MIAMI-DADE
HIV/AIDS PARTNERSHIP

WELCOME

Thank you for joining today's meeting of the

Care and Treatment Committee

Please sign in to have your attendance recorded.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
VII.	Reports	
	• Grantee/Recipient reports (Part A, Part B, and ADAP)	Recipients
	• Vacancies	Marlen Meizoso
	• Report to Committees (reference only)	All
VIII.	Standing Business	
	• FY 2022 MAI Carryover Adjustment	All
IX.	New Business	
	• 2022 Ryan White Co-Occurring Conditions **(Section 4)**	Dr. Robert Ladner
	• Unmet Needs in Miami-Dade HIV Community **(Section 8)**	Dr. Robert Ladner
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	• Service Categories **(Section 9)**	Marlen Meizoso
	• August Summary and Next Steps **(Section 11)**	Marlen Meizoso
	• Planning Council Meeting Survey	Marlen Meizoso
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **Sept. 14, 2023** at Main Library- **Auditorium**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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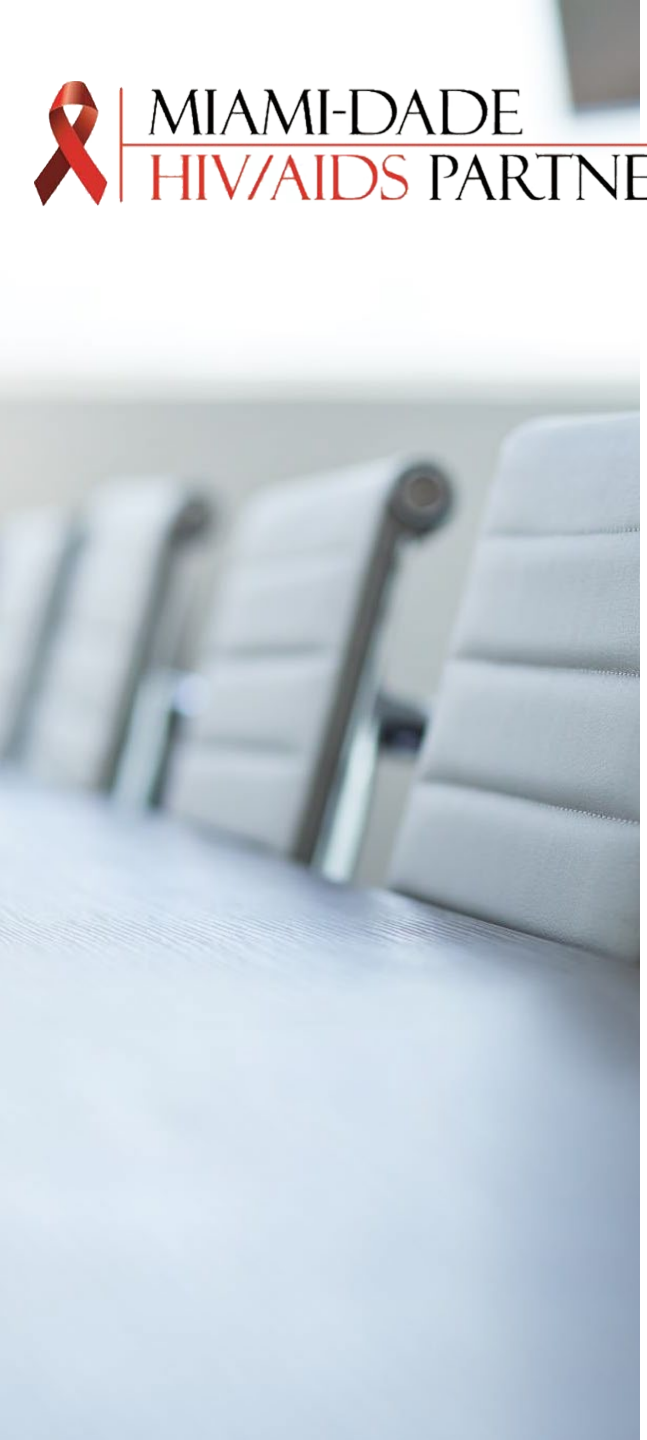
HIV/AIDS PARTNERSHIP



Meeting Housekeeping

Updated April 17, 2023

Miami-Dade County Main Library Version

Disclaimer & Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business in a fair and equitable manner.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

Language Matters!

In today's world, there are many words that can be stigmatizing. Here are a few suggestions for better communication.

Remember **People First** Language . . .
People with HIV, ***People*** with substance use disorders, ***People*** who are homeless, etc.

Please don't say **RISKS** . . . Instead, say **REASONS.**
Please don't say, **INFECTED with HIV** . . . Instead, say **ACQUIRED HIV, DIAGNOSED with HIV,** or **CONTRACTED HIV.**

Please **do not** use these terms . . .

Dirty . . . Clean . . . Full-blown AIDS . . . Victim . . .

General Housekeeping

- You must sign in to be counted as present.
- Place cell phones on mute or vibrate - *If you must take a call, please excuse yourself from the meeting.*
- Have your Cultural Center Parking Garage ticket validated at the Library front desk for a reduced parking rate.
- Eligible committee members should see staff for a voucher at the end of the meeting

Meeting Participation

- Raise your hand if you need clarification about any terminology or acronyms used throughout the meeting.
- Raise your hand to be recognized by the Chair or added to the queue.
- Discussion should be limited to the current Agenda topic or motion.
- Speakers should not repeat points previously addressed.
- Any attendee may be permitted to address the board as time allows and at the discretion of the Chair.

Resources

- Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- See staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.
- Today's presentation and supporting documents are online at aidsnet.org/meeting-documents/.

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Floor Open to the Public

“Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

“BSR has a dedicated line for statements to be read into the record. No statements were received.”

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Care and Treatment Committee Meeting8
Miami-Dade Public Library, Auditorium
101 West Flagler, Miami, FL 33130
July 13, 2023

#	Committee Members	Present	Absent
1	Alcala, Etelvina	X	
2	Grant, Gena		X
3	Henriquez, Maria	X	
4	Iadarola, Dennis		X
5	Mills, Vanessa		X
6	Siclari, Rick	X	
7	Shmuels, Diego	X	
8	Trepka, Mary Jo	X	
9	Wall, Dan	X	
Quorum: 4			

Guests	
Jose Camino	
Jennifer Ellison	
Keri Kratofil	
Javier Romero	
Staff	
Robert Ladner	Marlen Meizoso

All documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at www.aidsnet.org/meeting-documents. Copies were also provided to attendees.

I. Call to Order *Dr. Diego Shmuels*

Dr. Diego Shmuels, the Chair, introduced himself and called the meeting to order at 10:17 a.m. Dr. Shmuels indicated that long-standing member, Frederick Downs, Jr. passed away last month and requested a moment of silence.

II. Introductions *Dr. Diego Shmuels*

Members and guests introduced themselves around the room.

III. Meeting Housekeeping and Rules *Dr. Mary Jo Trepka*

Dr. Trepka reviewed the Housekeeping and Rules presentation, which reviewed the environmental reminders, parking, and meeting decorum for all participants.

IV. Floor Open to the Public *Dr. Mary Jo Trepka*

Dr. Trepka read the following:

Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any items on our agenda today. If there is anyone who wishes to be heard, I invite you to

speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

BSR has a dedicated line for statements to be read into the record. No statements were received.

There were no comments, so the floor was closed.

V. Review/Approve Agenda *All*

The Committee reviewed the agenda. There was a suggestion to swap items three and two on the agenda and combine the reallocation and carryover item since they were on one sheet. Staff also indicated they had an announcement. The Committee made a motion to approve the agenda as discussed.

Motion to accept the agenda with changes.
Moved: Maria Henriquez **Seconded: Etelvina Alcala** **Motion: Passed**

VI. Review/Approve Minutes of June 8, 2023 *All*

The Committee reviewed the minutes of June 8, 2023, and accepted them as presented.

Motion to accept the minutes from June 8, 2023, as presented.
Moved: Dan Wall **Seconded: Maria Henriquez** **Motion: Passed**

VII. Reports

- *Part A/Minority AIDS Initiative (MAI)* *Dan Wall*

Dan Wall indicated the End of Fiscal Year Recipient expenditure reports are posted online. No new expenditure reports are available since contracts are being executed. Current client counts are over 6,000, which is 1,000 clients higher than last year. Under Test and Treat Rapid Access, Mr. Wall inquired if the Committee wanted to change the reporting criteria. Currently reported totals are a running total from program inception. The Committee indicated that having year-to-date data would be more helpful. The AIDS Drug Assistance Program (ADAP) would like month to month data to match clients, but this is accessible in the Provide Enterprise system if authorization is granted. Mr. Wall indicated he will look into getting the necessary authorization.

The Ending the HIV Epidemic (EHE) Request for Proposals (RFP) closed in late June and the County is in the Cone of Silence.

Next week (Monday-Thursday) the Florida Comprehensive Planning Network (FCPN) will be meeting in Tama. Once again there were some delays with communication and planning due to staffing shortfalls at the Florida Department of Health.

- *Part B* *Marlen Meizoso*

Marlen Meizoso reviewed the April Part B report. For the month of April 2023, 107 clients were served at an expense of $51,939.44.

- *.ADAP* *Dr. Javier Romero*

Dr. Javier Romero reviewed the June 2023 ADAP report, as of July 5, 2023, including data on enrollments, pharmacy and insurance expenditures, program updates, medication additions, and current pharmacy listings. The client figures are low because of the changes to the enrollment eligibility period to 366 days. The next reporting period is November. Program updates were reviewed. There has been no news on any additional pharmacies being added in July. As a reminder, changes to pick up at a Magellan pharmacy are a client's choice.

- *General Revenue* *Marlen Meizoso*

Mrs. Meizoso reviewed the May 2023 General Revenue report. In the month of May 2023, 2,047 clients were served for $614,267.53 in expenditures. Year-to-date expenditures total were $3,732,552.93.

- *Vacancies* *Marlen Meizoso*

Mrs. Meizoso reviewed the June 2023 vacancy report which indicated there are twelve vacancies for members of the affected community on the Partnership, with Mr. Downs' passing. Current vacancies on the Care and Treatment Committee total seven although six are listed including seats for members of the affected community since Ryan Roelans resigned. Mr. Roelans suggested Jennifer Ellison, who works in the Outreach Department at Better Way as a member. Ms. Ellison was present and indicated her interest. The Committee voted to accept Ms. Ellison as a member. Staff urged members and guests to share vacancy information with clients or invite them to upcoming trainings and meetings.

Motion to accept Jennifer Ellison as a member of the Care and Treatment Committee.
Moved: Dan Wall **Seconded: Etelvina Alcala** **Motion: Passed**

VIII. Standing Business

- *None*

IX. New Business

- *YR 2023 Sweeps 2 Reallocation and YR 2022 Carryover* *All*

The Committee reviewed the FY 2023-24 Minority AIDS Initiative (MAI) Carryover and Reallocation funding sheets. There were reductions of $90,000 from one service category and proposed reallocations to two service categories, Medical Case Management, and

Outpatient/Ambulatory Health, which are high use categories. The Committee made a motion to reallocate the funds as indicated below.

Motion to reallocate FY 2023-24 (YR 33) MAI funding for total proposed allocations as follows, $943,920 to Medical Case Management and $1,241,041 to Outpatient/Ambulatory Health Services.
Moved: Dan Wall **Seconded: Rick Siclari** **Motion: Passed**

Under MAI Carryover funding there was $1,074,304 available to reallocate, and the Committee divided the evenly between Medical Case Management and Outpatient/Ambulatory Health Services.

Motion to allocate MAI Carryover funds as follows: $537,152 to Medical Case Management and $537,152 to Outpatient/Ambulatory Health Services.
Moved: Dan Wall **Seconded: Rick Siclari** **Motion: Passed**

Under Ryan White Part A funding there was $2,773,261 swept out of several categories and over $5 million dollars in requested funds. It is expected that with current expenditure patterns and client loads, the program may expend the majority of the funding. The Committee opted to fund the categories as indicated below.

