2024 MIAMI-DADE HIV/AIDS PARTNERSHIP NEEDS ASSESSMENT

2121 Ponce de Leon Blvd, ste. 240
Coral Gables, FL 33134
www.aidsnet.org

May 2024

The annual Priority Setting and Resource Allocation needs assessment process is a series of Care and Treatment Committee meetings. The results of the meetings are included in this book.

DISCLAIMER

Prepared by Behavioral Science Research Corporation for the Miami-Dade County Office of Management and Budget-Grants Coordination and the Miami Dade HIV/AIDS Partnership. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H89HA00005, CFDA #93.914 – HIV Emergency Relief Project Grants, as part of a Fiscal Year 2024 award totaling $8,094,759 as of February 20, 2024, with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. Government.

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- May 4, 2024 agenda
- April 11, 2024 minutes

SCHEDULE OF MEETINGS

Needs Assessment Topics

May 9, 2024 10:00AM-1:00 PM

Planning Council Responsibilities for Needs Assessment
Setting Priorities and Allocation Resource Process
HIV Epidemiology in Miami-Dade County, 2022

June 13, 2024 10:00 AM-1:00 PM

2023 EIIHA Data
2023 Ryan White Demographics
2023 Ryan White HIV Care Continuum

July 14, 2024 10:00 AM-1:00 PM

2023 Ryan White Co-Occurring Conditions
Other Funding and Dashboard Cards
2023 Client Satisfaction Survey Results

AUGUST 8, 2024 10:00 AM-1:00 PM

Community Input Results
Unmet Needs/Gaps
Service Categories
Projections

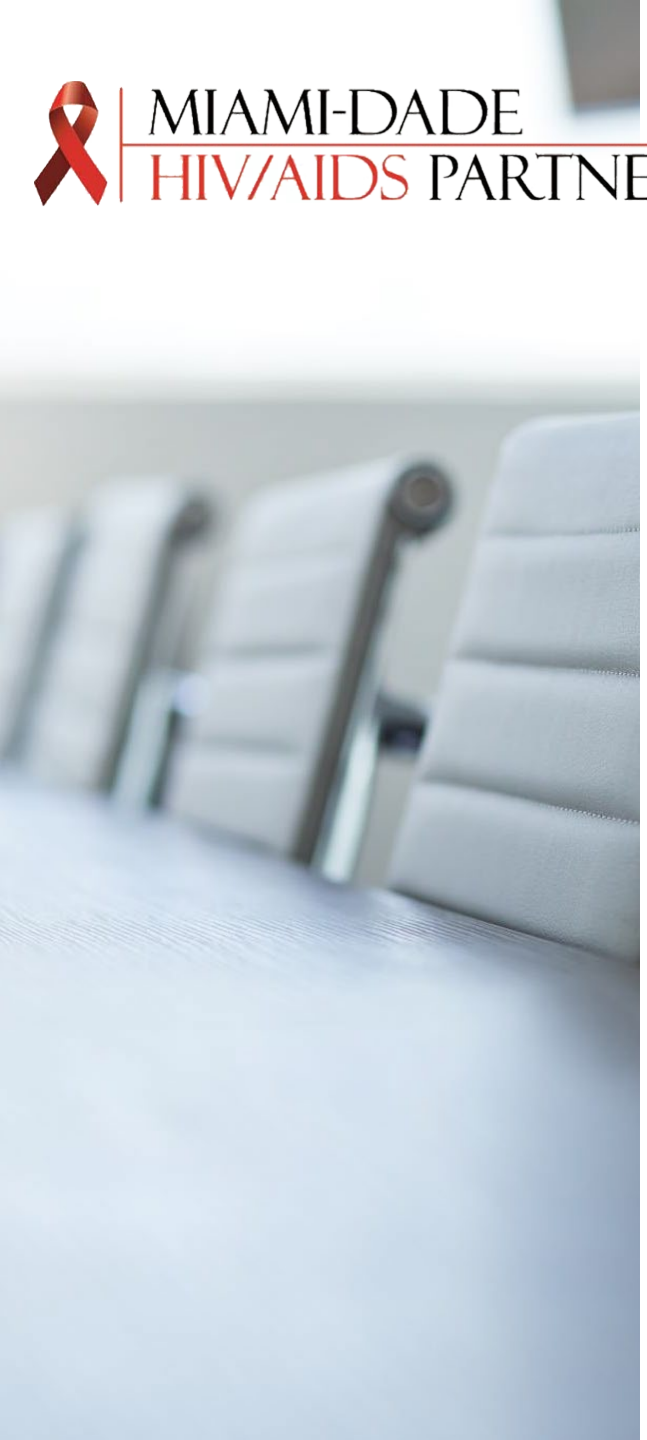
September 12, 2024 10:00 AM-12:00 PM

Special Directives
Priority Setting
Resource Allocations

HOUSEKEEPING AND RULES

SECTION 1

MIAMI-DADE HIV/AIDS PARTNERSHIP



Meeting Housekeeping- Care and Treatment

Updated April 8, 2024

Behavioral Science Research

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.*
- Eligible committee members should see staff for a voucher at the end of the meeting

Meeting Participation

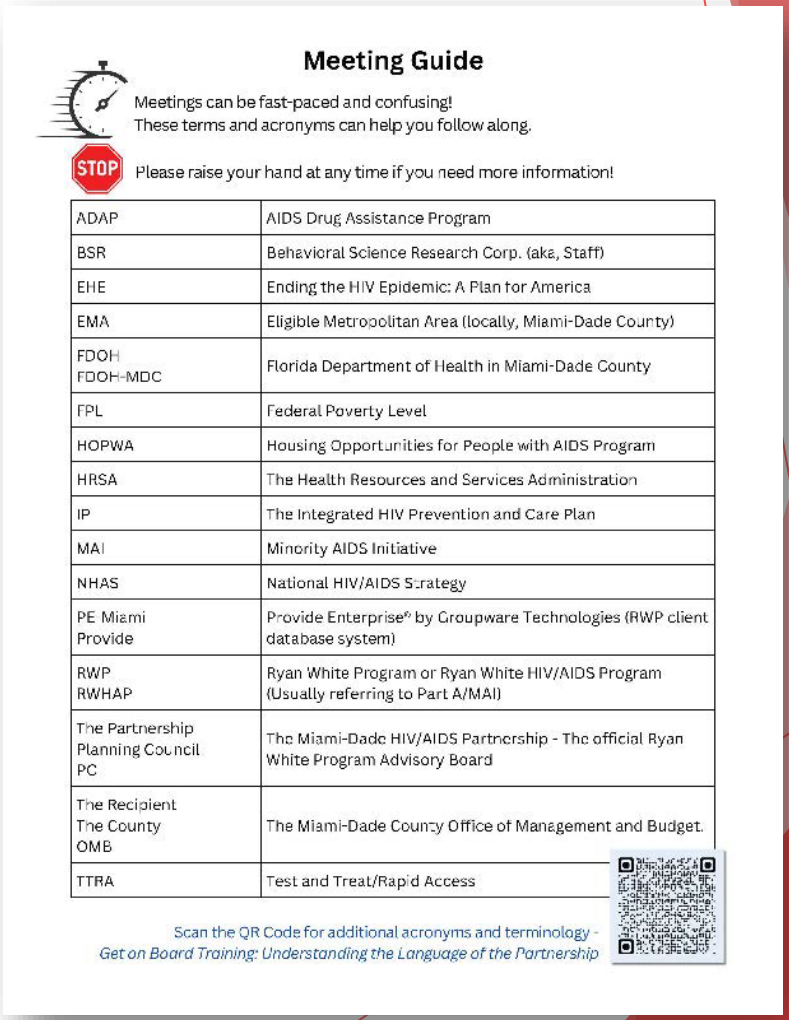
- Raise your hand if you need clarification about any terminology or acronyms used throughout the meeting.
- Raise your hand to be recognized by the Chair or added to the queue.
- Only members of the Committee vote on items.
- Discussion should be limited to the current Agenda topic or motion.
- Speakers 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.

Meeting Terminology

Meetings can be fast-paced and confusing!

Terms and acronyms you might hear at today's meeting are on the back of your Agenda.

Please raise your hand at any time if you need more information!



Meeting Guide

Meetings can be fast-paced and confusing!
These terms and acronyms can help you follow along.

STOP Please raise your hand at any time if you need more information!

ADAP	AIDS Drug Assistance Program
BSR	Behavioral Science Research Corp. (aka, Staff)
EHE	Ending the HIV Epidemic: A Plan for America
EMA	Eligible Metropolitan Area (locally, Miami-Dade County)
FDOH FDOH-MDC	Florida Department of Health in Miami-Dade County
FPL	Federal Poverty Level
HOPWA	Housing Opportunities for People with AIDS Program
HRSA	The Health Resources and Services Administration
IP	The Integrated HIV Prevention and Care Plan
MAI	Minority AIDS Initiative
NHAS	National HIV/AIDS Strategy
PE Miami Provide	Provide Enterprise® by Groupware Technologies (RWP client database system)
RWP RWHAP	Ryan White Program or Ryan White HIV/AIDS Program (Usually referring to Part A/MAI)
The Partnership Planning Council PC	The Miami-Dade HIV/AIDS Partnership - The official Ryan White Program Advisory Board
The Recipient The County OMB	The Miami-Dade County Office of Management and Budget.
TTRA	Test and Treat/Rapid Access

Scan the QR Code for additional acronyms and terminology -
Get on Board Training: Understanding the Language of the Partnership

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/the-partnership/#caretreatment2 or scan the QR code on your agenda.

RSVPs

RSVP!

Your RSVP Matters!

JOIN THE PARTNERSHIP!

We use RSVPs to determine if there will be a quorum of members and to make sure we have enough materials for all attendees. Please click a link below to let us know which meetings you can or cannot attend. All replies are helpful!

Meeting dates and locations are subject to change. For details, please see the latest meeting calendars at aidsnet.org/calendar.

Thank you for your time.

- January 2024
- February 2024
- March 2024
- April 2024
- May 2024
- June 2024
- July 2024
- August 2024
- September 2024
- October 2024
- November 2024
- December 2024

RETURN TO MENU

MIAMI-DADE HIV/AIDS PARTNERSHIP

2024 NEEDS ASSESSMENT

PROCESS FOR SETTING PRIORITIES AND ALLOCATING RESOURCES

The annual Priority Setting and Resource Allocation (PSRA) needs assessment process is a series of monthly Care and Treatment Committee meetings scheduled from May to September. The results of the needs assessment process including priorities and allocations will be included in the Ryan White Program's response to the HRSA Ryan White Program Notice of Funding Opportunities due in the Fall. Representatives of the affected community, community stakeholders, and service providers are urged to attend and participate.

STEP 1. TRAINING ON RESPONSIBILITIES

The committee will be trained in the responsibilities regarding the needs assessment and how to use data.

STEP 2. PROCESS REVIEW

The committee will discuss and agree on the foundation of the process, including:

- Procedures for community input at meetings; and
- Review and, if necessary, revise established principles for setting priorities and allocations (e.g., priority on the poorest, priority on the sickest, etc.).

The committee's decisions at any meeting during this process will be made available to all participants at subsequent meetings through minutes of the meetings which will be posted online.

STEP 3. COMMUNITY INPUT

The Committee may receive input in four ways:

1) Written or phone comments from members of the affected community will be accepted and provided to the committee during a meeting focusing on unmet need.
2) Committee members and non-members in attendance will be encouraged to participate in discussion and consensus-building throughout the needs assessment process by offering relevant information and stating their opinions.
3) Results of the client satisfaction survey.
4) Results of a virtual or in-person community town-hall meetings.

STEP 4. DATA REVIEW

Staff Support will provide an overview of HIV epidemiology, Ryan White Program client demographics and service utilization, cost of services, unmet need and other data for Miami-Dade County in advance of the meetings, posting the information at www.aidsnet.org/the-partnership/#needsassessment1 , and will provide summaries at the time of the meeting when these data are discussed. Information will include, as available:

- The HIV Epidemiology in Miami-Dade County, 2022;
- The number of clients and demographic composition of clients receiving services under the Ryan White Program in FY 2023 (March 1, 2023 – February 28, 2024);
- FY 2023 and current cost and funding allocations for existing Ryan White Program services;
- Other funding streams that cover the same services as the Ryan White Program and the number of HIV-positive recipients;
- HIV Care Continuum data;
- Estimates of unmet need; and
- Other issues relating to specific services.

Procedures for examining services will include:

- Review of information pertaining to definitions and cost and utilization of specific services at each meeting when services are discussed.

- Discussion and questions by committee members and others present to clarify and elicit additional information.

The committee will not make motions or take actions related to service priorities and funding allocations until after Step 4 has been completed.

STEP 5. SERVICE CATEGORIES

The committee will review and use needs assessment data as a basis for selecting service categories to be funded for the coming fiscal year. Currently funded service categories and demonstrated need will be reviewed to:

- Eliminate service categories for which no need is identified, focusing attention on the cost of the services and the impact that removing the services may have on the health of the affected community; and
- Identify and introduce new core and/or support service categories and seek to establish the basis of funding for these services, as needed.

Establishment of new categories must be based on data that demonstrate the extent of need and the lack of other funding sources or services to supply the area of need. ***Persons seeking to introduce new services are responsible for providing data on need and potential utilization: it will not be sufficient to assert that a particular service is needed without providing concrete data on the magnitude of that need among persons living with HIV/AIDS and the absence of non-Ryan White funding to support service provision for that need.*** Responsibility for providing data in support of proposed new services rests with the proposer. The committee will vote on the proposed new service(s) following presentation and review of the pertinent data.

The committee will review Policy Clarification Notice (PCN) #16-02 Service Standards, make any local edits as applicable, and make a motion to approve the document.

STEP 6. PRIORITY RANKING

The Committee will review needs assessment data once more. The Committee will follow the below process for establishing priority rankings of service categories for Part A and MAI.

- Members will complete a survey ranking services in order of importance prior to the final meeting;
- Guests will complete a survey ranking services in order of importance prior to the final meeting;
- Staff will tally the surveys and post the compiled services ranking of committee members and guests at the last meeting;
- The committee and others present will review this ranking, and based on discussion, make adjustments if necessary;
- The committee will come to a consensus on the final rank order of priorities and will adopt them by formal motion.

STEP 7. DIRECTIVES

After full consideration of relevant data reviewed during the needs assessment process, the committee may direct the Recipient to address unmet (or under-delivered) service priorities and to address other issues defined during the process. These may, among other things, address access issues to services for special populations or special geographic areas.

STEP 8. ALLOCATION OF FUNDS

The Committee will use the service priorities, established principles, and needs assessment data to allocate funds for Fiscal Year 2025 (March 1, 2025-February 28, 2026), generating a flat funding budget using the current grant award and a prospective resource allocation budget using the grant ceiling total.

Care and Treatment Committee members who work for subrecipients ("providers") currently funded by the Ryan White Program may vote on funding recommendations affecting a service category in which their employers provide services under Ryan White, as long as the member's employer is not the sole subrecipient ("provider") in that service category. Members who are "conflicted" in this way must declare their conflicted status during the meeting prior to discussion and vote of the service category. The conflicted member will then leave the meeting and he or she will be contacted by staff to rejoin the meeting once the conflicted vote is concluded. They will be emailed Form 8B, which will be completed and returned to staff within 48 hours after the conclusion of the meeting. Copies of completed Form 8Bs will be included with the minutes of the meeting.

STEP 9. DETERMINATION OF FINAL PRIORITIES AND ALLOCATIONS

The final priorities and allocations for Fiscal Year 2025 (March 1, 2025-February 28, 2026), as determined by the Care and Treatment Committee, will be presented to the full Partnership for approval.

NEEDS ASSESSMENT PREPARATION

SECTION 2

Planning Council Responsibilities AND Needs Assessment

May 9, 2024

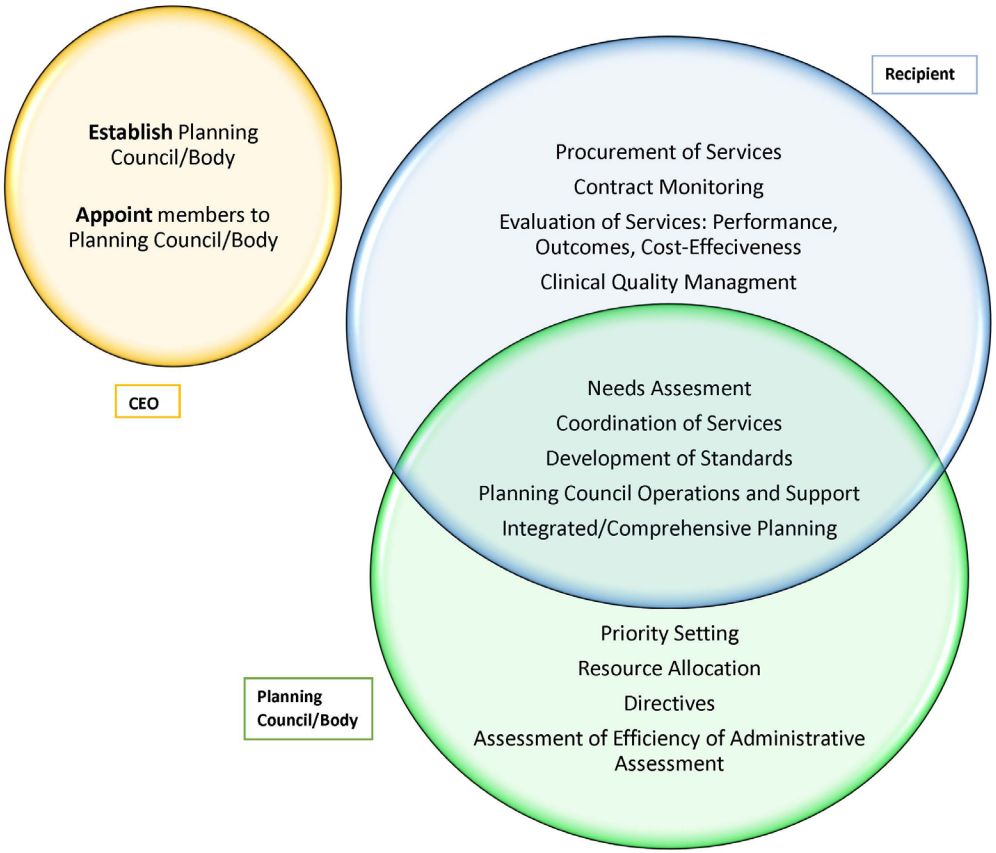
Presentation created by Behavioral Science Research Corp.

BEHAVIORAL SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

Responsibilities



HRSA Expectations

The planning council's (*Miami-Dade HIV/AIDS Partnership*) decisions about service priorities, service models, population emphases, and directives for the Recipient will be **data-based**.

Data used for decision making will include:

- Needs assessment and community input
- Service cost and utilization data
- System-wide (not subrecipient-specific) Quality Management data

The planning council will be trained and comfortable in reviewing, assessing, and using data.

Planning Council Legislative Responsibilities

Determine the **population** of individuals with HIV/AIDS in the Miami-Dade County eligible metropolitan area (EMA) and **demographics** and **needs** particularly for those who know their HIV status and are **not receiving HIV-related serv**ices; and address **disparities in access and services** among affected subpopulations and historically underserved communities.

Components of a Ryan White Needs Assessment

Epidemiological profile of HIV and AIDS cases and trends in Miami-Dade County.

A resource inventory of existing services.

A profile of provider capacity and capability - Availability, accessibility and appropriateness overall and for specific populations.

Estimate and assessment of unmet need- People with HIV who know their status but are not in care and People with HIV who do not know their status.

Estimate and assessment of people with HIV who are unaware of their status.

Assessment of service need gaps-Information about service needs of people with HIV and barriers to getting services.

Data Collection For This Year

- Surveillance (from Florida Department of Health in Miami-Dade)
- Ryan White Program demographic and utilization data (from the Provide Enterprise Miami system), as available
- Surveys
- Input from persons with HIV and
- Other funding information

Needs Assessment Dates*

10:00 a.m. to 1:00 p.m.

May 9, 2024

June 13, 2024

July 11, 2024

August 8, 2024

*September 12, 2024 (likely needed)

Book Location

Annual HIV/AIDS Needs Assessment

Decisions made during Needs Assessment drive the provision of services and distribution of funds for the next Ryan White Program fiscal year. All Partnership and committee members, Ryan White Program clients and other people with HIV, Ryan White Program subrecipients, and anyone interested in maximizing resources and improving services for people with HIV in Miami-Dade County are encouraged to participate in this and all Partnership activities.

2024 Needs Assessment

HIV Epidemiology In Miami-Dade County, 2022

- Policy Clarification Notice (PCN) #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
- Complete Needs Assessment Book
- Process for Setting Priorities and Allocating Resources
- Needs Assessment Responsibilities
- 2024 Guide to Dashboard Cards

Past Needs Assessments

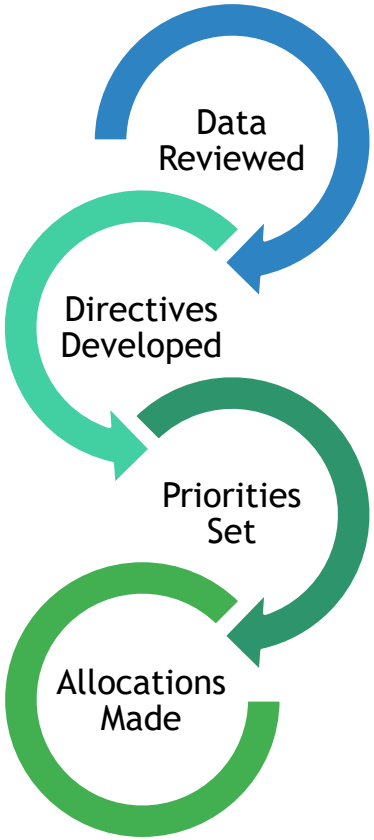
RETURN TO MENU

https://aidsnet.org/the-partnership/#needsassessment1

Steps for 2024 Needs Assessment Priority Setting and Resource Allocation (PSRA)

- Train on responsibilities and data elements; additional training materials will be included in the electronic book.
- Agree on the process and adopt it by motion; this will provide the outline for items that will be covered.

Steps for PSRA (**P**riority **S**etting and **R**esource **A**llocation)



Planning Council Responsibilities: **Developing 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.

Planning Council Responsibilities: **Setting Priorities**

- Determine what service categories are most important for people living with HIV in Miami-Dade County and place them in priority order.
- Planning council must establish a sound, fair process for priority setting and ensure that decisions are data-based and control conflict of interest.
- Take into account data such as utilization, epidemiological, and unmet needs.
- Priorities tend to change only a little from year to year and are not tied to funding or to service providers.
- Per HRSA guidance, **all** service categories will be prioritized.

Policy Clarification Notice #16-02

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.

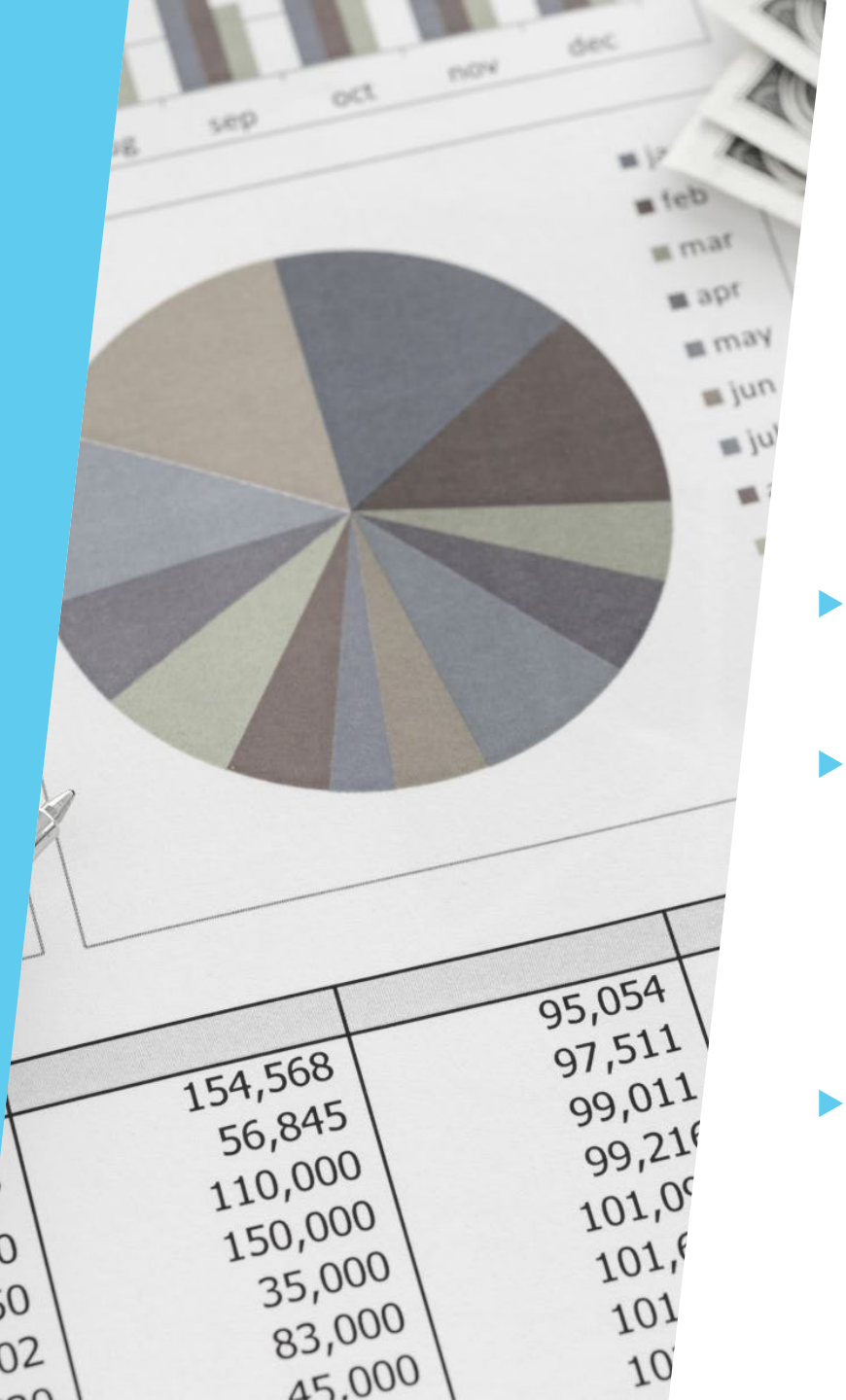
HRSA HAB has developed program policies that incorporate both HHS regulations

Core Medical Services

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support Services

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Linguistic Services
7. Medical Transportation
8. Non-Medical Case Management Services
9. Other Professional Services [e.g., Legal Services and Permanency Planning]
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Health Care and Support Services
13. Rehabilitation Services
14. Respite Care
15. Substance Abuse Services (residential)



Planning Council Responsibilities: **Resource Allocations**

- Decide how much money to allocate 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.
- Other funding streams, cost per client data and anticipated numbers of new clients coming into care should be considered in decision making.

