Central Florida HIV Planning Council

Planning Council Business Meeting Minutes

March 30, 2022

Call to Order: The Sr. Co-Chair, Gabriella Rodriguez called the meeting to order at 6:02 p.m. at the Courtyard by Marriott Downtown located at 730 N. Magnolia Ave., Orlando, FL. 32803

Members Present: Gabriella Rodriguez, Tim Collins, Vel Cline, Priscilla Torres, Bryan Dubac, Ira Westbrook, Alelia Munroe, Andres Acosta, Angela Hunt, Ida Starks, Keith Tremain via teleconference, Willie Beasley via teleconference, Flora Kavitch via teleconference, Grisela Hernandez via teleconference, Charlie Wright via teleconference, Kim Murphy via teleconference, Vickie Cobb-Lucien via teleconference.

Members Excused: Sam Graper, Jessica Seidita, Jermaine Malone

Absent: Jordan Almazan, Mike Alonso

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<td>Approval of the agenda:</td>
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The Planning Council reviewed the agenda and made the following updates:

Replaced Mr. Beasley’s name with Ms. Rodriguez’s name for the Vision Statement, Mission Statement, Conflict of Interest, Core Values and Group Agreement.
Replaced Ms. Seidita’s name with Planning Council Support for the Integrated Plan Ad hoc Committee report.
Replaced Ms. Yabrudy’s name with Ms. Bastien’s name for the Part A Monthly Expenditure Report.

Motion: Mr. Collins made a motion to approve the agenda with the updates. Ms. Buckley seconded the motion.
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<tr><th>In Favor</th><th>Against</th><th>Abstention</th></tr>
<tr><td>14</td><td>0</td><td>0</td></tr>
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The March agenda was approved by a unanimous roll call vote.

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<td>Approval of the February 23rd Minutes:</td>
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The Planning Council reviewed the February 23rd minutes and made the following update:

Changed the percentage of unconflicted members from 4% to 40% under the Membership & PR Marketing Committee report.

Motion: Mr. Cline made a motion to approve the minutes with the updated. Ms. Hunt seconded the motion.
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<tr><td>In Favor</td><td>Against</td><td>Abstention</td></tr>
<tr><td>15</td><td>0</td><td>0</td></tr>
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The February 23rd minutes were approved by a unanimous roll call vote.

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<td>Open the Floor for Public Comment:</td>
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There were no public comments.

Comment Cards:

Planning Council Support did not receive any comment cards.

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<td>Reports:</td>
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Membership and PR & Marketing Committee Meeting:

The committee discussed the membership matrix, PC reflectiveness, and committee roster. There are currently 23 Planning Council members, 13 (57%) that are PWH and 9 (39%) unconflicted members.
The committee reviewed the Central Florida HIV Planning council social media account insights for Facebook and Instagram.
The committee reviewed and approved one applicant summary to move forward with the interview process.
The committee voted on whether to stay together or unmerge their combined committee for the remainder of the planning cycle.

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	• **Service Systems & Quality and Needs Assessment & Planning Committee Meeting:** • The committee received an overview of the Part A Monthly Expenditure report, Part B Monthly Utilization report and overview from the Clinical Quality Management Workgroup update. • The committee received an overview of activities from the February 14th Integrated Plan Ad hoc Committee meeting. • The committee voted on whether to unmerge their combined committee for the remainder of the planning cycle. • The committee received a mini training on developing effective surveys and provided feedback on ways to maximize the return of the completed HIV Care Needs Surveys. • **Integrated Plan Ad Hoc Committee Meeting:** • The participants received an overview of the Town Hall meeting held on March 15th, 2022, including a review of the demographics of individuals that attended, common responses, and draft of the report that will be submitted to the Florida Comprehensive Planning Network (FCPN). • The participants also reviewed the Area 7 Resource inventory from the FCPN. • The participants started the planning process for the next community engagement event which will be a Town Hall for OSA case managers to express what their barriers are to providing quality car RWHAP clients. • **Town hall Report:** Ms. Marshall reviewed the following summary of responses from the townhall meeting:

	• From your observations and experiences, what are the two or three major problems in the system of care as it related to HIV prevention and care? • Most responses to this question made clear that gaps in transportation, housing, and limitations in service delivery continue to create challenges for the system of HIV prevention and care. Several participants agreed that when they are given referrals to services, it is common for the contact numbers and providers to no longer be in service. In addition, some individuals, such as those experiencing homelessness, are particularly challenged when given a resource list that requires telephone access. Another major concern identified is that there are other service needs that are not covered by Ryan White programs. • What are the barriers to engaging the community? • Most respondents agreed that a lack of or poor communication creates the most significant barriers to engaging the community. Several expressed frustrations with experiencing long wait times to receive a response from a case manager as well as having limited opportunities to provide feedback about the services they receive. These challenges create feelings of disengagement among PWH and beliefs that providers lack empathy or compassion for the community they are expected to serve. Several responses highlighted the need for improving communication between providers and clients that is non-judgmental and inclusive of unique lived experiences, suggesting that the system of care can benefit from increasing capacity for trauma-informed, destigmatizing, and harm reduction approaches to care. Similarly, providers also emphasized there are limited opportunities available to provide input on how to address barriers to care.

