Conferencing is an allowable taxonomy, and the recipient office encourages providers to utilize it.
10. Collect accurate client-level data on stages of the HIV Care Continuum to identify gaps in services and barriers to care.	10. Reporting has been structured and changed over the last few years; however, most data is still by human entry.
11. Implement formal policies addressing referrals amongst internal and external providers to maximize community resources	11. There is no significant update on this matter, and it remains uncertain whether it is permissible under contracts. At present, it is not a requirement.
12. Co-locate services where applicable, to facilitate a medical home for Part A clients.	12. No update on this.
13. Inform appropriate parties that coverage of services is contingent on available funds.	13. The Recipient Office includes payment contingent on funds in the contract.
14. Ensure that subrecipients have a plan to address payment of services when funds are low.	14. The Recipient Fiscal Team asks this question during monitoring of subrecipient agencies
15. Require providers to follow HHS guidelines for newly diagnosed clients who are not virally suppressed until virally suppressed.	15. Required activity outlined in universal standards and service delivery models

CORE MEDICAL SERVICES

Outpatient Ambulatory Health Services (OAHS)/ Integrated Primary Care and Behavioral Health

Services Criteria: (≤ 400%)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

1. **Develop a Collaborative Specialty Care Support System**
   Establish a coordinated system that enables subrecipient agencies to collaborate in supporting one another to provide screenings and access to specialty care for clients aging with HIV. Priority specialty care gaps in the Broward EMA include, but are not limited to, orthopedics, pulmonology, neurology, rheumatology, ophthalmology, gastroenterology, vision care, podiatry, cardiology, and endocrinology.

2. **Strengthen Documentation of Oral Health Counseling**
   Ensure licensed health care providers consistently document discussions with clients on the importance and benefits of maintaining oral health care alongside antiretroviral therapy, emphasizing its role in achieving viral suppression and improving both short- and long-term health outcomes.

Previous Recommendations	Recipient Response Recommendations for FY2026-2027 Status as of 04.28.2025
Recommendations for FY2026-2027	Recommendations for FY2026-2027
1. Require quarterly network meetings for MCMs, licensed health care providers, and Mental Health specialists with salary reimbursement for participation.	1. Network meetings have been implemented.
2. Inform Licensed health care providers when their client declines accepting ACA so they can address the issue.	2. The case managers have been heavily involved in this ACA process and insurance in general due to meetings with the recipient office. Case managers should be informing their licensed medical health care providers as appropriate. We currently do not have a mechanism otherwise to engage in this.
3. Refer all clients who struggle with retention in care or attaining viral load suppression to EHE services	3. This is already a requirement if a client has a high viral load or fell out of care recently. We are currently developing a process to identify and capture clients who are at risk of falling out of care or have recently done so, per PE.
Recommendations FY2024 and Previous Years	**Recommendations FY2024 and Previous Years**
1. Educate clients about: a. Medicare enrollment guidelines, especially those about late enrollment penalties beginning at age 64 and at least four months before they turn 65. (CEC Community Conversations -Long Term	1. The recipient office is working on this by coordinating with the State of Florida and changing reports/views in PE to show clients who may be eligible.

Survivors Awareness Day), b. Social Security Disability Insurance (SSDI) and potential Medicare benefits that are effective within 48 months of a client receiving SSDI, and c. Private Insurance/ Affordable Care Act (ACA) Options.	
2. Create more information about the food services eligibility for medical providers, clinical teams, and case managers. (2021-2022 Broward County HIV Community Needs Assessment).	2. We have had a few educational sessions about Food and Medical Nutritional Therapy with providers.
3. Integrate Test and Treat along with behavioral health screenings into primary care to enhance access to OAHS, which may require increased funding for additional staffing and service provision.	3. PHQ2-PHQ9 are already required. Increased funding is not an option at the moment.
4. Integrate Primary Care & Behavioral Services funded agencies to provide Outpatient Ambulatory Medical Care, Behavioral Health, and Care Coordination services.	4. All those are covered under IPCBH.
5. Providers should assess clients, offer brief therapy, and refer them to advanced care when necessary.	5. Current standard procedure
6. Integrate care provider collaboration with members of the client's treatment team outside of the organization.	6. Several providers collaborate, but the Recipient office can increase
7. Establish shared clinical outcomes and data sharing to maximize coordination and tracking of client health outcomes.	7. Unsure in this case what "shared" means. Service categories share similar outcomes
8. Require that Care Coordinators monitor the delivery of care; document care; identify progress toward desired health outcomes; review the care plan with clients in conjunction with the direct care providers; interact with involvement departments to ensure the scheduling and completion of tests, procedures, and consult track and support patients when they obtain services.	8. This is covered under case management if the client has accepted case management.
9. Provide after-hours services availability to include Crisis Intervention.	9. After-hours services are contractually required.
10. Coordinate referrals with other service providers; conduct follow-up with clients to ensure linkage to referred services.	10. When a client is referred, follow-up is required
11. Ensure providers are knowledgeable regarding the management of patients co-infected with HIV and Hepatitis C Virus (HCV).	11. Subrecipients received training on the recommended HIV and HCV topics a few years ago.
12. Incorporate prevention messages into the medical care of PWH/A: Undetectable=Untransmittable (U=U), or Treatment as Prevention	12. Current requirement under the standards of care.
13. Inform Disease Intervention Specialists (DIS) about clients who have stopped receiving care to confirm if they are out of care or relocated. Document communications between Part A service providers and DIS.	13. Current requirement in universal standards

