Wednesday, November 1, 2017
Ken Bargar, Prevention Community Co-Chair, Jim Roth, Department of Health Prevention Co-Chair, Kim Saiswick, Patient Care Community Co-Chair, and Kira Villamizar, Department of Health Patient Co-Chair, facilitated the meeting.

The meeting was called to order at 1:03 PM by Kira Villamizar. Roll Call was conducted by Ken Bargar and quorum was established. Community members and guests introduced themselves.

Ken Bargar requested a moment of silence for all those who have been affected by HIV/AIDS.

Kim Saiswick reviewed the content of the meeting packets.

The action items from the May 2017 Combined Patient Care and Prevention Planning Group Meeting were reviewed and discussed.

Bylaws Review and Approval
David Brakebill and Valerie Mincey, Co-Chairs, PCPPG Membership, Nominations, and Bylaws Committee
The revised Patient Care and Prevention Planning Group Bylaws were presented to the group.

*Ken Bargar motioned to approve the revised Bylaws and Steve Hoke seconded the motion. Motion approved unanimously.*

The AIDS Institute will update the Bylaws with the approved changes and distribute to the members.

HIV/AIDS Section Update
Laura Reeves, HIV/AIDS Section Administrator
Laura began by sharing the revised language for Florida’s Plan to Eliminate HIV Transmission and Reduced HIV-related Deaths (4-Key Components)

1. Implement routine HIV and Sexually Transmitted Infection (STI) screening in health care settings and priority testing in non-health care settings
2. Provide rapid access to treatment and ensure retention in care (Test and Treat)
3. Improve access to antiretroviral pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP)
4. Increase HIV awareness and community response through outreach, engagement, and messaging

The group agreed that the minor revisions to the language increased clarity for the 4-Key Component Plan.

Laura provided an overview of the Department of Health’s HIV/AIDS Budget

- **Ryan White – Florida Funding GY 2017-2018**
  - Part B - $120,790,979
  - Housing opportunities for persons with AIDS (HOPWA) - $6,287,570
  - Total - $127,078,549

- **Centers for Disease Control & Prevention (CDC) – Florida Funding GY 2017-2018**
  - Prevention - $34,948,461
  - Surveillance - $6,126,385
  - Total - $40,540,966

- **State Funding (FY 2017-2018)**
  - Prevention and Surveillance
  - Patient Care (Program and Pharmacy) - $33,357,660
  - Total - $36,150,728
Q: Do any of these figures include hepatitis dollars?
A: No, however, anything that we fund that his hepatitis related such as drugs on the ADAP formulary, hepatitis laboratories, etc. is included.
Q: In the future can we see the State General Revenue dollars related to hepatitis and the amount that the HIV/AIDS Program is “subsidizing” hepatitis testing and treatment for those that are co-infected?
A: Yes. Tom Bendle is presenting tomorrow and he will have some of that information.
Q: What portion of the Part B dollars are earmarked for ADAP?
A: Approximately $88 million of the $120 million is ADAP.

The group requested that the Part B dollars be broken down by category for future presentations.

<table>
<thead>
<tr>
<th>HIV Patient Care Resources</th>
<th>Funding</th>
<th>GY 12</th>
<th>GY 13</th>
<th>GY 14</th>
<th>GY 15</th>
<th>GY 16</th>
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<tr>
<td>Total Amount of rebates received</td>
<td>$ 6,227,664</td>
<td>$ 13,264,426</td>
<td>$ 25,619,603</td>
<td>$ 33,661,651</td>
<td>$ 45,915,457</td>
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<td>Federal Award received</td>
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<td>$120,241,487</td>
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<td>Total unexpended from rebates</td>
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<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 40,119,003</td>
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<td>Total unexpended from federal award</td>
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<td>$ 825,445</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 40,119,003</td>
<td>$ -</td>
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*As of 10/30/2017

The State is required to spend down all rebate dollars before they can draw on their federal award. The legislature has granted the HIV/AIDS Section spending authority over an additional $37 million in rebate dollars.

$50 million is the maximum amount of rebate dollars that Florida can recoup. Moving forward, budget plans will forecast this maximum dollar amount. The HIV/AIDS Section will not seek proposals from the local areas.

