



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

System of Care Committee Meeting

Thursday, May 7, 2026 - 9:30AM to 11:30AM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

[Join the meeting now](#)

Meeting ID: 286 040 210 637 17

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[+1 469-998-5921](tel:+14699985921), [588150094](tel:+1588150094)# United States, Dallas

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Phone conference ID: 588 150 094#

Chair: Jose Castillo • Vice Chair: Kendra Hayes

Purpose of The System of Care Committee: Aims to evaluate the system of care in Broward County and analyze the impact of local, state, and federal policy and legislative issues impacting people living with HIV in the Broward County EMA. The Committee will be responsible for advising the Council on how these issues may impact the Broward County EMA and may recommend response strategies.

This meeting is audio and video recorded.

Quorum for this meeting is 4

DRAFT AGENDA

ORDER OF BUSINESS

- I. Call to Order/Establishment of Quorum
 - a. Welcome from the Chair
 - b. Meeting Ground Rules
 - c. Statement of Sunshine
 - d. Introductions & Abstentions
- II. Moment of Silence
- III. Action Item: Approval of Agenda for May 7, 2026
- IV. Action Item: Approval of Meeting Minutes for April 2, 2026 (**Handout A**)
- V. Public Comment
- VI. Standard Committee Item(s): None
- VII. Old Business: None
- VIII. Discussion Items:
 - a. **Presentation:** Overview and Vote on How Best to Meet the Need/Priorities

Language for FY2027-2028 (**Handout B1, B2**), PCS Staff

- b. **Discussion:** HBTMTN Recommendations from the Part A Office, Recipient Office Staff.

Workplan Activity 1.3: Review and revise the HBTMTN language. Upon HIVPC approval, it serves as guidance for the Ryan White Part A Recipient on effectively addressing service priorities.

IX. New Business:

- a. **Update:** Quality Improvement Project Update, CQM Staff (**Handout C**)

Workplan Activity 3.1: Receive presentations on Quality Improvement Projects (QIPs) among service providers.

- b. **Update:** PSRA Data Presentation Workshops; May 18-20, 2026 at BRHPC, PCS Staff

Workplan Activity 1.1: Receive Needs Assessment training and presentation on the most recent Ryan White services needs assessment.

Workplan Activity 1.2: Receive presentations on service utilization trends and health outcomes within the Ryan White Part A system of care.

X. Recipient Report

XI. Public Comment

XII. Announcements

XIII. Agenda Items for Next SOC Meeting

- a. To be Determined

XIV. Next SOC Meeting Date: Thursday, June 4, 2026, at 9:30 a.m. Location: BRHPC and via Microsoft Teams Video Conference

XV. Adjournment

For a detailed discussion on any of the above items, please refer to the minutes available at the [HIV Planning Council Website](#)

Please complete your [meeting evaluation](#).

Three Guiding Principles of the Broward County HIV Health Services Planning Council

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

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

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

Broward County Board of County Commissioners

Mark D. Bogen (**Mayor**) • Robert McKinzie (**Vice-Mayor**) • Nan H. Rich • Michael Udine • Lamar P. Fisher • Steve Geller • Beam Furr • Alexandra P. Davis • Hazelle P. Rogers

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	5 Community Empowerment Committee (CEC) 3:00PM - 5:00PM	6	7 System of Care Meeting (SOC) 9:30AM - 11:30AM	8	9
10 	11	12	13	14 Local Pharmacy Assistance Committee (LPAC) 2:00PM - 4:00PM	15 Integrated Planning Work Group (IP) 11:30AM - 2:30PM	16
17	18 PSRA Data Presentation Workshop Day 1 10:00AM - 4:00PM 	19 PSRA Data Presentation Workshop Day 2 10:00AM - 4:00PM	20 PSRA Data Presentation Workshop Day 3 10:00AM - 4:00PM Quality Network Meeting (CQM) 10:00AM - 11:15AM In-Person	21 Executive Committee Meeting 12:45PM - 2:45PM	22	23
24	25 	26	27	28 HIV Planning Council Meeting 9:30AM to 11:30AM	29 Medical Case Management Meeting (CQM) 2:30PM - 3:45PM	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!
<p>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</p> <p>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.</p>	<p>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</p> <p>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.</p>	<p>Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fèt: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020</p> <p>Pou konfime enfòmasyon ou resewva sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyòl; oswa, si ou gen pwoblèm wè oswa tandè, rele 48 tè alavans pou yo ka fè aranjman pou ou.</p>
HIVPC Committee Descriptions		
<p>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.</p>		
<p>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 interest, and review attendance.</p>		
<p>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.</p>		
<p>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.</p>		
<p>Membership/Council Development Committee (MCDC): Recruits and screens applicants to ensure the Council meets demographic requirements. Provides recommendations, orientation, training for new members.</p>		
<p>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.</p>		
<p>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.</p>		