Motion to reallocate FY 2023-24 (YR 33) Formula and Supplemental grant funding for total proposed allocations as follows:
- **$6,174,853 to Medical Case Management;**
- **$14,555 to AIDS Pharmaceutical Assistance;**
- **$8,503,003 to Outpatient/Ambulatory Health Services;**
- **$3,388,975 to Oral Health Care;**
- **$345,700 to Health Insurance Services;**
- **$107,844 to Mental Health Services;**
- **$1,701,206 to Substance Abuse Residential;**
- **$38,128 to Substance Abuse Outpatient;**
- **$186,688 to Medical Transportation;**
- **$230,896 to Outreach; and**
- **$122,449 Other Professional Services (Legal).**

Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Because there was a conflicted member under the Food Bank categories these motions were made separately. The conflicted member stated his conflict and left the meeting for the duration of the vote. Additional money was added to the Food Bank service category since it is currently underfunded and last fiscal year spent over $2 million dollars. If expenditures continue to grow, some cost savings measures may need to be reimplemented (e.g., letter of medical necessity).

Motion to reallocate FY 2023-24 (YR 33) Formula and Supplemental grant funding of $1,179,244 to Food Bank.
Moved: Dan Wall **Seconded: Maria Henriquez** **Motion: Passed**

Motion to allocate 100% of Part A Carryover funding ($723,098) to Food Bank.
Moved: Dan Wall Seconded: Maria Henriquez Motion: Passed

Following the Food Bank votes returned to the meeting and will fill out form 8B.

- *2022 Ryan White Program (RWP) Utilization* *Dr. Robert Ladner*

Dr. Robert Ladner reviewed the Ryan White Program FY 2022 Ryan White Program Utilization Data. In FY 2022, the program served 8,590 clients, expended over $22 million dollars, and the average cost per client was $2,604 (highest in the last five years). Tables sorted alphabetically and by highest clients and expenditures were included. Additional summary information and details of access to each service category by ethnicity/race/gender were also reviewed.

- *Other Funding* *Marlen Meizoso*

Mrs. Meizoso reviewed the Other Funding presentation which provided background on other funding for services using information from the annual Women, Infants, Children and Youth (WICY) survey which request HIV specific funding for Parts B-D, General Revenue, and the other providers. This information was distributed and is included in the lower portion of the Dashboard cards.

Medicaid expenditure and demographics were also provided. There has been an increase of 12% in clients served and 10% in total expenditures from FY 2019-20 to FY 2021-22. As in prior years, Medicaid demographic data from the past three years were presented. Black/African Americans continue to be the largest ethnic group served by Medicaid (44%). Also, the program served slightly more men (54%) than women.

- *Dashboard Guide and Cards* *Marlen Meizoso*

Mrs. Meizoso reviewed the Tools for Needs Assessment: 2023 Guide to Dashboard Cards. This document explained how to read the Dashboard Cards, new items for 2023, and how to use the document. She reviewed the different sections of the dashboard cards and explained the sources of the various data, combining information from five years of utilization and priorities, a trend designation (e.g., up, down), other funders for HIV direct and support services, and notes on important items to consider for each service.

- *Reminders and Next Steps* *Marlen Meizoso*

Mrs. Meizoso reviewed the Reminders and Next Steps presentation which detailed the location of materials, remaining topics, and next meeting dates. The Committee was urged to review the online needs assessment book , which contains all materials and is updated for each meeting.

X. Announcements and Open Discussion *All*

Mrs. Meizoso announced that the Library is not available on the first Thursday of the month for the remainder of the calendar year.so meetings have been moved to the second Thursday, for August-October and December. In November, the meeting will be the second Wednesday. Dates are still subject to change, but members should take note. Also, at the end of today's meeting an evaluation survey will be emailed to all to complete.

Rick Siclari presented Keri Kratofil who will be replacing him shortly as CEO of Care Resource, once he retires.

No open discussion items were suggested.

XI. Next Meeting *Dr. Mary Jo Trepka*

The next meeting is scheduled for Thursday, August 17, 2023, at the Miami-Dade County Main Library Auditorium, 101 West Flagler Street, Miami, FL 33130, from 10:00 a.m. to 1:00 p.m.

XII. Adjournment *Dr. Diego Shmuels*

With business concluded, Dr. Shmuels thanked the members for participating in today's meeting and adjourned the meeting at 12:41 p.m.

FORM 8B MEMORANDUM OF VOTING CONFLICT FOR COUNTY, MUNICIPAL, AND OTHER LOCAL PUBLIC OFFICERS

LAST NAME—FIRST NAME—MIDDLE NAME	NAME OF BOARD, COUNCIL, COMMISSION, AUTHORITY, OR COMMITTEE
Siclari, Richard	Miami-Dade HIV/AIDS Partnership
MAILING ADDRESS [redacted]	THE BOARD, COUNCIL, COMMISSION, AUTHORITY OR COMMITTEE ON WHICH I SERVE IS A UNIT OF: ☐ CITY ☑ COUNTY ☐ OTHER LOCAL AGENCY
CITY [redacted] COUNTY Miami-Dade	NAME OF POLITICAL SUBDIVISION:
DATE ON WHICH VOTE OCCURRED July 13, 2023	MY POSITION IS: ☐ ELECTIVE ☑ APPOINTIVE

WHO MUST FILE FORM 8B

This form is for use by any person serving at the county, city, or other local level of government on an appointed or elected board, council, commission, authority, or committee. It applies to members of advisory and non-advisory bodies who are presented with a voting conflict of interest under Section 112.3143, Florida Statutes.

Your responsibilities under the law when faced with voting on a measure in which you have a conflict of interest will vary greatly depending on whether you hold an elective or appointive position. For this reason, please pay close attention to the instructions on this form before completing and filing the form.

INSTRUCTIONS FOR COMPLIANCE WITH SECTION 112.3143, FLORIDA STATUTES

A person holding elective or appointive county, municipal, or other local public office MUST ABSTAIN from voting on a measure which would inure to his or her special private gain or loss. Each elected or appointed local officer also MUST ABSTAIN from knowingly voting on a measure which would inure to the special gain or loss of a principal (other than a government agency) by whom he or she is retained (including the parent, subsidiary, or sibling organization of a principal by which he or she is retained); to the special private gain or loss of a relative; or to the special private gain or loss of a business associate. Commissioners of community redevelopment agencies (CRAs) under Sec. 163.356 or 163.357, F.S., and officers of independent special tax districts elected on a one-acre, one-vote basis are not prohibited from voting in that capacity.

For purposes of this law, a "relative" includes only the officer's father, mother, son, daughter, husband, wife, brother, sister, father-in-law, mother-in-law, son-in-law, and daughter-in-law. A "business associate" means any person or entity engaged in or carrying on a business enterprise with the officer as a partner, joint venturer, coowner of property, or corporate shareholder (where the shares of the corporation are not listed on any national or regional stock exchange).

* * * * * * * * * * * * * * * *

ELECTED OFFICERS:

In addition to abstaining from voting in the situations described above, you must disclose the conflict:

PRIOR TO THE VOTE BEING TAKEN by publicly stating to the assembly the nature of your interest in the measure on which you are abstaining from voting; *and*

WITHIN 15 DAYS AFTER THE VOTE OCCURS by completing and filing this form with the person responsible for recording the minutes of the meeting, who should incorporate the form in the minutes.

* * * * * * * * * * * * * * * *

APPOINTED OFFICERS:

Although you must abstain from voting in the situations described above, you are not prohibited by Section 112.3143 from otherwise participating in these matters. However, you must disclose the nature of the conflict before making any attempt to influence the decision, whether orally or in writing and whether made by you or at your direction.

IF YOU INTEND TO MAKE ANY ATTEMPT TO INFLUENCE THE DECISION PRIOR TO THE MEETING AT WHICH THE VOTE WILL BE TAKEN:

- You must complete and file this form (before making any attempt to influence the decision) with the person responsible for recording the minutes of the meeting, who will incorporate the form in the minutes. (Continued on page 2)

APPOINTED OFFICERS (continued)

- A copy of the form must be provided immediately to the other members of the agency.
- The form must be read publicly at the next meeting after the form is filed.

IF YOU MAKE NO ATTEMPT TO INFLUENCE THE DECISION EXCEPT BY DISCUSSION AT THE MEETING:

- You must disclose orally the nature of your conflict in the measure before participating.
- You must complete the form and file it within 15 days after the vote occurs with the person responsible for recording the minutes of the meeting, who must incorporate the form in the minutes. A copy of the form must be provided immediately to the other members of the agency, and the form must be read publicly at the next meeting after the form is filed.

DISCLOSURE OF LOCAL OFFICER'S INTEREST

I, Richard Siclari, hereby disclose that on July 13, 20 23 :

(a) A measure came or will come before my agency which (check one or more)

___ inured to my special private gain or loss;

___ inured to the special gain or loss of my business associate, _____ ;

___ inured to the special gain or loss of my relative, _____ ;

___ inured to the special gain or loss of _____, by whom I am retained; or

___ inured to the special gain or loss of Food for Life Network, which is the parent subsidiary, or sibling organization or subsidiary of a principal which has retained me.

(b) The measure before my agency and the nature of my conflicting interest in the measure is as follows:

FY 2023 Ryan White Part A Sweeps 2 reallocations and FY 2022 carryover allocation requested for food bank for which Food for Life Network is the sole provider.

If disclosure of specific information would violate confidentiality or privilege pursuant to law or rules governing attorneys, a public officer, who is also an attorney, may comply with the disclosure requirements of this section by disclosing the nature of the interest in such a way as to provide the public with notice of the conflict.

7/13/2023
Date Filed

[redacted]

NOTICE: UNDER PROVISIONS OF FLORIDA STATUTES §112.317, A FAILURE TO MAKE ANY REQUIRED DISCLOSURE CONSTITUTES GROUNDS FOR AND MAY BE PUNISHED BY ONE OR MORE OF THE FOLLOWING: IMPEACHMENT, REMOVAL OR SUSPENSION FROM OFFICE OR EMPLOYMENT, DEMOTION, REDUCTION IN SALARY, REPRIMAND, OR A CIVIL PENALTY NOT TO EXCEED $10,000.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
VII.	Reports	
	• Grantee/Recipient reports (Part A, Part B, and ADAP)	Recipients
	• Vacancies	Marlen Meizoso
	• Report to Committees (reference only)	All
VIII.	Standing Business	
	• FY 2022 MAI Carryover Adjustment	All
IX.	New Business	
	• 2022 Ryan White Co-Occurring Conditions **(Section 4)**	Dr. Robert Ladner
	• Unmet Needs in Miami-Dade HIV Community **(Section 8)**	Dr. Robert Ladner
	• 2022-23 Community Input/Town Hall Results **(Section 8)**	Marlen Meizoso
	• Service Categories **(Section 9)**	Marlen Meizoso
	• August Summary and Next Steps **(Section 11)**	Marlen Meizoso
	• Planning Council Meeting Survey	Marlen Meizoso
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **Sept. 14, 2023** at Main Library- **Auditorium**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Part A

RYAN WHITE PART A GRANT AWARD (Grant #: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR33

FORMULA AND SUPPLEMENTAL FUNDING

Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2023 Part A service months up to June 2023, as of 8/10/2023. This report reflects reimbursement requests that were due by 7/20/2023, and have been paid thus far. Pending Part A reimbursement requests that have been received and are in the review process currently total $4,875,176.21.