One of the challenges of spending rebate dollars is that funds are not received right away and sometimes cross over grant years. Funds must be spent in the year they are received but if they are received late in the grant year, there is the ability to roll-over rebate dollars to the next grant year.

Q: Are you looking at the local level to distribute some of these funds to contracted partners?
A: There are some challenges. We would like to increase funding but if the non-DOH contractor was secured through a request for proposals (RFP) their contract cannot be increased with rebate dollars. The money would have to go to a lead agency and who could in turn contract with local providers. Since nine county health departments (CHDs) currently serve as lead agencies, it is going to appear that the money is staying within the Department of Health but that really isn’t the case. We are encouraging CHDs to work with local providers.

Q: We have asked for goals and expectations for all the lead agencies including the CHDs. To date, I am not aware that they have been established. There is too much variability at the local level. At what point does the community say what they need in order to keep clients in care and undetectable?
A: We are currently required by the legislature to do an evaluation of the Patient Care delivery system. They were specifically interested in the methodology and where we were giving money to and how that aligned with the epidemic. That is due at the beginning of December. By June 30 we will have a total evaluation of the Patient Care system by Germane Solutions. Hopefully we will have some findings at the next face-to-face meeting.
Q: Since you won’t be requesting proposals moving forward, does that mean you have a plan for spending the $50 million each year?
A: We will still work with our local planning areas and lead agencies to determine what the local needs are. Depending on what happens with insurance premiums and our application for $11 million in relief funds, we estimate that $32 million of the $50 million will be needed to support ADAP. Added positions to the county health departments to work in the community (linkage coordinators, peer navigators, and perinatal coordinators) will expend $8 million annually. $10 million will remain.

The ADAP Rebate Spending Plan was shared with the group including a list of sample activities that were funded:
1. Pharmaceuticals and other associated Pharmacy Costs - $43 million planned
2. County Health Department Services - $15.8 million planned
   - Increased Staffing
     - Linkage to Care Specialists
     - Peer Navigators
     - Perinatal Navigators
     - Enhance Test and Treat Initiatives – staff, pharmaceuticals, telehealth
     - Increase Housing Placement
3. State Health Department Services - $23 million planned
   - ADAP Insurance Premiums
   - Laboratory Costs for Hepatitis and Genotype Testing
   - Increased Patient Care Services
   - Regional or Topic Specific Minority Events
   - Clinician Educational Materials
   - Patient Care System Evaluation
   - Statewide Meetings – Lead Agency, Case Managers
     - The Lead Agency Meeting will be held December 5-7, 2017 in Tampa and the Case Managers Meeting is tentatively scheduled for January or February 2018.
   - Staffing
     - Fiscal Auditor for Lead Agencies
     - Surveillance and Data Management
     - Community Programs, ADAP, Clinical Quality Management and Budget

Q: Are there plans to provide education to community medical providers on Ryan White funding?
A: The HIV/AIDS Section recently had a request for proposals (RFP) on this subject. HIV/AIDS Section Administration will check on the status of the award and report back to the group.

Laura announced that a new Performance Management Unit has been created. It will be staffed by a Clinical Quality Manager, the newly hired Performance and Quality Manager - Brandi Knight, and Tamara McElroy.

Q: One key element is missing: external stakeholder's evaluation of Lead Agencies.
A: Partner evaluation is important. There is a tool to measure partner performance and Brandi Knight will be working on those types of projects.

2016 Data Review
Lorene Maddox, MPH, Surveillance Data Analysis Manager
Lorene provided a review of 2016 HIV-related data. Caveats for interpreting the data included the following:
- HIV cases by year of diagnosis represent HIV cases diagnosed in that year, regardless of AIDS status at time of diagnosis
- AIDS and HIV Cases by year of diagnosis are not mutually exclusive and cannot be added together
- HIV prevalence data represent persons who were living with a diagnosis of HIV in the reporting area through the end of the calendar year (regardless of where they were diagnosed)
- Adult cases represent ages 13 and older; pediatric cases are those under the age of 13. For data by year, the age is by age of diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis
• Unless otherwise noted, Whites are non-Hispanic, Blacks are non-Hispanic and Other (which may be omitted in some graphs due to small numbers) represents Asian, American Indian, or mixed races
• Unless otherwise noted, area and county data will exclude Department of Corrections cases