AIDS PHARMACEUTICALS (LOCAL)

Services Criteria: (≤ 400%)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2027-2028 Status as of 04.28.2025
1. Include drugs used for Test and Treat.	1. Included in the service delivery model
2. Report clients who have fallen out of care to Disease Intervention Specialists to determine if clients are not in care or have moved to a different payer source.	2. Included in the service delivery model

ORAL HEALTH CARE (OHC)

Services Criteria: (≤ 300%)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2027-2028 Status as of 04.28.2025
1. Plan to accommodate the increased demand for services due to additional service locations.	1. Included in the service delivery model
2. Maintain specialty oral health care services and provide care beyond extractions and restoration to include, but not be limited to, full or partial dentures and surgical procedures, periodontal work, and root canals.	2. Included in the service delivery model
3. Increase Oral Health Care collaboration with mental health providers.	3. Included in the service delivery model
4. Expand and separate Oral Health Care services funding into two components: Routine maintenance care and Specialty Care.	4. Included in the service delivery model

HEALTH INSURANCE CONTINUATION PROGRAM (HICP)

Criteria: (≤ 300% PL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

Maintain a sustainable infrastructure to support access to affordable health coverage for eligible clients through the HICP in response to ADAP changes. This framework will include HICP funding for ACA premiums, clearly defined Federal Poverty Level (FPL) eligibility criteria, and the established cap on ACA premium assistance.

Previous Recommendations	Recipient Response Recommendations for FY2027-2028 Status as of 04.28.2025
1. Establish a protocol to increase clients' access to HICP.	1. Current standard procedure
2. Develop materials for clients to use as quick references.	2. Current standard procedure
3. Maintain routinized payment systems to ensure timely payments of deductibles and co-payments.	3. Current standard procedure

MENTAL HEALTH SERVICES (MH)

Services Criteria: (≤ 300% PL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2026-2027 Status as of 04.28.2025
<u>Recommendations for FY2026-2027</u>	<u>Recommendations for FY2026-2027</u>
1. Require Mental Health specialists to attend quarterly Behavioral Health network meetings with salary reimbursement for participation.	1. The Recipient Office cannot require specific subrecipient personnel to attend meetings and can only encourage participation; however, attendance can be enforced at the agency level.
2. Increase access to Mental Health services (i.e., offer tele-mental health services and or meet with clients in the field)	2. Telehealth has always been an option.
Recommendations FY2024 and Previous Years	**Recommendations FY2024 and Previous Years**
1. Inform the medical team about clients who missed mental health	1. Included in the service delivery model

appointments to promptly reengage them in services. Ensure all communications with licensed medical health care providers are thoroughly documented.	
2. Provide Trauma-Informed Mental Health Services, referring clients to the prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.	2. Included in the service delivery model
3. Provide after-hours availability to include Crisis Intervention.	3. Included in the service delivery model

MEDICAL CASE MANAGEMENT (MCM)

Services Criteria: (≤ 300% PL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2026-2027 Status as of 04.28.2025
<u>Recommendations for FY2026-2027</u>	<u>Recommendations for FY2026-2027</u>
1. Require MCMs to attend quarterly MCM network meetings with salary reimbursement for participation.	1. The Recipient Office cannot require specific subrecipient personnel to attend meetings and can only encourage participation; however, attendance can be enforced at the agency level.
2. For clients failing to achieve undetectable viral load (UDVL), increase MCM attendance at licensed health care provider visits and increase MCM out-of-office interactions or tele-MCM visits, when appropriate.	2. During monitoring, most agencies identified clients who were difficult to retain in care. In response, MCMs accompanied these clients to their medical appointments to support adherence. However, there is currently no formal requirement addressing individuals who have not achieved viral suppression.
Recommendations FY2024 and Previous Years	**Recipient Response Recommendations FY2024 and Previous Years**
1. Provide case managers and other service providers with information on the linkage between HIV treatment and management and the various support services.	1. Included in the service delivery model
2. Educate clients beginning at age 64 and at least four months before they turn 65 about Medicare enrollment guidelines, especially those about late enrollment penalties. *(CEC Community Conversations -Long Term Survivors*	2. Included in the service delivery model

Awareness Day, 2023)	
3. Coordinate referrals with other service providers; conduct follow-ups with clients to ensure linkage to referred services.	3. Included in the service delivery model
4. Report changes in viral load status as clients progress through the program.	4. Included in the service delivery model

MEDICAL NUTRITION THERAPY (MNT)