Project #: BURW3302	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount Formula	16,452,284.00	FORMULA	FY 2023 Award
Grant Award Amount Supplemental	8,484,983.00	SUPPLEMENTAL	$24,937,267
Carryover Award FY'22 Formula		CARRYOVER	
Total Award	**$ 24,937,267.00**		

CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover Allocations
3	AIDS Pharmaceutical Assistance	88,255.00	
8	Health Insurance Services	595,700.00	
2	Medical Case Management	5,869,052.00	
9	Mental Health Therapy/Counseling	132,385.00	
6	Oral Health Care	3,088,975.00	
5	Outpatient/Ambulatory Health Svcs	8,847,707.00	
12	Substance Abuse - Outpatient	44,128.00	
	CORE Services Totals:		18,666,202.00

Priority Order	Support Services	Allocations	Carryover Allocations	
4	Emergency Financial Assistance	0.00		
7	Food Bank	529,539.00	0.00	529,539
13	Medical Transportation	154,449.00		
15	Other Professional Services	154,449.00		
14	Outreach Services	264,696.00		
10	Substance Abuse - Residential	2,074,206.00		
	SUPPORT Services Totals:		3,177,339.00	
DIRECT SERVICES TOTAL:		**$**	**21,843,541.00**	

Total Core Allocation	18,666,202.00	
Target at least 80% core service allocation	17,474,832.80	
Current Difference (Short) / Over	**$ 1,191,369.20**	
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,493,726.00**	
Quality Management	**$ 600,000.00**	
(+) Unobligated Funds / (-) Over Obligated:		
Unobligated Funds (Formula & Supp)	$ -	
Unobligated Funds (Carry Over)	$ -	3,093,726.00

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**85.45%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**2.41%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**10.00%**	**Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover Expenditures
5606970000	AIDS Pharmaceutical Assistance	0.00	
5606920000	Health Insurance Services	0.00	
5606870000	Medical Case Management	85,405.90	
5606860000	Mental Health Therapy/Counseling	0.00	
5606900000	Oral Health Care	402,110.00	
5606610000	Outpatient/Ambulatory Health Svcs	538,164.31	
5606910000	Substance Abuse - Outpatient	570.00	
	CORE Services Totals:	1,026,250.21	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	529,492.20	0.00	529,492.20
5606460000	Medical Transportation	6,468.75		
5606890000	Other Professional Services	0.00		
5606950000	Outreach Services	0.00		
5606930000	Substance Abuse - Residential	0.00		
	SUPPORT Services Totals	535,960.95		
	TOTAL EXPENDITURES DIRECT SVCS & % :	**$**	**1,562,211.16**	**7.15%**

	Formula Expenditure %	**12.93%**	
5606710000	**Recipient Administration**	**565,471.17**	
5606880000	**Quality Management**	**0.00**	565,471.17

	FY 2023 Award	Carryover	
Grant Unexpended Balance	**22,809,584.67**	-	22,809,584.67
Total Grant Expenditures & %		**$**	**2,127,682.33** **8.53%**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**65.69%**	**Danger!!!!!**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**0.00%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**2.27%**	**Within Limit**

Printed on: 8/10/2023

MAI

RYAN WHITE PART A GRANT AWARD (Grant#: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR33

MINORITY AIDS INITIATIVE (MAI) FUNDING

Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2023 MAI service months up to June 2023, as of 8/10/2023. This report reflects reimbursement requests that were due by 7/20/2023, and have been paid thus far. Pending MAI reimbursement requests that have been received and are in the review process currently total $421,248.34.

PROJECT #: BURW3302	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI	2,621,581.00	MAI
Carryover Award FY'22 MAI		MAI_CARRYOVER
Total Award	**$ 2,621,581.00**	

CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations		
	AIDS Pharmaceutical Assistance			
	Health Insurance Services			
1	Medical Case Management	903,920.00		
4	Mental Health Therapy/Counseling	18,960.00		
	Oral Health Care			
5	Outpatient/Ambulatory Health Svcs	1,281,041.00		
8	Substance Abuse - Outpatient	8,058.00	2,211,979.00	
	Support Services	**Allocations**		
6	Emergency Financial Assistance	0.00		
	Food Bank			
9	Medical Transportation	7,628.00		
	Other Professional Services			
10	Outreach Services	39,816.00		
	Substance Abuse - Residential		47,444.00	
	DIRECT SERVICES TOTAL:		**$ 2,259,423.00**	
	Total Core Allocation	2,211,979.00		
	Target at least 80% core service allocation	1,807,538.40		
	Current Difference (Short) / Over	**$ 404,440.60**		
	Recipient Admin. (OMB-GC)	**$ 262,158.00**		
	Quality Management	**$ 100,000.00**		
	(+) Unobligated Funds / (-) Over Obligated:			
	Unobligated Funds (MAI)	$ -	362,158.00	2,621,581.00
	Unobligated Funds (Carry Over)	$ -		

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover Expenditures	
5606970000	AIDS Pharmaceutical Assistance			
5606920000	Health Insurance Services			
5606870000	Medical Case Management	10,979.15		
5606860000	Mental Health Therapy/Counseling	0.00		
5606900000	Oral Health Care			
5606610000	Outpatient/Ambulatory Health Svcs	55,251.99		
5606910000	Substance Abuse - Outpatient	0.00		66,231.14
Account	**Support Services**	**Expenditures**	**Carryover Expenditures**	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank			
5606460000	Medical Transportation	2,193.75		
5606890000	Other Professional Services			
5606950000	Outreach Services	0.00		
5606930000	Substance Abuse - Residential			2,193.75
	TOTAL EXPENDITURES DIRECT SVCS & %:		**$ 68,424.89**	**3.03%**
5606710000	**Recipient Administration**	**50,072.02**		50,072.02
5606880000	**Quality Management**	**0.00**		
	Grant Unexpended Balance	**FY 2023 Award (118,496.91)**	**Carryover -**	-118,496.91
	Total Grant Expenditures & % (Including C/O):		**$ 118,496.91**	**4.52%**

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**97.90%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.81%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**10.00%**	**Within Limit**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**96.79%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**0.00%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**1.91%**	**Within Limit**

Printed on: 8/10/2023

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **June 2023**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A
Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	3	14	3	6
Health Insurance Premium and Cost Sharing Assistance	0	896	0	525
Medical Case Management	8,475	33,626	4,155	6,348
Mental Health Services	50	192	25	46
Oral Health Care	846	3,316	637	1,619
Outpatient Ambulatory Health Services	1,583	8,189	1,021	2,928
Substance Abuse Outpatient Care	0	7	0	5
Support Services				
Food Bank/Home Delivered Meals	0	4,209	0	827
Medical Transportation	107	1,345	99	418
Other Professional Services	104	442	20	43
Outreach Services	57	251	35	90
Substance Abuse Services (residential)	55	632	2	16
TOTALS:	11,280	53,119		

Total unduplicated clients (month): 4,740

Total unduplicated clients (YTD): 7,228

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 08/10/2023

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **June 2023**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	3	14	3	6
Health Insurance Premium and Cost Sharing Assistance	0	896	0	525
Medical Case Management	7,588	30,258	3,812	6,035
Mental Health Services	49	188	24	43
Oral Health Care	846	3,316	637	1,619
Outpatient Ambulatory Health Services	1,407	7,313	911	2,787
Substance Abuse Outpatient Care	0	7	0	5
Support Services				
Food Bank/Home Delivered Meals	0	4,209	0	827
Medical Transportation	100	1,296	92	405
Other Professional Services	104	442	20	43
Outreach Services	55	246	33	85
Substance Abuse Services (residential)	55	632	2	16
TOTALS:	10,207	48,817		

Total unduplicated clients (month): 4,442

Total unduplicated clients (YTD): 7,060

REPORT COMPILED ON: 08/10/2023

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **June 2023**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	887	3,368	435	690
Mental Health Services	1	4	1	3
Outpatient Ambulatory Health Services	176	876	124	360
Support Services				
Medical Transportation	7	49	7	22
Outreach Services	2	5	2	5
TOTALS:	1,073	4,302		

Total unduplicated clients (month): 516

Total unduplicated clients (YTD): 894

REPORT COMPILED ON: 08/10/2023

Miami-Dade County Ryan White Part A/MAI Program

Service Unit Definitions

Service Categories	Service Unit Definition
Core Medical Services	
AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program; LPAP)	1 filled prescription
Health Insurance Premium & Cost Sharing Assistance	1 health insurance payment (copayment or deductible)
Medical Case Management (MCM; Incl. Treatment Adherence)	1 MCM encounter
Mental Health Services	1 individual or group encounter
Oral Health Care	1 oral health care visit
Outpatient/Ambulatory Health Services	1 medical visit
Substance Abuse Outpatient Care	1 individual or group encounter
Support Services	
Emergency Financial Assistance (limited access)	1 filled prescription
Food Bank	1 bag of groceries
Medical Transportation	1 medical transportation voucher or one-way rideshare trip
Other Professional Services (Legal Assistance & Permanency Planning)	1 hour of legal assistance
Outreach Services	1 individual encounter
Substance Abuse Services-Residential	1 day of residential substance abuse services

NOTE: MAI-funded services are limited to minority clients from priority subpopulations or emerging need subpopulations.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
VII.	Reports	
	• Grantee/Recipient reports (Part A, Part B, and ADAP)	Recipients
	• Vacancies	Marlen Meizoso
	• Report to Committees (reference only)	All
VIII.	Standing Business	
	• FY 2022 MAI Carryover Adjustment	All
IX.	New Business	
	• 2022 Ryan White Co-Occurring Conditions **(Section 4)**	Dr. Robert Ladner
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X.	Announcements and Open Discussion	All
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XII.	Adjournment	Dr. Diego Shmuels

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For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Provider Agency Name & Address
FDOH in Miami-Dade County
1350 N.W. 14th St.,
Miami, 33125

Contract Name: 2023-2024 Miami Dade CHD RW Consortia

Florida Department of Health

Expenditure/Invoice Report

Program Name: Patient Care-Consortia

Area Name:AREA 11A

Month: June

Year: 2023-2024

Report generated on: 08/08/2023

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	June	0	0	$125,915.00	$4,233.03	$12,646.81	10%
Medical Case Management (including treatment adherence)	June	63	63	$120,000.00	$9,211.50	$28,255.50	24%
Mental Health Services - Outpatient	June	18	84	$30,000.00	$2,730.00	$4,420.00	15%
Emergency Financial Assistance	June	40	40	$845,780.00	$41,221.07	$96,554.62	11%
Non-Medical Case Management Services	June	22	22	$273,970.00	$12,824.86	$34,619.49	13%
Referral for Health Care/Supportive Services	June	437	1,346	$181,451.60	$18,489.84	$42,784.28	24%
Clinical Quality Management	June	0	0	$68,508.03	$1,451.01	$13,357.91	19%
Planning and Evaluation	June	0	0	$34,224.37	$2,507.98	$8,037.39	23%
Totals		**580**	**1555**	**$1,679,849.00**	**$92,669.29**	**$240,676.00**	

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend

ADVANCE(S) INFORMATION:

Total Advances	$0.00
Previous Reductions	$0.00
Current Reductions	$0.00
Remaining Advances	$0.00

Total Contract Amount	$1,679,849.00
Minus Expended Y-T-D	$240,676.00
Minus UNPAID Advances	$0.00
Balance To Draw	$1,439,173.00

Total Expenditures this period:	$92,669.29
Less Advance Payback this period:	$0.00
AMOUNT OF FUNDS REQUESTED THIS REPORT:	**$92,669.29**

I certify that the above report is a true, accurate and correct reflection of the activities this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature & Title of Provider Agency Official | **Date** | **Contract Manager Signature** | **Date**

Contract Manager's Supervisor Signature | **Date**

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

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August 2, 2023

ADAP Miami-Dade / Summary Report* – JULY 2023

Month	1st Enrollments	Re-Enrollments	OPEN	CHD Pharmacy	RXs	Patients	RX/Pt	Payments	Premiums	~ Premium
Apr-23	113	737	6,364	$1,564,028.71	2,750	931	3.0	$3,638,506.77	2,562	$1,420.18
May-23	94	393	6,441	$2,677,106.06	2,897	952	3.0	$3,640,335.31	2,574	$1,414.27
Jun-23	101	125	6,809	$1,802,814.62	3,138	1,018	3.1	$3,673,007.70	2,616	$1,404.05
Jul-23	84	105	6,995	$1,645,498.21	2,879	965	3.0	$3,664,239.62	2,620	$1,398.56
Aug-23										
Sep-23										
Oct-23										
Nov-23										
Dec-23										
Jan-24										
Feb-24										
Mar-24										
FY23/24 >	392	1,360	6,995	$7,689,447.60	11,664	3,866	3.0	$14,616,089.40	10,372	$1,409.19

SOURCE: Provide - DATE: 08/05/23 - Subject to Review & Editing

** NOTE: West Perrine: 529 clients (08/04/23) - Expenditures not included in this report.*

PROGRAM UPDATE

* 08/04/23: Cabenuva ® utilization @ ADAP Miami: 216 patients. Direct Dispense 142 *(66 %)*; Premium Plus 74 *(34 %)*
* 04/01/23: Medicaid Unwinding (4/1/23-3/31/24): Eligible for ADAP approved plans. Medicaid letter (<400%); not letter (75%-400%).
* 07/01/23: **NEW** Updated Uninsured Pharmacy PBM pharmacies: Navarro Specialty Pharmacy

CURRENT Ongoing CHD Pharmacy **Services**		
1	FDOH CHD Pharmacy @ Flagler Street	On Site
2	FDOH CHD Pharmacy @ Flagler Street	Mail order
3	FDOH ADAP Program @ West Perrine	CVS Specialty Mail Order

PHARMACY SELECTION:
Pharmacy selection is the client's choice only. Providers, case managers, pharmacies, and agencies, must refer client to ADAP Miami Program Office to process pharmacy selection and document choice.