Planning Council Responsibilities: **Resource Allocations and Managing Conflicts**

Process should be fair, data-based and free of conflicts 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.

Planning Council Responsibilities: **Resource Allocations Restrictions**

Core Services

- HRSA requires no less than 75% of funds be allocated to core services (unless the program has a waiver).

Support Services

- Remaining funds may be allocated to support services.
- Funded support services need to be linked to positive medical outcomes which are outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

SERVICE CATEGORIES (ALPHABETIC ORDER)	FY 2022 EXPENDITURES	FY 2022 %	FY 2024 RECOMMENDED ALLOCATION [1]	FY 2024 %
AIDS PHARMACEUTICAL ASSISTANCE [C]	$3,954.10	0.02%	$	%
EMERGENCY FINANCIAL ASSISTANCE [S]	$0.00	0.00%	$	%
FOOD BANK*/HOME DELIVERED MEALS [S]	$2,540,864.00	12.07%	$	%
HEALTH INSURANCE PREMIUM AND COST SHARING FOR LOW-	$297,151.61	1.41%	$	%
MEDICAL CASE MANAGEMENT, INC. TREATMENT ADHERENCE	$5,414,520.00	25.72%	$	%
MEDICAL TRANSPORTATION [S]	$153,904.90	0.73%	$	%
MENTAL HEALTH SERVICES [C]	$63,570.00	0.30%	$	%
ORAL HEALTH CARE [C]	$3,273,644.50	15.55%	$	%
OTHER PROFESSIONAL SERVICES (LEGAL SERVICES AND	$67,581.00	0.32%	$	%
OUTPATIENT/AMBULATORY HEALTH SERVICES [C]	$8,063,884.64	38.30%	$	%
OUTREACH SERVICES [S]	$114,924.86	0.55%	$	%
SUBSTANCE ABUSE OUTPATIENT CARE [C]	$4,401.00	0.02%	$	%
SUBSTANCE ABUSE SERVICES (RESIDENTIAL) [S]	$1,053,590.00	5.00%	$	%

Sample Budget Sheet

Budget Development Options

Two (2) Budgets: Flat and Increase (up to allowable threshold)

OR

Three (3) Budgets: Flat, Decrease (determine %), and Increase (up to allowable threshold)

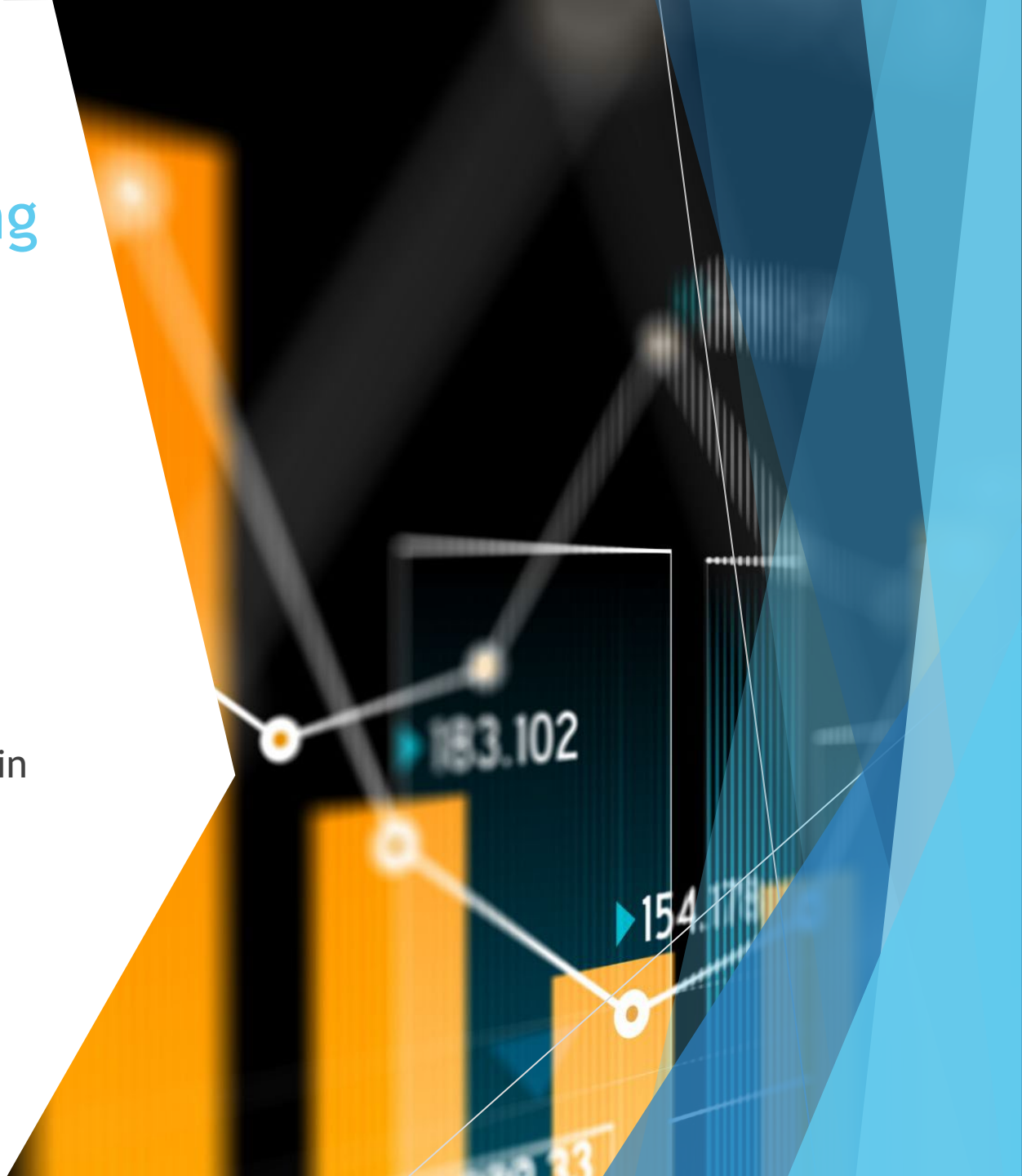
Some Basic Points Regarding Data

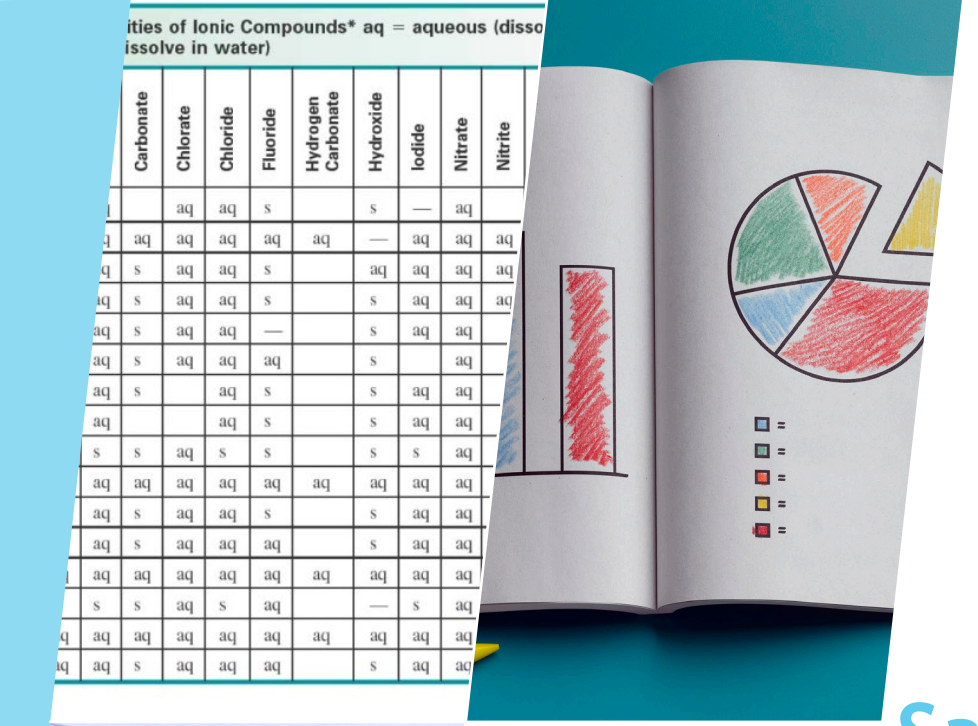
Different types of charts provide a visualization of the data.

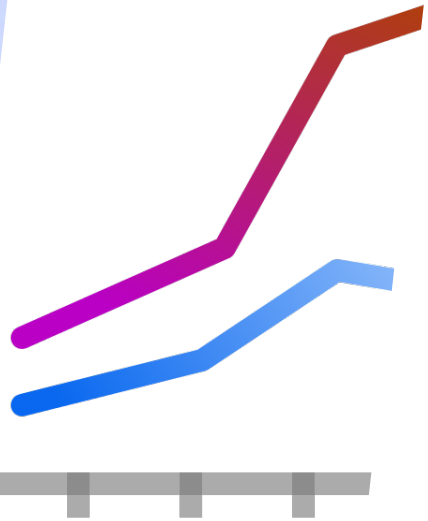
Sources of data should always be identified.

Patterns in the data may have implications for the way we provide services in Miami-Dade County.

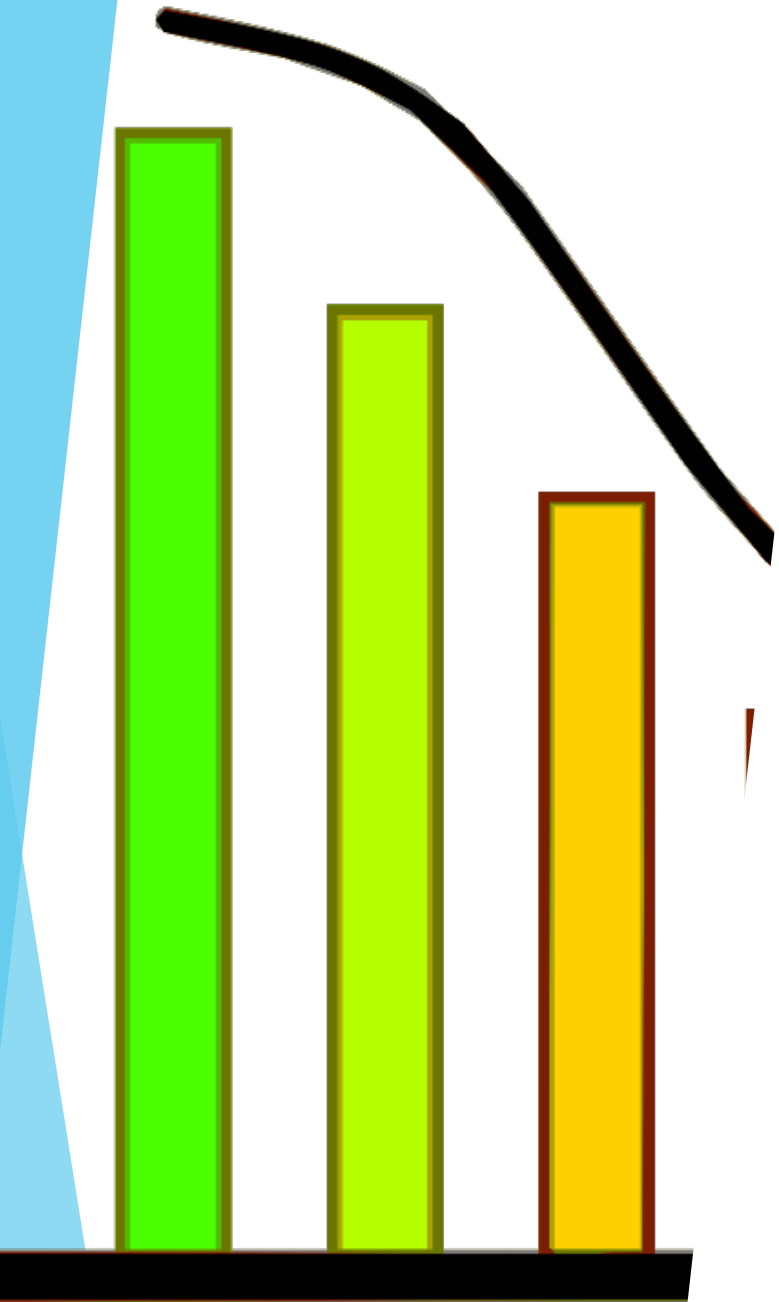
Data should be used to make decisions.







Sample Data and Chart Types



Epi Data

Number of people living with a disease.

Epidemiologic Profile

- Describes the HIV Epidemic in the Miami-Dade service area.
- Focuses on the social and demographic groups most affected by HIV and the behaviors that can transmit HIV.
- Data are provided by the Florida Department of Health
- Estimates the number and characteristics of persons with HIV who know their status but are not in care (unmet need) and those who are unaware of their HIV status.

“Epi” Terms (new)

Incidence - the number of **new** cases of a disease in a population during a defined period of time – such as the number of new HIV cases in Miami-Dade County as of December 31 of the reference year.

Incidence rate - The frequency of new cases of a disease that occur per unit of population during a defined period of time – such as the rate of new HIV cases per 100,000 in Miami-Dade County as of December 31 of the reference year.

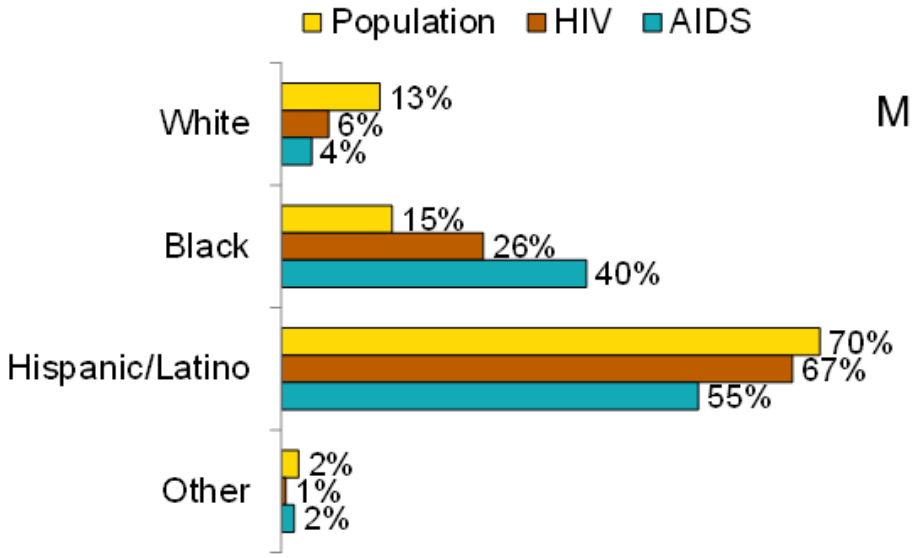
“Epi” Terms (total)

Prevalence - The total number of people in a defined population with a specific disease or condition at a given time – such as the total number of people diagnosed with HIV in Miami-Dade County as of December 31 of the reference year.

Prevalence rate - The total or cumulative number of cases of a disease per unit of population as of a defined date – such as the rate of HIV cases per 100,000 population diagnosed in Miami-Dade County as of December 31 of the reference year.

Sample EPI Data Using a Bar Graph

Adult HIV and AIDS Diagnoses and Population by Race or Ethnicity, 2022, Miami-Dade County



Miami-Dade County Adult Population Estimate
N=2,369,628

HIV
N=1086

AIDS
N=404

Florida HEALTH

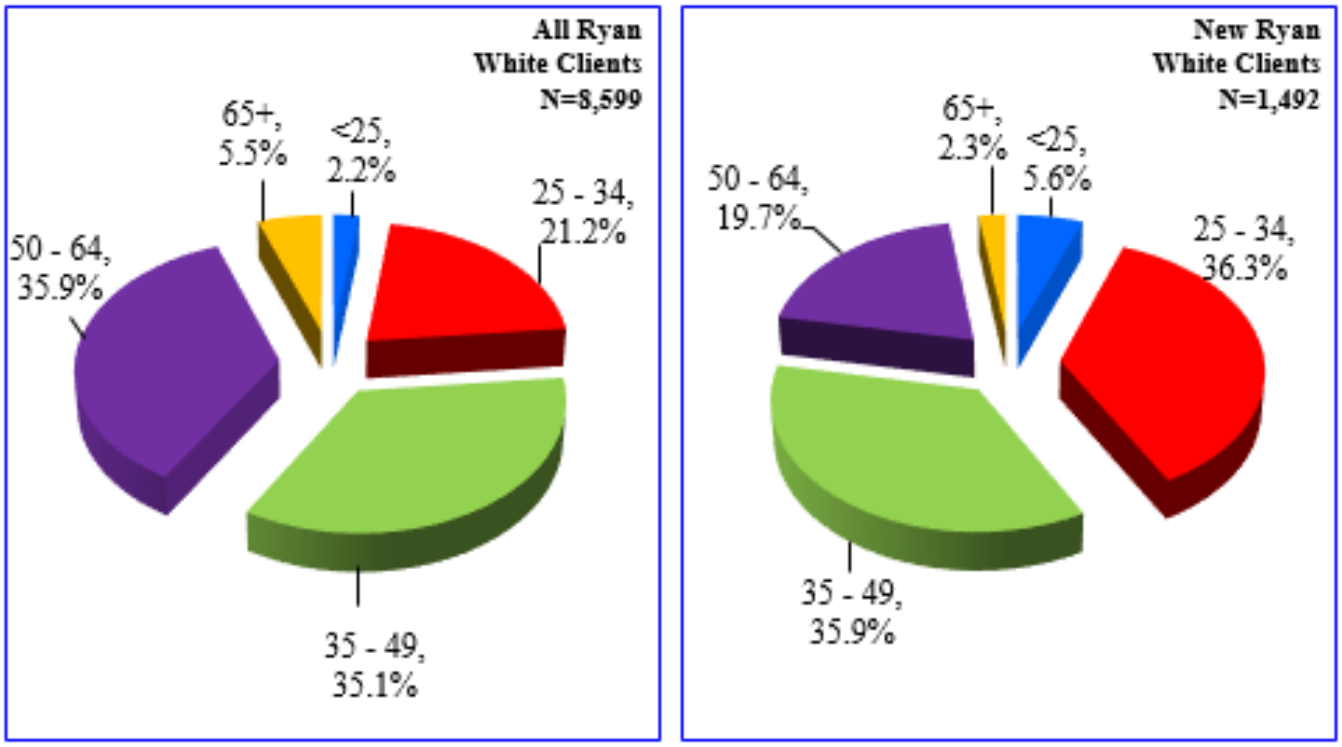
Rounding may cause percentages to total more or less than 100.

Demographics

Statistical data relating to the population and particular groups within it.

Sample Demographics Using a Pie Graph

Age Distribution of New and Total Clients in Care
Ryan White Program, FY 2022



Service Utilization

A measure of expenditures and units of service across service categories.

Sample Utilization Using a Chart

Total Number of Unduplicated Clients Served
by Service Category (Alphabetic listing)

SERVICE CATEGORIES	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
RWP TOTAL	9,578	9,031	8,127	8,411	8,590
AIDS Pharmaceutical Assistance (Local)	697	605	185	183	157
Emergency Financial Assistance	N/A	N/A	N/A	N/A	N/A
Food Bank	701	715	735	712	1,130
Health Insurance Premium & Cost Sharing Assist	1,307	1,335	1,125	1,255	1,440
Medical Case Management, inc. Treatment Adherence (includes Peer Support)	8,496	8,116	7,378	7,842	8,085
Medical Transportation Services	638	720	94	645	743
Mental Health Services	327	274	95	121	107
Oral Health Care	3,381	3,170	1,711	2,237	2,577
Other Professional Services - Legal Services	76	66	48	44	103
Outpatient/Ambulatory Health Services	5,447	5,317	4,281	4,422	4,540
Outreach Services	624	472	130	116	158
Substance Abuse Services Outpatient	115	55	0	17	22
Substance Abuse Services (Residential)	169	95	70	66	72

Sample Utilization Using Text

Medical Transportation (MTS)

- Utilization of Ryan White Program dollars for this service category has been increasing since FY 2021. FY 2022 expenditures are 56% higher than FY 2021 and are the highest in five years.
- EASY monthly pass accounted for 23% of the service, and ride shares (Uber/Lyft) accounted for 73%.

Dashboard Cards

Tool to visualize utilization and other funding data.

2023 Needs Assessment Dashboard Cards
Ryan White Program

CORE SERVICE: AIDS PHARMACEUTICAL ASSISTANCE

Ranking, Allocation, and Direct Services Expenditure History

Fiscal Year	Final Expenditure	Category Expense as %
FY 2018	$21,934,627.17	0.39%
FY 2019	$22,984,844.87	0.25%
FY 2020	$17,660,128.37	0.03%
FY 2021	$19,018,258.46	0.02%
FY 2022	$22,372,383.35	0.02%

Trend
Expenses and Clients
↓

Fiscal Year	Final Allocation	Final Expenditure	% Spent
FY 2018	$237,000.00	$86,209.75	36.38%
FY 2019	$187,000.00	$57,843.29	30.93%
FY 2020	$66,007.00	$5,993.21	9.08%
FY 2021	$83,595.00	$4,379.02	5.24%
FY 2022	$84,492.00	$3,954.10	4.68%

Fiscal Year		Part A Final Allocation	Part A Final	% Spent
FY 2018	4	$137,000.00	$81,547.76	59.52%
FY 2019	4	$87,000.00	$52,697.84	60.57%
FY 2020	3	$66,007.00	$5,993.21	9.08%
FY 2021	9	$83,595.00	$4,379.02	5.24%
FY 2022	4	$84,492.00	$3,954.10	4.68%

Fiscal Year		MAI Final Allocation	MAI Final	% Spent
FY 2018	3	$100,000.00	$4,661.97	4.66%
FY 2019	7	$100,000.00	$5,145.45	5.15%
FY 2020	N/A	N/A	N/A	N/A
FY 2021	N/A	N/A	N/A	N/A
FY 2022	N/A	N/A	N/A	N/A

Service Program

Limitations: **400% FPL**

Fiscal Year	RW Clients	Clients Served	Served as % RW Clients	Expenditure	Avg Per Client
FY 2018	9,578	697	7.3%	$86,210.00	$123.69
FY 2019	9,031	605	6.7%	$57,843.29	$95.61
FY 2020	8,127	185	2.3%	$5,993.21	$32.40
FY 2021	8,420	183	2.2%	$4,379.02	$23.93
FY 2022	8,590	156	1.8%	$3,954.10	$25.35

Other Funding Streams 2022

	Funder	Expended	Number of Clients	Cost per Client
1	ADAP	$28,342,384	4,587	$6,179
2	General Revenue	$262,520	547	$480
3	Medicaid	$109,082,428	5,435	$20,070
4	Part C	$25,492	N/A	N/A

Other Funding Streams 2023

	Funder	Expended	Number of Clients	Cost per Client
1	ADAP	$26,005,586	4,589	$5,667
2	General Revenue	$351,172	446	$787
3	Medicaid	$112,742,680	6,121	$18,419
4	Part C	$30,873	N/A	N/A

Notes:
Expenditures continue on a downward trend because most clients access the ADAP program for this service.

Sample Dashboard Card Using Tables

Other Funding

Non-Part A funding in the community for persons living with HIV.