Services Criteria: (≤300% PL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2027-2028 Status as of 04.28.2025
1. Ensure that a licensed registered dietitian or other licensed nutrition professional provides a medically tailored menu and food choice development.	1. Included in the service delivery model
2. Ensure that diets and meals recommended by a licensed registered dietician or licensed nutritional professional will be based on a nutritional assessment and a prescription by a licensed healthcare provider to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes for clients.	2. Included in the service delivery model
3. Coordinate referrals with other service providers; conduct follow-ups with clients and provide feedback to prescribing clinicians on patients' progress	3. Included in the service delivery model

SUBSTANCE ABUSE – OUTPATIENT SERVICES

Services Criteria: (≤ 300% PL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2026-2027 Status as of 04.28.2025
Recommendations for FY2026-2027	**Recommendations for FY2026-2027**

1. Increase client access to Substance Abuse services (i.e., offer on-demand tele-mental health services)

Recommendations FY2024 and Previous Years

1. Ensure that substance abuse treatment services are offered to all consumers with an active substance use disorder. (2021-2022 Broward County HIV Community Needs Assessment).

1. Telehealth is an option. However, the current model is a Day/Night model.

Recommendations FY2024 and Previous Years

1. Included in the service delivery model

SUPPORT SERVICES

Case Management (Non-Medical)

Services Criteria: (≤ 300% PL)

FY2027-2028 FPL To Be Determined

Recommended Language

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2026-2027 Status as of 04.28.2025
<u>Recommendations for FY2026-2027</u> 1. Identify community referral options that facilitate secure housing for clients. 2. Identify housing obstacles that negatively impact retention in care to help clients consistently access and engage with their healthcare services. 3. Educate clients to increase awareness of EHE housing assistance	<u>Recommendations for FY2026-2027</u> 1. Current housing providers also have connections to other community resources; housing resources are extremely thin right now. 2. The EHE housing program has a housing assessment that includes some of this information, and we already track housing status. 3. Housing services are 100% utilized, clients are educated; however, services are limited.

Recommendations FY2024 and Previous Years	Recipient Response Recommendations FY2024 and Previous Years Status as of 04.28.2025
1. Educate clients about: a. Medicare enrollment guidelines, especially those pertaining to late enrollment penalties beginning at age 64 and at least four months before clients turn 65. *(CEC Community Conversations -Long Term Survivors Awareness Day, 2023),*	1. Included in the service delivery model

b. Social Security Disability Insurance (SSDI) and potential Medicare benefits that are effective within 48 months of a client receiving SSDI, and c. Private Insurance/ACA Options.	
2. Implement the Test and Treat Program to increase linkage to care, retention in care, and viral load suppression.	2. Included in the service delivery model
3. Deliver specialized staff training to guarantee that clients receive comprehensive information regarding the transition to insurance plans, encompassing medication collection, co-payments, network adherence, and other pertinent details.	3. Included in the service delivery model
4. Offer client education to decrease fear and denial and encourage entry into primary medical care.	4. Included in the service delivery model
5. Educate clients on the importance of remaining in primary medical care.	5. Included in the service delivery model
6. Direct a minimum of 30% of the personnel funded for Non-Medical Case Management to be allocated to Peer positions.	6. Included in the service delivery model
7. Incorporate prevention messages into the medical care of PWH/A.	7. Included in the service delivery model
8. Educate consumers on their role in the case management process.	8. Included in the service delivery model
9. Provide initial/ongoing training and development for HIV peer workers.	9. Included in the service delivery model
10. Provide clients with a comprehensive summary of health care plan benefits, detailing both coverage and limitations.	10. Included in the service delivery model
11. Inform clients about the various types of health care providers (i.e., Primary Care, Urgent Care, and Specialty Care).	11. Included in the service delivery model
12. Follow up with new clients within 90 days of certification to confirm their engagement in care.	12. Included in the service delivery model

Case Management (Non-Medical)
CENTRALIZED INTAKE AND ELIGIBILITY DETERMINATION (CIED)
Services Criteria: 400% HIV+ Broward County Resident (All Clients)
FY2027-2028 FPL To Be Determined
Recommended Language

Recommendations for FY2027-2028
No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2026-2027 Status as of 04.28.2025
Recommendations for FY2026-2027	Recommendations for FY2026-2027
1. Conduct education sessions for clients on the recertification and co-pay processes	1. We can look into a YouTube series, perhaps. HICP has acknowledgment forms, and case managers have been advised of the process.
2. Determine which clients are eligible for ACA services and assist them with completing their applications as necessary	2. This is already being done.
3. Increase the client's awareness of Medicare enrollment timing and provide the client guidance for enrollment in the program	3. Currently, we have case managers who are aware (or should be at this point). We can look into additional assistance; we currently have competing priorities.
Recommendations FY2024 and Previous Years	**Recipient Response Recommendations FY2024 and Previous Years Status as of 04.28.2025**
1. Inform clients aged 64 to begin preparing to transition to Medicare and direct them to create an online account at www.ssa.gov	1. Current standard procedure
2. Guide clients for Ryan White Part A/B dual eligibility determination due to the (reciprocity and NOE process).	2. Current standard procedure
3. Guide clients for Ryan White Part A/B dual eligibility determination due to the (reciprocity and NOE process).	3. Current standard procedure
4. Ensure the locations and service hours target historically underserved populations that HIV disproportionately impacts.	4. CIED staff are based at eleven (11) RW agencies located within underserved areas.
5. Maintain collaborative agreements with treatment adherence programs and other key entry points to facilitate rapid eligibility determination for the newly diagnosed and clients who have fallen out of care.	5. CIED has MOUs with eight (8) RW agencies, which house CIED staff
6. Distribute the client handbook to provide an overview of the purpose of Ryan White Part A services and include the following:	6. CIED will distribute client handbooks once received from the Recipient Office. The CIED consent form includes client rights and