ADDITIONAL Pharmacies - Magellan RX PBM Miami-Dade – As of 7/1/23		
1	AIDS Healthcare Foundation	Four (4) sites
2	Borinquen Healthcare Center	One (1) site
3	Miami Beach Community Health Center	Three (3) sites
4	WINN DIXIE Stores	Seven (7) sites
5	CVS Specialty Mail Order	Mail Order / Monroeville, PA
6	Community Health of South Florida - CHI	Two (2) sites
7	**NEW** Navarro Specialty Pharmacy	Mail Order

For additional information: www.ADAPMiami.com or ADAP.FLDOHMDC@flhealth.gov

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

July 21, 2023

The Miami-Dade HIV/AIDS Partnership

The official Ryan White Program Planning Council in Miami-Dade County and the Advisory Board for HIV/AIDS to the Miami-Dade County Mayor and Board of County Commissioners. Complete a brief New Member Interest Form to find out more: www.surveymonkey.com/r/DRJP5N5 or scan the QR code.

Opportunities for Ryan White Program Clients

12 *seats are available to Ryan White Program Clients who are not affiliated or employed by a Ryan White Program Part A funded service provider.*

Opportunities for General Membership

5 *seats are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the relevant knowledge, skills and expertise in these membership categories:*

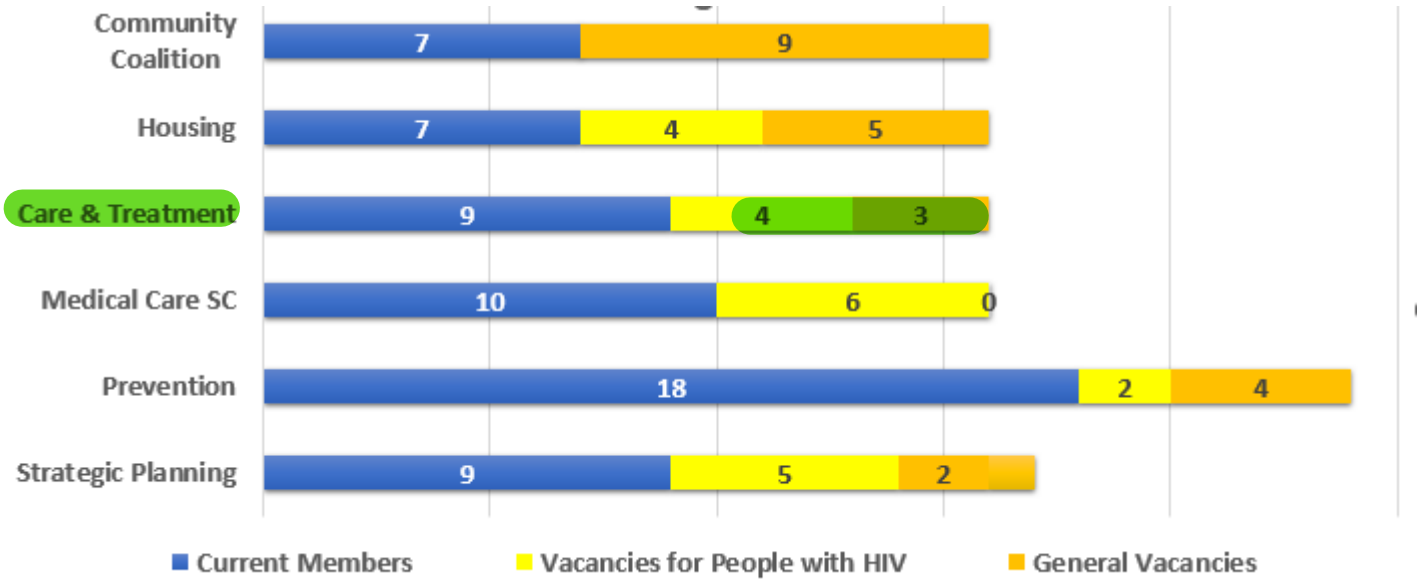
Representative with HIV and Hepatitis B or C
Other Federal HIV Program Grantee Representative (SAMHSA)
Federally Recognized Indian Tribe Representative
Mental Health Provider Representative
Miami-Dade County Public Schools Representative

Applicants Pending Appointment

Ryan White Program Part D Representative
Hospital or Health Care Planning Agency Representative

Partnership Committees

Committees are now accepting applications for new members.
People with HIV are encouraged to apply.



MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
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XII.	Adjournment	Dr. Diego Shmuels

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Partnership Report to Committees and Subcommittee
July 17, 2023 Meeting

Supporting documents related to motions in this report are available are online at aidsnet.org/ meeting-documents/, or from staff at Behavioral Science Research Corporation (BSR). For more information, please contact hiv-aidsinfo@behavioralscience.com.

Members recognized outgoing Chair, Dennis Iadarola, and presented him with a plaque for his service.

Members recognized the passing of Frederick Downs, Jr., and agreed to submit a resolution to the Mayor (prepared by the Assistant County Attorney) to make a proclamation recognizing Mr. Downs' many years of service to the community.

Members heard regular reports and approved the following motions:

Care and Treatment Committee

1. Motion to reallocate FY 2023-24 (YR 33) Ryan White Part A Formula and Supplemental grant funding of $1,179,244 to Food Bank.

2. Motion to allocate 100% of Ryan White Part A Carryover funding ($723,098) to Food Bank.

3. Motion to reallocate FY 2023-24 (YR 33) Ryan White Part A Formula and Supplemental grant funding for total proposed allocations as follows: $6,174,853 to Medical Case Management; $14,555 to AIDS Pharmaceutical Assistance; $8,503,003 to Outpatient/Ambulatory Health Services; $3,388,975 to Oral Health Care; $345,700 to Health Insurance Services; $107,844 to Mental Health Services; $1,701,206 to Substance Abuse Residential; $38,128 to Substance Abuse Outpatient; $186,688 to Medical Transportation; $230,896 to Outreach; and $122,449 Other Professional Services (Legal).

4. Motion to reallocate FY 2023-24 (YR 33) MAI funding for total proposed allocations as follows: $943,920 to Medical Case Management; and $1,241,041 to Outpatient/Ambulatory Health Services.

5. Motion to allocate MAI Carryover funds as follows: $537,152 to Medical Case Management; and $537,152 to Outpatient/Ambulatory Health Services.

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MIAMI-DADE COUNTY RYAN WHITE PART A

FY 2023-24 (YR 33) MINORITY AIDS INITIATIVE (MAI) CARRYOVER GRANT FUNDING ALLOCATIONS

SWEEPS 2 (SW2) - REVISED CARRYOVER ALLOCATIONS

YR 33 RANKING ORDER [1]	SERVICE CATEGORIES	CORE/SUPPORT	ALLOCATIONS AFTER SW2 [2]	CARRYOVER ALLOCATIONS	PROPOSED REVISED CARRYOVER ALLOCATIONS [3]
1	MEDICAL CASE MANAGEMENT	**CORE**	$ 943,920	~~$ 537,152~~	$ 490,109
4	MENTAL HEALTH SERVICE	**CORE**	$ 18,960		
5	OUTPATIENT/AMBULATORY HEALTH	**CORE**	$ 1,241,041	~~$ 537,152~~	$ 490,109
6	EMERGENCY FINANCIAL ASSISTANCE	SUPPORT	$ -		
8	SUBSTANCE ABUSE OUTPATIENT CAR	**CORE**	$ 8,058		
9	MEDICAL TRANSPORTATION	SUPPORT	$ 7,628		
10	OUTREACH SERVICES	SUPPORT	$ 39,816		
	SUBTOTAL		**$ 2,259,423**	~~**$ 1,074,304**~~	**$ 980,218**
	CLINICAL QUALITY MANAGEMENT		$ 100,000		
	ADMINISTRATION (10%)		$ 262,158		
	GRAND TOTAL		**$ 2,621,581**	~~**$ 1,074,304**~~	**$ 980,218**

REVISED Prior Year Funds Available for Carryover:

$ 980,218

YR 33 Current Award (Breakdown by Funding Source)

$	16,452,284
$	8,484,983
$	**2,621,581**
$	**27,558,848**

NOTES:

[1] YR 33 ranking order is based on the Needs Assessment's allocation as provided in the FY 2023 Noncompeting Continuation (NCC) Progress Report which includes non-funded services. Please see attached for the complete list of prioritized core medical and support services for this jurisdiction.

[2] Allocations after SW2 totals, CORE Services Total = $2,211,979 (98%); SUPPORT Services Total = $47,444 (2%); CLINICAL QUALITY MANAGEMENT (3.8%).

[3] **The available amount of FY 2022 MAI Carryover funds has been revised to exclude unexpended prior year (i.e., FY'20 MAI) funds received that, as per HRSA's current guidance, cannot be carried forward into FY 2023.**

Updated for: 08/17/2023

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RYAN WHITE PROGRAM CO-OCCURRING CONDITIONS FY 2022

PRESENTED AUGUST 17, 2023

DEFINITIONS

<136% FPL: Ryan White Program (RWP) clients with an income of up to 136% of the federal poverty level (FPL).

ACA: Affordable Care Act

AIDS Dx: RWP clients with an AIDS diagnosis.

COC: Co-Occurring Conditions

Hepatitis B or C: RWP clients who have had a positive Hepatitis B or Hepatitis C lab test result within the last three (3) fiscal years.

Homeless/Unstably Housed: RWP clients who reported having non-permanent housing (homeless, transient, or transition) and/or answered the question "With whom are you living?" with either "I am Homeless" or "I live in a group home/shelter" during the fiscal year.

Mental Illness: RWP clients who received mental health counseling and/or psychiatric services in the current fiscal year.

MMSC: Male-to-Male Sexual Contact

No Health Insurance: RWP clients with no other forms of health insurance including Medicare, Medicaid, VA benefits, private health insurance (including ACA), or employer-paid insurance.

Subs. Use: RWP clients who have used drugs or alcohol in the past 12 months, currently use injection drugs, have received substance abuse counseling in the fiscal year thru the RWP, or currently attend AA/NA meetings.

STI: RWP clients who had a positive lab test result for either Syphilis, Gonorrhea, or Chlamydia during the fiscal year.

VL: Viral load.

WoCA: Women of child-bearing age; RWP female clients between the ages of 15 and 44.

SUMMARY OF FINDINGS

The are **seven** (7) **Special Need Group**s(SNG) that the Miami-Dade County RWP looks at:

- Substance Users
- Black/African-American (BAA) males with heterosexual HIV acquisition
- Black/African-American (BAA) males with MMSC HIV acquisition
- Black/African-American (BAA) females
- Women of Childbearing Age (WoCA)
- Haitian males and females
- Hispanic males with MMSC HIV acquisition.

The are **eight** (8) **co-occurring conditions** (COC) of interest to the Miami Dade County RWP:

- Poverty (<136% of FPL)
- No other forms of health insurance/coverage
- AIDS diagnosis
- STI (chlamydia, gonorrhea, and/or syphilis) infection
- Hepatitis B or C infection
- Substance use
- Mental illness
- Being homeless or unstably housed.

SUMMARY OF FINDINGS CONT.