**FORT LAUDERDALE/BROWARD EMA BROWARD HIV HEALTH
SERVICES PLANNING COUNCIL**

AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

System of Care Committee & Quality Management

Joint Committee Meeting

Thursday, April 2, 2026 - 9:30AM

Meeting at Broward Regional Health Planning Council and via Microsoft Teams

SOC Chair: Jose Castillo • SOC Vice Chair: Kendra Hayes

QMC Chair: Bisiola Fortune-Evans • QMC Vice Chair: Matthew Patterson

DRAFT MINUTES

SOC Members Present: T. Pietrogallo, J. Castillo, F. D'Amore, A. Murphy

SOC Members Absent: K. Hayes, J. De La Nuez

QMC Members Present: B. Fortune-Evans, R. Jimenez, M. Patterson, O. Davy, C. Williams

QMC Members Absent: S. McLeod

Part A Recipient Staff Present: G. James, T. Thompson, B. Spaulding, R. Pena, W. Cius

Part B Recipient Staff Present: S. Cook, J. Rodriguez

Planning Council/Clinical Quality Management Staff Present: G. Berkeley Martinez, M. Rosiere, M. Lacroix, S. Isidore, D. Liao, D. Cestaro-Seifer

Guests Present: S. Tinsley, J. Hidalgo, K. Tyree, D. DeLima, B. Barnes, A. Khan, H. Singh, T. Adeagbo, M. Sylvestre, A. Occelien, N. Lewis, J. Rivero, M. DiMaria, K. Whyte, M. Rajner, R. Pierre

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

The SOC Chair called the meeting to order at **9:30AM**. The SOC Chair welcomed all attendees. Attendees were notified that the SOC meeting is based on Florida's "Government-in-the-Sunshine Law and meets reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by the SOC Chair, Committee members, Recipient Staff, PCS & CQM Staff, and guests by roll call, followed by a moment of silence.

Public Comment

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters about HIV/AIDS and services in Broward County. There were no public comments.

Meeting Approvals

Motion #1: T. Pietrogallo, on behalf of the SOC Committee, made a motion to approve the April 2, 2026, System of Care & Quality Management Joint Committee agenda. The motion was seconded by F. D'Amore and adopted unanimously.

Public comment.

None.

Standard Committee Items

None.

Discussion Items

None.

Old Business

None.

New Business

- a. **Data Presentation:** Health Insurance Continuation Program (HICP) Premiums & Impact on Ryan White Part A System of Care

T. Thompson, Part A Representative, provided clarification on the purpose of the joint QMC and SOC meeting, emphasizing that the primary goal is to determine whether to cover insurance premiums, supported by data, projected impact, and any necessary Service Delivery Model (SDM) changes. He noted that all funding parameters, including costs, caps, and eligibility, will be determined by PSRA if the recommendation is approved.

He highlighted that the committee's focus should be on whether premium payments meet HRSA affordability guidelines, meaning costs should be comparable to or less than providing direct care services. Data presented included analyses from BRHPC and Part A; however, detailed cost considerations are more relevant to PSRA.

T. Thompson stated that premium assistance would only be feasible for clients eligible for Advanced Premium Tax Credits (100–250% FPL), as unsubsidized premiums are cost-prohibitive. He noted the current special enrollment period ends April 30, with a goal to implement any changes by May 1. He added that individuals between 100–150% FPL are consistently cost-effective, while costs increase at 201–250% FPL and may exceed direct service costs beyond that range.

He also shared that most clients are already engaged in some services, commonly food bank or oral health, and noted that insured clients demonstrate higher viral suppression rates (94–95%) compared to uninsured clients (85–86%), indicating improved health outcomes despite associated costs.