Sample Other Funding Streams Using a Chart

AIDS Pharmaceutical Assistance (Prescription Drugs)

Other Funding Streams 2022

	Funder	Expended	Number of Clients	Cost per Client
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2	General Revenue	$262,520	547	$480
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Notes:

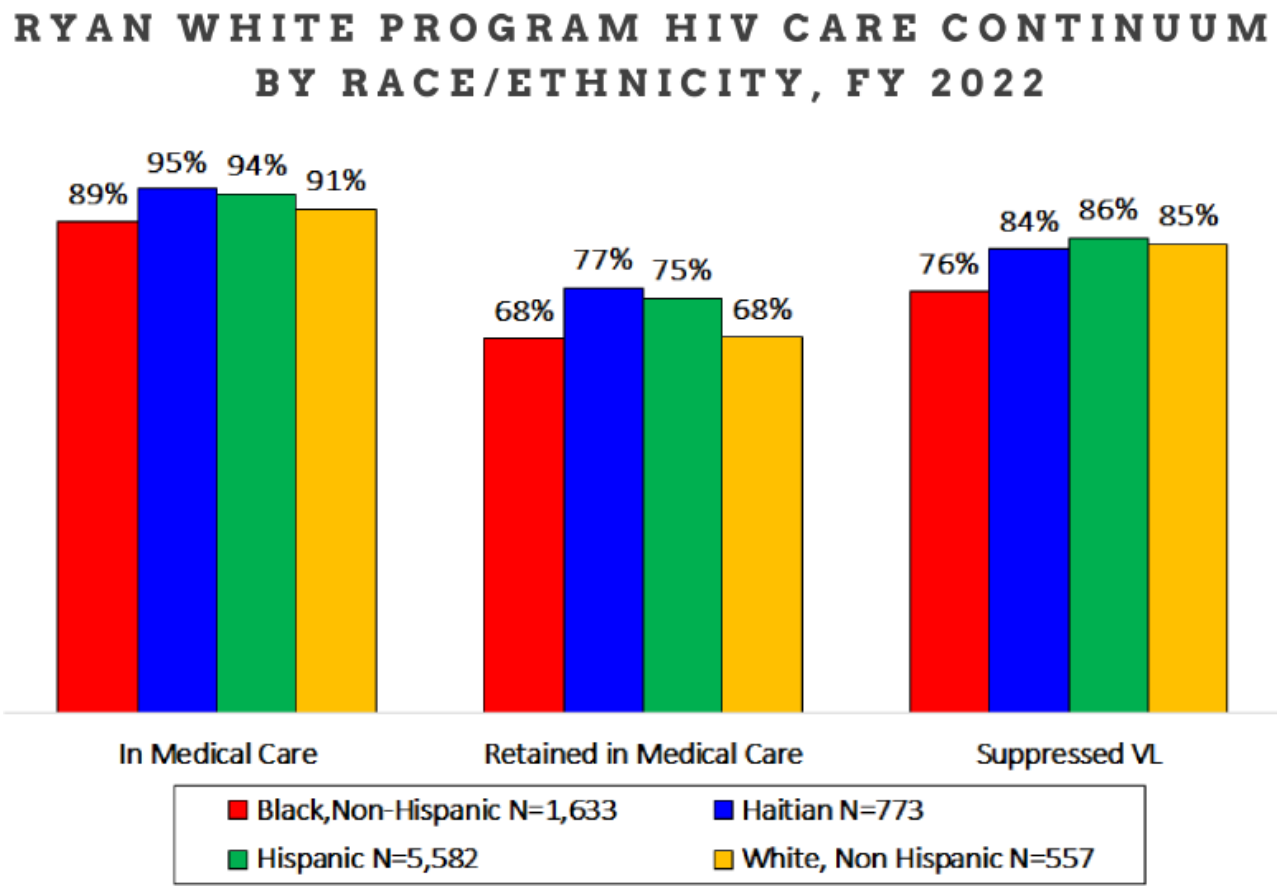
Expenditures continue on a downward trend because most clients access the ADAP program for this service.

Care Continuum

Model that outlines the steps/stages that people with HIV go through whose goal is viral suppression.*

*Ending the Epidemic

Sample HIV Care Continuum Using a Bar Graph



How do we connect the data?

- Priorities
- Allocations
- Directives

Address identified service needs or underserved groups

Per client cost= estimate allocation

Use of Service Utilization and Continuous Quality Improvement Data

- **Priority Setting**

What service categories have fully used all funding, which had waiting lists, which had unused resources, which needed more funding?

- **Resource Allocation**

How can we use cost per client data to determine funding allocations for anticipated new clients?

- **Developing Directives**

What access to care issues have been identified and how can these be addressed?

Data Driven Decisions

Think 3D!

But ultimately, it's about . . .

Using **data**, within established Ryan White program guidelines, to make informed **priority** and **funding** decisions to **improve service delivery** to people living with HIV in Miami-Dade County.

Thank You

Behavioral Science Research

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

2024 Needs Assessment Preparation

Slides in this presentation provided by Planning CHATT . Some local data have been added to provide context.

Understanding the Legislation

Authorizing the Ryan White HIV/AIDS Program (RWHAP)

Module 1 (revised)

Topics

- History and Evolution of the Ryan White HIV/AIDS Program (RWHAP) Legislation
- Overview of RWHAP Parts
- Understanding Part A

History and Evolution of RWHAP Legislation

RWHAP Legislation

- Largest Federal government program specifically designed to provide services for people with HIV – $2.5 billion in funding in FY 2020 including new funding for Ending the Epidemic
- Third largest Federal program serving people with HIV – after Medicaid and Medicare
- First enacted as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990
- Current legislation is the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act)
- Provides grants awarded to the chief elected officials of the city or county, who designates a lead agency to administer the funds.

Purpose of RWHAP Legislation

- Began as “emergency relief” for overburdened healthcare systems at a time when effective medications were not available
- **Now:**
  - “Revise and extend the program for providing life-saving care for those with HIV/AIDS”
  - “Address the unmet care and treatment needs of persons with HIV by funding primary health care and support services that enhance access to and retention in care”

Importance of RWHAP: Scope

- More than 1.2 million people in the U.S. age 13 years and older are living with HIV as of 2018.
- About 1 in 7 (nationally) do not know their status
- More than half of million people are receiving at least one medical, health, or related support service through the Ryan White Program provider in 2018, with many clients receiving multiple types of services.

Importance of RWHAP: Client Need

- RWHAP serves people with HIV who are low-income and do not have insurance that covers their HIV care and medications – over 60% have incomes below the federal poverty line
- RWHAP is the payer of last resort – funds may not be used to pay for items or services that are eligible for coverage by other federal or state programs or private health insurance
- RWHAP is not an “entitlement” program: it must operate using the funds appropriated annually by Congress and awarded to recipients

Importance of RWHAP: Outcomes

- Nationwide, more than 80% of RWHAP clients in 2016 were retained in care – they had at least two outpatient ambulatory health services (OAHS) visits during the year, at least 90 days apart.
  - In Miami-Dade, 75% retained in Ryan White Care in FY 2019
- Nationwide, about 85% of clients receiving outpatient OAHS through RWHAP achieved viral suppression in 2016
  - Up from 69.5% in 2010
  - In Miami-Dade, 86% of OAHS clients virally suppressed in FY 2019 2019

Factors Affecting HIV Services

- The epidemic continues, especially among traditionally underserved and hard-to-reach populations – but new diagnoses have been declining since 2008
- Because of effective therapies, people with HIV can live nearly normal life spans if they begin treatment early and stay in care
- Treatment is prevention – viral suppression prevents HIV transmission
- Changes in health care system and financing have affected how RWHAP funds are used at the state and local levels

Tools for Ending the Epidemic

- National goals to end the epidemic, first developed through the National HIV/AIDS Strategy (NHAS)
- The HIV care continuum, which helps track the estimated number of people living with HIV, percent diagnosed, and percent who are linked to care, retained in care, and achieve viral suppression
- Performance measures developed by HRSA/HAB to assess quality of care and clinical outcomes of RWHAP-funded services
- Ending the Epidemic: A Plan for America

National Goals to End the Epidemic

2020 Goals:

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve a more coordinated national response to the HIV epidemic

Performance Measures Portfolio

- Established in 2013
- Focus on critical areas of HIV care and treatment, including processes (like development of treatment plans) and outcomes (like viral suppression rates)
- Alignment with milestones along the HIV care continuum
- Can be used by individual providers or at a system of care level – by all RWHAP-funded providers in a service area

Overview of RWHAP Parts

The Ryan White HIV/AIDS Program

- Provides a comprehensive system of care for people with HIV
- Most funds support primary medical care and other medical-related and support services
- Provides ongoing access to HIV medications
- Small amount of funds used for technical assistance, clinical training, and development of innovative models of care

The Ryan White HIV/AIDS Program (cont.)

- Includes five Parts: A, B, C, D, and F
- Administered by the HIV/AIDS Bureau (HAB), within the Health Resources and Services Administration (HRSA)
- RWHAP Parts designed to work together to ensure a comprehensive system of care in urban, suburban, and rural communities throughout the U.S.

RWHAP Part A

- Funding for areas hardest hit by the HIV epidemic
- Funding for two categories of metropolitan areas:
  - **Eligible Metropolitan Areas** (EMAs), with at least 2,000 new cases of AIDS reported in the past 5 years and at least 3,000 people living with HIV
  - **Transitional Grant Areas** (TGAs), with 1,000 – 1,999 new cases of AIDS reported in the past 5 years and at least 1,500 people living with HIV
- Funds are used to develop or enhance access to a comprehensive system of high quality community-based care for low-income people with HIV

RWHAP Part B

- Funding to all 50 States, DC, Puerto Rico, U.S. territories and jurisdictions to improve the quality, availability, and organization of HIV health care and support services
- Provides funds for medical and support services
- Includes the AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications, through direct purchase and purchase of health insurance
- Also provides funds to emerging communities with a growing epidemic, reporting 500-999 new cases in the past 5 years

RWHAP Part C

- Funding to support “early intervention services”: comprehensive primary health care and support services for PLWH in an outpatient setting
- Competitive grants to local community-based organizations, community health centers, health departments, and hospitals
- Priority on services in rural areas and for traditionally underserved populations
- Capacity development grants provided to help public and nonprofit entities deliver HIV services more effectively

RWHAP Part D

- Funding to support family-centered HIV primary medical and support services for women, infants, children, and youth living with HIV
- Competitive grants to local public and private health care entities, including hospitals, and public agencies
- Includes services designed to engage youth with HIV and retain them in care
- Recipients must coordinate with HIV education and prevention programs designed to reduce the risk of HIV infection among youth

RWHAP Part F: Dental Services

Two types of dental programs:

- Dental Reimbursement Programs run by dental schools and other dental programs
- Community Based Dental Partnership Program, to provide dental services for PLWH while providing education and clinical training for dental care providers

RWHAP Part F: Minority AIDS Initiative (MAI)

- Funds used to improve access to HIV care and health outcomes for disproportionately affected racial and ethnic minorities
- Part A programs apply for MAI funds as part of the annual application and receive funds on a formula basis
- Formula is based on the number of racial and ethnic minority individuals with HIV/AIDS in the jurisdiction

RWHAP Part F: Special Project of National Significance (SPNS)

- Supports the development of innovative models of care to better serve people with HIV, and to address emerging client needs
- Competitive funding
- Projects include a strong evaluation component
- Promising models are disseminated

RWHAP Part F: AIDS Education and Training Centers (AETCs)

- Supports a network of 8 regional centers that provide targeted, multidisciplinary education and training programs for health care providers serving PLWH
- Intended to increase the number of providers prepared and motivated to counsel, diagnose, treat, and medically manage PLWH
- AETC's National Clinician Consultation Center responds to questions from clinicians

Importance of Collaboration Across RWHAP Parts

- Representatives of all RWHAP Parts as members of Part A planning councils/planning bodies (PC/PBs).
  - In Miami-Dade, this is the Miami-Dade County HIV/AIDS Partnership
- Collaboration in development of the HRSA/CDC Integrated HIV Prevention and Care Plans, submitted by RWHAP Parts A & B
- Coordination in targeting and use of resources

Coordination of Care Across Parts

A single RWHAP client living in an EMA or TGA might:

- Receive medications through RWHAP Part B ADAP
- Get oral health care from a RWHAP Part F-funded dental program or Part A-funded Oral Health Care subrecipients
- Obtain other services funded through RWHAP Part A, Part C, and/or Part D
- Participate in a RWHAP Part F demonstration SPNS project

Understanding Part A

Ryan White HIV/AIDS Programs: Part A

- Funding for Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are severely & disproportionately affected by the HIV epidemic
- In 2018, 24 EMAs and 28 TGAs
- Service areas can include a single county or a multi-county area
- 11 programs have service areas that cross state boundaries

RWHAP Part A

- **Funds go to the Chief Elected Official (CEO)** of "the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS" [§2602(a)(1)]
- Recipient must establish an **Intergovernmental Agreement (IGA)** with any jurisdiction with at least 10% of the total number of reported cases of AIDS to establish a mechanism for allocating resources to address their service needs [§2602(a)(2)]

RWHAP Part A (cont. 1)

Legislative requirement for extensive community planning, including participation of consumers of RWHAP Part A services

- EMAs required to have *planning councils that decide how program funds will be used*
- TGAs strongly encouraged by HRSA/HAB to maintain planning councils
- TGAs that choose not to have planning councils encouraged to have planning bodies with roles, responsibilities and membership that are as much like planning councils as possible

RWHAP Part A (cont. 2)

RWHAP Part A programs receive both "formula" and "supplemental" funding:

- Part A formula funding is based on the number of living cases of HIV and AIDS in the EMA or TGA
- Minority AIDS Initiative (MAI) formula funding is based on the number of minorities living with HIV and AIDS
- Supplemental funding is competitive, based on demonstration of additional need in the annual application

Services Fundable under RWHAP Part A

- **Core medical services** identified in legislation as being essential (no less than 75%)
  Outpatient/Ambulatory Health Services, Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals, Oral Health Care, Mental Health Services, AIDS Pharmaceutical Assistance, Substance Abuse Outpatient Care, Medical Case Management, including Treatment Adherence Services, Early Intervention Services, Home Health Care, Home and Community-Based Health Services, Hospice Services and Medical Nutrition Therapy

Services Fundable (cont. 2)

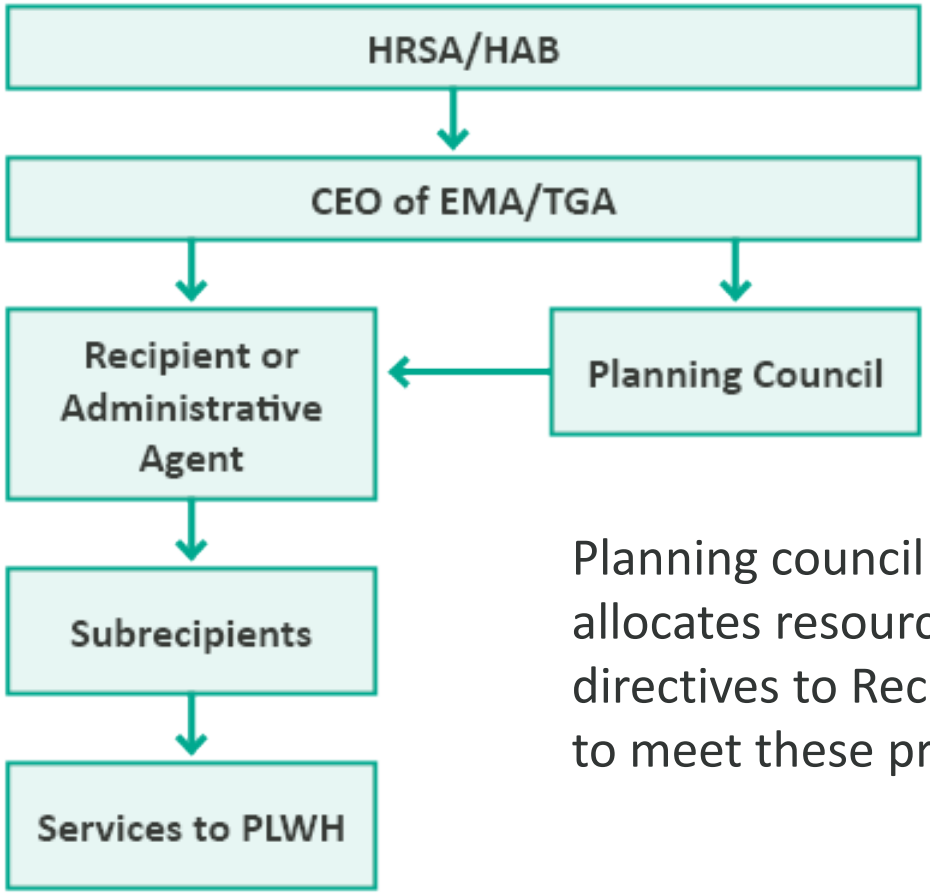
- **Support services** needed so that people with HIV can reach their medical outcomes (no more than 25% of total funding)
  Emergency Financial Assistance, Food Bank/Home-Delivered Meals, Other Professional Services (Legal Services and Permanency Planning), Medical Transportation, Outreach Services, Substance Abuse Services (residential), Non-Medical Case Management, Child Care Services, Health Education/Risk Reduction, Housing, Linguistic Services, Psychosocial Support Services, Rehabilitation Services and Respite Care

- HRSA/HAB provides service definitions and descriptions
  Refinements to service categories and definitions in 2016 and 2018 [Policy Clarification Notice (PCN) #16-02]

Collaboration between Recipient and Planning Council/Planning Body

- Recipient (Miami-Dade County) receives and administers funds and is responsible for contracting with providers (subrecipients) who provide care and treatment
- Planning council/planning body (the Partnership) decides how best to use available funds to help support a community-based system of care for people with HIV
- Recipient and Partnership work closely together, sharing responsibility for tasks like needs assessment and integrated/comprehensive planning

Flow of RWHAP Part A Decision Making & Funds



Planning council sets priorities, allocates resources, and gives directives to Recipient on how best to meet these priorities

EPIDEMIOLOGICAL "EPI" DATA

SECTION 3

HIV Epidemiology In Miami-Dade County, 2022

DEPARTMENT OF HEALTH

Kira Villamizar
HIV/AIDS Program Coordinator
Florida Department of Health

Data as of 6/30/2023

Acronyms

- **HIV:** Human Immunodeficiency Virus
- **AIDS:** Acquired Immune Deficiency Syndrome
- **IDU:** Injection Drug Use
- **MMSC:** Male-to-Male Sexual Contact
- **MSM:** Men Who Have Sex with Men

Acronyms, continued

- **IDU:** Injection Drug Use
- **MMSC:** Male-to-Male Sexual Contact
- **MMSC/IDU:** Male-to-male sexual contact and injection drug use.
- **MSM:** Men Who Have Sex with Men
- **nPEP**: Non-Occupational Post-Exposure Prophylaxis
- **PEP**: Post-Exposure Prophylaxis
- **PrEP**: Pre-Exposure Prophylaxis

Acronyms, continued

- **PWH**: Persons with HIV
- **PWID**: Persons Who Inject Drugs
- **STI**: Sexually Transmitted Infection
- **VL**: Viral Load

Technical Notes

- Data for 2020 and 2021 should be interpreted with caution due to the impact of a public health emergency on HIV testing, care-related services, and case surveillance activities in state and local jurisdictions.

- Unless otherwise noted, all data in this presentation are as of 6/30/2023.

Technical Notes, continued

- Each year, the HIV data for the previous calendar year and all prior years back to 1979 are finalized and frozen for reporting purposes on June 30. The frozen data are used in all data reports until the following June 30, when the continuously deduplicated HIV/AIDS data set will be finalized and frozen again.

- Unless otherwise noted, population-related data (such as rates) are provided by FLHealthCHARTS as of 6/30/2023.

Technical Notes, continued

- HIV-Related deaths represent persons with an HIV diagnosis in the CDC's enhanced HIV/AIDS Reporting System (eHARS) who resided in Florida at death and whose underlying cause of death was HIV, regardless of whether their HIV status was reported in Florida.

- STI data are derived from the Surveillance Tools and Reporting System (STARS) and provided by the STD Prevention and Control Section as of 7/01/2023.

Technical Notes, continued

- HIV diagnoses by year represent persons whose HIV was diagnosed in that year, regardless of AIDS status at time of diagnosis.

- AIDS and HIV diagnoses by year are not mutually exclusive and cannot be added together.

Technical Notes, continued

- HIV prevalence data represent PWH living in Florida through the end of the calendar year, regardless of where they were diagnosed.

- For diagnosis data over time, sub-geographical area data exclude Florida Department of Corrections (FDC) and Federal Correctional Institution (FCI) diagnoses. For prevalence data, area and county data include FDC and FCI data.

Technical Notes, continued

- Adult diagnoses represent people ages 13 years and older; pediatric diagnoses represent people under the age of 13 years.
  - For data by year of diagnosis, age is by age at diagnosis.
  - For prevalence data, age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.

Technical Notes, continued

- Unless noted, White and Black people are non-Hispanic/Latino, and Other (which may be omitted in some graphs due to small numbers) represents American Indian/Alaska Native, Asian/Pacific Islander, or multi-racial.

Definitions of Mode of Exposure Categories

- **Heterosexual:** Sexual contact between a male and female who received an HIV diagnosis or had a known HIV risk.
- **Other Sexual Contact:** Other sexual contact resulting in a person acquiring HIV.
- **Other Risk**: Includes recipients of clotting factor for hemophilia or other coagulation disorders, recipients of HIV-infected blood or blood components other than clotting factor or of HIV-infected tissue, perinatal and other pediatric risks, or other confirmed risks.

Florida's Four Key Components Plan To Eliminate HIV Transmission and Reduce HIV-Related Deaths

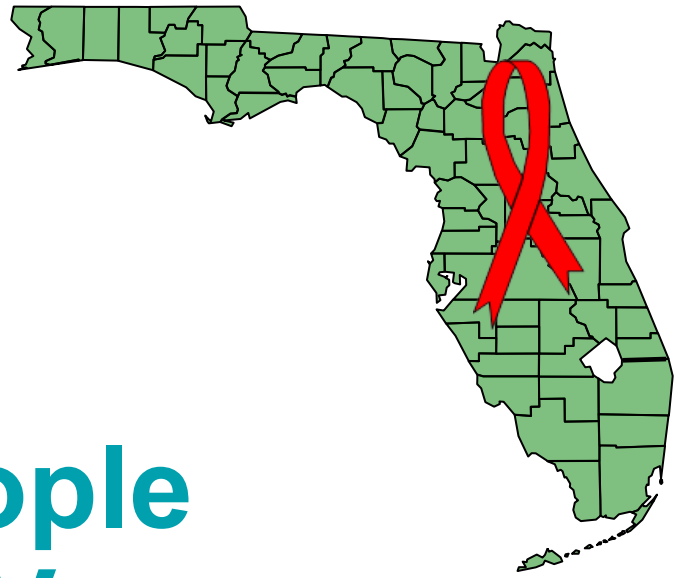
- Implement routine HIV and STI screening in health care settings and priority testing in non-health care settings.

- Provide rapid access to treatment and ensure retention in care (Test and Treat).

Florida's Four Key Components Plan To Eliminate HIV Transmission and Reduce HIV-Related Deaths, Continued

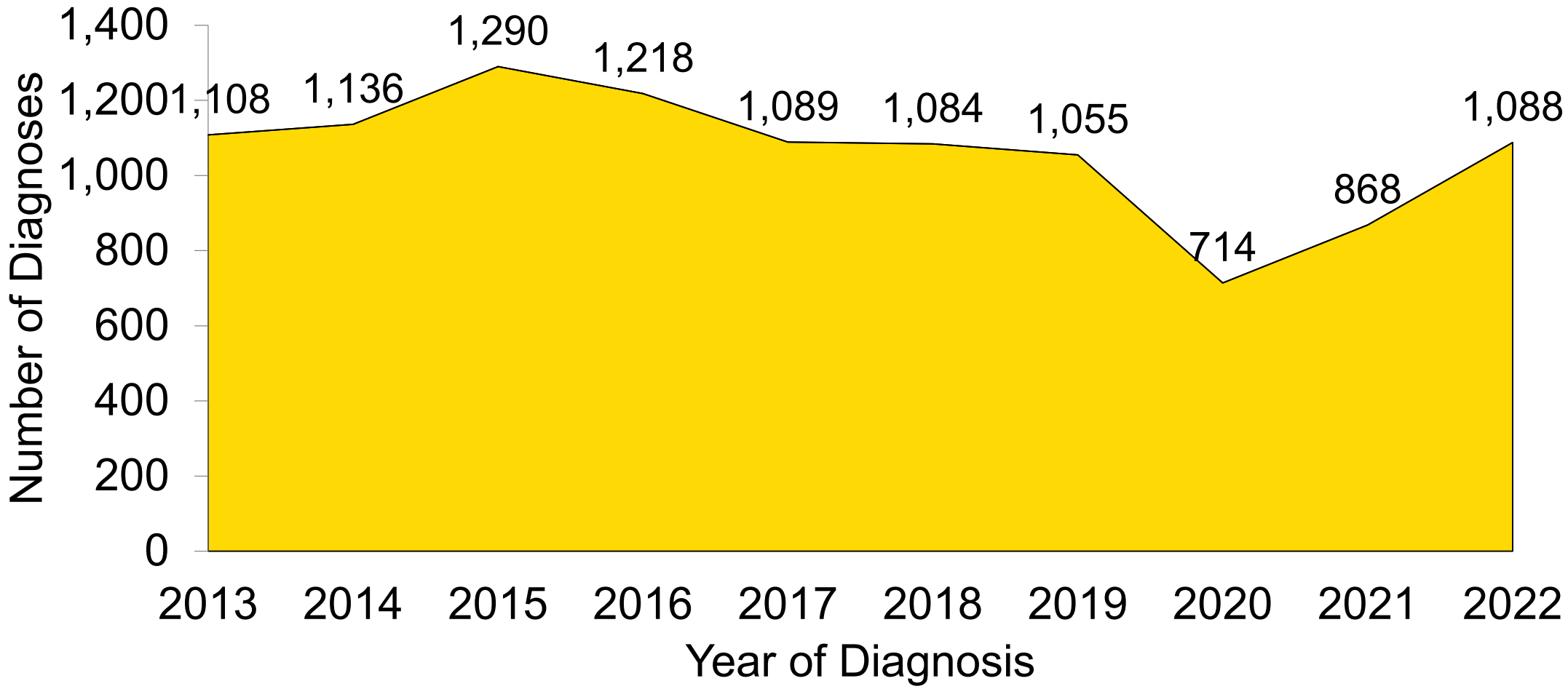
- Improve and promote access to antiretroviral PrEP and nPEP.

- Increase HIV awareness and community response through outreach, engagement, and messaging.