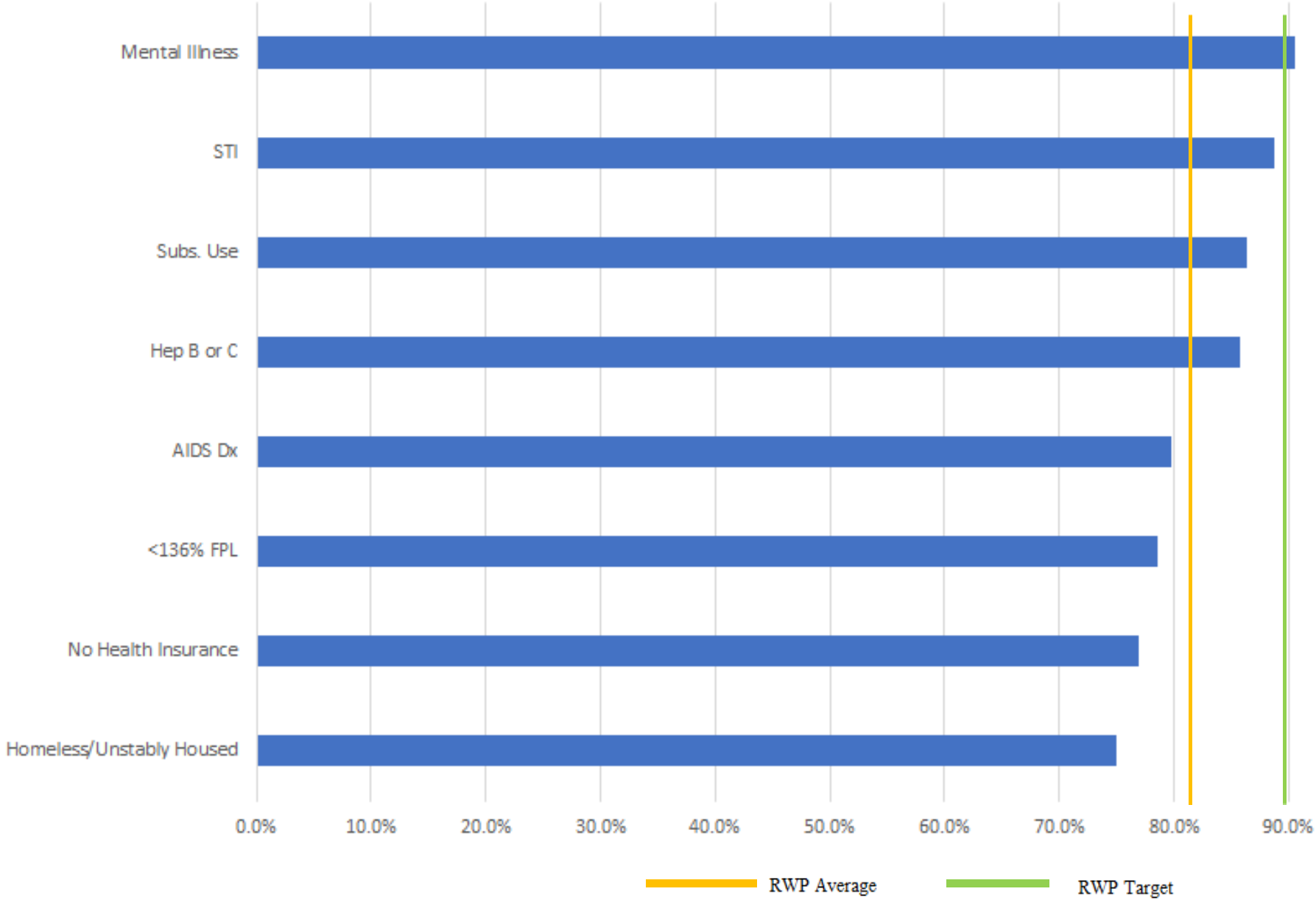
Special Need Groups (SNG):

- Hispanic MMSC (VL suppression 84.8%) was the SNG with the highest VL suppression rate.
  -Accounted for 48.0% of the total RWP population.
- Black MMSC had the lowest VL suppression rate (74%).

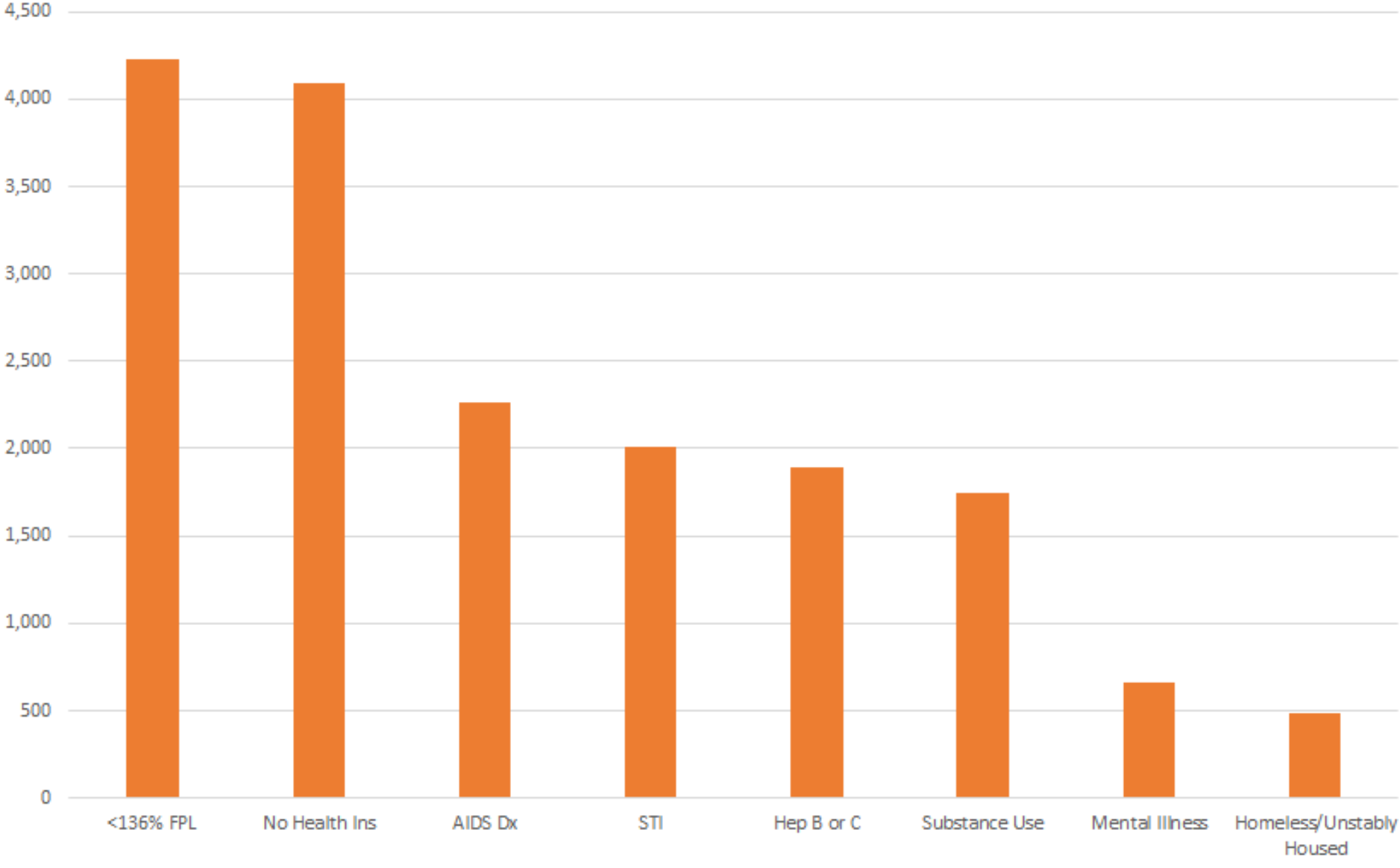
Co-Occurring Conditions (COC):

- Clients with Mental Illness showed the highest VL suppression rate (91%).
- Clients with Hepatitis B or C and clients with Sexually Transmitted Infections (STI) had average VL suppression rates higher than the RWP average.
- Clients who were homeless had the lowest VL suppression rate (75%).
- Clients with mental illness and homeless clients showed the two highest annual costs per client, $4,720 and $4,195 respectively.

VL Suppression % by Co-occuring Condition, FY 2022



Client Ns by Co-Occcurring Condition, FY 2022



Incidence of Co-Occurring Conditions Among Special Need Populations, FY 2022

SPECIAL NEEDS GROUPS	Total N	<136% FPL	No Health Ins.	Any AIDS Dx	STI	Hep B or C	Subs. Use	Mental Illness	Homeless/ Unstably Housed	VL Supp % of Special Needs Groups
Total RWP Clients	8,599 100%	4,228 49.2%	4,092 47.6%	2,267 26.4%	2,013 23.4%	1,892 22.0%	1,747 20.3%	662 7.7%	489 5.7%	82.0%
Hispanic MMSC	4,129 48.0%	1,731 41.9%	1,764 42.7%	713 17.3%	1,347 32.6%	1,045 25.3%	939 22.7%	289 7.0%	122 3.0%	84.8%
Black MMSC	531 6.2%	273 51.4%	270 50.8%	113 21.3%	195 36.7%	160 30.1%	163 30.7%	43 8.1%	52 9.8%	74.0%
Black Male Hetero	476 5.5%	304 63.9%	277 58.2%	194 40.8%	62 13.0%	84 17.6%	106 22.3%	38 8.0%	74 15.5%	79.0%
Black Female	531 6.2%	322 60.6%	241 45.4%	221 41.6%	21 4.0%	70 13.2%	53 10.0%	44 8.3%	39 7.3%	74.8%
Haitian Males + Females	772 9.0%	419 54.3%	354 45.9%	363 47.0%	50 6.5%	116 15.0%	32 4.1%	59 7.6%	30 3.9%	82.9%
WoCA, Age 15-44	412 4.8%	250 60.7%	243 59.0%	105 25.5%	28 6.8%	70 17.0%	66 16.0%	62 15.0%	40 9.7%	74.8%
Substance Users	1,747 20.3%	848 48.5%	897 51.3%	324 18.5%	597 34.2%	561 32.1%	1,747 100%	194 11.1%	209 12.0%	86.4%
VL Supp % of Clients	82.0%	78.6%	77.0%	79.8%	88.7%	85.7%	86.4%	90.5%	75.0%	

Treatment Costs by Co-Occurring Conditions, FY 2022

Co-Occurring Condition	FY 2022 RWP Clients w/ Co-Occurring Condition		Total Tx Cost (from PE Billed Service Detail Data)	Avg. Tx Cost per Client
	# of RW clients with COC	% of RW clients		
All RWP Clients	8,599	100%	$22,649,227.14	$2,636.39
<136% FPL	4,228	49.2%	$12,825,907.64	$3,037.16
Only RWP	4,092	47.6%	$13,264,236.41	$3,244.68
AIDS diagnosis	2,267	26.4%	$5,973,057.97	$2,651.16
STI	2,013	23.4%	$6,628,735.37	$3,292.96
Hepatitis B or C	1,892	22.0%	$6,042,098.65	$3,193.50
Substance Use	1,747	20.3%	$5,517,359.93	$3,158.19
Mental Illness	662	7.7%	$3,120,294.70	$4,720.57
Homeless/UH	489	5.7%	$2,273,713.58	$4,195.04

THANK YOU!

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UNMET NEEDS IN THE MIAMI-DADE HIV COMMUNITY

PRESENTED AUGUST 17, 2023

UNMET NEED TABLE

Persons With HIV, in Care and Not in Care Florida Department of Health and Ryan White HIV/AIDS Program Miami-Dade County, CY/FY 2021				
	FDOH: Epi Data, Persons with HIV	FDOH: Epi Data, Persons Not in Care	FDOH: Epi Data, Persons in Care, Not RWP	RWP: Provide Miami Data, Persons in Care
N of cases	27,782	7,572	11,792	8,418
Gender	%	%	%	%
Male	76.0	76.0	72.5	80.9
Female	23.6	23.6	27.6	18.0
Race/Ethnicity	%	%	%	%
White	9.9	10.7	11.3	7.2
Black + Haitian	39.3	44.4	43.2	29.3
Hispanic	50.0	45.5	40.8	62.9
All Other	1.0	0.2	1.7	0.7
Age	%	%	%	%
Under 25	1.9	1.1	1.8	2.7
25-34	12.7	9.2	9.6	20.2
35-49	28.0	26.1	24.2	35.0
50+	57.4	63.5	64.5	42.0

UNMET NEED SUMMARY POINTS

Epidemiological data provided by the Florida Department of Health for CY 2021 show:

27,782 total persons with HIV in Miami-Dade County in **CY 2021**

7,572 of these persons were not in care in CY 2021 (27% of 27,782)