	• What are the barriers to starting and staying in care? • Folks with unstable housing need a safe place to keep HIV medication • The availability of services varies by area. Lack of consistency in how services are provided from agency to agency. (Ex. Peer Support and Transportation) • Getting other agencies that are not HIV service providers to partner with HIV provider • A lack of social support services for PWH • No assistance for services outside of HIV care • A lack of complimentary services for mental health. Mental health services are not readily available when someone is in need and individuals must wait to receive care. • Dental services are limited and not prioritized for HIV treatment (Dental is seen as a wraparound service) • Being constantly sent to other numbers when calling for help. No one picks up or addresses the issue. Two years without dental services. • Lack of rapid-start programs • Transportation/ability to go to appointments. • What are some solutions to consider in reducing barriers? • Opportunity for medication lockers for folks with unstable housing to have a safe place to put their belongings (specifically their HIV medications), like Amazon drop boxes. • Create and support drop-in centers (for wraparound services). Having other complimentary services (computer and phone access) available at RW provider offices. • A program to ensure that phone numbers for clients to call are updated. This is essential for clients experiencing homelessness, those who do not have

	access to technology/internet to look up services themselves. A centralized resource center for HIV related resources is needed (like 211 for HIV). • Advertise to the community, what services are available to them, how they can get into care. How do we get that information out to people who are not already aware of what is going on in the HIV community? (Suggestion: ads in community centers and gyms) • Improve communication about the entire network of providers – there are a lot of options for people who need care. Create a centralized resource hub and include non-Ryan White providers assisting with HIV treatment, PrEP, and testing. Helps clients not feel stuck with their providers if their needs are not being met. • Community education • HIV health education and services for youth (even if services cannot be provided on campus) • People over pathology: Advocacy groups, voter registration initiatives, engaging faith-based organizations, and businesses. Having more people outside of HIV at the planning table. • Intersectionality • Organizations need to hire more people with lived experiences vs. education, especially for peer support. Consider HIV workforce capacity for the system. • Consider working with providers to improve their connections with the community – get case managers out into the field to ensure they are responsive to the needs of PWH. • Representatives from Tallahassee attending meetings. Getting elected officials to be present at meetings, such as town halls. • Services and appointments on weekends and application assistance

	• What do you think is the most important factor in addressing the HIV epidemic in your community? • *Note: Due to time constraints, this question was not addressed because participants answered it indirectly in the previous questions.* • Online responses included: education on access to care and pharmaceuticals, to encourage testing, education on available programs, fostering intra-community dialogue about HIV, education on prevention, and addressing issues with transportation. • Do you believe the community has a role or any responsibility in HIV prevention and care? • If yes, what do you consider to be the role of the community in HIV prevention/care? • If no, why don't you think the community has a responsibility in HIV prevention/care? • *Note: Due to time constraints, this question was not addressed because participants answered it indirectly in the previous questions.* • Twenty-five respondents online answered "yes" and 1 answered "no". There was no further explanation for why the participants answered this way. • Do you believe the community has a role or any responsibility in HIV prevention and care? • If yes, what do you consider to be the role of the community in HIV prevention/care? • If no, why don't you think the community has a responsibility in HIV prevention/care? • *Note: Due to time constraints, this question was not addressed because participants answered it indirectly in the previous questions.*

	• Twenty-five respondents online answered “yes” and 1 answered “no”. There was no further explanation for why the participants answered this way. • • What are some activities from the last integrated plan that we should consider including in the new plan? • More support and funding for grassroots and community-led interventions (EHE) • More peer support available • Health clinics in hospitals (serving PWH) • Training on respect/customer service for case management • Reducing stigma • Increase knowledge and availability for HIV services • Increase access to care and improve health outcomes for PWH • Increase funding for specific programs • Increase community field work • Extend education on PrEP and continue the expansion of new medications and services • Provider cultural competency programs • Integrated plan written in patient accessible language • More testing available (mobile testing) • Not in plan: educational fundraisers to help prevent stigma • **Part A Monthly Expenditure Report:** • **(Expenditures as of January 31, 2022)** • Ms. Bastien reported the following: • Target: 92.23% • Actual: 78.83% • Dif: 13.40%