a. Client rights and responsibilities, b. Names of providers, complete with addresses and phone numbers, and c. Grievance procedures.	responsibilities, a directory of providers with full contact details, and grievance procedures.
7. Always offer a dedicated live operator phone line during normal business hours.	7. This feature is accessible through the Broward Regional Health Planning Council at 954-566-1417.
8. Ensure that the intake data collected for clients categorized as unspecified is sufficiently comprehensive to fully utilize gender-related classifications within PE.	8. Current standard procedure: I*tem is updated in accordance with Executive Order 14168, issued on January 20, 2025. (Unspecified terminology recommended by QMC during the 3/20/2025 meeting.)*

EMERGENCY FINANCIAL ASSISTANCE

Services Criteria: (≤ 300% FPL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2027-2028 Status as of 04.28.2025
1. Include drugs used for Test and Treat.	1. Included in the EFA service delivery model
2. Provide limited one-time or short-term pharmaceutical assistance for Ryan Part A client	2. Included in the EFA service delivery model

FOOD SERVICES

Services Criteria (as of 10/1/2023): ≤150% FPL with 1 unit per month

FY2027-2028

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Previous Recommendations	Recipient Response Recommendations for FY2027-2028 Status as of 04.28.2025
1. Develop detailed information about the eligibility criteria for food services for licensed healthcare providers, clinical teams, and case managers.	1. Included in the service delivery model

2. Enhance collaboration with the client's primary care physicians and nutrition counselors to ensure that the client's nutritional requirements are adequately addressed.	2. Included in the service delivery model
3. Conduct workshops and training sessions aimed at enhancing clients' understanding of healthy eating and nutrition in relation to their health management.	3. Included in the service delivery model

LEGAL SERVICES

Services Criteria: (≤ 300% FPL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Handout D