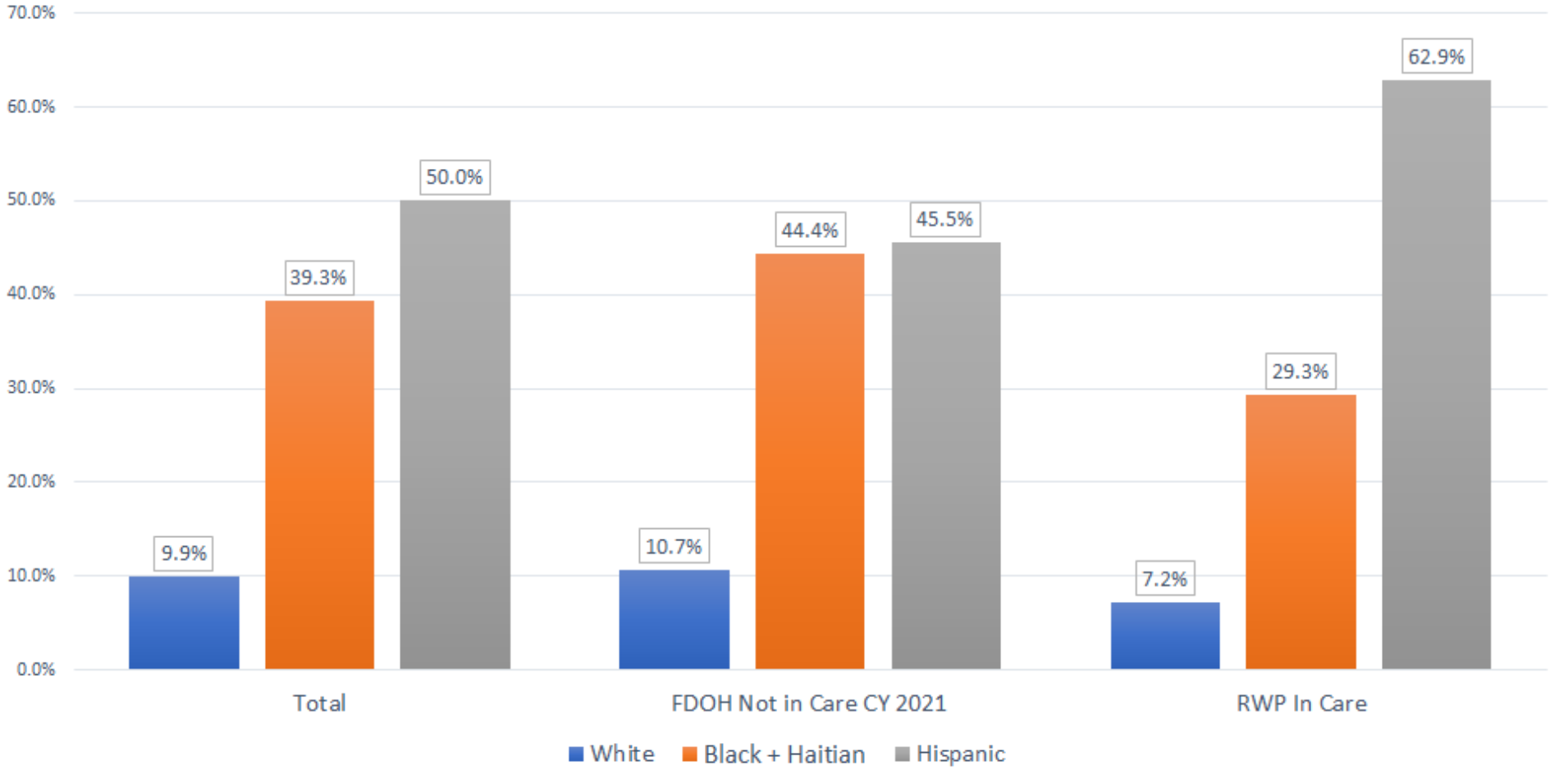
- 3,445 Hispanic persons with HIV were not in care (25%)
- 3,362 African Americans and Haitians with HIV were not in care (31%)
- 810 non-Hispanic whites with HIV were not in care (30%)

8,418 persons with HIV were in Ryan White Program (RWP) **care** in FY 2021 (30%)

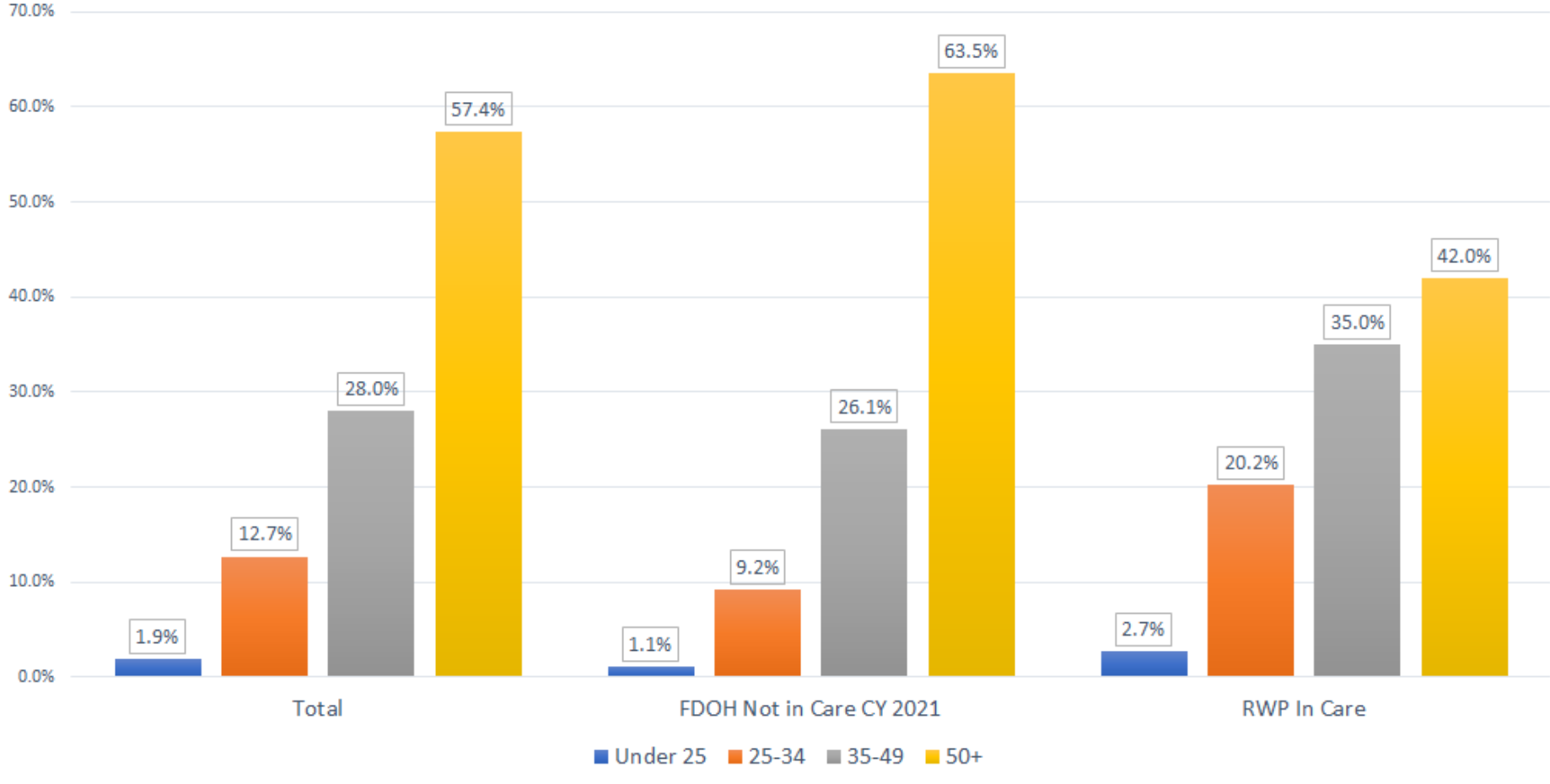
- 39% of 13,936 Hispanic persons with HIV were in RWP care
- 23% of 10,198 African Americans and Haitians were in RWP care
- 22% of 2,750 non-Hispanic whites with HIV were in RWP care

RACE/ETHNICITY COMPARISON, CY/FY 2021

EPI TOTAL, NOT IN CARE, IN RWP CARE



AGE DISTRIBUTION COMPARISON, CY/FY 2021
EPI TOTAL, NOT IN CARE, IN RWP CARE



UNMET NEED AND DEMOGRAPHICS

Comparisons of Epi data and RWP clients in care show significant demographic differences between the RWP clients in care and the Miami-Dade clients out of care.

- Substantial over-representation of Hispanic clients in RWP care, compared to Miami-Dade total persons with HIV and persons who are out of care
- Substantial under-representation of African American/Haitian clients in RWP care

THE CHALLENGE

What mechanisms does the Ryan White Program have to address **unmet community HIV care needs** within its existing structure?

THANK YOU!

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2022-2023 COMMUNITY INPUT

INTEGRATED PLAN DEVELOPMENT AND VIRTUAL TOWN HALL

PRESENTED AUGUST 17, 2023

INTRODUCTION

Concerns gathered from Integrated Plan sessions, the Needs Assessment Town ,and other Public Input opportunities are included in this presentation, as well as updates on progress to date

2022 Community Input: 2022-2026 Integrated HIV Prevention & Care Plan

In early 2022, as part of Integrated Plan development, 12 community listening sessions, focus groups, and key informant interviews were conducted across a variety of stakeholder groups.

April 2023 Town Hall

On April 26, 2023, the Partnership hosted a virtual town hall for Ryan White clients. One client attended; all other attendees were subrecipient staff members.

Other Public Input

The Partnership maintains a phone and website feedback line; no comments have been gathered.

HOUSING

Concerns

- There is a severe housing crisis with limited affordability and availability.
- Housing costs have risen, wait lists are long and slow moving, and incomes are limited.
- Housing Opportunities for Persons with AIDS (HOPWA)programs are not sufficient to cover short-term or long-term housing needs.
- Participants expressed panic and frustration about:
  -Escalating housing costs;
  -Awful landlords;
  -Run-down/unsafe housing;
  -Discrimination based on HIV status; and
  -Fear of eviction.

Progress

- Additional Ryan White Part B funds have been allocated to housing
- Miami-Dade County released an Ending the Epidemic (EHE) Request for Proposal for a Housing Stability Service program, "housing as healthcare". Results of the RFP are pending.

TRANSPORTATION

Concerns

- Additional access to transportation is needed and Medical Case Managers (MCM) must make clients aware of available transportation vouchers.
- Getting to and from appointments is vital.
  - -For some, a medical visit is an all-day event if traveling on public transportation.
  - -Some clients choose to travel far from their home area in efforts to avoid the stigma of getting HIV services in their own neighborhood.
- Transportation to pick up prescriptions is vital.
- AIDS Drug Assistant Program (ADAP) locations are not convenient for many.
  - -Participants were not aware of ADAP home delivery.
  - -Participants were not aware of pick-up options at local CVS pharmacies.

Progress

- ADAP has expanded pharmacy access through Magellan to 17 sites.
- Having a three-month supply of medications cuts down on some transportation needs.

COMMUNICATION

Overall, participants indicated they were receiving the medical care needed.

Concerns

Improvements in communication are necessary on every level of service delivery from front office to doctor's office to address:

- Language barriers in both verbal and print communication;
- Microaggressions and biases (overt and unrecognized) based on gender, race, ethnic, and economic factors;
- Self-stigmatizing behavior;
- Developing a relationship with clients so they don't just feel like a number;
- Opportunities for using modern technology (appointment reminders, telehealth, etc.);
- Maintaining confidentiality, particularly for clients who have not disclosed their HIV status; and
- Making clients aware of all available services (not just those at a single agency).

Progress

The Integrated Plan includes an objective to address stigma by addressing HIV-status bias, trauma-informed care, status neutral care, and patient-centered care however, this is a complex issue.

MENTAL HEALTH

Concerns

- Mental health must be addressed to assist clients with treatment adherence.
- Particularly since the COVID pandemic, clients have increased anxiety and depression.
- Untreated mental health issues and increased substance use was reported.
- Many particpants indicated not being aware of eligibility to mental health services. Subrecipients (MCM) need to make all clients aware of access points for mental health service. MCM cannont just refer to inter-agency services.
- Limited appointment times for psychiatric treatment was noted as a barrier to care.

Progress

Ryan White Outpatient/Ambulatory Health Services was expanded to allow billing for mental health services (albeit with some restrictions).

DENTAL (ORAL HEALTH CARE)

Concerns

- Dentists have limited appointment availability.
- Appointments for specialty services are difficult to schedule.

Progress

Additional funds have been allocated to oral health care in an effort to increase access.

FOOD INSECURITY

Concerns

- Many participants indicated being in need and not aware of food bank services,
- Subreceipients (MCM) need to make all clients aware of food bank availability.
- With increased financial pressures, cost saving measures may need to be implemented in FY 2023.