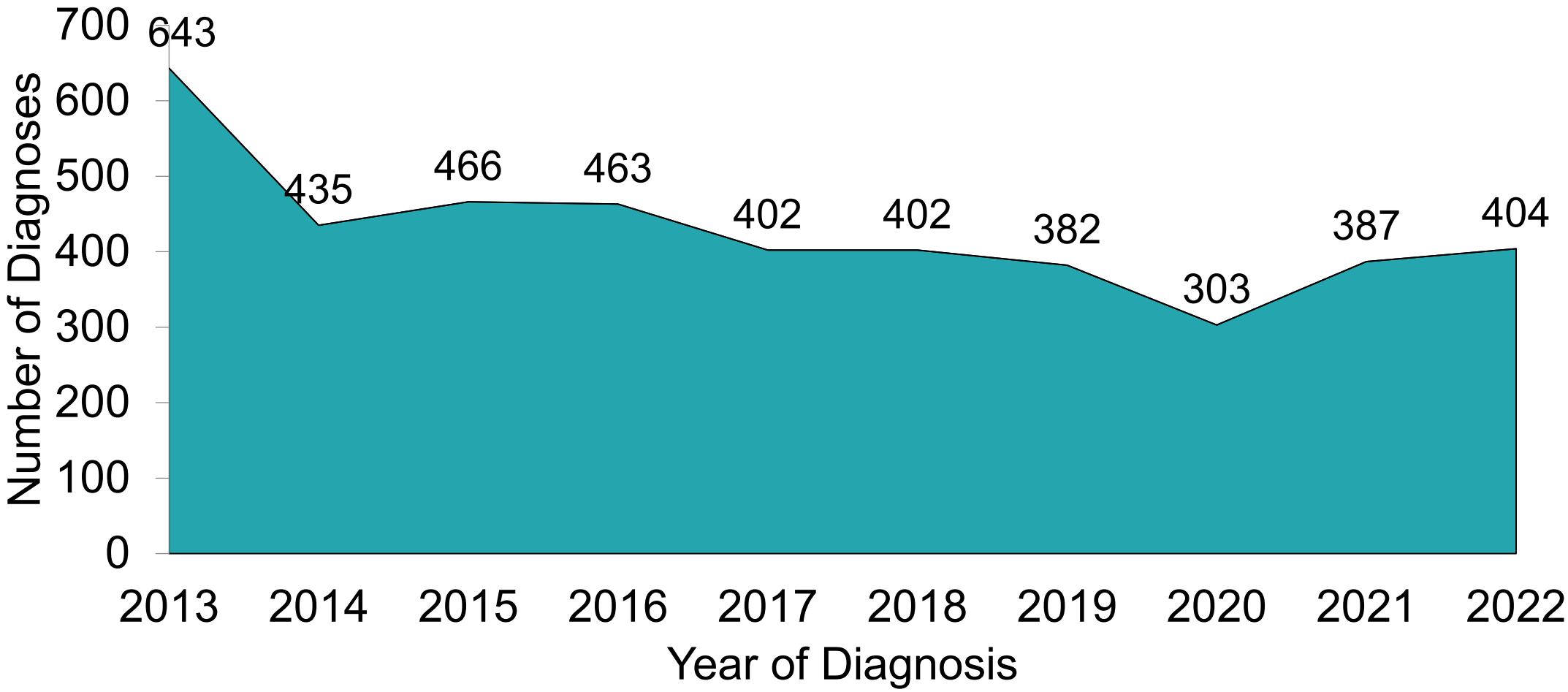


Demographics of People Diagnosed with HIV

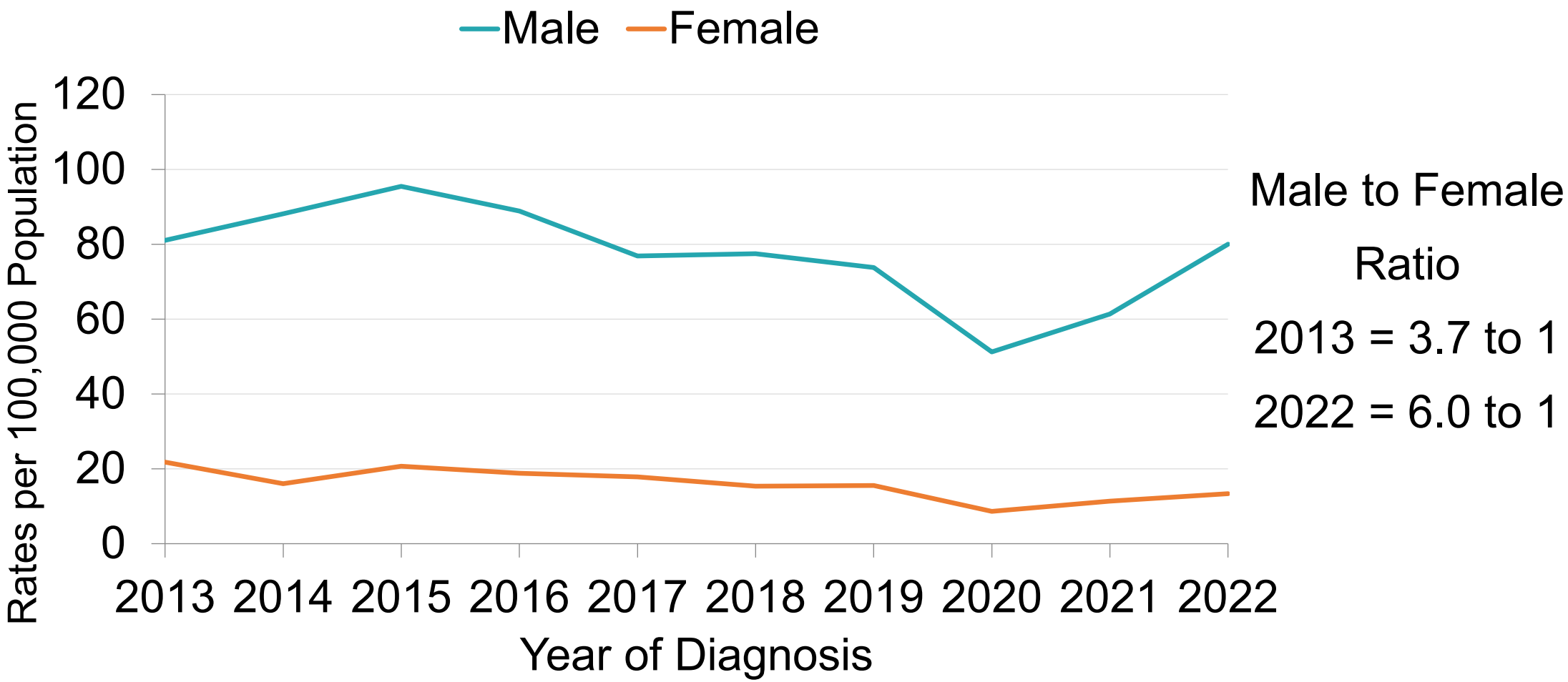
Diagnoses of HIV, 2013–2022, Miami-Dade County



Diagnoses of AIDS, 2013–2022, Miami-Dade County



Adult HIV Diagnosis Rates by Sex, 2013–2022, Miami-Dade County



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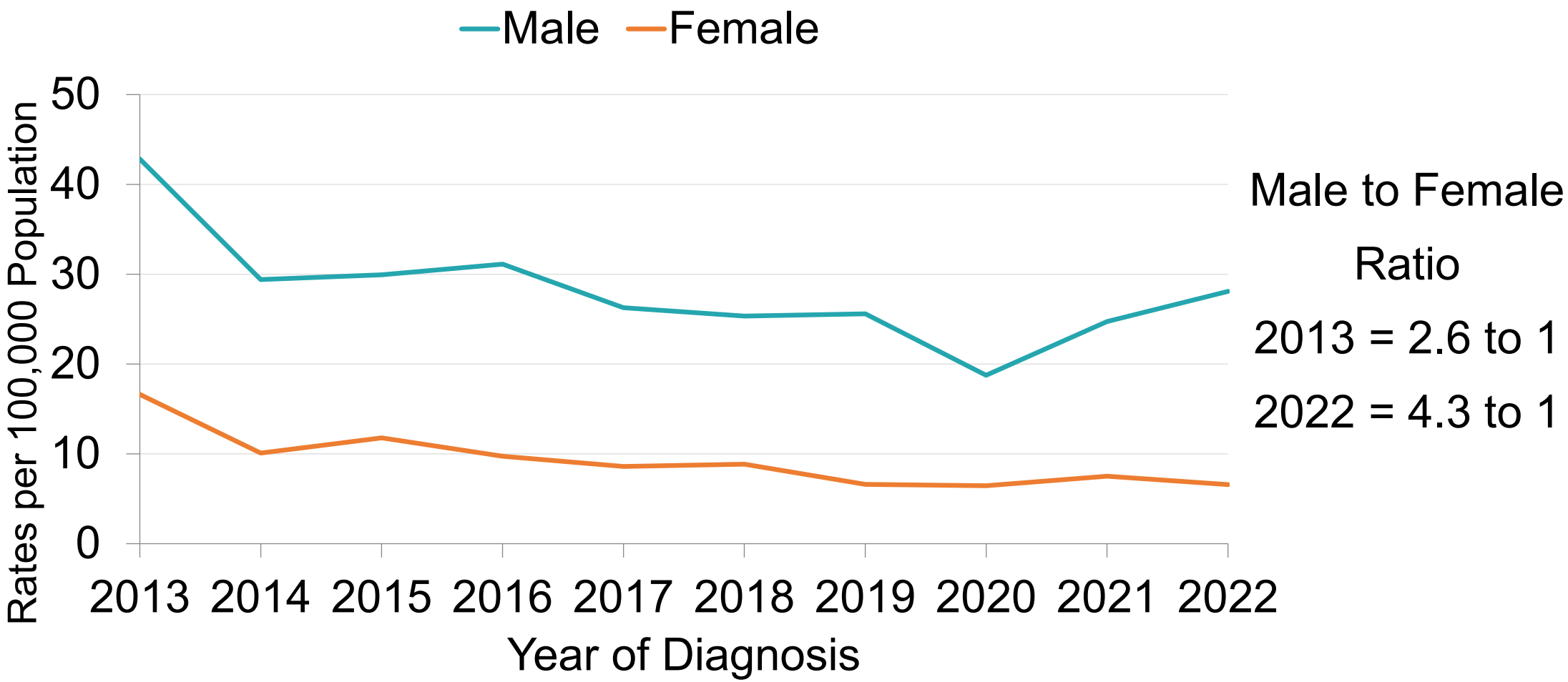
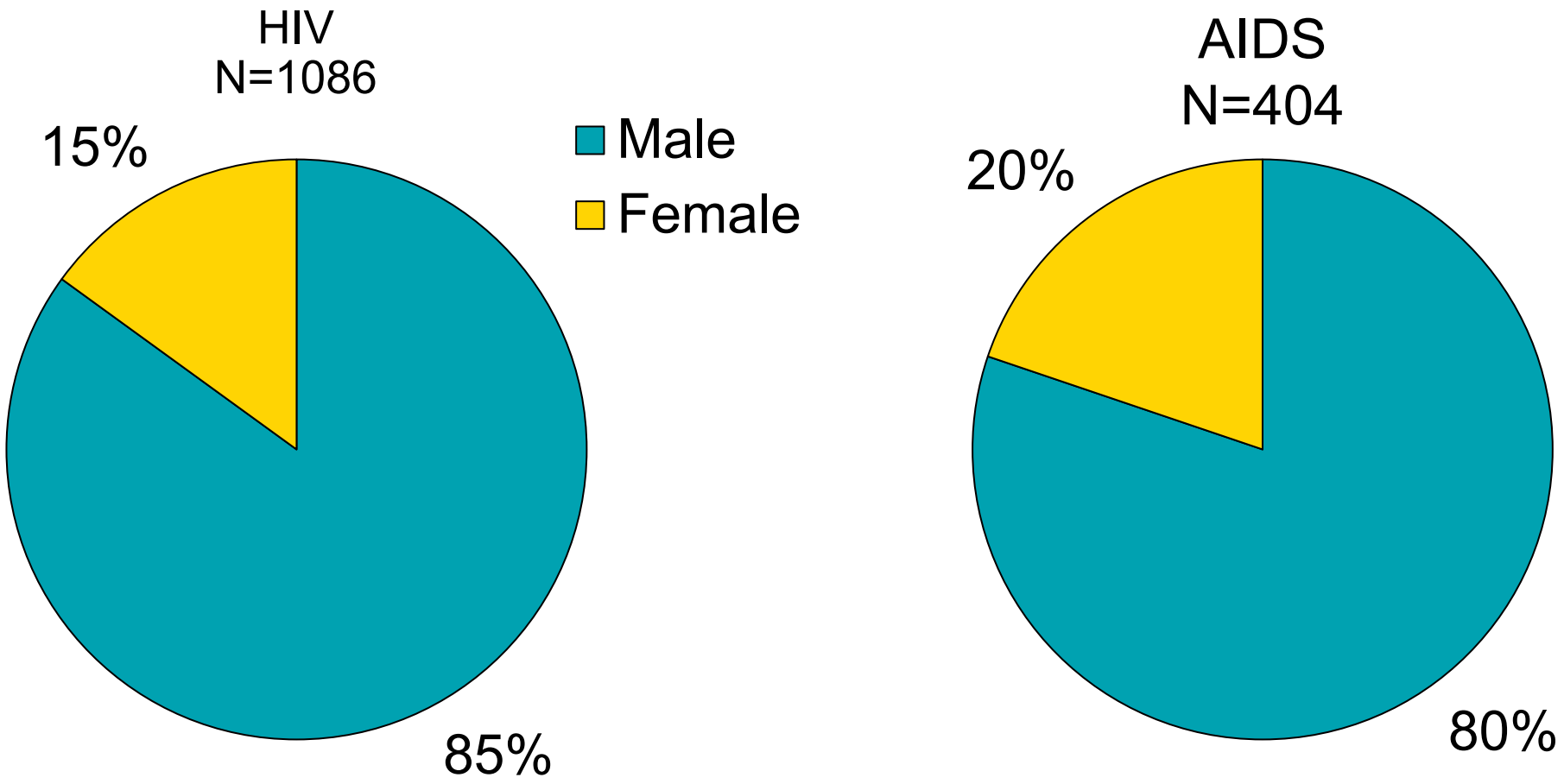
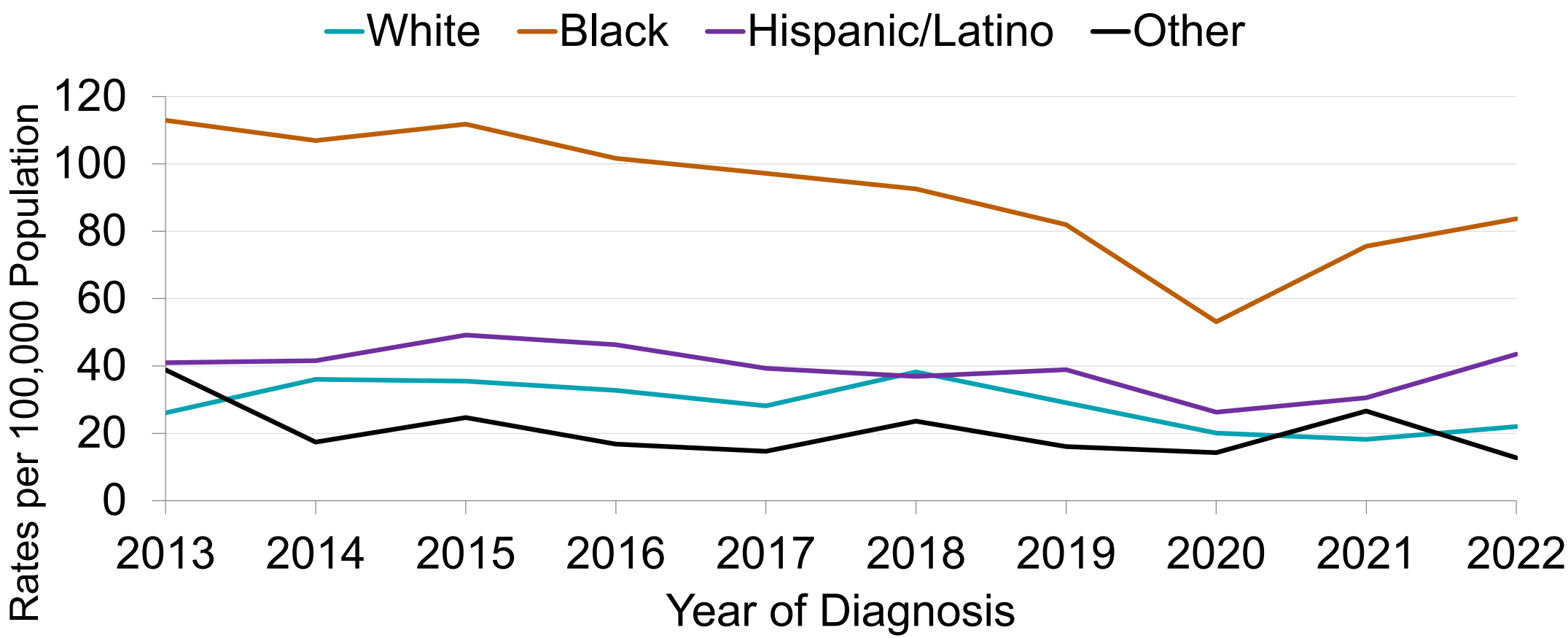


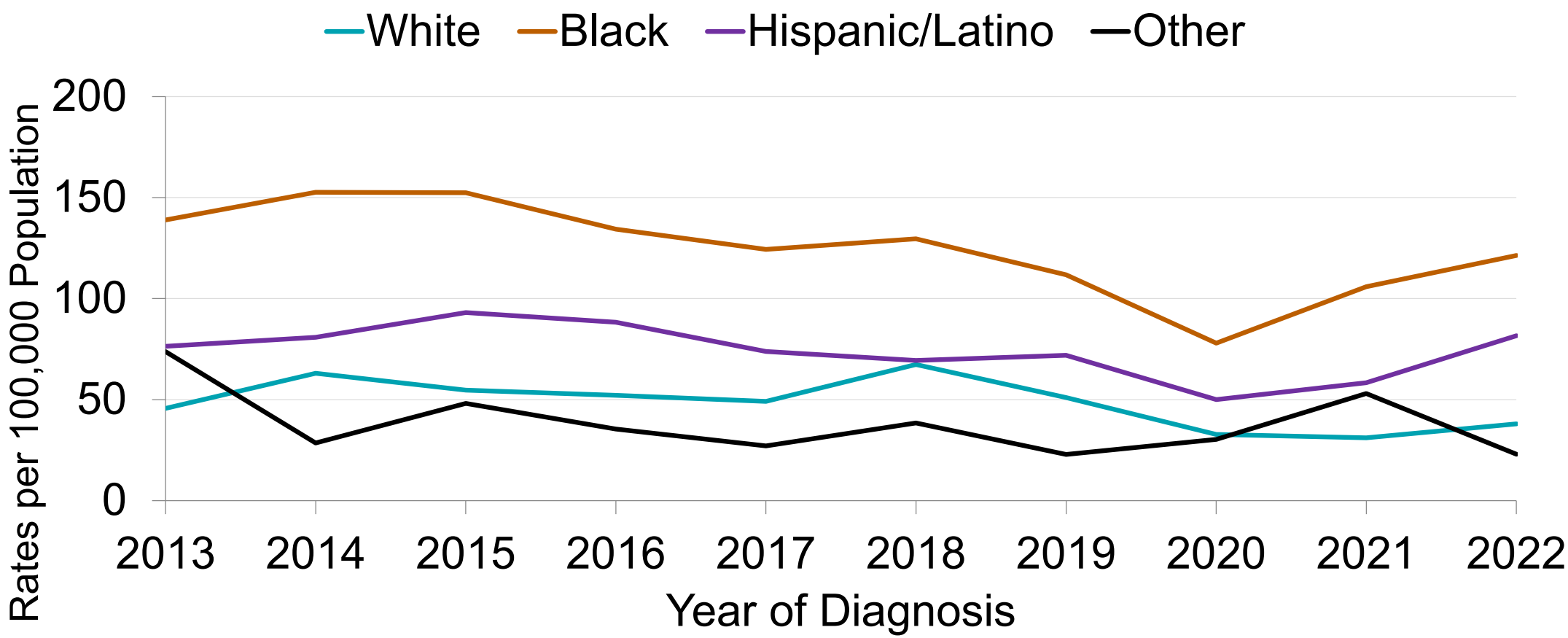
Adult HIV and AIDS Diagnoses By Sex, 2022, Miami-Dade County



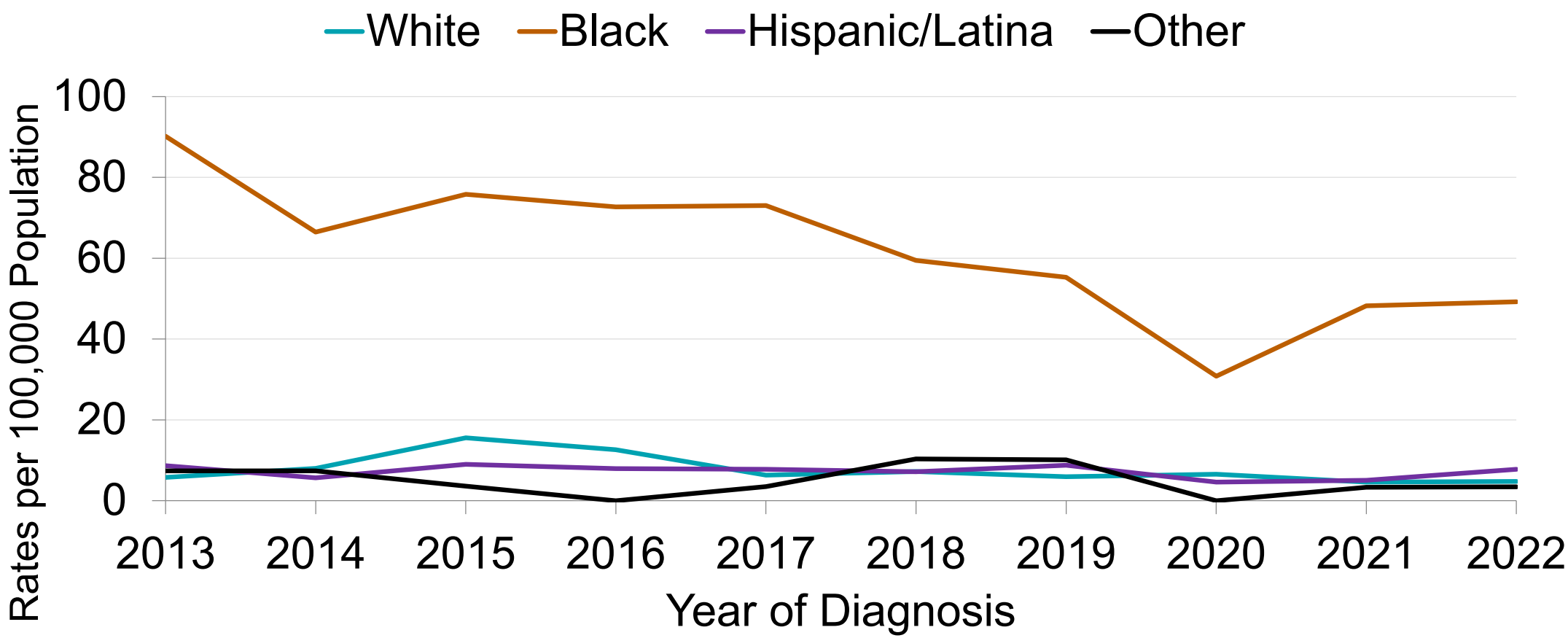
Adult HIV Diagnosis Rates By Race or Ethnicity, 2013–2022, Miami-Dade County



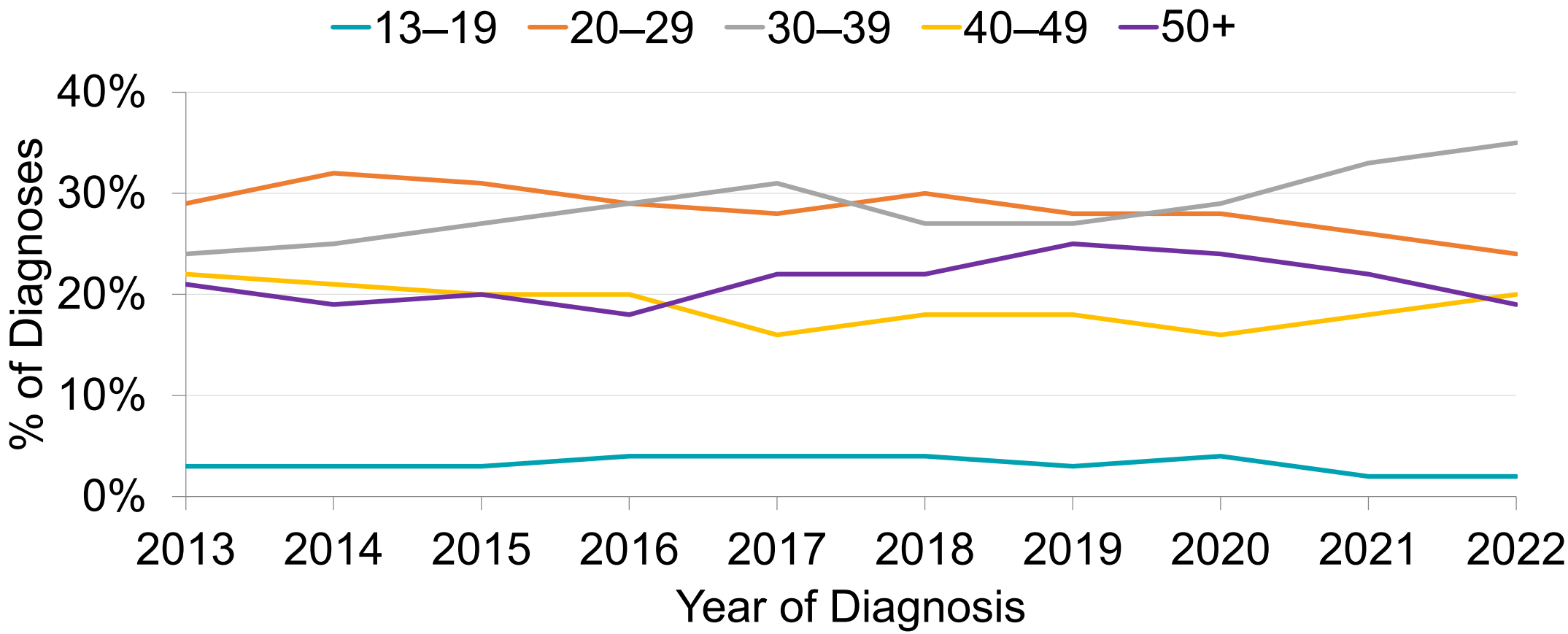
Adult Male HIV Diagnosis Rates By Race or Ethnicity, 2013–2022, Miami-Dade County