Following the review the committee had a brief discussion. B. Fortune-Evans and T. Pietrogallo raised questions regarding cost comparisons and service utilization, while T. Thompson explained the average annual direct care cost. It was also noted that insured clients demonstrate higher viral suppression rates (94–95%) compared to uninsured clients (85–86%). M. Rosiere provided data on ADAP enrollment and suggested a capped funding model used in other jurisdictions to manage costs and maximize the number of clients served.

B. Fortune-Evans emphasized the committee's role in focusing on data, service delivery model changes, and appropriate FPL ranges rather than funding decisions, which fall under PSRA. J. Rodriguez clarified differences in cost-effectiveness between ADAP and Ryan White Part A and stressed the importance of affordability when determining coverage. S. Tinsley raised concerns about plan accessibility in Broward County, while N. Lewis and J. Castillo discussed approaches in other jurisdictions. Following the discussion, the Committee made a motion.

Motion #2: On behalf of the SOC Committee, B. Fortune-Evans moved to approve the payment of premiums for Affordable Care Act plans using Health Insurance Continuation Program (HICP) funds. The motion was seconded by M. Patterson and passed unanimously.

Motion #3: On behalf of the SOC Committee, B. Fortune-Evans moved to set approve Federal Poverty Level (FPL) range at 100–250% for assistance with premium payments. The motion was seconded by M. Patterson. The committee had a brief discussion and approved with one nay from T. Pietrogallo.

Discussion: T. Pietrogallo raised concerns about the variability and potential cost burden within the 200–250% FPL range. T. Thompson clarified that the figures presented were based on median estimates and noted that some plans may still fall within cost-effective thresholds. He emphasized that decisions regarding premium caps and total funding limits fall under PSRA, while SOC and QMC should remain focused on health outcomes and identifying an appropriate FPL range. B. Fortune-Evans supported the 100–250% FPL range, noting that this population has significant need and could benefit from improved access to comprehensive care, with funding caps to be determined later.

M. Rosiere provided updated enrollment data, indicating that approximately 580 clients would likely utilize premium assistance, and noted that projections may overestimate participation. She also clarified assumptions related to plan selection and cost-sharing reductions. T. Pietrogallo reiterated the importance of considering the broader system of care and overall costs, while M. Patterson expressed support for expanding access to private insurance, noting it could reduce strain on the Ryan White system and improve coverage options. The committee generally agreed that setting a broader FPL range allows flexibility, with cost controls to be addressed subsequently.

J. Hidalgo raised concerns about potential increased demand, noting that currently insured clients may seek to enroll if premium assistance becomes available, and questioned how eligibility would be determined within the limited implementation timeframe. She also inquired whether individuals with existing coverage, including Medicare, could enter the program, potentially increasing enrollment beyond projections. B. Fortune-Evans clarified that the motion applies only to Affordable Care Act plans and does not include Medicare, and reiterated that eligibility criteria, caps, and implementation details will be determined by the Grantee's Office and PSRA. J. Rodriguez confirmed that Medicare recipients would not be eligible. B. Fortune-Evans emphasized that the role of SOC and QMC is to expand access and move the recommendation forward, with urgency, to ensure timely implementation through expedited processes.

b. Discussion: Health Insurance Continuation Program (HICP) Service Delivery Model

T. Thompson opened with a disclaimer that while the Service Delivery Model (SDM) is being drafted collaboratively, the final authority rests with the recipient and County Attorney's Office. He noted that the average cost per client is \$1,435, with integrated primary care and oral health as the primary cost drivers. T. Thompson clarified that the SDM is primarily a provider-facing document that will be publicly available online, but not directly distributed to clients. Instead, providers—particularly case managers—will be responsible for educating clients, supported by targeted outreach based on clients' last point of service using ledger data.

Discussion then focused on refining eligibility and program requirements. T. Thompson, with input from M. Rosiere, clarified that the HICP will pay premiums for clients who qualify for and are receiving an APTC, and that clients must be compliant with filing federal taxes. It was agreed that plan selection would not be limited to a single option, as PSRA will establish cost thresholds and eligibility criteria, including FPL ranges. T. Pietrogallo raised concerns about minimum unduplicated client requirements in the SDM, which T. Thompson explained were tied to contractual obligations and may be removed from the SDM. Additional requirements discussed included submission of monthly invoices to confirm active enrollment, and removal of outdated caps from the SDM in favor of referencing the taxonomy table.