Rank	Providers	Service	Service Description	FY 24 Clients	FY 25 Clients	% of Total FY25 Clients	FY 25 Final Expenditure	FY 25 Initial Allocation		FY 25 Avg Client Cost	FY 25 New Clients		FY 25 Unbillables due to Allocation Cap	FY 25 # of unbillable clients served	FY 26 Initial Allocation	FY 26 Projected Clients	Justification/Factors to Consider	Increase/Decrease Due to Factors		Increase/Decrease Due To Client Utilization		Recommended FY 27 Allocation	
#	#			#	#	%	$	$	%		#	%				#		%	$	%	$	%	$
	7	Outpatient Ambulatory Health Services (OAHS)	Supports diagnostic and therapeutic services, such as primary care, diagnostic testing including laboratory testing, treatment adherence, and specialty services provided directly to a client by a licensed healthcare provider in an outpatient medical setting **Currently funded by Ryan White Part A**	2,800	3,134	37%	$5,482,758	$5,296,953	50%	$1,749.44	598	19%	**$301,627.33**	**1716**	**$ 5,296,953.00**	3,317	OAHS continues to be one of our most accessed services. Historically we see final expenditures exceed the initial allocation with provider unbillables due to allocation cap at year end each year. Due to changes in Florida ADAP benefits that may result in additional clients seeking Part A ambulatory assistance in FY26 and FY27, we recommend a dollar amount increase of $449,100 for the service category.	8%	$449,100	0.0%	$0	52%	$5,746,053
	3	AIDS Pharmacy Assistance (LPAP)	Provides HIV-related medications to low-income clients living with HIV; can also provide access to medications by using program funds to purchase health insurance coverage and through medication cost sharing; **The AIDS Drug Assistance Program is administered by the state through RWHAP Part B, but the Part A LPAP program provides assistance for medications not on the ADAP formulary.**	17	5	0%	$2,779	$192,925	2%	$555.87	0	0%	**$0.00**	**12**	**$ 192,925.00**	13	ADAP assistance had been temporarily drastically reduced by the State in early 2026 and the future of the program remains uncertain. Due to this uncertainty and the potential that Part A will be responsible for HIV-related medication support, we recommend a dollar amount increase of $184,610 for the service category.	96%	$184,610	0%	$0	3%	$377,535
	4	Oral Health	Supports outpatient diagnostic, preventive, and therapeutic oral health services by dental health care professionals based on an oral health treatment plan Broward County RWPA Oral Health Care services funding is separated into two components: Routine Maintenance Care; and Specialty Care. **Currently funded by Ryan White Part A**	2,273	2,256	27%	$2,744,896	$2,491,092	24%	$1,216.71	429	19%	**$113,375.36**	**159**	**$ 2,491,092.00**	2,347	Utilization rates for oral health care remain high with provider unbillables due to allocation cap each year. Routine services are leading the utilization. There remains only one specialty provider. As with ambulaory, there is concern that individuals losing health insurance might also look to Part A for their oral health services. We recommend a $200,000 reduction in the Oral Health Specialty subcategory and a $495,925 increase in Oral Health Routine. This is a recommended overall increase of $259,925.	10%	$259,925	0%	$0	25%	$2,751,017
	1	Health Insurance Premium & Cost Sharing (HICP)	Provides financial assistance to enable PLWH to maintain health insurance or standalone dental insurance by paying their premiums or other cost-sharing expenses, including co-pays, deductibles, and funds to contribute to a client's Medicare Part D true out-of-pocket costs (TrOOP) **Currently funded by Ryan White Part A and Part B**	1088	1452	17%	$619,439	$822,465	8%	$426.61	29	2%	**$0.00**	**0**	**$ 822,465.00**	1,514	HICP had a steady downward trend in recent years. However, with the elimination of ADAP Premium Assistance, HICP will offer premium assistance to a subset of clients who qualify. We recommend that the allocation for this service category be unchanged.	0%	$0	0.00%	$0	7%	$822,465
	9	Medical Case Management	Provides client-centered activities designed to improve health outcomes, such as assessment of service needs, development and updating of an individualized care plan, coordinated access to medical care and support services, continuous client monitoring, treatment adherence counseling **Currently funded by Ryan White Part A**	620	539	6%	$878,845	$837,923	8%	$1,630.51	71	13%	**$166,895.03**	**254**	**$ 837,923.00**	612	Overall MCM has continued to see increased utilization above the initial allocation, even with assistance from EHE funds. In order to provide some financial support to ambulatory and LPAP we recommend a slight decrease of $17,842.	-2%	($17,842)	0.00%	$0	7%	$820,081
	3	Mental Health	Supports diagnostic and therapeutic services, such as primary care, diagnostic testing including laboratory testing, treatment adherence, and specialty services provided directly to a client by a licensed healthcare provider in an outpatient medical setting **Currently funded by Ryan White Part A**	111	84	1%	$123,387	$203,125	2%	$1,468.89	22	26%	**$1,811.64**	**53**	**$ 203,125.00**	91	Utilization in this category has been low for the last several years, including fewer clients being seen. We recommend a decrease $73,125, with a slight increase for MAI.	0%	$0	-36%	($73,125)	1%	$130,000
	1	Medical Nutrition Therapy	The goal of MNT is to provide medically tailored food items and meals that are approved by a licensed registered dietitian or other licensed nutrition professional that reflect appropriate dietary therapy based on evidence-based practice guidelines. Diets and meals recommended by a licensed registered dietician or licensed nutritional professional will be based on a nutritional assessment and a prescription by a medical provider to address medical diagnoses, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes for clients. Clients are required to report to the clinician at a minimum quarterly to discuss their progress and nutritional treatment plan goals. **Currently funded by Ryan White Part A**	88	285	3%	$246,628	$300,000	3%	N/A	13	N/A	**$0.00**	**31**	**$ 300,000.00**	312	Medical Nutrition Therapy is a newly funded service under Part A and has seen underutilization relative to its initial allocation. We recommend a decrease of $50,000.	0%	$0	-17%	($50,000)	2%	$250,000
	1	Substance Abuse (outpatient)	Provides outpatient services for the treatment of drug or alcohol use disorders, including both drug-free treatment and counseling and medication-assisted therapy, harm reduction; can include syringe access services that meet current appropriations law and applicable HHS-, HRSA-, and HAB-specific guidance; does not include the purchase of syringes **Currently funded by Ryan White Part A**	35	35	0%	$185,683	$380,684	4%	$5,305.22	9	26%	**$59,608.94**	**112**	**$ 380,684.00**	78	Substance Abuse continues to see significant Part A underutilization. We recommend a decrease of $230,684 to Part A funding, with no reduction for MAI.	0%	$0	-61%	($230,684)	1%	$150,000
		CORE TOTAL					**$10,284,415**	$10,525,167	80%						**$ 10,525,167.00**				**$875,793**		**-$303,809**	**84.4%**	**$11,047,151**