Adult Female HIV Diagnosis Rates By Race or Ethnicity, 2013–2022, Miami-Dade County



Adult HIV Diagnoses by Age At Diagnosis, 2013–2022, Miami-Dade County

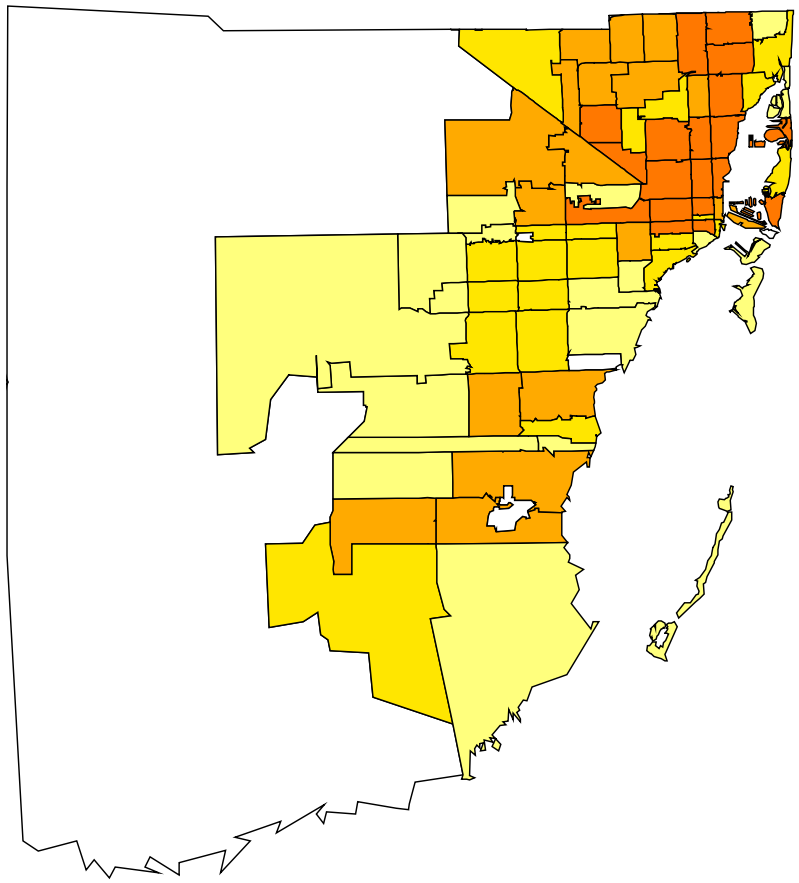


Adult HIV Diagnoses by ZIP Code of Residence At Diagnosis, 2020–2022, Miami-Dade County

Adult HIV Diagnoses

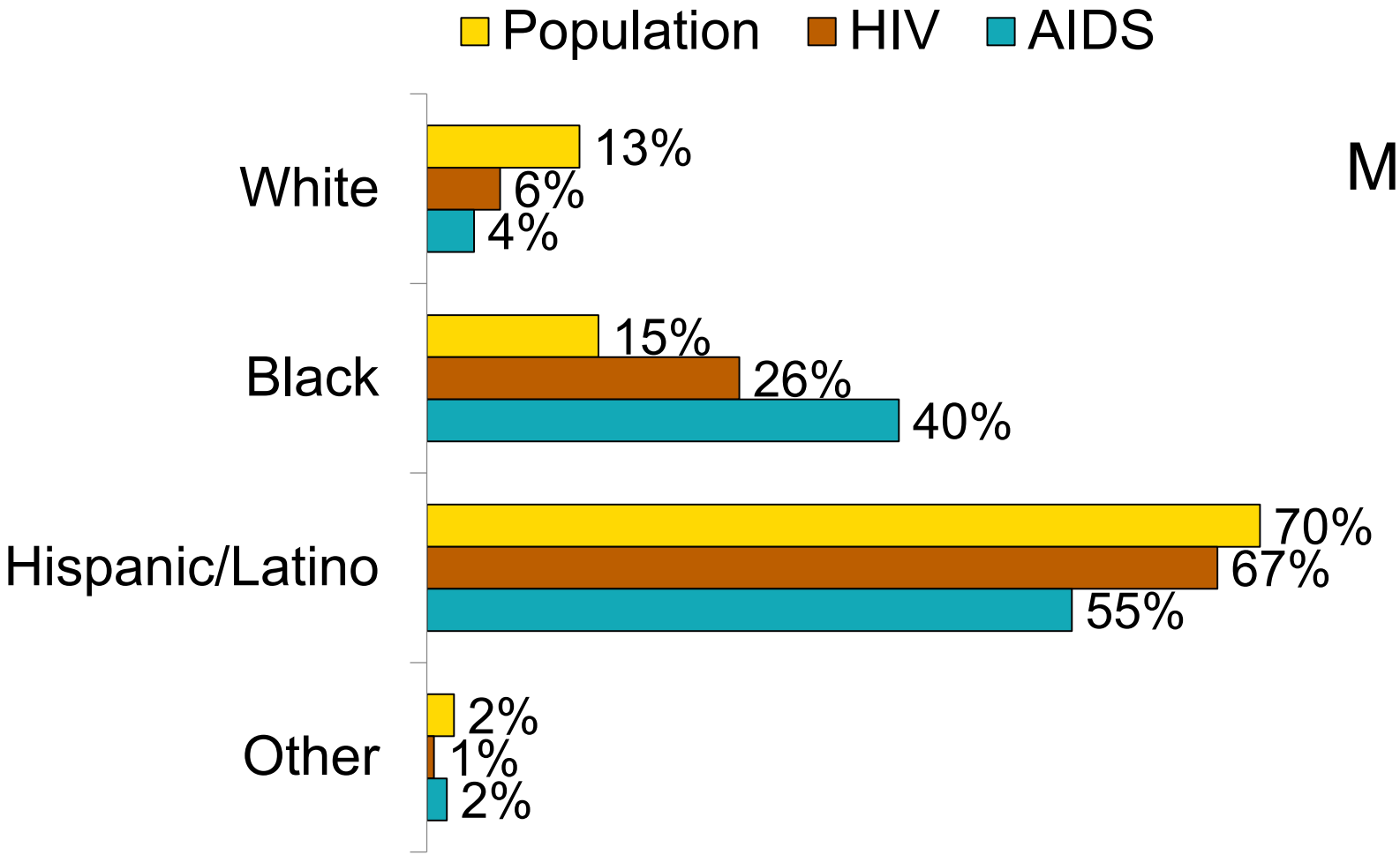
- 0
- 1–15
- 16–29
- 30–48
- >=49

N=2,616



County map boundaries include agricultural and/or conservation areas, which may not be populated.

Adult HIV and AIDS Diagnoses and Population by Race or Ethnicity, 2022, Miami-Dade County



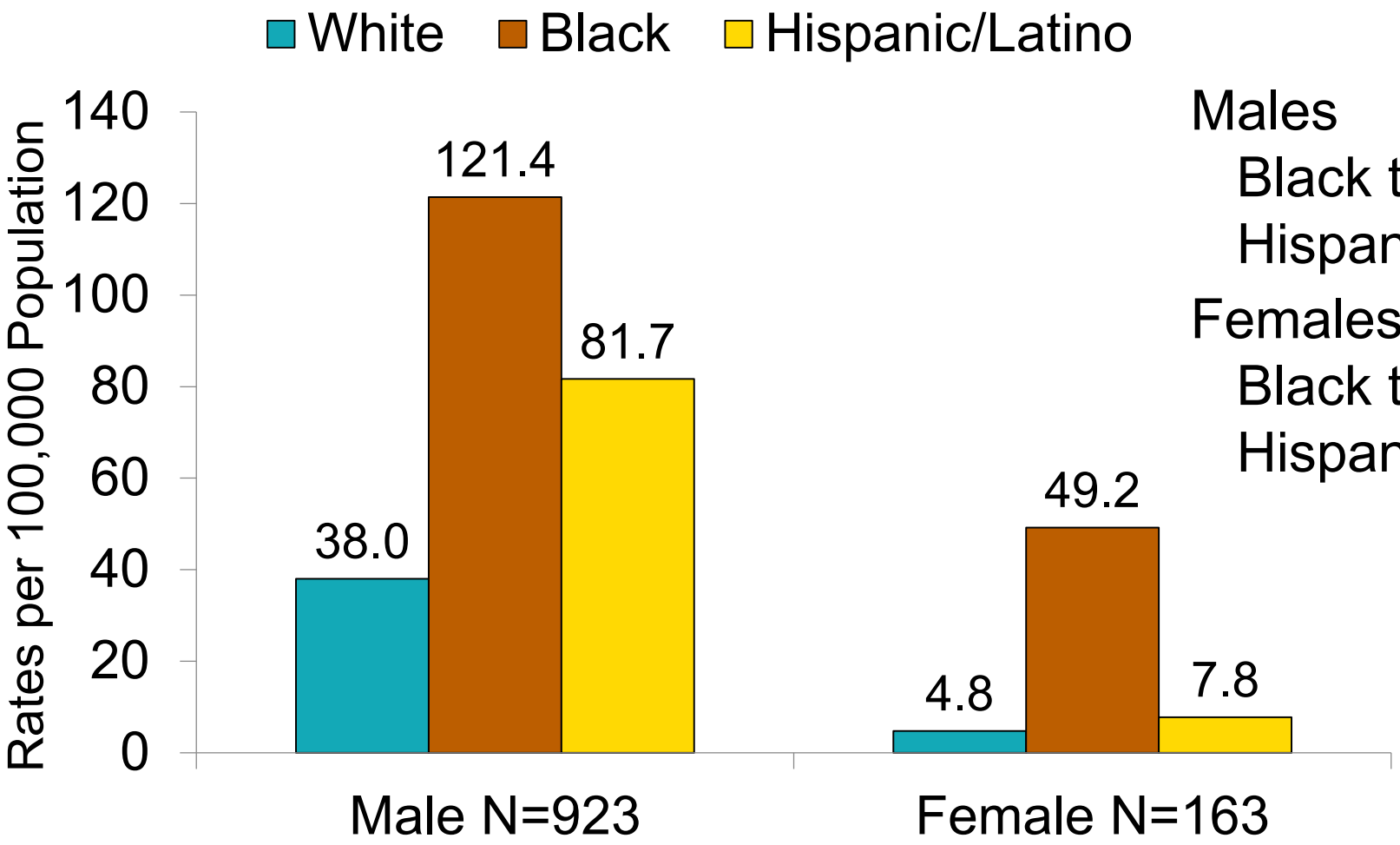
Miami-Dade County Adult Population Estimate
N=2,369,628

HIV
N=1086

AIDS
N=404

Rounding may cause percentages to total more or less than 100.

Adult HIV Diagnosis Rates by Sex And Race or Ethnicity, 2022, Miami-Dade County



Rate Ratios

Males

Black to White: 3.2 to 1

Hispanic/Latino to White: 2.1 to 1

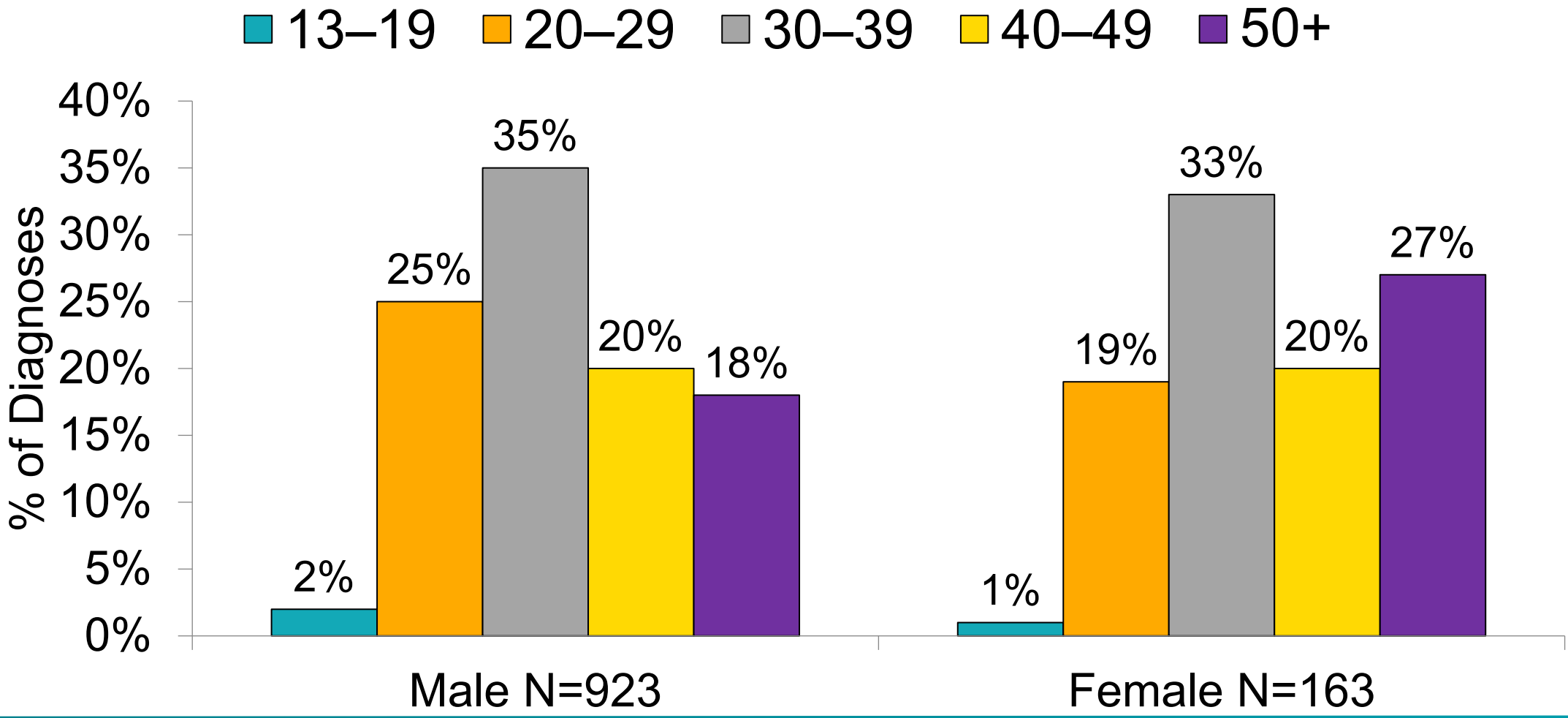
Females

Black to White: 10.3 to 1

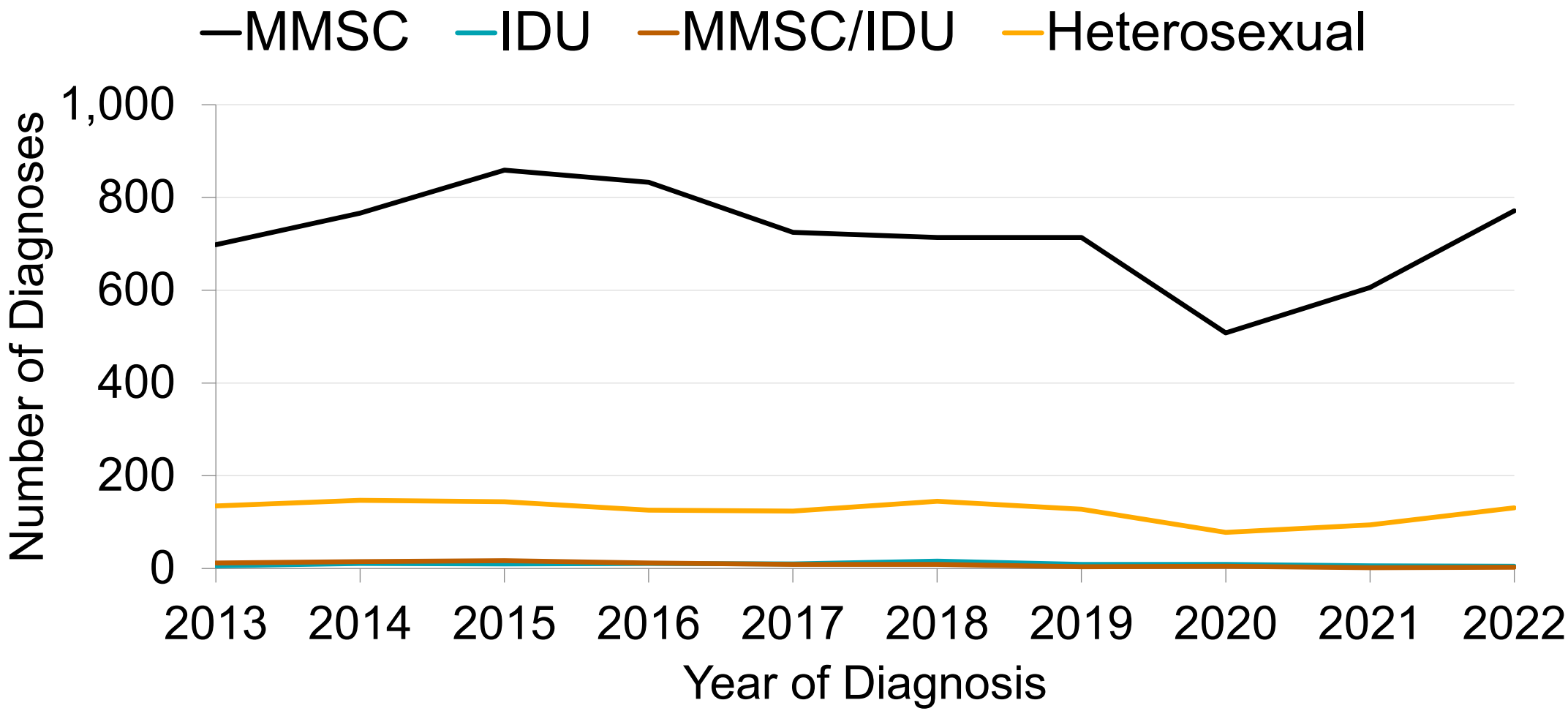
Hispanic/Latina to White: 1.6 to 1

Rounding may cause percentages to total more or less than 100.

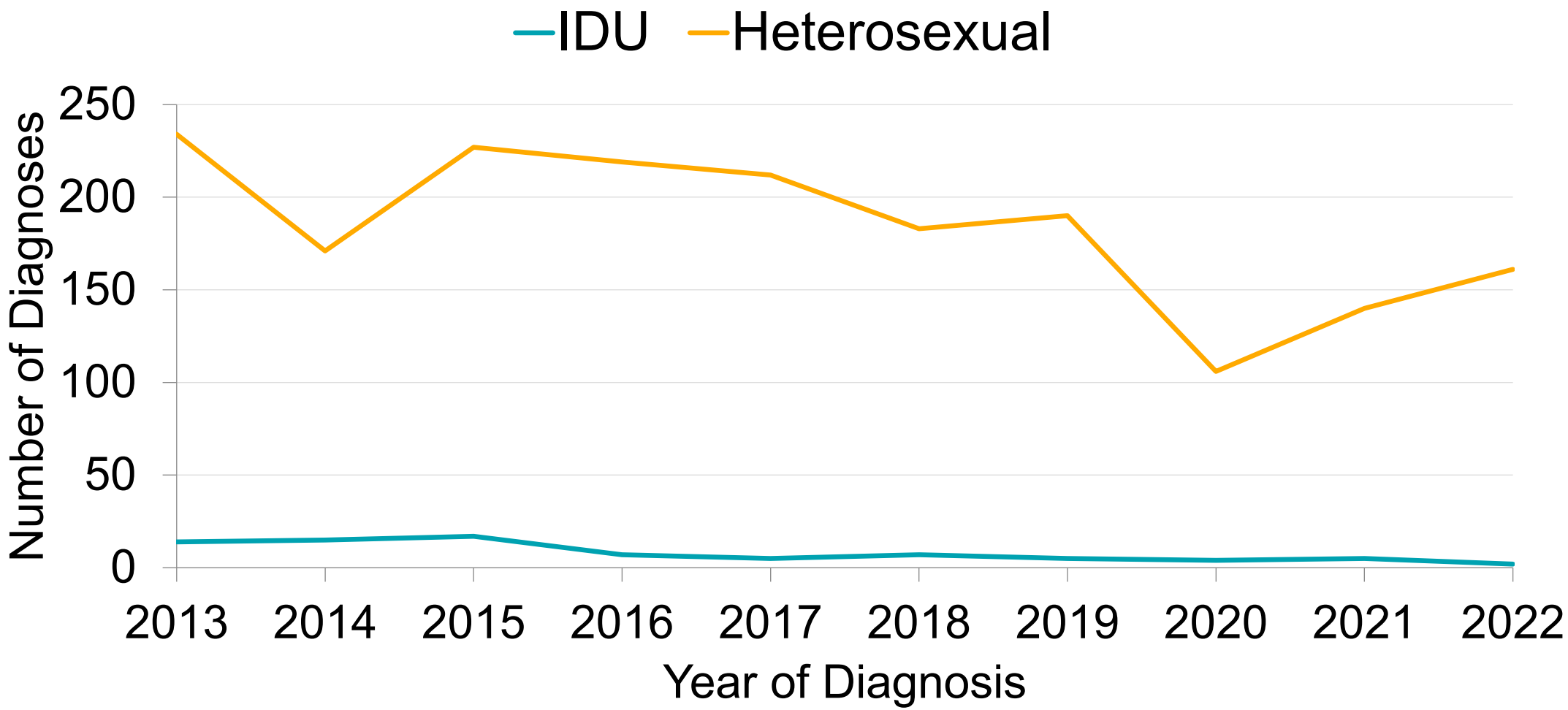
Adult HIV Diagnoses By Sex and Age at Diagnosis, 2022, Miami-Dade County

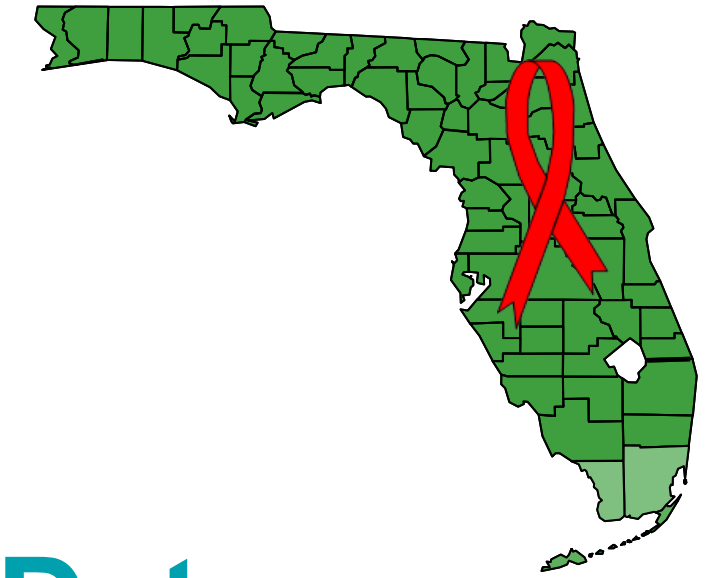


Adult Male HIV Diagnoses by Mode of Exposure, 2013–2022, Miami-Dade County



Adult Female HIV Diagnoses by Mode of Exposure, 2013–2022, Miami-Dade County



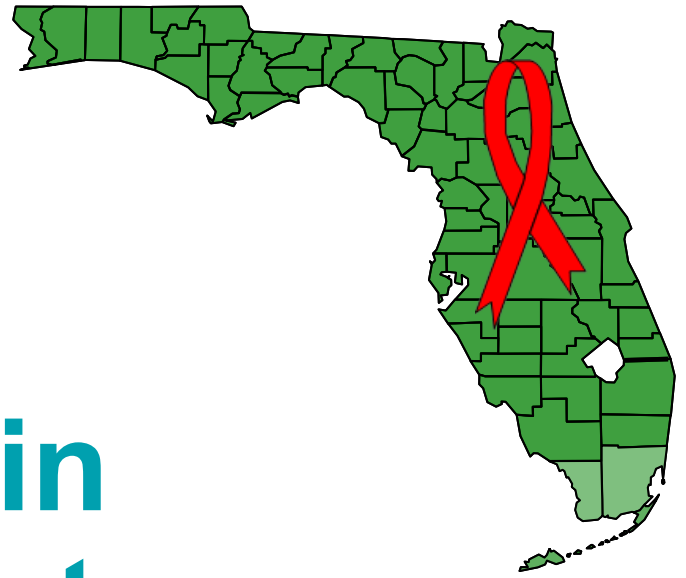


HIV Co-morbidity Data

PWH with a Co-occurring Diagnosis of an STI by Type and Year of STI Report, 2018–2022, Miami-Dade County

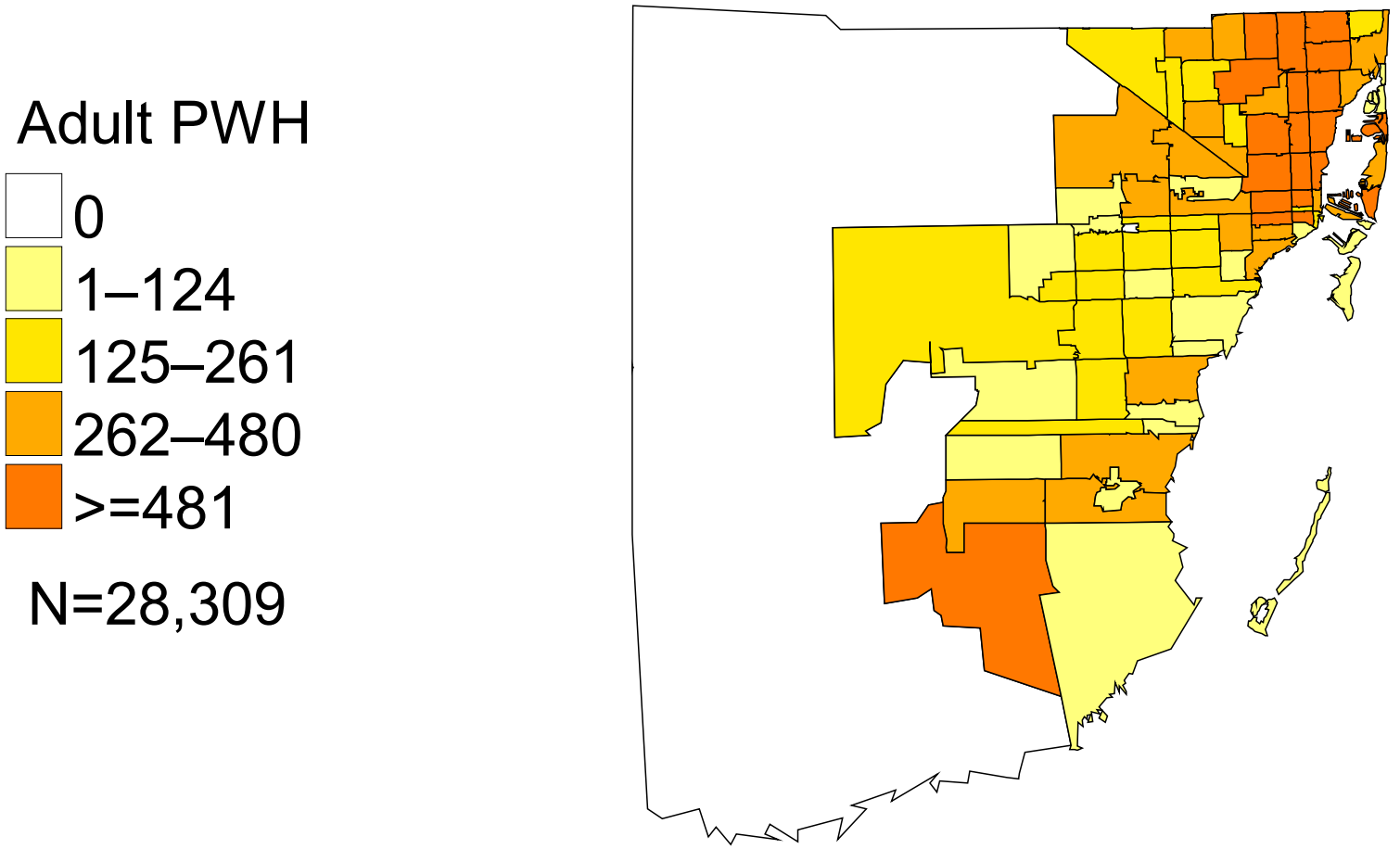
Year of STI Report	HIV/ Early Syphilis[1]	HIV/ Chlamydia	HIV/ Gonorrhea
2018	934	804	814
2019	1,005	964	1,042
2020	1,104	844	962
2021	1,255	1,210	1,197
2022	1,242	1,234	1,272
Percentage Change	33%	53%	56%

[1]Primary, secondary and early non-primary, non-secondary syphilis.