The committee also addressed accountability and compliance issues related to premium payments and tax refunds. W. Cius and J. Castillo emphasized the need for clear language requiring clients to return

any excess premium-related refunds, while M. Rosiere recommended enforcing tax return submission (by June 1) to ensure compliance, including suspension of services for noncompliance. Clarifications were made to ensure refund policies only apply to excess premium payments tied to APTC, to avoid confusion. M. Rajner suggested providing community resources for tax preparation, while B. Fortune-Evans and S. Tinsley highlighted the need for clear communication around tax timelines and potential client confusion, especially for those who owe taxes. T. Thompson confirmed that exceptions could be made on a case-by-case basis and noted that, due to time constraints, the SDM will be released following PSRA decisions with later review and final approval by SOC and QMC.

Motion #4: On behalf of the SOC Committee, B. Fortune-Evans moved to add the following language and changes to the Health Insurance Continuation Program (HICP) Service Delivery Model (SDM). The motion was seconded by M. Patterson and approved with one nay from T. Pietrogallo.

SOC & QMC Health Insurance Continuation Program Service Delivery Model Updates

- 1. Add Under “Program Requirements”: The HICP can pay premiums for clients that qualify for and are receiving an advanced tax credit. To qualify for premiums, clients must also be compliant with filing their tax returns on page 6 of 23**
- 2. Remove “ADAP Premium Assistance Program” on page 6 of 12**
- 3. Remove “A minimum of 804 unduplicated Clients must be provided Services under this program annually” on page 2 of 12**
- 4. Remove “up to \$6,500 per year, per Client)” on page 2 of 12**

Following the motion the committee had a brief discussion. D. Cestaro-Seifer emphasized the importance of consistent implementation of the SDM, recommending the development of a standardized best practice checklist or workflow to ensure all providers interpret and operationalize the model uniformly. She stressed that the approach must remain person-centered and highlighted the need for clear, consistent messaging across teams. T. Thompson responded that standardized talking points will be developed and distributed to providers to promote consistency in communication. He reiterated that while the SDM is publicly accessible, it is primarily designed to guide providers in service delivery and requirements, and the talking points will support aligned messaging during implementation.

Recipient Report

Part A: The Recipient Office reported that two abstracts have been accepted for presentation at the Ryan White Conference. One abstract, to be presented by Brianne and T. Thompson, focuses on re-engagement of client data. A second abstract, presented by Brianne and W. Cius, will highlight faith-based initiatives and related activities. Additionally, G. Berkeley Martinez, T. Thompson, and S. Tinsley will present on the Planning Council Use of Data, which was requested by HRSA. It was also noted that HICP has an abstract related to the use of artificial intelligence in programming processes.

Part B: Clients experiencing disruptions in accessing their medications—such as those currently on Biktarvy who have not yet been switched due to the need for an in-person visit and updated labs—may be referred to the health department for emergency medication assistance. Additionally, clients who have or recently had insurance and are undergoing medical treatments, such as chemotherapy or other necessary procedures, may receive premium payment assistance to help maintain their coverage during this time.

Data Requests

None.

Public Comment

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

Agenda Items for Next Meeting

- I. Next Meeting Date: Thursday, May 7, 2026, at 9:30 a.m. Location: BRHPC and via Microsoft Teams Video Conference

Announcements

- **Man Up Festival** (CEC approved community outreach activity) - **Saturday, May 2, 2026**, from 12:00 PM to 6:00 PM at Reverend Samuel Delevoe Memorial Park (2520 NW 6th St, Fort Lauderdale, FL 33311). This exciting event will feature entertainment, health screenings, and fun competitions! Don't miss out on the three-legged race, water balloon toss, food trucks, and more. We hope to see you there!
- **Quality Network Meeting FY25-26 Presentations:** The first Quality Network meeting of the new fiscal year will focus on presentations of the FY 2025–2026 Quality Improvement (QI) Projects, as selected by Network providers. The meeting will be held as a virtual, extended three-hour session on **Wednesday, April 15, 2026, from 9:00 AM to 12:00 PM**, to allow all participating agencies the opportunity to present their work and outcomes. This session will provide an opportunity to highlight achievements, share best practices, and learn from one another's quality improvement efforts.