Progress

- The Ryan White Program does not require a letter of medical necessity to recieve food bank service.
- Federal Povery Level requirement for Food Bank is 400% so all Ryan White clients are eligible.
- Additional funds were swept into Food Bank.

APPOINTMENTS

Concerns

- For those who are in school or are working full- or part- time, there is difficulty fitting appointments into their schedule
- More appointments are needed outside of conventional business hours.

Progress

- Some subrecipients do offer appointments outside of conventional business hours.
- The EHE RFP includes expansion of telehealth.

THANK YOU!

WWW.AIDSNET.ORG

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
VII.	Reports	
	• Grantee/Recipient reports (Part A, Part B, and ADAP)	Recipients
	• Vacancies	Marlen Meizoso
	• Report to Committees (reference only)	All
VIII.	Standing Business	
	• FY 2022 MAI Carryover Adjustment	All
IX.	New Business	
	• 2022 Ryan White Co-Occurring Conditions **(Section 4)**	Dr. Robert Ladner
	• Unmet Needs in Miami-Dade HIV Community **(Section 8)**	Dr. Robert Ladner
	• 2022-23 Community Input/Town Hall Results **(Section 8)**	Marlen Meizoso
	• Service Categories **(Section 9)**	Marlen Meizoso
	• August Summary and Next Steps **(Section 11)**	Marlen Meizoso
	• Planning Council Meeting Survey	Marlen Meizoso
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **Sept. 14, 2023** at Main Library- **Auditorium**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Ryan White Program Part A Priorities

FY 2024-2025

As Part of the annual Needs Assessment process and keeping in mind all the presentations made during the Needs Assessment, use this survey to rank all **28** service categories for **Part A** from highest priority (1) to lowest priority (28) for people living with HIV in Miami-Dade County. Please see HRSA Policy Clarification Notice #16-02 for additional details.

1= first most important, 2= second most important, and so on down to 28=least important

Rank	Services
	AIDS Drug Assistance Program (ADAP) Treatment [C]
	AIDS Pharmaceutical Assistance (Local Pharmacy Assistance Program) [C]
	Child Care Services [S]
	Early Intervention Services [C]
	Emergency Financial Assistance [S]
	Food Bank/Home-Delivered Meals [S]
	Health Education/Risk Reduction [S]
	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals [C]
	Home and Community Based Health Care [C]
	Home Health Care [C]
	Hospice Services [C]
	Housing Services [C]
	Linguistic Services [S]
	Medical Case Management, including Treatment Adherence Services [C]
	Medical Nutrition Therapy [C]
	Medical Transportation (Vouchers) [S]
	Mental Health Services [C]
	Non-Medical Case Management [S]
	Oral Health Care [C]
	Other Professional Services (Legal Assistance and Permanency Planning) [S]
	Outpatient/Ambulatory Health Services [C]
	Outreach Services [S]
	Psychosocial Support [S]
	Referral for Health Care and Support Services [S]
	Rehabilitation Services [S]
	Respite Care [S]
	Substance Abuse Outpatient Care [C]
	Substance Abuse Services (Residential) [S]
	C=core services S=support services

Ryan White Program Minority AIDS Initiative (MAI) Priorities

FY 2024-2025

Minority AIDS Initiative (MAI) funds support innovative models to improve health outcomes for people with HIV in **racial** and **ethnic minority communities**. Keeping in mind all the presentations made during the Needs Assessment, use this survey to rank all **28** service categories from highest priority (1) to lowest priority (28) for people living with HIV who are racial and ethnic minority communities in Miami-Dade County. Please see HRSA Policy Clarification Notice #16-02 for additional details.

1= first most important, 2= second most important, and so on down to 28=least important

Rank	Services
	AIDS Drug Assistance Program (ADAP) Treatment [C]
	AIDS Pharmaceutical Assistance (Local Pharmacy Assistance Program) [C]
	Child Care Services [S]
	Early Intervention Services [C]
	Emergency Financial Assistance [S]
	Food Bank/Home-Delivered Meals [S]
	Health Education/Risk Reduction [S]
	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals [C]
	Home and Community Based Health Care [C]
	Home Health Care [C]
	Hospice Services [C]
	Housing Services [C]
	Linguistic Services [S]
	Medical Case Management, including Treatment Adherence Services [C]
	Medical Nutrition Therapy [C]
	Medical Transportation (Vouchers) [S]
	Mental Health Services [C]
	Non-Medical Case Management [S]
	Oral Health Care [C]
	Other Professional Services (Legal Assistance and Permanency Planning) [S]
	Outpatient/Ambulatory Health Services [C]
	Outreach Services [S]
	Psychosocial Support [S]
	Referral for Health Care and Support Services [S]
	Rehabilitation Services [S]
	Respite Care [S]
	Substance Abuse Outpatient Care [C]
	Substance Abuse Services (Residential) [S]
	C=core services S=support services

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under...an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*

Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

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

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

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals
Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- 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.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care
Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

See also Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

USING MAI FUNDS EFFECTIVELY: TAILORING SERVICES FOR LOCALLY IDENTIFIED SUBPOPULATIONS

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

Resource Overview

Goals/Purpose of MAI funding
The Ryan White HIV/AIDS Program's (RWHAP) Minority AIDS Initiative (MAI) provides additional funding under RWHAP Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV. Under RWHAP Part A, MAI formula grants are used to fund core medical and support services that will improve access and reduce disparities in health outcomes for minority populations in metropolitan areas hardest hit by HIV/AIDS.

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

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

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

Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations

Introduction

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

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

History

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

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

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

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

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

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

Allowable Uses of MAI Funds under RWHAP

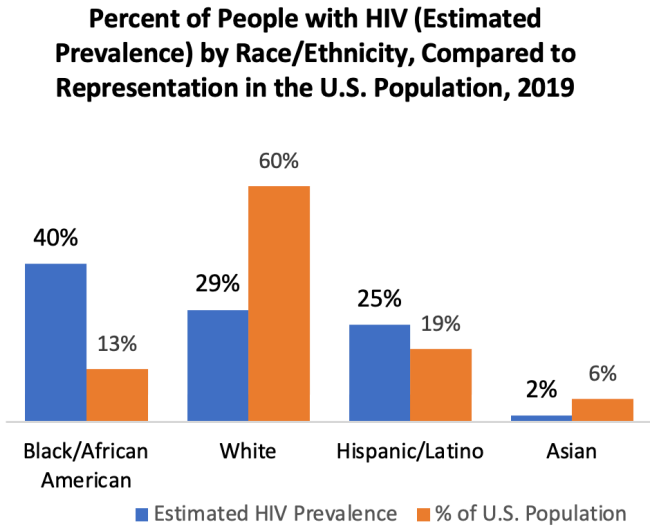
Several HHS agencies receive MAI funding, and each agency and each RWHAP Part uses funds differently. Use of funds under each RWHAP Part is summarized below. Expectations for other agencies are provided in Attachment A and may help PC/PBs in developing resource inventories covering other funding streams.

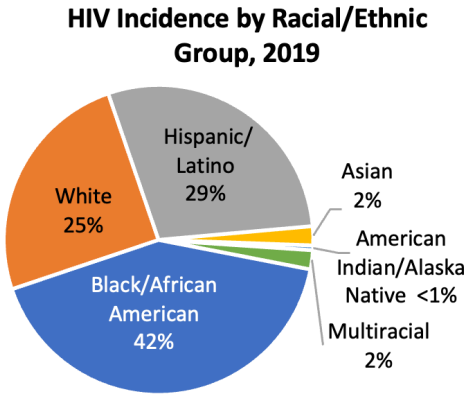
MAI funding under RWHAP is legislatively authorized, and the HIV/AIDS Bureau has specified allowable uses by Part: [4]

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

Continuing Need

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

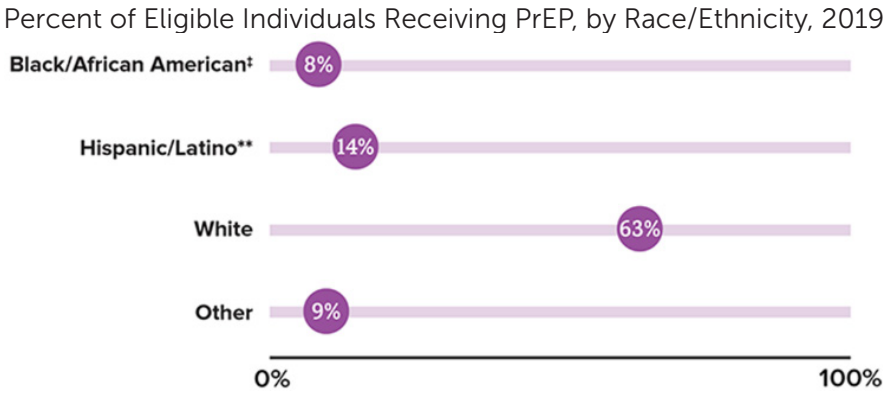




Source: CDC

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

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



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

MAI under RWHAP Part A

Applications and Funding

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

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

HIV/AIDS Bureau Expectations

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

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

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

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

Inappropriate Use of MAI Funds under RWHAP Part A

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

Examples of MAI Activities in RWHAP Part A EMAs/TGAs

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

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

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

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

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

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

PC/PB MAI-related Roles

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

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

Using Needs Assessment in MAI Planning

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

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

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

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

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

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

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

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

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

Using Allocations and Directives to Improve Subpopulation Treatment Outcomes

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

Challenges in Using MAI Funds Effectively

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

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

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

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

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

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

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

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

Sound Practices for PC/PBs in Using MAI Funds

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

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

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

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

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

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

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

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

Putting It All Together: A Comprehensive Scenario

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

Tailoring Services to Improve Subpopulation Treatment Outcomes

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

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

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

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

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

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

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

SAMHSA: MAI funds are used for activities including:

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

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

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

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

References

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

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

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

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

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

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

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

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

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

[10] *Ibid,* p 24.

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

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

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

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

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

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

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
VII.	Reports	
	• Grantee/Recipient reports (Part A, Part B, and ADAP)	Recipients
	• Vacancies	Marlen Meizoso
	• Report to Committees (reference only)	All
VIII.	Standing Business	
	• FY 2022 MAI Carryover Adjustment	All
IX.	New Business	
	• 2022 Ryan White Co-Occurring Conditions **(Section 4)**	Dr. Robert Ladner
	• Unmet Needs in Miami-Dade HIV Community **(Section 8)**	Dr. Robert Ladner
	• 2022-23 Community Input/Town Hall Results **(Section 8)**	Marlen Meizoso
	• Service Categories **(Section 9)**	Marlen Meizoso
	• August Summary and Next Steps **(Section 11)**	Marlen Meizoso
	• Planning Council Meeting Survey	Marlen Meizoso
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **Sept. 14, 2023** at Main Library- **Auditorium**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

SUMMARY AND NEXT STEPS

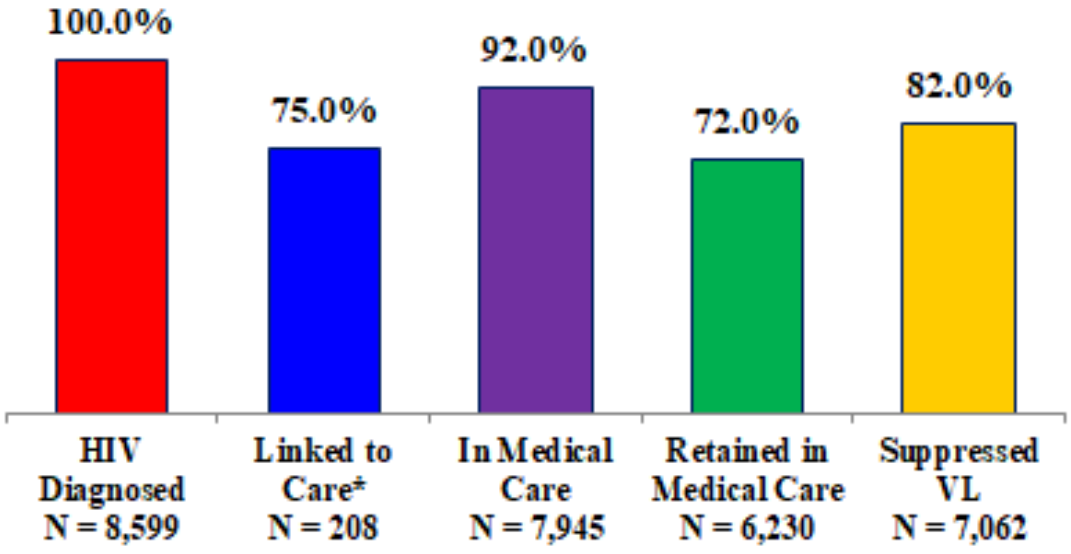
August 17, 2023 version

EPI DATA (SECTION 3)

BASED ON FLORIDA DEPARTMENT OF HEALTH (FDOH) DATA, CY 2021, FROM 2020 TO 2021, MIAMI-DADE SHOWS SIGNIFICANT INCREASES IN:

- Both HIV and AIDS prevalence
- % of persons with HIV acquired through male-to-male sexual contact
- % of persons with HIV who are Hispanic
- Number of persons with HIV who are transgender
- % of persons with HIV over 50 years of age
- % of persons with HIV who are co-infected with STIs

HIV CONTINUUM (SECTION 3)



Data from Ryan White Program (RWP), FY 2022

Clients in medical care, retained in care and with suppressed VL are higher in 2022 than in 2020.