	Part B Monthly Expenditure Report: (Expenditures as of January 31, 2022) • Ms. Andre reported the following: • Target:83% • Actual: 75% • Dif: 8% • **Clinical Quality Management Workgroup Report:** Ms. Andre reported the following: • **Brevard 4th Quarter & 2021 Annual Performance Measures Data:** Part A EMA data was not available at the time of this report and will be shared at a later date. Ms. Mendoza-Cardenal presented Brevard data for the fourth quarter core measures. The fourth quarter ended at the end of calendar year 2021 and therefore represents the annual data for 2021. Despite fluctuations in the data throughout each quarter, there was an increase to overall viral load suppression in Brevard from 83% to 86%, bringing the total percentage consistent with 2020 and 2019 levels. The percentage of clients prescribed ART decreased from 100% to 97% in the last quarter, however, this represents an increase overall from 89% in 2020. Annual Retention decreased to 65% in the fourth quarter, which is also a two-point decrease overall from 67% in 2020. All three OAHS core measures fell short of the proposed targets for 2021, although Prescribed ART came within one point of the target 98%. Viral Load Suppression of MCM clients increased to 82.6% in the fourth quarter, just shy of the target 83.5% for 2021. Annual Retention in MCM decreased to 59.7% in the last quarter, but still exceeded the annual target of 53.4% overall. Viral Load Suppression of local pharmacy (LPAP) services increased to 90%, exceeding the annual target of 87.3%. Viral Load Suppression of clients receiving Non-Medical Case Management increased in

	the last quarter to 85.9%, although this is still below the annual target of 86.3%. Annual Retention of Non-Medical Case Management showed a decrease in the last quarter to 65.6%, but this is still above the annual target for 2021 of 56.2%. • **Brevard 4th Quarter Viral Suppression Rate Disparities Report**: Part A EMA data was not available at the time of this report and will be shared at a later date. Ms. Mendoza-Cardenal presented data for the fourth quarter viral load suppression disparities in Brevard County. System-wide Viral Load Suppression for Brevard increased to 86.1% in the final quarter, representing just under a one-point increase since 2020. All age groups saw an increase to VLS in the final quarter except among clients 25-34 years and 55-64 years. These age groups both saw a decrease overall since 2020 at –4.6% for 25-34 years and –2.94% for 45-54 years. 19–24-year-olds saw the greatest increase since 2020 by 15.38 points. By gender, both male and female clients saw increases from 2020 to 2021 by 1.65% and 0.12%, respectively. Transgender clients saw a 10% decrease from 2020 to 50%, however, this is affected by small shifts in the denominator. By race and ethnicity, Black and Latinx clients saw an increase to VLS at 82.65% and 92.66%, respectively. White and Other/Unknown saw a decrease in VLS to 87.13% and 88.24%, with the greatest drop happening among Other/Unknown clients by almost 12 percentage points. By ECHO disparity subpopulations, African American/Latina Women showed a slight VLS decrease of less than a percentage point to 84.82%, while MSM of Color and Youth (13-24) saw significant increases in VLS by ten points and 12.8 points respectively. However, Youth (76.92%) and Transgender (50%) clients still see the greatest disparities in VLS. When looking at housing status, there was no change in VLS among those with non-permanent housing at 100%. Those

	with stable and temporary housing saw increases to 87.3% and 63.64%, respectively. While unstably housed clients showed a decrease from the previous quarter, this is still a 1.59% increase from 2020. By risk factor, the groups that saw an increase in VLS were MMSC (88.52%), PWID (87.69%), and MMSC/PWID (80%). Perinatal and Transfusion risk groups saw decreases in VLS, with the largest being among Perinatally acquired infection (12.5% decrease). VLS among Hemophilia and Other risk factor individuals remained the same at 100%. All HIV status groups saw an increase in VLS from the previous quarter, however, VLS for the HIV+ Not AIDS group (86.26%) represented a decrease in VLS from 2020 by approximately 1 percent. Although several insurance type groups saw an increase in VLS from the previous quarter, most still experienced a decrease in VLS from 2020. The largest decreases were among those with No Insurance (-6.19%), Medicare (-3.61%), and Private Insurance (-13.68%). VLS among clients with VA insurance increased by 33.33 points to 66.67% and Other remained the same at 100%, although this is a 15-point increase from 2020. VLS by FPL saw increases to those with FPLs at or below 300% in the final quarter. VLS for those between 301 to 400% FPL decreased to 94.23% from 100% in the previous quarter. Since 2020, those at or below 100% FPL and between 201-300% saw increases by 2.6 and 1.47 points, respectively. Those with FPL between 101 and 200 decreased (-2.81%) as did those with FPL between 301 and 400% (-3.63%) since 2020. Ms. Seidita asked about the sum of the denominators in certain disparity groups exceeding the denominator for the system wide VLS of 777, as is the case for Insurance Type. It was determined that this is true for certain disparity groups like Insurance Type where a client may have more than one type of insurance recorded in the system, like Medicaid and Medicare or Medicare and