Adjournment

There being no further business, the meeting was adjourned at **11:11 AM**

Attendance CY 2026

Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
	Meeting Date	6	C	C	2 (Joint)									
1	Pietrogallo, T.	X	C	C	X									
2	Castillo, J.; Chair	X	C	C	X									
3	D'Amore, F.	X	C	C	X									
4	Murphy, H.A.	X	C	C	X									
5	Hayes, K.; Vice-Chair	X	C	C	A									
6	De La Nuez, J.	A	C	C	A									
Quorum = 4		5	C	C	4									

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

SYSTEM OF CARE “HOW BEST TO MEET THE NEED/PRIORITIES” RECOMMENDATIONS FY2026-2027 OVERVIEW

Broward County HIV Health Services Planning Council
Broward County Health Care Services Ryan White Part A Program
Presented by Planning Council Support Staff: May 2026



WHAT IS “HOW BEST TO MEET THE PRIORITIES?”

Section 2602(b)(4)(C)(ii) of the Public Health Services (PHS) Act

- **Requirement:** RWHAP Part A Planning Councils (PCs) must establish priorities for fund allocation.
- **How Best to Meet Priorities:** Also known as "how best to meet the need" locally
- **Considerations:**
 - Demonstrated (or probable) cost-effectiveness
 - Outcome-effectiveness of proposed strategies and interventions
- **Directives:** Typically address:
 - Populations to be served
 - Geographic areas to be served
 - Service models or strategies to be utilized



Note:

- **HRSA Terminology:** How Best to Meet Priorities
- **Broward County Terminology:** How Best to Meet the Need

WHAT IS “HOW BEST TO MEET THE NEED” LANGUAGE (HBTMTN)?

How best to meet the need may include directives about

- **where** services should be,
- **who** the services should be targeted to,
- or **how** services are delivered.



WHY IS HBTMTN IMPORTANT?

- These directives help ensure that funding and services are targeted as effectively as possible.
- Certain directives are also entered into provider contracts, so providers understand what is expected of them.

Example:

- **Needs Assessment/Data:** Indicates People Living With HIV (PWH) need care coordination or alternative hours care.
- **Directive:** Addressed under Medical case management or Non-medical case management service category.



HOW IS HBTMTN LANGUAGE DEVELOPED?

- Directives are informed by multiple data sources, including epidemiological data, U.S. Census data, focus groups, listening sessions, and the HIV needs assessment.
- These data sources collectively identify:
 - Priority populations (who to target)
 - Geographic service needs (where to focus)
 - Barriers to care (how to deliver services effectively)



SAMPLE OF HBTMTN LANGUAGE RECOMMENDATIONS

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 orthopedics, pulmonology, neurology, rheumatology, ophthalmology, gastroenterology, vision, and podiatry.

2. **Strengthen Documentation of Oral Health Counseling**

Ensure medical 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

Recommendations for FY2026-2027

1. Mandate quarterly network meetings for MCMs, Practitioners, and Mental Health specialists with salary reimbursement for participation.
2. Inform Practitioners when their client declines accepting ACA so they can address the issue.
3. Refer all clients who struggle with retention in care or attaining viral load suppression to EHE services

Recipient Response

Recommendations for FY2026-2027

Status as of 04.28.2025

Recommendations for FY2026-2027

1. Network meetings have been implemented.
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 medical practitioners as appropriate. We currently do not have a mechanism otherwise to engage in this.
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 or have recently fallen out of care, per PE.

WHEN IS HBTMTN DEVELOPED?

SOC committee review
and discuss previous
year's language



SOC committee
approves new
language by service
category



SOC committee submits
new recommended
language to the PSRA
committee *(if applicable)*



NEXT STEPS

- **May 7, 2026:**
 - SOC will receive an overview of the purpose of the “How Best to Meet the Need” Language
 - SOC will decide and vote on new or revised language by RW service category.
- **May 18, 2026**
 - SOC recommendations will be presented to the PSRA committee at the three-day workshops: May 18-20th
 - PSRA Committee will vote on HBTMTN recommendations during the May 20th meeting
- **May 28, 2026**
 - HIVPC will vote on HBTMTN recommendations



QUESTIONS?

Discussion



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 are 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).