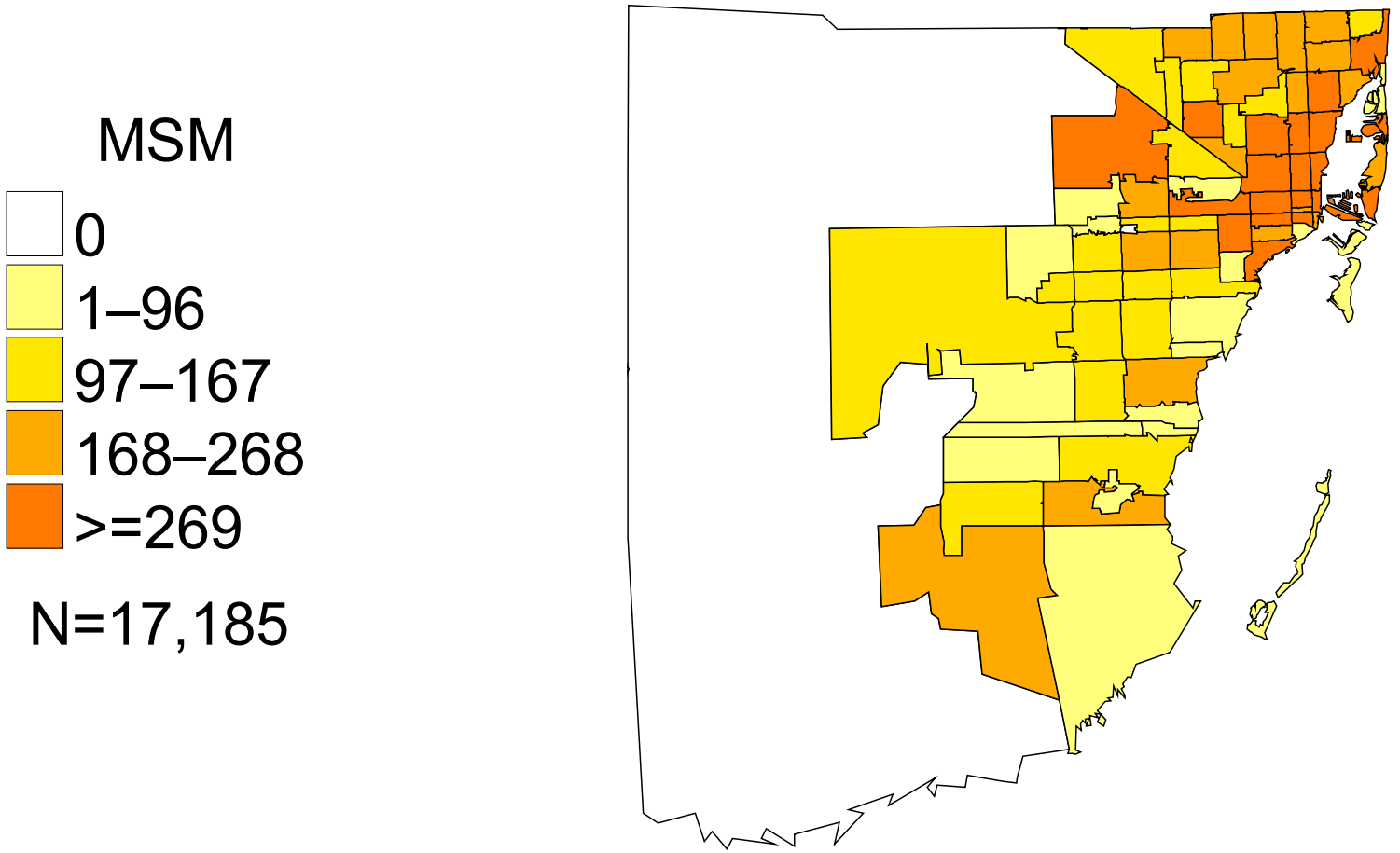
HIV Prevalence in Miami-Dade County

Adult PWH by ZIP Code of Residence,[1] 2022
Living in Miami-Dade County



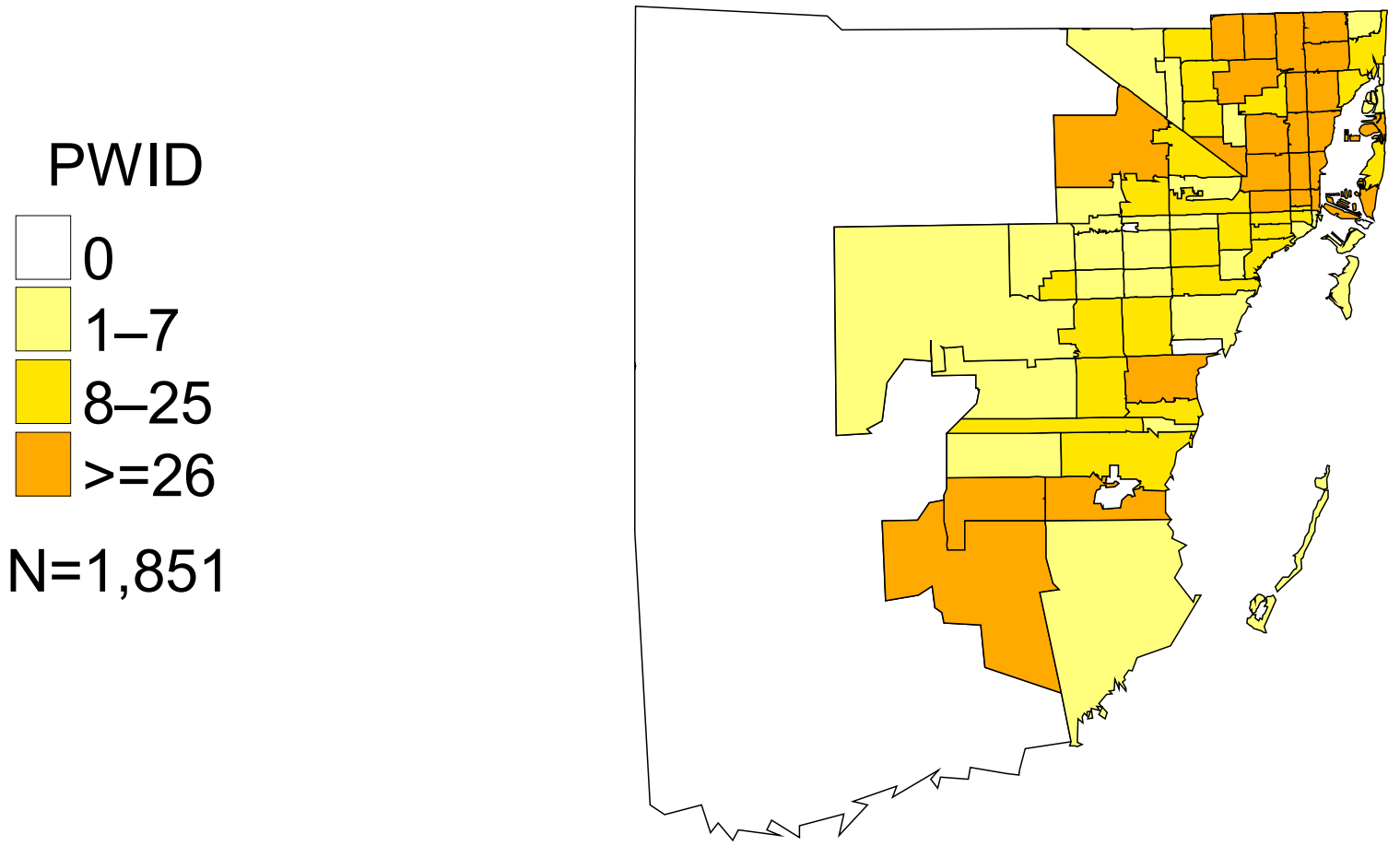
[1]Excludes homeless persons and persons with unknown ZIP codes.

MSM[1] with HIV by ZIP Code of Residence,[2] 2022 Living in Miami-Dade County



[1]Data includes MSM/PWID.
[2]Excludes homeless persons and persons with unknown ZIP codes.

PWID[1] with HIV by ZIP Code of Residence,[2] 2022 Living in Miami-Dade County



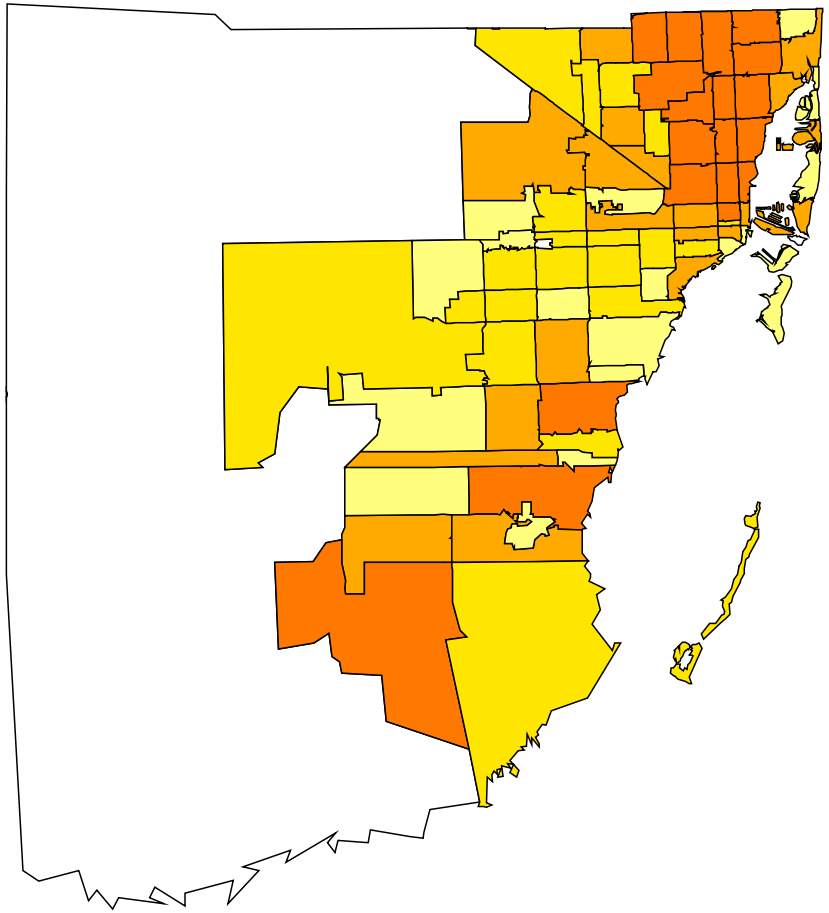
[1]Data includes MSM/PWID.
[2]Excludes homeless persons and persons with unknown ZIP codes.

Persons with Heterosexual Contact with HIV by ZIP Code of Residence,[1] 2022, Living in Miami-Dade County

Heterosexual Contact

- 0
- 1–31
- 32–54
- 55–173
- >=174

N=9,433

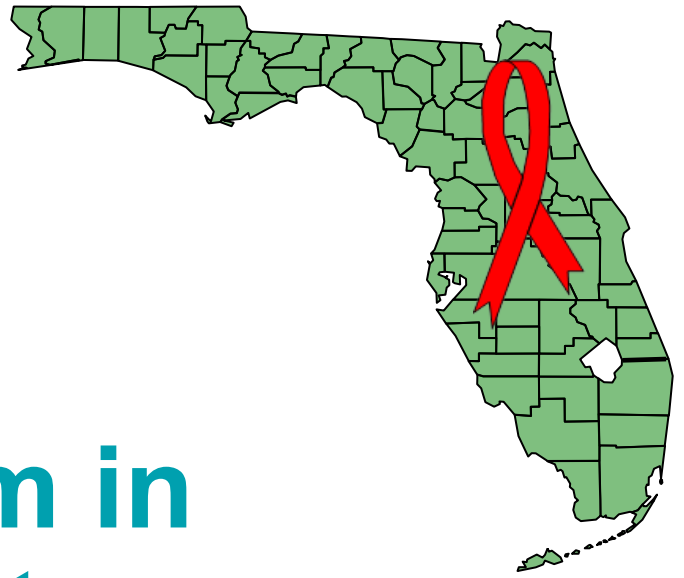


[1]Excludes homeless persons and persons with unknown ZIP codes.

Adults with HIV, 2022, Living in Miami-Dade County

		Male #	%	Female #	%	Total #	%
Race/ Ethnicity	White	2,474	8%	281	<1%	2,755	9%
	Black	6,436	22%	4,430	15%	10,866	37%
	Hispanic/Latino	12,942	45%	1,828	6%	14,770	51%
	Other	263	<1%	75	<1%	338	1%
Age Group	13-19	37	<1%	16	<1%	53	<1%
	20-29	1,456	5%	315	1%	1,771	6%
	30-39	4,239	14%	871	3%	5,110	17%
	40-49	4,108	14%	1,309	4%	5,417	18%
	50+	12,275	42%	4,103	14%	16,378	57%
Mode of Exposure	MMSC	16,785	58%	0	<1%	16,785	58%
	IDU	763	2%	524	1%	1,286	4%
	MMSC/IDU	612	2%	0	<1%	612	2%
	Heterosexual Contact	3,700	12%	5,906	20%	9,606	33%
	Other Sexual Contact	117	<1%	3	<1%	120	<1%
	Other risk	138	<1%	182	<1%	320	1%

Rounding may cause percentages to total more or less than 100.



HIV Care Continuum in Miami-Dade County

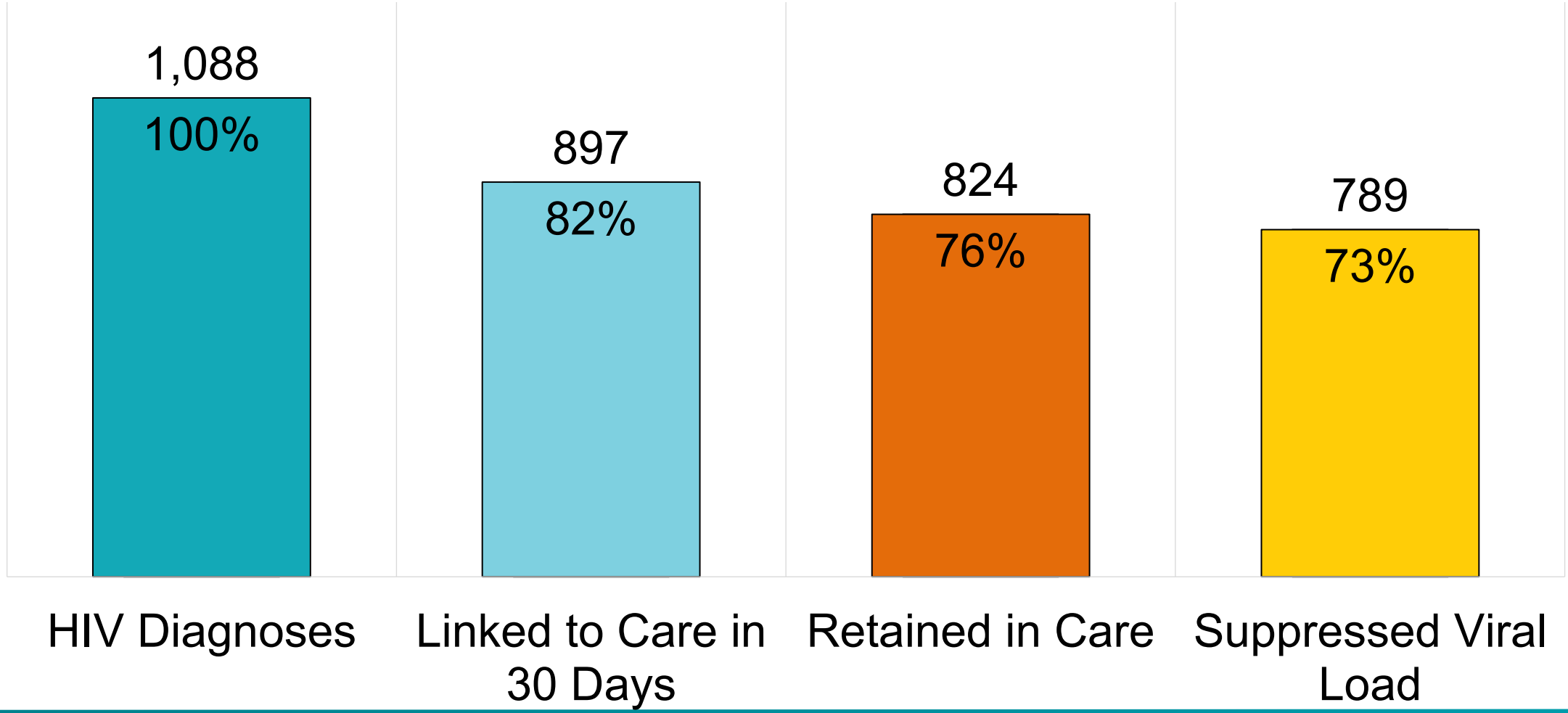
HIV Care Continuum Definitions

- **PWH:** Persons with HIV living in Florida at the end of 2022.
- **In Care:** PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2022 through 3/31/2023.
- **Retained in Care:** PWH with two or more documented VL or CD4 labs, medical visits or prescriptions at least three months apart from 1/1/2022 through 6/30/2023.

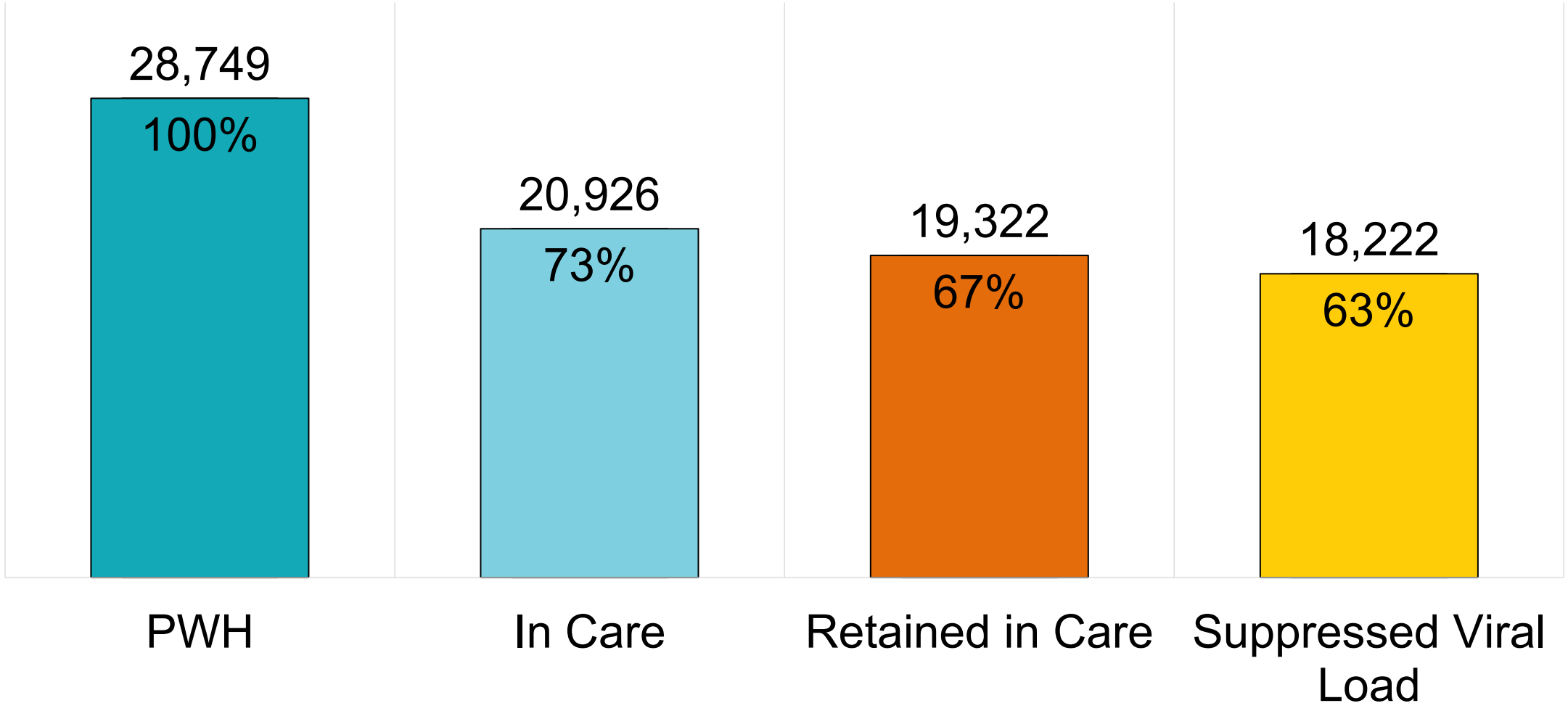
HIV Care Continuum Definitions, continued

- **Suppressed Viral Load**: PWH with a suppressed VL (<200 copies/mL) on their last VL lab from 1/1/2022 through 3/31/2023.
- **Not in Care:** PWH with no documented VL or CD4 lab, medical visit or prescription from 1/1/2022 through 3/31/2023.
- **Linked to Care**: PWH with at least one documented VL or CD4 lab, medical visit, or prescription following their first HIV diagnosis date.