Rank	Providers	Service	Service Description	FY 24 Clients	FY 25 Clients	% of Total FY25 Clients	FY 25 Final Expenditure	FY 25 Initial Allocation		FY 25 Avg Client Cost	FY 25 New Clients		FY 25 Unbillables due to Allocation Cap	FY 25 # of unbillable clients served	FY 26 Initial Allocation	FY 26 Projected Clients	Justification/Factors to Consider	Increase/Decrease Due to Factors		Increase/Decrease Due To Client Utilization		Recommended FY 27 Allocation	
#	#			#	#	%	$	$	%		#	%				#		%	$	%	$	%	$
	1	Non-Medical Case Management Services [Centralized Intake & Eligibilty Determination (CIED)]	Supports client-centered activities focused on improving access to and retention of needed core medical and support services. Provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and other needed services, and sometimes help in accessing public and private programs for which clients may be eligible, based on activities such as an initial assessment of service needs, development and regular re-evaluation of an individualized care plan, client monitoring, and timely and coordinated access to medically appropriate levels of health and support services and continuity of care **Currently funded by Ryan White Part A and Part B**	4,529	4,408	52%	$416,442	$349,378	14%	$94.47	421	10%	**$75,968.00**	**1496**	**$ 349,378.00**	4,389	CIED remains highly utilized, with unbillables due to allocation cap at the end of FY25-26. We recommend maintaining initial CIED (Part A and MAI) funding overall in line with the current FY26-27 contracted levels.	0%	$0	0%	$0	17%	$349,378
	10	Non-Medical Case Management (Case Management)	Provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services **Currently funded by Ryan White Part A**	3,287	2,820	33%	$1,433,554	$1,184,359	46%	$508.35	409	15%	**$441,816.65**	**1178**	**$ 1,184,359.00**	3,216	NMCM Case Management utilization has continued steadily increasing. Due to ADAP changes and the goal of increasing Ambulatory, LPAP and Oral Health funding, we recommend a decrease of $364,278.	-31%	($364,278)	0.00%	$0	40%	$820,081
	3	Emergency Financial Assistance	EFA provides limited one-time or short-term payments to assist clients with emergent needs for paying for medication not covered ADAP or AIDS Pharmaceutical Assistance (Local). Provision of allowable Ryan White Part A pharmaceutical assistance to a client beyond thirty (30) days must not be funded through EFA. Ryan White funds are used for EFA only as a last resort, ensuring that insurance plans, Patient Assistance Programs ("PAPs"), pharmaceutical vouchers and/or pharmaceutical samples are utilized in advance of EFA. **Currently funded by Ryan White Part A and B (Test & Treat)**	201	133	2%	$167,010	$125,992	5%	$1,255.71	69	52%	**$0.00**	**0**	**$ 125,992.00**	178	Utilization of EFA for Test and Treat ARVs and other allowable medications has seen a slight increase as this program is distinguished from AIDS Pharmaceutical Assistance (Local). Test and Treat medications are, however, also funded by Ryan White Part B. We recommend a reduction of $10,120 as we investigate potentially eliminating this service category from Part A.	-8%	($10,120)	0%	$0	6%	$115,872
	3	Food Bank/Food Voucher	Provides grocery items or a voucher program to purchase food Can be used for essential non-food items limited to personal hygiene products and household cleaning supplies, plus water filtration/purification systems in communities with water safety issues **- Currently funded by Ryan White Part A and EHE: Food Bank and Food Vouchers** **- Currently funded by Ryan White Part B: Home Delivered Meals**	2,802	1,833	22%	$640,084	$782,586	30%	$349.20	272	15%	**$0.00**	**31**	**$ 782,586.00**	1,921	Food Bank/Voucher utilization has decreased overall since FPL eligibility requirements have tightened. Due to ADAP changes and the goal of increasing Ambulatory, LPAP and Oral Health funding, we recommend a decrease of $100,000 from Food Bank and a decrease of $47,586 from Food Voucher. This is an overall decrease of$147,586 from the service category.	-19%	($147,586)	0%	$0	31%	$635,000
	1	Other Professional Services (Legal Services)	Supports professional and consultant services, including legal services, permanency planning, and income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits **Currently Funded by Ryan Part A (Legal Services)**	97	80	1%	$129,138	$129,151	5%	$1,614.22	32	40%	**$0.00**	**0**	**$ 129,151.00**	88	Legal services utilization has remained steady historically. We recommend maintaining FY26-27 funding levels.	0%	$0	0%	$0	6%	$129,151
		SUPPORT					**$2,786,228**	**$2,571,466**	**20%**						**$ 2,571,466.00**				**-$521,984**		**$0**	**15.6%**	**$2,049,482**
		CORE & SUPPORT TOTAL					**$13,070,643**	**$13,096,633**	**100%**						**$ 13,096,633.00**							**100%**	**$13,096,633**

FY27-28 Recommended % Allocated to core services:	**84.4%**
FY27-28 Recommended % Allocated to support services:	**15.6%**