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 Counselor perspectives as qualitative evidence of:
 - Program and client achievements
 - Ongoing challenges in accessing Broward RW Part B treatment and care services

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)
 - Network members

Previous Recommendations (2026-2027)

1. Address higher viral loads among various demographic groups, including individuals of Black/African Americans, Haitian descent, and Youth/adolescents (18-28 yrs old)

Recipient Response Recommendations for FY2026-2027 Status as of 05.04.2026

1. The Recipient Office added viral load individuals to the monthly calls to give a list of those who were deemed to have "high viral loads". We also made it a priority talking point during monitoring with providers, the current Viral Suppression at the end of the year

2. Increase on-demand telehealth adoption and training for clients and providers, including NMCM/MCM
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 compliance in executing these recommendations.
8. Consider establishing an on-demand healthcare team to meet the needs of urgent Medical Practitioner, MCM, NMCM, Behavioral Health, and Peer client needs.
9. Develop a planned collaborative process for RWPA Medical Practitioners' 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

- is sitting at 90%
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.
 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

**Recipient Response
Recommendations for FY2025-2026
Status as of 04.28.2025**

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

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 other key points of entry to facilitate rapid eligibility determination for the newly diagnosed and for clients who have fallen out of care.
8. Enhance the emphasis on adherence and retention in medical care, inclusive of sub-populations not achieving viral load suppression, including but not

**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 Specialists through the Broward County Health Department.
8. We established disparities in care back in 2019/2020 and contracted with an MAI NMCM provider to facilitate services. Retention in Care

limited to:

- a. Black heterosexual men and women
 - b. Black men who have sex with men (MSM) 18-38 years of age
9. Integrate care collaboration with members of the client's service providers.
 10. Collect accurate client-level data on stages of the HIV Care Continuum to identify gaps in services and barriers to care.
 11. Implement formal policies addressing referrals amongst internal and external providers to maximize community resources
 12. Co-locate services where applicable, to facilitate a medical home for Part A clients.
 13. Inform appropriate parties that coverage of services is contingent on available funds.
 14. Ensure that subrecipients have a plan to address payment of services when funds are low.
 15. Require providers to follow HHS guidelines for newly diagnosed clients who are not virally suppressed until virally suppressed.

(RIC) has been steadily increasing amongst vulnerable populations

9. Case Conferencing is an allowable taxonomy, and the recipient office encourages providers to utilize it.
10. Reporting has been structured and changed over the last few years; however, most data is still by human entry.
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. No update on this.
13. The Recipient Office includes payment contingent on funds in the contract.
14. The Recipient Fiscal Team asks this question during monitoring of subrecipient agencies
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 orthopedics, pulmonology, neurology, rheumatology, ophthalmology, gastroenterology, vision, and podiatry.

2. Strengthen Documentation of Oral Health Counseling

Ensure medical 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
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Recommendations for FY2026-2027

1. Mandate quarterly network meetings for MCMs, Practitioners, and Mental Health specialists with salary reimbursement for participation.
2. Inform Practitioners when their client declines accepting ACA so they can address the issue.
3. Refer all clients who struggle with retention in care or attaining viral load suppression to EHE services

Recommendations for FY2026-2027

1. Network meetings have been implemented.
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 medical practitioners as appropriate. We currently do not have a mechanism otherwise to engage in this.
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 or have recently fallen out of care, per PE.

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 Survivors Awareness Day),

Recommendations FY2024 and Previous Years

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.

- 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).
 - 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.
 - 4. Integrate Primary Care & Behavioral Services funded agencies to provide Outpatient Ambulatory Medical Care, Behavioral Health, and Care Coordination services.
 - 5. Providers should assess clients, offer brief therapy, referring them to advanced care when necessary.
 - 6. Integrate care provider collaboration with members of the client's treatment team outside of the organization.
 - 7. Establish shared clinical outcomes and data sharing to maximize coordination and tracking of client health 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.
 - 9. Provide after-hours services availability to include Crisis Intervention.
 - 10. Coordinate referrals with other service providers; conduct follow-up with clients to ensure linkage to referred services.
 - 11. Ensure providers are knowledgeable regarding the management of patients co-infected with HIV and Hepatitis C Virus (HCV).
 - 12. Incorporate prevention messages into the medical care of PWH/A: Undetectable=Untransmittable (U=U), or Treatment as Prevention
 - 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.
- 2. We have had a few educational sessions about Food and Medical Nutritional Therapy with providers.
 - 3. PHQ2-PHQ9 are already required. Increased funding is not an option at the moment.
 - 4. All those are covered under IPCBH.
 - 5. Current standard procedure
 - 6. Several providers collaborate, but the Recipient office can increase
 - 7. Unsure in this case what "shared" means. Service categories share similar outcomes
 - 8. This is covered under case management if the client has accepted case management.
 - 9. After-hours services are contractually required.
 - 10. When a client is referred, follow-up is required
 - 11. Subrecipients received training on the recommended HIV and HCV topics a few years ago.
 - 12. Current requirement under the standards of care.
 - 13. Current requirement in universal standards