Persons Who Received an HIV Diagnosis Along the HIV Care Continuum in 2022, Miami-Dade County

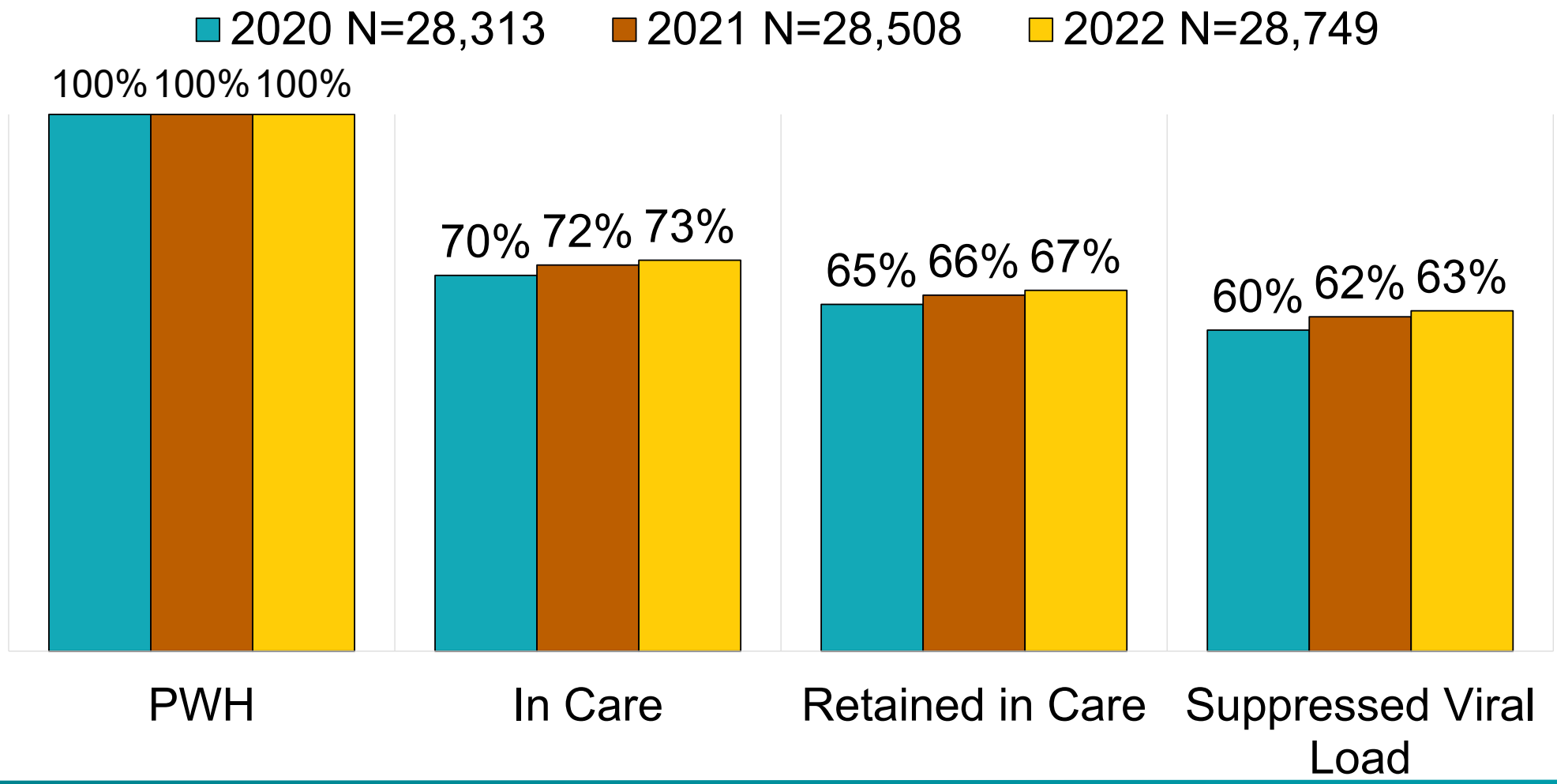


PWH Along the HIV Care Continuum in 2022, Living in Miami-Dade County

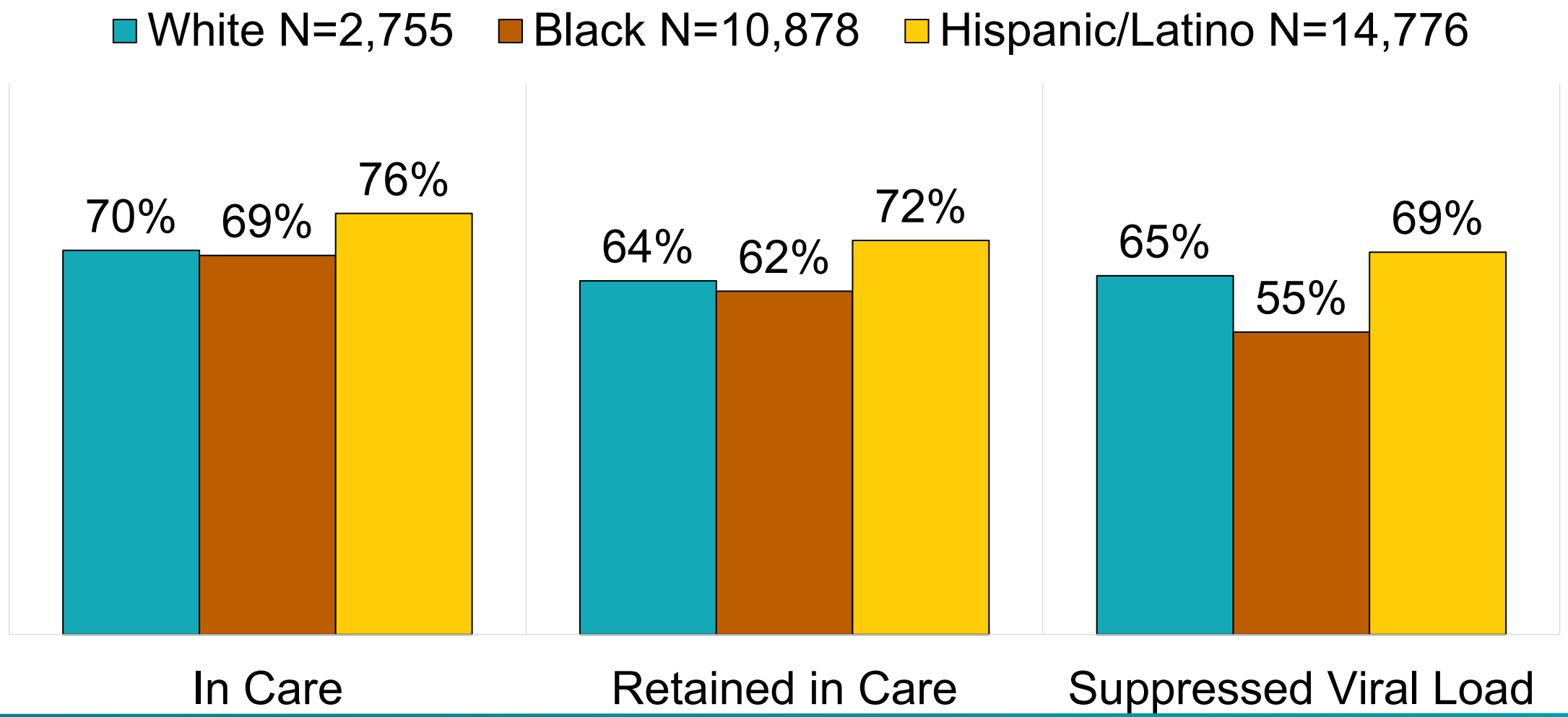


Note: 90% of persons retained in care had a suppressed viral load.

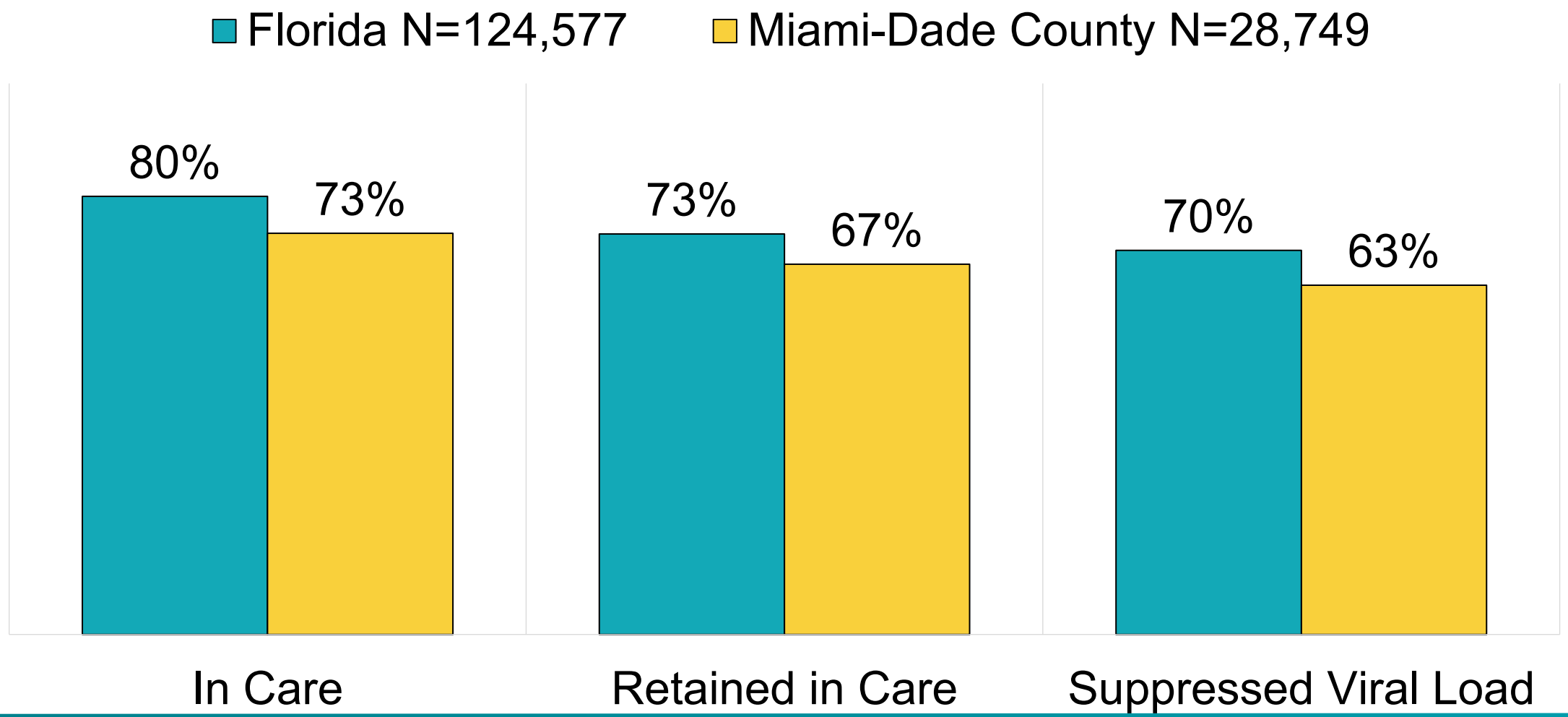
PWH Along the HIV Care Continuum, 2020–2022, Living in Miami-Dade County



PWH by Race or Ethnicity Along the HIV Care Continuum In 2022, Living in Miami-Dade County



PWH Along the HIV Care Continuum in 2022, Living in Florida Compared to Miami-Dade County

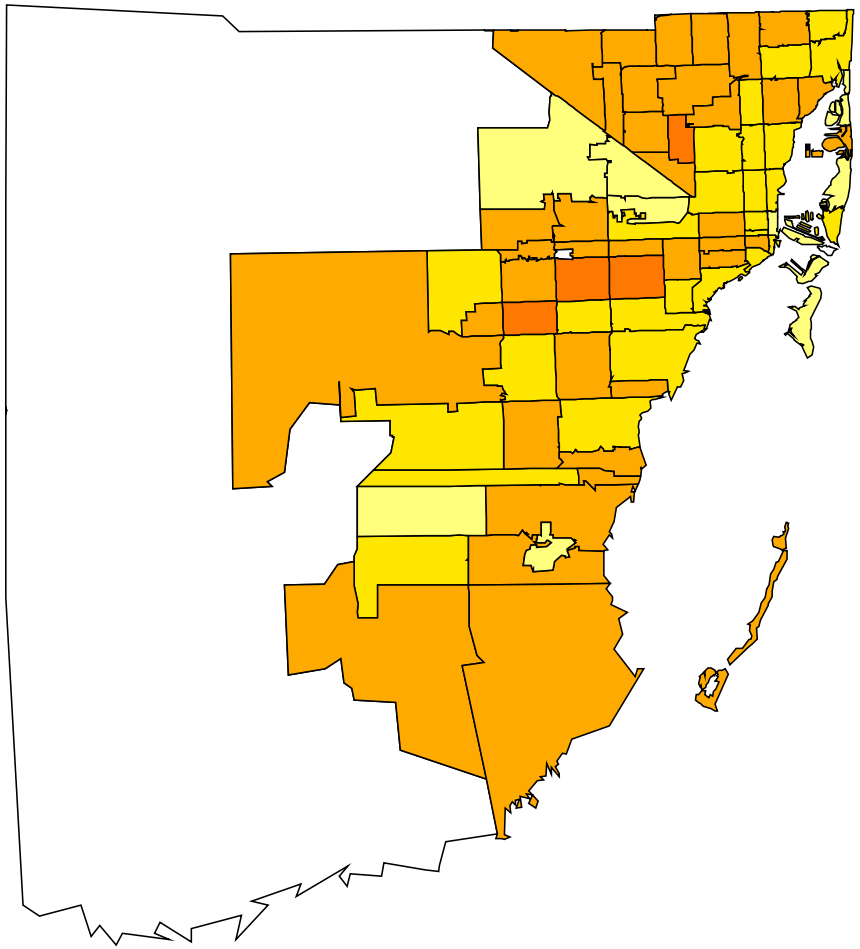


Percentage of PWH Who Were Retained in Care by ZIP Code of Residence[1] in 2022, Living in Miami-Dade County

Retained in Care

- <50%
- 50%–59%
- 60%–69%
- 70%–79%
- 80%–100%

Overall 68%



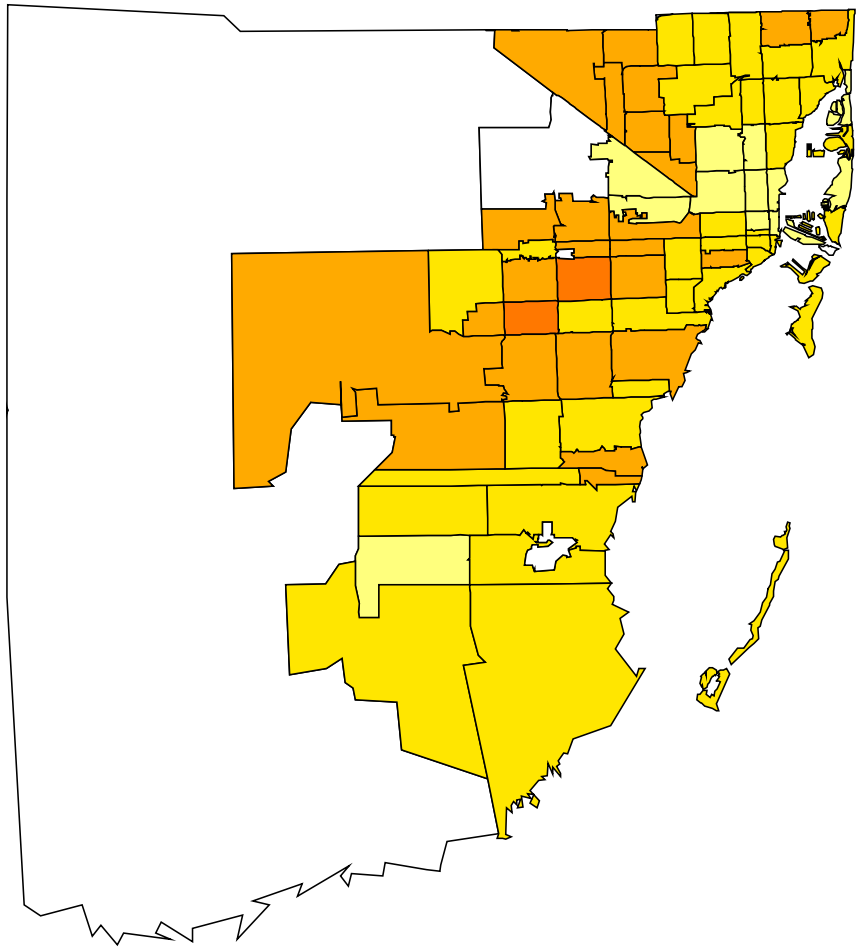
[1]Excludes data from homeless persons and persons with unknown ZIP codes.

Percentage of PWH Who Had a Suppressed VL by ZIP Code of Residence,[1] 2022, Living in Miami-Dade County

Suppressed VL

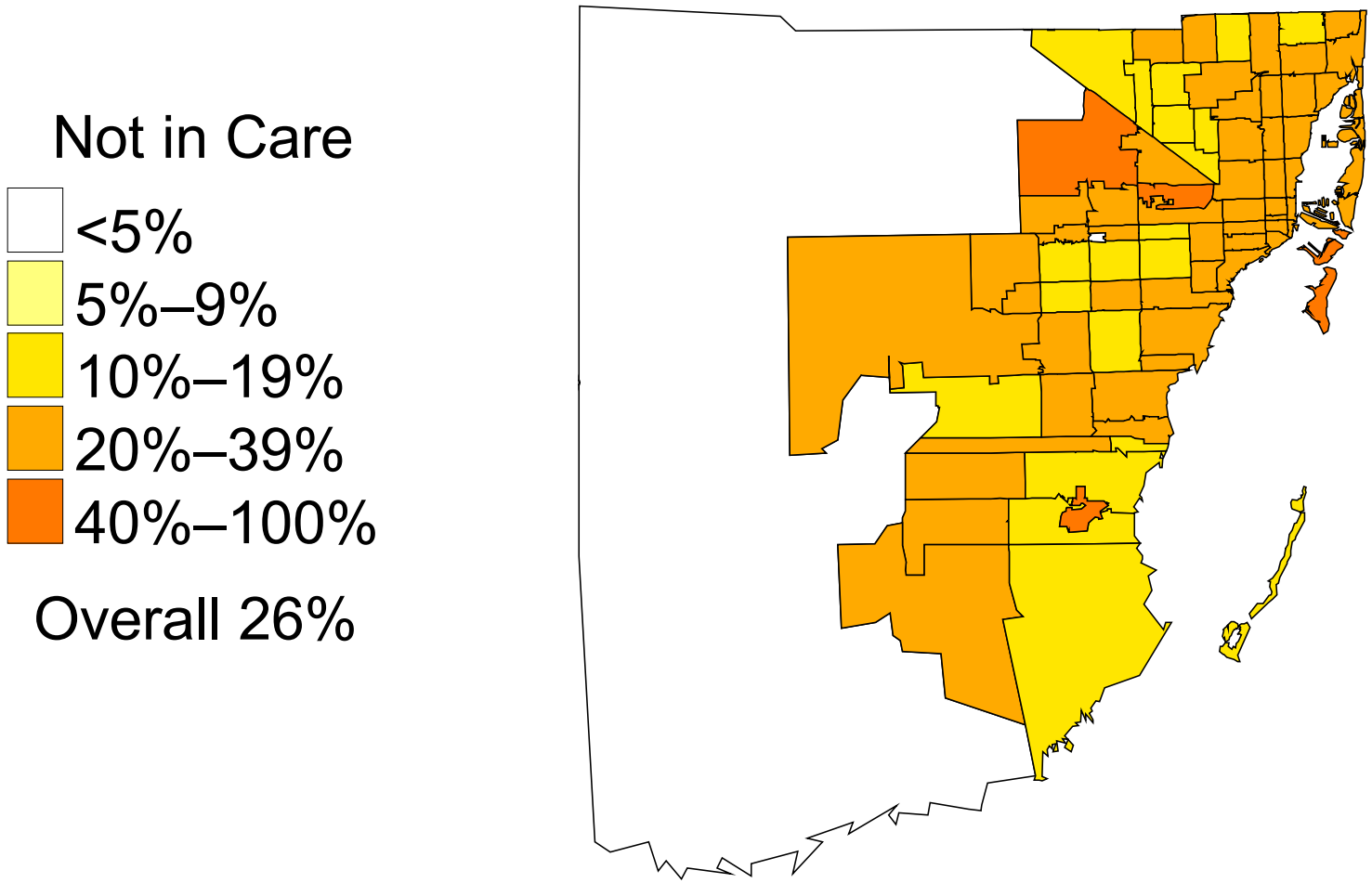
- <50%
- 50%–59%
- 60%–69%
- 70%–79%
- 80%–100%

Overall 64%

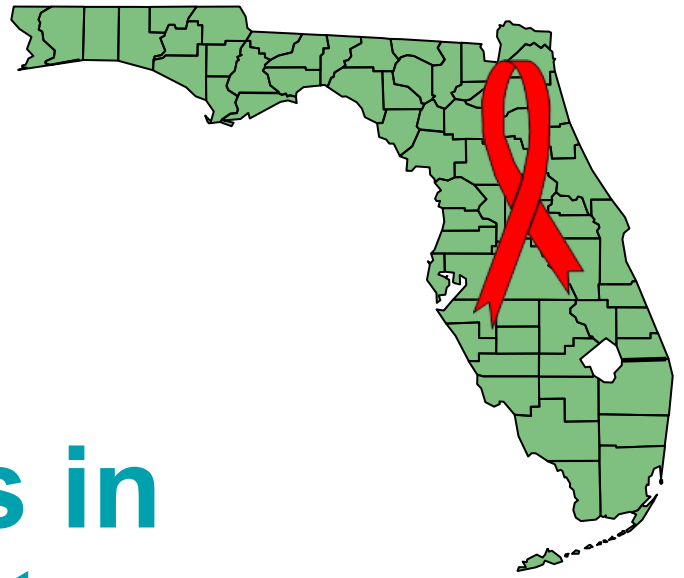


[1]Excludes data from homeless persons and persons with unknown ZIP codes.

Percentage of PWH Who Were Not in Care by ZIP Code of Residence[1] in 2022, Living in Miami-Dade County

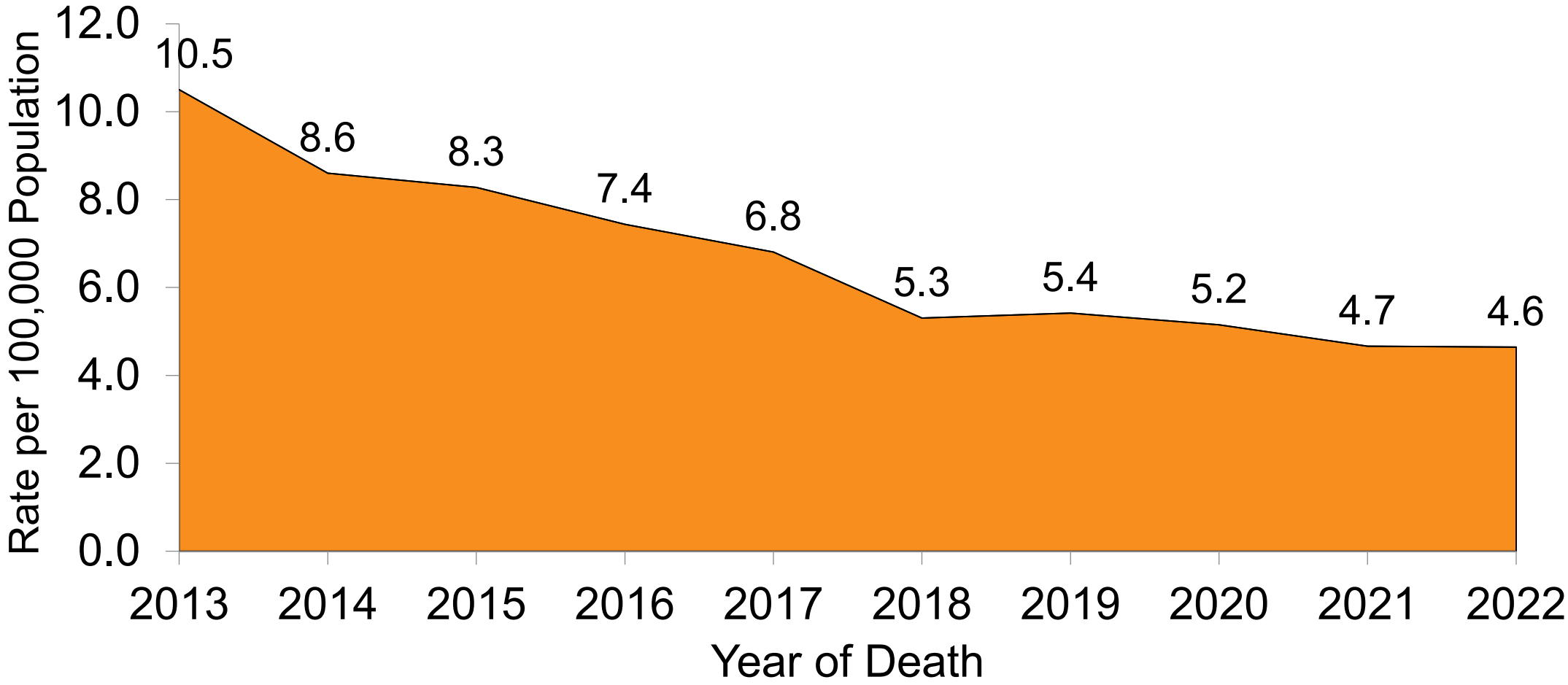


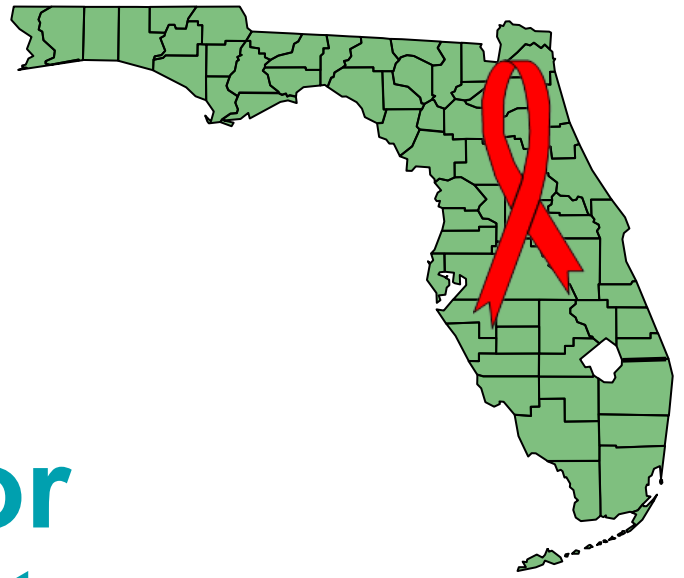
[1]Excludes data from homeless persons and persons with unknown ZIP codes.