	Private (ADAP). This would account for a higher denominator than the 777 clients measured by Core VLS. • **Complete Annual Organizational Assessment:** Ms. Andre presented the annual organizational assessment for review by the committee. Ms. Bastien and Ms. Andre reported that both Parts A and B were in development of agency and staff recognition & incentive programs; Ms. Andre proposed soliciting feedback from Part B agency staff through monthly networking meetings (referenced in A.1., B.1., C.1., C.2., and D.1.). Regarding the following unmet goals (A.1. score 5, "Review the results of quality of care data at the subrecipient level when making programmatic and financial funding decisions.; Consider the quality of care at the subrecipient level when making programmatic and financial funding decisions"), Dr. Baker-Hargrove provided insight that other HRSA agencies are moving to a value-for-service system rather than a fee-for-service system. Ms. Bastien reported that Part A has included a quality management provision in their Request for Proposals (A.1., C.1.). Regarding the following unmet goal (B.1. score four, "A culture of quality is in evidence by the nature of diverse QI projects that are posted in common areas for review") Ms. Seidita suggested that QI projects be publicized in the Central Florida HIV Planning Council's Red Ribbon Times; Ms. Andre and Ms. Mendoza-Cardenal will coordinate with the Planning Council Support office. There was a discussion around B.1. score five in which Ms. Seidita requested that lead agencies provide subrecipients with support in developing accessible QI training; Ms. Andre agreed to develop a list of topics. Dr. Baker-Hargrove inquired about how QI principles were currently being disseminated to staff by the lead agency; Ms. Mendoza-Cardenal responded that standardization training was being held during monthly networking

	meetings. Ms. Seidita suggested identifying primary QI staff at each agency and offering targeted training going reviewing performance measures and data flow. Regarding the following unmet goal (D.1. score five, “Comparison to larger aggregate data set is used to set OSA programmatic targets and targets are met for at least 75% of measures”), Ms. Seidita recommended using Brevard and OSA data as two separate sets and comparing each set to state data in order to reach this goal. Ms. Andre reported that the Part B Lead Agency will develop educational seminars and training to provide subrecipients in order to satisfy G.2. score five. • Ms. Buckley recommended that future reports be broken down into easy-to-read graphs instead of a summary format.
New Business:	**Quorum Resolution:** • The Planning Council reviewed the 2021-22 quorum resolution for the Executive Committee and Planning Council that expires at the end of the month. The Planning Council the discussed pros & cons of extending the resolution until the end of the planning cycle. After much discussion, the Planning Council decided that quorum resolution should remain in place until the end of the planning cycle. Motion: Mr. Acosta made a motion for the quorum resolution to remain in place for the Executive Committee and the Planning Council until September. Ms. Buckley seconded the motion. **Friendly Amendment:** • Ms. Munroe made a friendly amendment to change the language of the motion to say that quorum the resolution should stay in place until September 30, 2022. Ms. Rodriguez restated the motion with the friendly amendment.

In Favor	Against	Abstention
14	0	0

The motion for the quorum resolution to remain in place for the Executive Committee and Planning Council until September 30, 2022, was approved by a unanimous roll call vote.

Letter of Support Policy & Procedure:

- The Planning Council reviewed and updated the Letter of Support Policy and Procedure. After a brief discussion, the committee decided to approve the policy & procedure with the updates.

Motion: Mr. Cline made a motion to approve the Letters of Support Policy & Procedure with the updates. Mr. Collins seconded the motion.

In Favor	Against	Abstention
14	0	0

The motion to approve the Letter of Support Policy & Procedure was approved by a unanimous roll call vote.

Review of Policies & Procedures:

- The Planning Council reviewed the new Review of Policies and Procedures P&P. After a brief discussion, the committee decided to approve the policy & procedure with addition of the letter of support verbiage.

Motion: Ms. Buckley made a motion to approve the Review of the Policies and Procedure P & P. Ms. Hunt seconded the motion.

In Favor	Against	Abstention
13	0	0

	The motion to approve the Review of Policies and Procedures P&P was approved by a unanimous roll call vote.
ACTION ITEMS	
Item	
Next Meeting	Wednesday, April 27, 2022
Adjournment:	7: 45 p.m.

Prepared by: David Bent Date: 4/1/2022

Approved by: [signature] Date: 4/27/22