AIDS PHARMACEUTICALS (LOCAL)

Services Criteria: ($\leq 400\%$)

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: ($\leq 300\%$)

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. Mandate 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

1. Inform the medical team about clients who missed mental health appointments to promptly reengage them in services. Ensure all

Recommendations FY2024 and Previous Years

1. Included in the service delivery model

- communications with medical practitioners 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.
 - 3. Provide after-hours availability to include Crisis Intervention.
- 2. Included in the service delivery model
 - 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
<p><u>Recommendations for FY2026-2027</u></p> <ul style="list-style-type: none"> 1. Mandate MCMs to attend quarterly MCM network meetings with salary reimbursement for participation. 2. For clients failing to achieve undetectable viral load (UDVL), increase MCM attendance at medical practitioner visits and increase MCM out-of-office interactions or tele-MCM visits, when appropriate. 	<p><u>Recommendations for FY2026-2027</u></p> <ul style="list-style-type: none"> 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. During monitoring, most agencies identified clients who were difficult to retain in care. In response, Medical Case Managers (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

- 1. Provide case managers and other service providers with information on the linkage between HIV treatment and management and the various support services.
- 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 Awareness Day, 2023)*
- 3. Coordinate referrals with other service providers; conduct follow-ups with

**Recipient Response
Recommendations FY2024 and Previous Years**

- 1. Included in the service delivery model
- 2. Included in the service delivery model
- 3. Included in the service delivery model

clients to ensure linkage to referred services.

- 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 medical 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 1. Increase client access to Substance Abuse services (i.e., offer on-demand tele-mental health services)	Recommendations for FY2026-2027 1. Telehealth is an option. However, the current model is a Day/Night model.

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).

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

Recommendations for FY2026-2027

- 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

Recipient Response

Recommendations for FY2026-2027

Status as of 04.28.2025

Recommendations for FY2026-2027

- 1. Current housing providers also have connections to other community resources, however housing resources are extremely thin right now.
- 2. 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

- 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),
 - b. Social Security Disability Insurance (SSDI) and potential Medicare benefits that are effective within 48 months of a client receiving SSDI, and

Recipient Response

Recommendations FY2024 and Previous Years

Status as of 04.28.2025

- 1. Included in the service delivery model

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: 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
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Recommendations for FY2026-2027

1. Conduct education sessions for clients on the recertification and co-pay processes
2. Determine which clients are eligible for ACA services and assist them with completing their applications as necessary
3. Increase the client's awareness of Medicare enrollment timing and provide the client guidance for enrollment in the program

Recommendations for FY2026-2027

1. We can look into a YouTube series, perhaps. HICP has acknowledgment forms, and case managers have been advised of the process.
2. This is already being done.
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

1. Inform clients aged 64 to begin preparing to transition to Medicare and directs them to create an online account at www.ssa.gov
2. Guide clients for Ryan White Part A/B dual eligibility determination due to the (reciprocity and NOE process).
3. Guide clients for Ryan White Part A/B dual eligibility determination due to the (reciprocity and NOE process).
4. Ensure the locations and service hours target historically underserved populations that HIV disproportionately impacts.
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.
6. Distribute the client handbook to provide an overview of the purpose of the Ryan White Part A services and include the following:
 - a. Client rights and responsibilities,

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

1. Current standard procedure
2. Current standard procedure
3. Current standard procedure
4. CIED staff are based at eleven (11) RW agencies located within underserved areas.
5. CIED has MOUs with eight (8) RW agencies, which house CIED staff
6. CIED will distribute client handbooks once received from the Recipient Office. The CIED consent form includes client rights and responsibilities, a directory of providers with full contact details, and

- b. Names of providers, complete with addresses and phone numbers, and
 - c. Grievance procedures.
7. Always offer a dedicated live operator phone line during normal business hours.
 8. Ensure that the intake data collected for clients categorized as unspecified is sufficiently comprehensive to fully utilize gender-related classifications within PE.

grievance procedures.