FY 27-28 RECOMMENDED PART A + MAI

CORE	**$11,462,151**	**81.2%**
SUPPORT	**$2,660,552**	**18.8%**
TOTAL	**$14,122,703**	**100%**

Rank	Providers	Service	Service Unit Definition	FY 2025 Clients	% of Total FY25 Clients	FY 25 Final Expenditure	FY 25 Initial Allocation		FY 23 Avg Client Cost	FY 25 New Clients		FY 26 Projected Clients	FY 25 Unbillables	FY 26 Initial Allocation	Justification/Factors to Consider	Increase/Decrease Due to Factors		Increase/Decrease Due To Client Utilization		Recommended FY 27 Allocation	
#	#			#	%	$	$	%	#	#	%	#				%	$	%	$	%	$
	1	Outpatient Ambulatory Health Services (OAHS)	Diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting.	1	0%	$625	$125,000	26%	N/A	1	N/A	5		$ 125,000.00	There is one MAI provider in this category currently and that provider has seen significant underutilization. We recommend a decrease of $75,000.	0%	$0	-60%	$ (75,000)	**12%**	$50,000
	1	Mental Health	Outpatient psychological and psychiatric assessment, diagnosis, and treatment services offered to clients living with HIV. Services are conducted in an outpatient group or individual session.	26	0%	$68,813	$62,469	13%	$2,646.65	6	23%	38		$ 62,469.00	This category under MAI has generally seen full utilization, with any over-utilization being captured under Part A. We recommend an increase of $2,531.	0%	$0	4%	$ 2,531	**16%**	$65,000
	1	Substance Abuse (Outpatient)	Outpatient services for the treatment of drug or alcohol use disorders.	67	1%	$454,443	$300,000	62%	$6,782.73	17	25%	78		$ 300,000.00	This category under MAI has generally been highly over-utilized, with over-utilization being captured under Part A. Substance Abuse services overall; however, has been underutilized the last several years. We recommend maintaining the FY26-27 funding level.	0%	$0	0%	$ -	**72%**	$300,000
		MAI CORE TOTAL				**$523,880**	**$487,469**	**48%**	**$ 9,429.37**	**24**										**40.4%**	**$415,000**

Rank	Providers	Service	Service Unit Definition	FY 2025 Clients	% of Total FY25 Clients	FY 25 Final Expenditure	FY 25 Initial Allocation		FY 23 Avg Client Cost	FY 23 New Clients		FY 26 Projected Clients	FY 25 Unbillables	FY 26 Initial Allocation	Justification/Factors to Consider	Increase/Decrease Due to Factors		Increase/Decrease Due To Client Utilization		Recommended FY 27 Allocation	
#	#			#	%	$	$	%	#	#	%	#				%	$	%	$	%	$
	1	Non-Medical Case Management - Centralized Intake & Eligibilty Determination (CIED)	Provides guidance and assistance in accessing medical, social, community, legal, financial, and other needed services.	5,253	64%	$541,424	$424,066	79%	$ 103.07	394	8%	5,314	57,006	$ 424,066.00	CIED remains highly utilized. The majority are MAI clients with MAI overutilization being captured under Part A. There were unbillables due to allocation cap at the end of FY25-26. We recommend maintaining initial CIED (Part A and MAI) funding overall in line with the current FY26-27 contracted levels.	0%	$0	0%	$ -	**69%**	$424,066
	4	Non-Medical Case Management	Assessment of service needs, development and updating of an individualized care plan, coordinated access to medical care and support services, continuous client monitoring, treatment adherence counseling	414	5%	$274,413	$ 114,535.00	11%	$662.83	42	10%	511	95,310	$ 114,535.00	NMCM Case Management utilization has continued steadily increasing. In order to mitigate some of the reduction to Part A funding due to responses to ADAP changes, we recommend an MAI increase of $72,469.	63%	$72,469	0%	$ -	**18%**	$187,004
		MAI SUPPORT TOTAL				**$815,837**	**$538,601**	**52%**		**436**										**59.6%**	**$611,070**
		MAI CORE & SUPPORT TOTAL				**$1,339,718**	**$1,026,070**	**100%**		**460**							**$0**			**100%**	**$1,026,070**

Handout E

Priority Setting and Resource Allocation Committee (PSRA) Workplan FY2026-2027

Meeting Time & Frequency: Every third Thursday of the month, from 9:30am to 11:30am
Committee Purpose: Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on "How Best to Meet the Need".

T =On Target B = Behind Target C = Completed

Activity	Description	Action Steps/Deliverable	Responsible Party	Projected Month	Progress	Notes
Objective 1: Plan, prioritize, allocate, and monitor Ryan White services and expenditures.						
1.1	PSRA Overview	1. Explain Purpose and Goals a. Define what PSRA is and why it is essential for planning HIV services. b. Highlight its role in meeting HRSA requirements and addressing community needs. 2. Outline Key Components a. Describe the steps: data review, priority setting, resource allocation, and directives. b. Identify committees involved (QMC, SOC, CEC) and their contributions. 3. Present Timeline a. Provide an annual schedule for PSRA activities, including data collection, analysis, and decision-making.	PCS Staff	March 2026	C	
1.2	Federal Poverty Level Eligibility Determination for service categories	1. Define income thresholds based on the current Federal Poverty Level guidelines. 2. Specify percentage limits (e.g., ≤100%, ≤250% FPL) for each service category in compliance with RWHAP requirements.	Recipient Office	April 2026	C – March 2026	