HIV-Related Deaths in Miami-Dade County

Rate of HIV-Related Deaths 2013–2022, Miami-Dade County





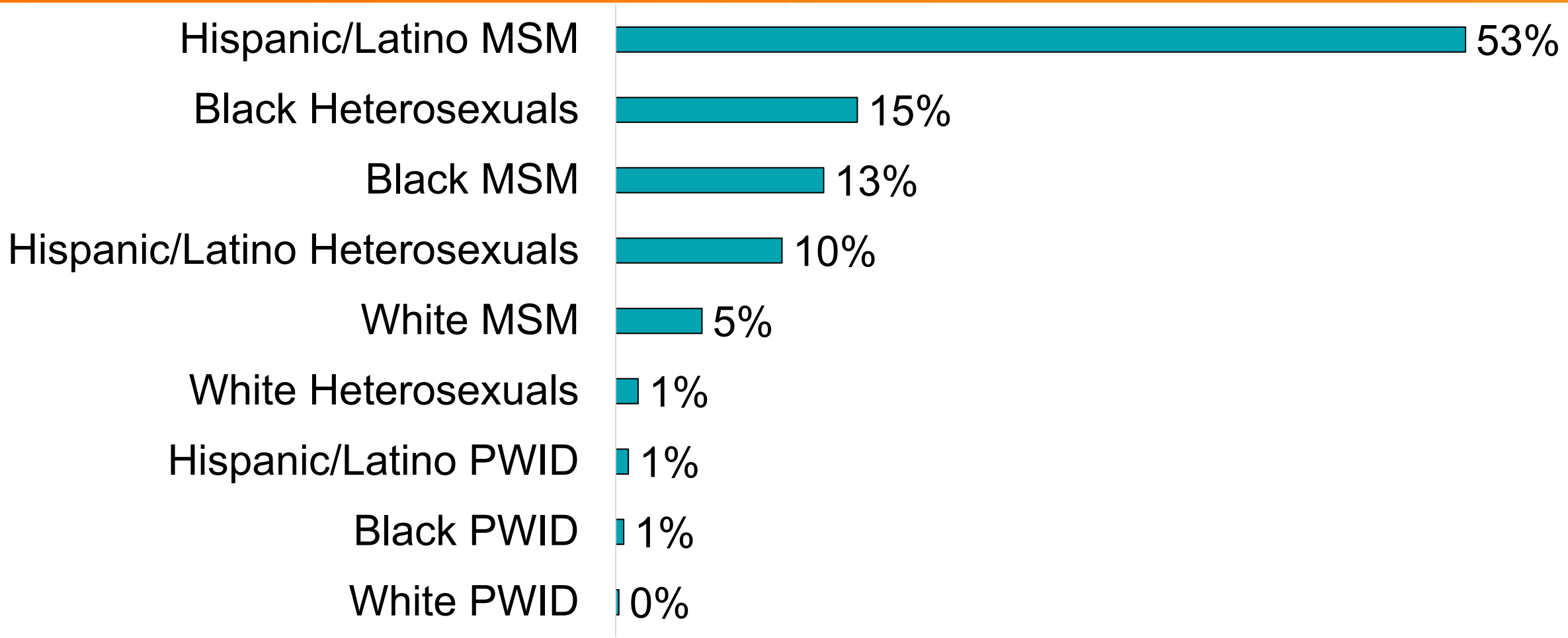
HIV Prevention for Miami-Dade County

Priority Populations for Primary HIV Prevention

- These data were calculated from HIV diagnoses 2020–2022 and represent the proportion of each race or mode of exposure group to the total diagnoses.

- These data are used to identify and prioritize testing, PrEP and other HIV prevention services to those at greatest risk for acquiring HIV in Florida.

Priority Populations for Primary HIV Prevention in 2022, Miami-Dade County



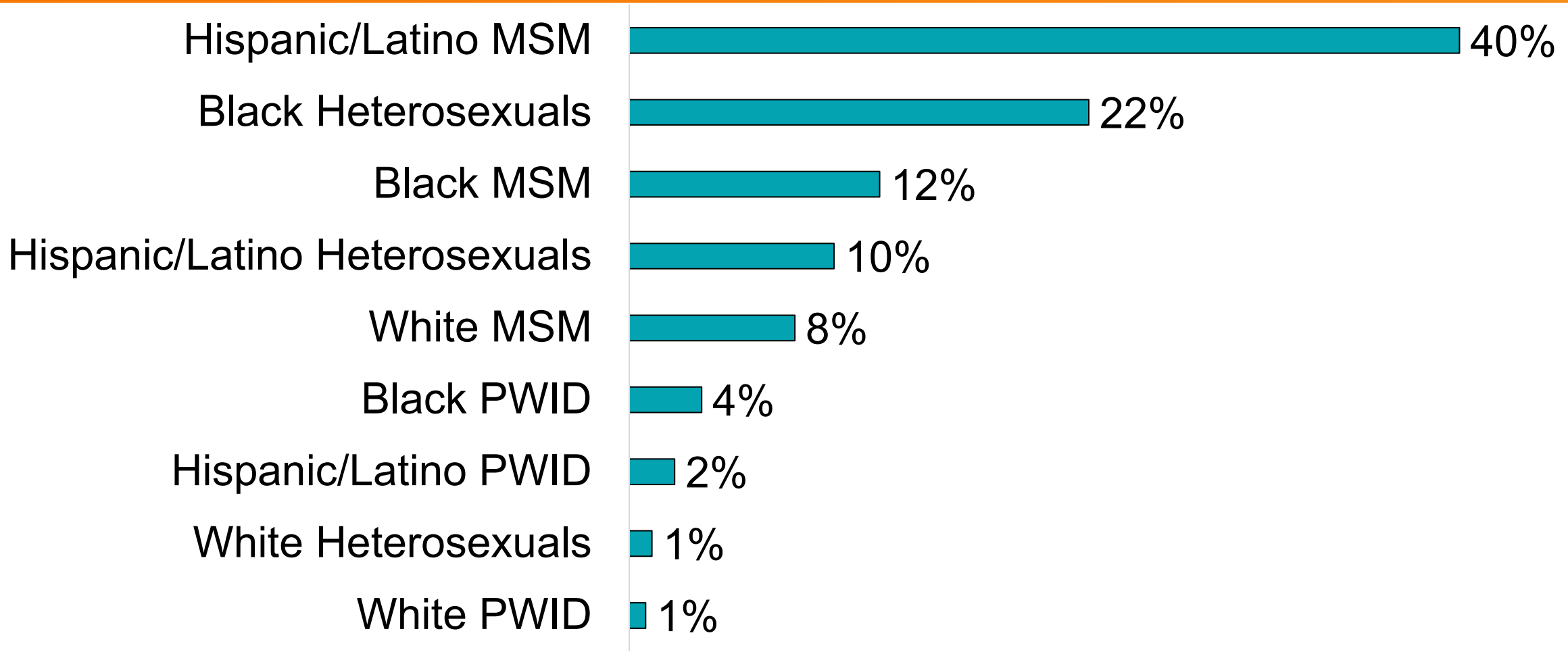
MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Data is for HIV diagnoses 2020–2022. Rounding may cause percentages to total more or less than 100.

Priority Populations for Prevention for PWH

- These data were calculated from PWH living in Florida at year-end 2022 and represent the proportion of each race or mode of exposure group to the total PWH.

- These data are used to prevent further transmission of HIV for those already diagnosed with HIV by providing linkage to care and other services to improve health outcomes and viral suppression to those who need it.

Priority Prevention Populations for PWH
In 2022, Living in Miami-Dade County



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive.
Rounding may cause percentages to total more or less than 100.

HIV Testing

Everyone between the ages of 13 and 64 should get tested for HIV at least once. Persons at increased risk for HIV should get tested at least annually. Visit knowyourhivstatus.com for testing options in your area or to order a free at-home testing kit.

Florida law (section 384.31, Florida Statutes) requires all pregnant women to be tested for HIV and other STIs at their initial prenatal care visit, again at 28–32 weeks and at labor and delivery if their HIV status is unknown.

PrEP

PrEP medication, taken as directed, can reduce the risk of acquiring HIV through sexual contact by over 90% and through injection drug use by 70%. Condoms are still important during sex to prevent other STIs and unwanted pregnancy. STIs are increasing in Florida and can increase HIV risk. To find a PrEP provider who can help you decide if PrEP is right for you, visit preplocator.org.

Antiretroviral Therapy (ART)

For PWH, starting ART as soon as possible improves health outcomes and quality of life by reducing viral load and the risk of disease progression. People living with HIV who take antiretroviral medication as prescribed and achieve and maintain an undetectable viral load cannot transmit HIV to their sexual partners. ART is recommended for all PWH, regardless of how long they have had HIV or how well they feel. To find a care provider or to learn more about the resources available to PWH, visit floridaaids.org.

Florida HIV/AIDS Hotline

1-800-352-2437 English
1-800-545-7432 Spanish
1-800-243-7101 Haitian Creole
1-888-503-7118 Hearing/Speech Impaired
211bigbend.org/flhivaidshotline
Text ‘FLHIV’ or ‘flhiv’ to 898211

For more information, email
DiseaseControl@flhealth.gov

Some Useful Links

Department of Health HIV/AIDS Section
floridaaids.org

Department of Health, FLHeathCHARTS
FLHealthCHARTS.gov: Home

Ending the HIV Epidemic (EHE) Dashboard
https://www.flhealthcharts.gov/EHE/rdPage.aspx?rdReport=Overview

CDC HIV Surveillance Reports (State and Metro Data)
cdc.gov/hiv/library/reports/hiv-surveillance.html

CDC's Morbidity and Mortality Weekly Report (Special Articles on Diseases, Including HIV)
cdc.gov/mmwr

U.S. Census Data (Available by State and County)
census.gov

World Health Organization: who.int/data/gho/data/themes/hiv-aids

Florida HIV/AIDS Surveillance Data
Miami-Dade County Contact

Anthoni Llau
Florida Department of Health in
Miami-Dade County
Phone: 305-470-6984
Email: Anthoni.Llau@flhealth.gov

HIV/AIDS surveillance data are frozen on June 30 for the previous calendar year. These are the same data used for FLHealth CHARTS and all grant-related data.
flhealthcharts.com/charts/CommunicableDiseases/default.aspx

Department of Health

Thank you!

SERVICE DEMOGRAPHICS

SECTION 4

OTHER FUNDING AND DASH BOARD CARDS

SECTION 5

UNMET NEED

SECTION 6

HRSA SERVICE CATEGORIES

USING MAI FUNDS

SECTION 7

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

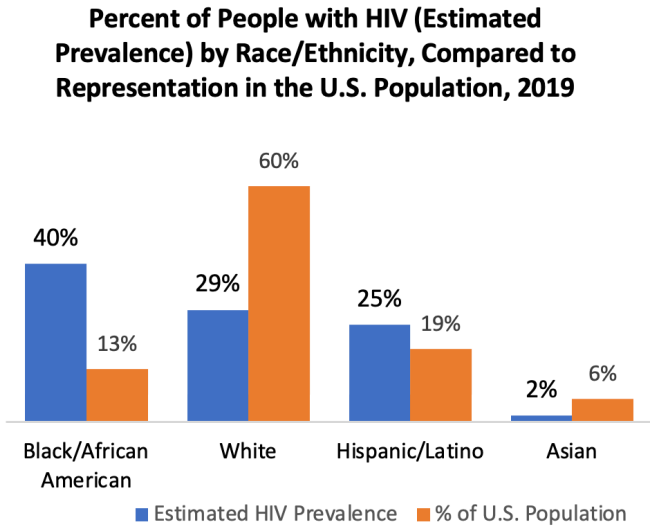
Several HHS agencies receive MAI funding, and each agency and each RWHAP Part uses funds differently. Use of funds under each RWHAP Part is summarized below. Expectations for other agencies are provided in Attachment A and may help PC/PBs in developing resource inventories covering other funding streams.

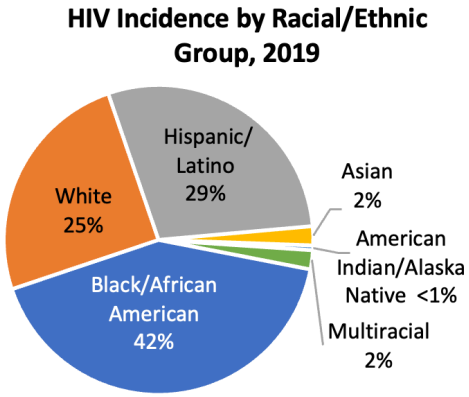
MAI funding under RWHAP is legislatively authorized, and the HIV/AIDS Bureau has specified allowable uses by Part: [4]

- **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]

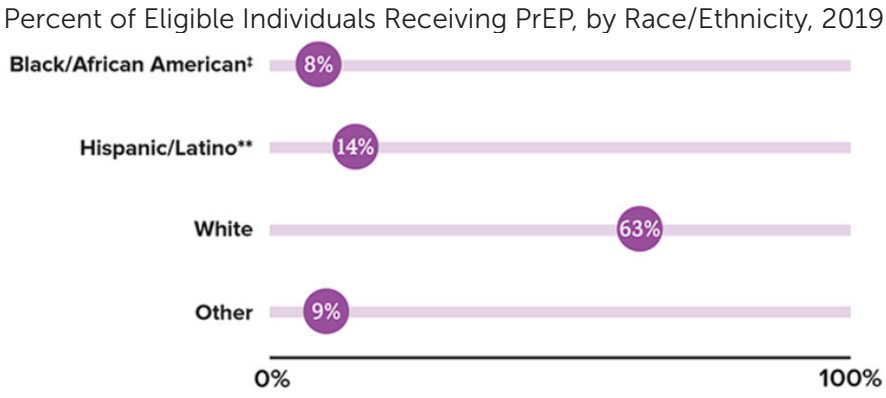




Source: CDC

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/

PRIORITIES, ALLOCATIONS, AND BUDGETS

SECTION 8

ADDITIONAL MATERIALS

SECTION 9

2024 HHS FEDERAL POVERTY GUIDELINES
Annual Income Ranges (Gross Household Income)
(approximate calculations)

(Effective March 1, 2024 through February 28, 2025 for Ryan White Part A & MAI Services in Miami-Dade County, FL)

Family Size	A 100-135%	B 136-150%	C 151-200%	D 201-250%	E 251-300%	F 301-400%	G ≥401%
1	< or equal to $15,060 - $20,481	$20,482 - $22,740	$22,741 - $30,270	$30,271 - $37,800	$37,801 - $45,330	$45,331 - $60,390	$60,391 +
2	< or equal to $20,440 - $27,797	$27,798 - $30,863	$30,864 - $41,083	$41,084 - $51,303	$51,304 - $61,523	$61,524 - $81,963	$81,964 +
3	< or equal to $25,820 - $35,114	$35,115 - $38,987	$38,988 - $51,897	$51,898 - $64,807	$64,808 - $77,717	$77,718 - $103,537	$103,538 +
4	< or equal to $31,200 - $42,431	$42,432 - $47,111	$47,112 - $62,711	$62,712 - $78,311	$78,312 - $93,911	$93,912 - $125,111	$125,112 +
5	< or equal to $36,580 - $49,748	$49,749 - $55,235	$55,236 - $73,525	$73,526 - $91,815	$91,816 - $110,105	$110,106 - $146,685	$146,686 +
6	< or equal to $41,960 - $57,065	$57,066 - $63,359	$63,360 - $84,339	$84,340 - $105,319	$105,320 - $126,299	$126,300 - $168,259	$168,260 +
7	< or equal to $47,340 - $64,381	$64,382 - $71,482	$71,483 - $95,152	$95,153 - $118,822	$118,823 - $142,492	$142,493 - $189,832	$189,833 +
8	< or equal to $52,720 - $71,698	$71,699 - $79,606	$79,607 - $105,966	$105,967 - $132,326	$132,327 - $158,686	$158,687 - $211,406	$211,407 +
+1	$5,380	$8,070	$10,760	$13,450	$16,140	$21,520	$21,574 +

SOURCE: HHS Poverty Guidelines for 2024. *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (Based on the table titled, "2024 Poverty Guidelines for the 48 Contiguous States and the District of Columbia")*

IMPORTANT NOTES:

1) Using the table above as a guide for families/households with more than eight (8) members, add $5,380 for EACH additional family/household member.

2) The Miami-Dade County Ryan White Program Provide® Enterprise Miami data management system will be programmed according to these guidelines, effective March 1, 2024 through February 28, 2025.

3) Income eligibility for the following Ryan White Part A and Minority AIDS Initiative (MAI) Program-funded services in Miami-Dade County is limited to program-eligible clients who have a gross household income at or below 400% of the Federal Poverty Level (FPL). The 400% FPL income limit applies to all locally-funded Ryan White Part A and MAI Program service categories.

4) **Please be advised that this document is simply an internal reference tool and the rounding calculations may be slightly off.** Percentage calculations in the table above are rounded to avoid gaps between whole number dollar amounts. The first number for each household size in column A is exact per the 2024 HHS Poverty Guidelines, as are the calculations in the Provide® Enterprise Miami data management system.

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AGENDA AND MINUTES

SECTION 10

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, May 9, 2024

10:00 a.m. – 1:00 p.m.

Care Resource Community Health Center, Midtown Miami
3510 Biscayne Blvd, 1st Floor, Community Room
Miami, FL 33137

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Rick Siclari
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of April 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• None	
IX.	New Business	
	• Planning Council Responsibilities and Needs Assessment **(Section 2)**	Marlen Meizoso
	• Setting Priorities and Allocating Resource Process (**Section 1**)	All
	• Miami-Dade HIV Epi Profile Data, 2022 (**Section 3**)	Dr. Robert Ladner
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **June 13, 2024** at **Care Resource**	Rick Siclari
XII.	Adjournment	Dr. Mary Jo Trepka

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

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

Care and Treatment Committee Meeting
Care Resource Health Care Center, Midtown Miami
3510 Biscayne Blvd, 3rd Floor Executive Board Room
Miami, FL 33137

April 11, 2024 Minutes

#	Committee Members	Present	Absent
1	Fils Aime, Louvens	X	
2	Henriquez, Maria	X	
3	Mills, Vanessa	X	
4	Siclari, Rick	X	
5	Shmuels, Daniel		X
6	Shmuels, Diego		X
7	Trepka, Mary Jo	X	
8	Wall, Dan	X	
Quorum: 4			

Guests	
Brooks, Jimmie	
Fernandez, Chad	
Gonzalez, Tivisay	
Ingram, Trillion	
Leiva, German	
Kratofil, Keri	
Poblete, Karen	
Staff	
Hilton, Karen	Meizoso, Marlen
Ladner, Robert	

All documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at https://aidsnet.org/the-partnership#caretreatment2.

I. Call to Order *Dr. Mary Jo Trepka*

Dr. Mary Jo Trepka, the Chair, called the meeting to order at 10:18 a.m.

II. Introductions *Dr. Mary Jo Trepka*

Members, guests, and staff introduced themselves.

III. Meeting Housekeeping *Marlen Meizoso*

Marlen Meizoso reviewed the meeting housekeeping presentation.

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 that was distributed and posted in advance of the meeting. Rick Siclari was not present yet so any item with his name should be changed to Dr. Mary Jo Trepka until he arrives.

Motion to accept the agenda, with the change as noted.
Moved: Dan Wall **Seconded: Vanessa Mills** **Motion: Passed**

VI. Review/Approve Minutes of March 14, 2024 *All*

The committee reviewed the minutes of March 14, 2024, and approved it as presented.

Motion to accept the minutes from March 14, 2024, as presented.
Moved: Louvens Aime **Seconded: Dan Wall** **Motion: Passed**

VII. Reports

- *Part A* *Dan Wall*

Dan Wall reviewed Ryan White Program (RWP) expenditures and clients served to date. As of the latest FY 2023 yearend report, the RWP has served 9,060 unduplicated clients, including 1,591 Minority AIDS Initiative (MAI) clients. This is more than last year's total. Final payments are still being processed. Part A has expended 87% of funds and MAI has expended 56% of funds. Some carryover is expected after all expenditures are reconciled, although this will be less than it has been in past years.

The Recipient has received the HRSA site visit report for the January 2024 visit. Some findings and recommendations include that Partnership membership does not reflect the epidemic (as reflected in FDOH epidemiology data); concerns about billable service activity related to training; the need for the Recipient to develop a more detailed grievance procedure; the need for planning council involvement in planning council staff support budgets; and the need for faster contract execution. Some improvement options were offered. HRSA complemented the data visualization provided by BSR CQM, the positive relationships reported between subrecipient providers and the Recipient, the dedicated Recipient and BSR staff, and the exceptional planning council website. The Recipient has 30 days to reply to the report.

Test and Treat/Rapid Access has enrolled 704 clients since the last report.

The Recipient attended an Ending the HIV Epidemic conference. The Recipient is working with the Quick Connect provider to establish a partnership with FDOH and the Gilead Frontlines of Communities in the United States (FOCUS) Program to station a linkage specialist at two Jackson

locations and the Baptist emergency room. There will also be an expanded media and an outreach campaign focusing on Liberty City and the Beach, concentrating on MSM of color between 18-39 years of age. In addition, a smart phone app called "Positive Peers" will be made available.

A member indicated that some clients are being fraudulently enrolled in Affordable Care Act insurance plans. Clients and/or medical case managers who encounter these fraudulent enrollments are advised to contact the state insurance commissioner.

- *Vacancies* *Marlen Meizoso*

Mrs. Meizoso reviewed the vacancy report as of April. There are vacancies on all Committees and the Partnership. Currently there are eight vacancies in Care and Treatment. If anyone knows of candidates who may be interested in the work of the Committee, staff encourages these persons to be invited to a Committee meeting or training, or be directed to staff for further information.

There are two applicants for the Committee, Tivisay Gonzalez and German Leiva. Both applicants introduced themselves and expressed their interest in joining the Committee.

Motion to recommend Tivisay Gonzalez and German Leiva as members of the Care and Treatment Committee.
Moved: Dan Wall **Seconded: Vanessa Mills** **Motion: Passed**

VIII. Standing Business

- *Service Definition Development Continued* *All*

The Committee reviewed the April version of the Service Definitions Development document. Of the five original services, only three remained, which were addressed as indicated below.

Psychosocial Support

Staff presented a revised service definition, based on the discussion at the last meeting. Areas of specific concern were highlighted and reviewed. The Committee recommended the following:

- Delete "reimbursement will be provided at a flat rate" because the Service Description states elsewhere that the Recipient will set the reimbursement rates;
- Add "(individual client counseling only)" …to client progress; and
- Strike the rest of the sentence, "and …supervisor as applicable".

The Committee made no additional recommended changes and made a motion to accept the document with the changes noted.

Motion to approve the Psychosocial Service Definition as amended.
Moved: Dan Wall **Seconded: German Leiva** **Motion: Passed**

Housing

Staff had drafted a model Housing Service Definition based on the Ending the HIV Epidemic (EHE) Housing Services description and the HRSA Policy Clarification Notice (PCN) #16-02 which was discussed and reviewed at the last meeting. Members clarified the definition of participation in other housing assistance programs ("receiving assistance from"), and with no other changes to the document, the Committee moved to accept the Housing Service Definition as amended.

Motion to approve the Housing Service Definition as amended.
Moved: Dan Wall **Seconded: German Leiva** **Motion: Passed**

Non-Medical Case Management

The Committee discussed Non-Medical Case Management Service Definition and reviewed an updated infographic of the difference between medical and non-medical case management functions when Peers are employed. HRSA wants non-medical case management available at non-traditional sites, and will not accept this service as an expanded Peer activity. Billing data for various activities for peers and medical case managers were reviewed. While the parameters provided under non-medical case management under PCN #16-02 seem to duplicate most of the services provided under medical case management, except for adherence counseling, if clients have the option to select to see either a medical or non-medical case management this would eliminate the duplication because they would select one or the other. HRSA had indicated that for clients who are virally suppressed, they would not need go to a medical case manager when that level of services is not warranted.

Motion to adopt the HRSA PCN#16-02 definition on the Service Definition Development document as the service definition for Non-Medical Case Management.
Moved: Dan Wall **Seconded: Rick Siclari** **Motion: Passed**

Bundling

The Committee considered a final clarification of the configuration of the required bundling of Outpatient/Ambulatory Health Services (OAHS) with Medical Case Management (MCM) and Mental Health (MH). Based on prior discussions, staff provided an infographic of all case management-related and mental health-related services that could be bundled with OAHS. The Committee indicated they also wanted to include Medical Transportation with Medical Case Management, which is the current active bundle. The Committee did not want to add Psychosocial Support and Non-Medical Case Management to allow for nontraditional providers to apply for the next RFP. The Committee moved to add Medical Transportation as part of the new bundle. Although Medical Transportation and Mental Health Services are required elements of the OAHS bundle, they may be offered independently as well.

Motion to add Medical Transportation to the upcoming RFP bundle of Outpatient Ambulatory Health Services with Medical Case Management and Mental Health Services.
Moved: Dan Wall **Seconded: Rick Siclari** **Motion: Passed**

Since the meeting end time was near, the Committee made a motion to extend the meeting by 15

minutes.

Motion to extend the meeting by 15 minutes.
Moved: Vanessa Mills **Seconded: Maria Henriquez** **Motion: Passed**

IX. New Business

- *IDEA Exchange: T-Sharp Study* *All*

Chad Fernandez and Jimmie Brooks provided a presentation on the T-Sharp Study being conducted by the IDEA Exchange. The IDEA Exchange offers status-neutral syringe exchange services to persons who inject drugs, in a non-stigmatizing setting, as a harm reduction outreach activity. Contact information was also shared for any providers who wish to refer clients to the study.

X. Announcements and Open Discussion *All*

Mrs. Meizoso announced the Needs Assessment starts next month and is scheduled through August. This year it may extend into September and must conclude by October.

HRSA and CDC have issued a "Dear Colleague" letter announcing the rise of congenital syphilis. Attendees were asked to share the letter widely. It will also be shared with the Medical Care Subcommittee.

XI. Next Meeting *Rick Siclari*

The next meeting is scheduled for Thursday, May 9, 2024, at Care Resource from 10:00 a.m. to 1:00 p.m.

XII. Adjournment *Dr. Mary Jo Trepka*

With business concluded, Dr. Trepka thanked Care Resource for their hospitality, members for their work at today's meeting, and adjourned the meeting at 12:14 p.m.