7. This feature is accessible through the Broward Regional Health Planning Council at 954-566-1417.
8. Current standard procedure: *Item is updated in accordance with Executive Order 14168, issued on January 20, 2025. (Unspecified terminology recommended by QMC during the during the 3/20/2025 meeting.)*

EMERGENCY FINANCIAL ASSISTANCE

Services Criteria: (\leq 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): \leq 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 medical providers, clinical teams, and case managers.	1. Included in the service delivery model

- | | |
|--|--|
| <ul style="list-style-type: none"> 2. Enhance collaboration with the client's primary care physicians and nutrition counselors to ensure that the client's nutritional requirements are adequately addressed. 3. Conduct workshops and training sessions aimed at enhancing clients' understanding of healthy eating and nutrition in relation to their health management. | <ul style="list-style-type: none"> 2. Included in the service delivery model 3. Included in the service delivery model |
|--|--|

LEGAL SERVICES

Services Criteria: (\leq 300% FPL)

FY2027-2028 FPL To Be Determined

Recommended Language

Recommendations for FY2027-2028

No recommended language for FY2027-2028

Agency Quality Improvement Projects (QIPs)

During FY25–26, the CQM team supported Quality Network members in carrying out QIPs within their agencies, resulting in the completion of multiple projects and strengthening the role of quality representatives as mentors and champions of organizational change. Technical assistance included guidance on checkpoint submissions, crafting aim statements, and implementing PDSA cycles. As these quality mentors continue to advance QI initiatives, the project’s impact will ultimately be reflected in the health outcomes of clients served across the 16 participating agencies.

Subrecipient	QIP Topic
Agency A	Increase annual <i>retention in care</i> at the downtown clinic cohort from 0% to 67% by December 2025.
Agency B	Increase Behavioral Health Services from 25% to 75% by November 28, 2025, among Hispanic and Haitian clients who reintegrate and keep their Behavioral Health continuity-of-care appointments.
Agency C	To create a RRICT and <i>increase retention in care and viral load suppression</i> in 10 T&T clients from 0 to 85% by Dec 31, 2025.
Agency D	Increase <i>viral suppression, appointment adherence, and overall perceived health</i> by 27% through physical activity interventions and participation incentives by November 3, 2025.
Agency E	Increase <i>patient adherence to follow-up care</i> from a baseline of 50% adherence to scheduled follow-up appointments to 75% adherence to scheduled follow-up appointments by 12/31/2025 in Test and Treat patients undergoing HIV testing.
Agency F	Increase the percentage of <i>documented cervical cancer screenings</i> (CCS) from 33% to 60% through sequential interventions by December 31, 2025
Agency G	Increase <i>attendance at medical appointments</i> from 50% to 75% through supportive interventions by 5 months (July 1st-Dec 1st,2025).
Agency H	Increase <i>retention in HIV care</i> and ongoing treatment from a baseline of 55% to 85% through enhanced appointment reminders and subsidized transportation by January 2026.
Agency I	Increase the number of clients with a recent <i>viral load result</i> (within the 3-to-6-month period) to 90% of total clients.
Agency J	Increase <i>service utilization</i> from 80 (Quarters 1-3) to 85 (Qs1-3) by the end of Q3 FY25-26 (November 30, 2025) in clients utilizing Ryan White-funded legal services.

Agency K	Decrease STIs in HIV positive patients by <i>frequent screening and treatment</i> from 28% to 23% by December 2025
Agency L	Decrease our <i>missed appointment rate</i> for new patients from 35% to 20% by 11/30/25 for all new patients referred by a designated Case Manager.
Agency M	Increase the number of clients achieving viral suppression/undetectable status from 39 to 20 by November 30, 2025.
Agency N	Increase the rate of <i>VLS results</i> in PE from 90% to 93% for Clients with HIV receiving food bank services by December 31, 2025.
Agency O	Increase <i>active engagement</i> from 67% to at least 85% among the current trauma-informed counseling participants by the end of the next reporting period.
Agency P	Improve <i>retention in HIV care</i> by standardizing follow-up scheduling and lab review processes by November 1, 2025.



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.



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 respekte menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesèsè 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

EIHA: 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 Notice

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.