1.3	Review data relevant to the PSRA process (including recommendations from QMC, SOC, and CEC).	1. Core and support services utilization scorecards 2. Part A Client Health Outcome and HIV Continuum Data 3. HIV Needs Assessment: Community input through focus groups, surveys, community forums, and key informants. 4. HIV Epidemiology (FDOH) 5. Community Empowerment Committee ranking of Part A Services 6. Integrated HIV Prevention & Care Plan 7. RW Parts A-F, EHE, and HOPWA funding presentations. 8. Review 2025 Ryan White Program Services Report (RSR) 9. Unmet Need / (EIIHA- Early Identification of Individuals living with HIV/AIDS) *2027 – 2031 Broward Integrated HIV Prevention & Care Plan; **Section III**. Data Sets and Assessments*	PSRA/PCS Staff/HIV Stakeholders	May 2026	C - May PSRA 3 Day Data Workshops	
1.4	Annually review the SOC committee recommendations on language for meeting identified needs. This fulfills the HRSA requirement to provide the Recipient with directives on how best to address established service priorities.	Evaluate “How Best to Meet the Need” language recommendations from the SOC committee. *2027 – 2031 Broward Integrated HIV Prevention & Care Plan; **Section IV.** Situational Analysis*	SOC/PCS staff/PSRA	May 2026	C - May PSRA 3 Day Data Workshops	
1.5	Prioritize/Rank core medical and support services as defined in HRSA policy clarification notice 16-02	Use data elements in objectives 1.2, 1.3, 1.4, and 1.5 to inform the prioritization/ranking of core and support services.	PSRA	May 2026	C - May PSRA 3 Day Data Workshops	

		*2027 – 2031 Broward Integrated HIV Prevention & Care Plan; **Section II.** Community Engagement & Planning*				
1.6	Allocate RW Part A core medical and support services by service category annually.	Allocate RW Part A core medical and support services funds. *2027 – 2031 Broward Integrated HIV Prevention & Care Plan; **Section IV.** Situational Analysis*	PSRA	May 2026	C - May PSRA 3 Day Data Workshops	
1.7	Monitor expenditures and allocations bi-annually.	Recommend fund reallocations ('Sweeps') across service categories to ensure full utilization of RWHAP Part A funds and address priority service needs *2027 – 2031 Broward Integrated HIV Prevention & Care Plan; **Section IV.** Situational Analysis*	PSRA	• June 2026 • August 2026 • November 2026	T	
1.8	Review and approve the PSRA work plan annually.	Approve the work plan during the designated annual review session. *2027 – 2031 Broward Integrated HIV Prevention & Care Plan; **Section V**. Goals and Objectives*	PSRA	November 2026	T	
1.9	Review and update PSRA committee policies and procedures.	1. Verify compliance with HRSA guidelines and any applicable local or federal regulations. 2. Prepare a revised version of the policy, highlighting changes for transparency.	PSRA	January 2027	T	
1.10	Review Core Medical Services Waiver Updates	Support the Recipient Office submission of the HRSA RWHAP Core Medical Services Waiver Request Attestation Form	Recipient Office	March 2026	C	
Objective 2: Assess the Efficiency of the Administrative Mechanism (Ryan White Part A Office).						
2.1	Ensure surveys are distributed annually to the Part A Recipient Office,	Receive update on the annual assessment surveys distribution to the Part A Recipient Office, RWPA Subrecipient Agencies, and the HIVPC.	PCS Staff	September 2026	T	

	RWPA Subrecipient Agencies, and the HIVPC.					
2.2	Ensure subrecipient contracts are executed, and providers are reimbursed efficiently and promptly by the RWPA Recipient.	Receive survey results and submit final report, recommendations/findings to the HIVPC and the Recipient Office.	PCS Staff	January 2027	T	
Objective 3: Assess the Affordable Care Act (ACA) enrollment and the status of the Minority AIDS Initiative (MAI)						
3.1	Review how the ACA affects access to HIV services and insurance coverage for eligible clients.	1. Track ACA enrollment periods and outreach efforts within the service area. 2. Evaluate enrollment data to identify gaps in coverage among priority populations.	Recipient Office	• July 2026 • October 2026	T	
3.2	Determine the impact of the Minority AIDS Initiative on client outcomes.	Assess MAI funding trends and the impact on service delivery.	Recipient Office	• June 2026 • July 2026	T	

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

ADAP: AIDS Drugs Assistance Program

Administration HUD: U.S Department of Housing and Urban Development

IW: Integrated Workgroup

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

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

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

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

HIV HSSS: HIV Human Services Software System

HIVPC: Broward County HIV Health Services Planning Council

HOPWA: Housing Opportunities for People with AIDS

HRSA: Health Resources Services Administration

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

NBHD: North Broward Hospital District (Broward Health)

NGA: Notice of Grant Award

NHAS: National HIV/AIDS Strategy

NMCM: Non-Medical Case Management

NOFO: Notice of Funding Opportunity

nPEP: Non-Occupational Post Exposure Prophylaxis

NSU: Nova Southeastern University

nPEP: Non-occupational Post-Exposure Prophylaxis

OAHS: Outpatient Ambulatory Health Services

OHC: Oral Health Care

PCN: Policy Clarification Notic

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

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

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.