Black/African-American male-to-male sexual contact (formerly MSM) have the lowest VL suppression rates.

Hispanic male-to-male sexual contact have the highest VL suppression rates.

DEMOGRAPHICS (SECTION 4)

Demographic characteristics of RWP clients

- Increase in number of clients served, from 8,127 in 2020 to 8,590 in 2022
- Over 40% are 50 years old and older
- Over 80 % are Male
- Over 60% are Hispanic
- Transgender clients account for a little over 1% (1.2%) of clients
- Male-to-male sexual contact accounts for 74% of male HIV acquisition
- Spanish as primary language accounts for 57% of clients, up from 45% in FY 2018
- Most clients (49.2%) have an FPL of 135% or less
- Affordable Care Act insurance coverage among clients has risen to 36% of clients, up from 23% in FY 2018.

CO-OCCURRING CONDITIONS (SECTION 4)

Special Need Groups (SNG):
Hispanic MMSC (48% of total clients) has the highest VL suppression rate (85%).
Black MMSC (6% of total clients) had the lowest VL suppression rate (74%).

Co-Occurring Conditions (COC):
Clients with Hepatitis B or C and clients with Sexually Transmitted Infections (STI) had an average VL suppression rate higher than the RWP average.

Homeless had the lowest VL suppression rate, 75%.

Clients with mental illness and homeless accounted for the two highest annual costs per client, $3,362 and $4,195 respectively.

UTILIZATION (SECTION 5)-CLIENTS

Service Categories Sort by Total Number of Unduplicated Clients in FY 2022

SERVICE CATEGORIES	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Medical Case Management, inc. Treatment Adherence (includes Peer Support)	8,496	8,116	7,378	7,842	8,085
Outpatient/Ambulatory Health Services	5,447	5,317	4,281	4,422	4,540
Oral Health Care	3,381	3,170	1,711	2,237	2,577
Health Insurance Premium & Cost Sharing Assist	1,307	1,335	1,125	1,255	1,440
Food Bank	701	715	735	712	1,130
Medical Transportation Services	638	720	94	645	743
Outreach Services	624	472	130	116	158
AIDS Pharmaceutical Assistance (Local)	697	605	185	183	157
Mental Health Services	327	274	95	121	107
Other Professional Services - Legal Services	76	66	48	44	103
Substance Abuse Services (Residential)	169	95	70	66	72
Substance Abuse Services Outpatient	115	55	0	17	22
Emergency Financial Assistance	N/A	N/A	N/A	N/A	N/A

UTILIZATION (SECTION 5)-EXPENSES

Service Categories Sort by Total Expenditures in FY 2022

SERVICES CATEGORIES	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
CORE SERVICES					
Outpatient/Ambulatory Health Services	$9,112,521	$9,391,615	$7,397,592	$7,729,584	$8,724,251
Medical Case Management, inc. Treatment Adherence (includes Peer Support)	$5,308,840	$5,776,806	$5,283,942	$5,744,512	$6,031,337
Oral Health Care	$2,841,838	$3,547,495	$1,645,879	$2,533,062	$3,273,644
Health Insurance Premium & Cost Sharing Assistance	$502,536	$372,895	$289,193	$298,950	$297,152
Mental Health Services	$133,790	$135,505	$90,019	$60,239	$64,577
AIDS Pharmaceutical Assistance (Local)	$86,210	$57,843	$5,993	$4,379	$3,954
Substance Abuse Services Outpatient	$55,390	$23,970	$23,556	$1,356	$4,971
SUPPORT SERVICES					
Food Bank	$1,451,528	$1,851,369	$1,303,702	$1,338,778	$2,540,864
Substance Abuse Services (Residential)	$1,854,140	$1,237,830	$1,320,120	$968,310	$1,053,590
Outreach Services	$307,380	$332,602	$148,155	$140,761	$151,423
Medical Transportation	$139,855	$140,937	$5,642	$100,956	$159,552
Other Professional Services - Legal Services	$140,599	$115,976	$146,336	$97,371	$67,581
Emergency Financial Assistance	N/A	N/A	N/A	N/A	N/A

OTHER FUNDING (SECTION 6)

Other funding data showed there are several other sources for services with the Medicaid program being the largest program.

Dashboard cards provide data on priorities (current and historical) and expenditures/allocations (current and historical) to assist the Committee in its decision-making process.

DASHBOARD CARDS (SECTION 7)

SERVICES TRENDING UP BY CLIENTS SINCE 2021

Food Bank

Health Insurance

Legal Services

Medical Case Management

Medical Transportation

Oral Health Care

Outpatient/Ambulatory Health

Outreach

Substance Abuse Services*

SERVICES TRENDING DOWN BY CLIENTS SINCE 2021

AIDS Pharmaceutical Assistance

Mental Health

*outpatient and residential

CLIENT SATISFACTION (SECTION 8)

Many clients working-have issues getting appointments.

Most clients speak Spanish so it important for providers to have multilingual staff at provider sites.

For those clients with ACA plans, 15% did not use the GAP card.

Service satisfaction has improved in outpatient ambulatory health services but continues to be low for oral health.

While stigma is felt by a number of client groups in a number of dimensions, particularly among younger clients, instances of discriminatory or stigmatizing behavior among subrecipients are extremely rare.

REMAINING STEPS

All data presentations are **complete**.

FINAL NEEDS ASSESSMENT MEETING- SEPTEMBER 14, 2023

Three items remain in the needs assessment/priority setting resource allocation (PSRA) process: **directives** (as applicable), **priority setting**, and **resource allocation**.

DIRECTIVES

Provide guidance to the Recipient on desired ways to respond to identified service needs, priorities, and/or shortfalls.

Often specify use or non-use of a particular service model, or address geographic access to services, language issues, or specific populations.

May have cost implications.

Usually only a small number are developed.

Must be followed by Recipient in procurement, contracting, or other service planning.

PRIORITY SETTING

Determining what service categories are most important for people living with HIV in Miami-Dade County and place them in priority order.

Priorities are **not** tied to funding or to service providers.

Decisions should be data-based.

All **28** service categories will be prioritized for Part A and MAI.
See section 9 of your needs assessment book for PCN#16-02.

A survey will be sent to members and guests after the meeting whose results will be tallied and presented in aggregate at the following meeting.

RESOURCE ALLOCATION

Data such as other funding streams, cost per client, and anticipated numbers of new clients coming into care should be considered in how money is allocated to each service category.

Resource allocation is not tied to priorities; some lower-ranked service categories may receive disproportionate funding because they are expensive to provide.

Per Committee request, two budgets will be developed, one flat and one NOFA (notice of funding allowable).

RESOURCE ALLOCATION-CONFLICT OF INTEREST

If a member is the sole provider in a service category and funds are being allocated, the conflicted member must **recuse** him/herself from voting. The member will follow a formal disclosure process, complete form 8B, and will step outside of the room both during discussion of and voting on the conflicted item. He/she may return to the meeting once the discussion and voting are concluded.

Conflicted providers on the **Care and Treatment Committee** under Ryan White Program Part A *Food for Life* (**Food Bank**) and under Minority AIDS Initiative(MAI) *Borinquen Medical Centers* (**Mental Health**, **Outreach**, and **Substance Abuse Outpatient).**

REMAINING STEPS-FINAL REMINDERS

REVIEW ALL ITEMS POSTED ONLINE AT

WWW. AIDSNET.ORG

SEPTEMBER 14, 2023
10 A.M. TO 1 P.M.
MIAMI-DADE COUNTY MAIN LIBRARY
101 WEST FLAGLER STREET,
AUDITORIUM
MIAMI, FL 33130

RSVP for the meeting!

and

THANK YOU for participating in one of the central task of the planning council!

THANK YOU!

WWW.AIDSNET.ORG

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, August 17, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Introductions	All
III.	Meeting Housekeeping and Rules	Dr. Mary Jo Trepka
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 13, 2023	All
VII.	Reports	
	• Grantee/Recipient reports (Part A, Part B, and ADAP)	Recipients
	• Vacancies	Marlen Meizoso
	• Report to Committees (reference only)	All
VIII.	Standing Business	
	• FY 2022 MAI Carryover Adjustment	All
IX.	New Business	
	• 2022 Ryan White Co-Occurring Conditions **(Section 4)**	Dr. Robert Ladner
	• Unmet Needs in Miami-Dade HIV Community **(Section 8)**	Dr. Robert Ladner
	• 2022-23 Community Input/Town Hall Results **(Section 8)**	Marlen Meizoso
	• Service Categories **(Section 9)**	Marlen Meizoso
	• August Summary and Next Steps **(Section 11)**	Marlen Meizoso
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X.	Announcements and Open Discussion	All
XI.	Next Meeting: **Sept. 14, 2023** at Main Library- **Auditorium**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Meeting Preference Exercise for Planning Council Members
- Care and Treatment Committee -

The Miami-Dade HIV/AIDS Partnership's Executive Committee has been working on strategies for improving meeting experience and increasing participation of current and prospective members.

Remember, meetings are usually scheduled for 2 hours not including an estimated 1-hour travel time.

Replies will be reported to this committee and the Executive Committee and will assist staff in drafting 2024 calendars.

---

1. Please indicate which days of the week you are able to commit to attending the **Care and Treatment Committee** meeting.

    ____ Monday ____ Tuesday

    ____ Wednesday ____ Thursday ____ Friday

---

2. Please indicate what times of day you are able to commit to attending the **Care and Treatment Committee** meeting.

    ____ 9:30 a.m. to 11:30 a.m.

    ____ 10:00 a.m. to 12:00 p.m.

    ____ 12:00 p.m. to 2:00 p.m.

    ____ 2:00 p.m. to 4:00 p.m.

    ____ 3:30 p.m. to 5:30 p.m.

    ____ 4:00 p.m. to 6:00 p.m.

    ____ 5:00 p.m. to 7:00 p.m.

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3. Please indicate the locations where you are able to commit to attending the **Care and Treatment Committee** meeting.

    ____ Behavioral Science Research Corp., 2121 Ponce de Leon #240, Coral Gables, FL 33134

    ____ Miami-Dade County Public Library, 101 West Flagler Street, Miami, FL 33130

    ____ Care Resource, 3510 Biscayne Blvd, Miami, FL 33137

    ____ Other location: Please include location address:_____

Thank you!

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NOTICE

ATTENTION ATTENDEES!

The walkway from the Cultural Arts Parking Garage to the MDC Main Library will be CLOSED from

September 13, 2023 to October 27, 2023.

To access the Library, exit on the first floor of the garage, cross the street, and take the stairs or ramp up to the Library. A parking payment kiosk is located on the first floor of the garage by the elevators.

MIAMI-DADE
HIV/AIDS PARTNERSHIP

The Community Coalition invites you to our

August Roundtable Dinner

People with HIV are encouraged to attend!
Be part of the HIV Community who speaks for the HIV Community!

HIV CRIMINALIZATION

Kamaria Laffrey, Co-Executive Director of the Sero Project, will lead us through a roundtable discussion about HIV criminalization.

Monday, August 28, 2023
5 PM - 7 PM
Latinos Salud
640 NE 124th Street
North Miami, FL 33161

Please RSVP!
hiv-aidsinfo@behavioralscience.com
or (305) 445-1076.

Join the Partnership!
Click here to get started!

MIAMI-DADE
HIV/AIDS PARTNERSHIP

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Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | twitter.com/HIVPartnership | instagram.com/hiv_partnership/

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