Key Findings
• In 2015, Florida had an HIV case rate of 24.0 per 100,000 people. Florida ranked the second highest among states with only Louisiana having higher rates. The US average case rate of 12.3 per 100,000 people. Miami and Fort. Lauderdale, take the top two rankings for metropolitan statistical areas with case rates of 51.2 and 34.8 respectively.
• In 2016, 367,812 HIV tests were administered with a 1.0% seropositivity rate.
• Trends over the past 10 years (2007-2016)
  o Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak of HIV cases in 2007. This was followed by a general decline in diagnosed cases through 2013.
  o Overall HIV case rates have decreased by 23%. However, there has been an 8% increase over the past three years.
  o An increase in new HIV cases, primarily among white and Hispanic MSM, has been observed since 2014.
  o The same Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 also led to an artificial peak of AIDS cases in 2008.
  o Since 2008, there has been a general decline in diagnosed AIDS cases over the past ten years. Another surge in the expansion of ELR in 2012 was followed by another increase in AIDS cases in 2013. AIDS cases have decreased by 2% over the past three years (2014-2016). Expanded efforts to link people and retain people in care may be a contributor to this decrease.
  o The results show there has been a decline in perinatally acquired HIV births in Florida from 109 cases in 1993, to 8 cases in 2016 (93% reduction). There are various initiatives and resources in place that have allowed for this decrease by further educating local providers in the importance of testing pregnant women for HIV and then offering effective treatment during the pregnancy and at delivery to further decrease the chances of transmission.
  o In 2016, the case rate was 46.4 per 100,000 males in Florida compared to a rate of 61.1 in 2007. Over the past ten years, the rate of HIV cases has decreased among females more quickly than rates have decreased among males. The result is an increase in the male-to-female rate ratio, from 2.7:1 in 2007 to 3.8:1 in 2016. The relative increase in male HIV cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM).
  o Over the past ten years, HIV Cases decreased among blacks by 30% and among whites by 40%. In contrast, there was a 17% increase in HIV Cases among Hispanics during this same period. HIV cases went up among all race/ethnicity groups in the past year.
  o From 2007 to 2016, the proportion of HIV cases among blacks decreased from 46% to 42% and among whites from 31% to 24% respectively. In contrast, the proportion of HIV cases among Hispanics increased from 21% to 32% during the same time period.
  o Over the past ten years, the proportion of adult HIV cases increased by 11 percentage points for the 20-29 age group (20% to 31%). In contrast, the proportion of adult HIV cases decreased by 11 percentage points for the 40-49 age (30% to 19%), over the same time period. The other age groups remained fairly level.
  o MSM remains as the primary mode of exposure among male HIV cases in Florida, followed by high risk heterosexual contact. MSM cases have increased by 19% since leveling off in 2013.
  o Heterosexual contact continues to be the dominant mode of exposure among females.
• Where are the diagnosed cases of HIV occurring in Florida?
  o The highest case rates can be found in Miami-Dade, Broward, Orange, Duval, Leon and Collier counties.
• Demographics of new HIV cases in Florida
  o There are 17,191,788 people over the age of 13 currently living in Florida. 4,955 of those were new HIV cases in 2016 and 2,117 new AIDS cases in 2016
Compared to whites who represent 50% of Florida’s adult population but only 24% of new HIV cases, Blacks comprise only 15% of the adult population in Florida, but represent 42% of adult HIV cases and 50% of adult AIDS cases diagnosed in 2016.

Hispanics comprise 23% of Florida’s adult population, yet account for 32% of the HIV cases and 24% of the AIDS cases.

The HIV case rate among black males is over 5 times higher than for white males, while the case rate for Hispanic males is almost 3 times higher than white males. More dramatically, the HIV case rate among black females is over 13 times higher than that for white females. The case rate among Hispanic females is nearly 2 times higher than white females. Contributing factors include:

- Late diagnosis of HIV
- Access to/acceptance of care
- Delayed prevention messages
- Stigma
- Prevalence of HIV and Non-HIV STDs in the community
- Prevalence of injection drug use
- Complex matrix of factors related to socioeconomic status
- Immigrants from outside of the United States

The AIDS case rate among black males is nearly 7 times higher than for white males, while the case rate for Hispanic males is over 2 times higher than white males. More dramatically, the HIV case rate among black females is over 15 times higher than that for white females. The case rate among Hispanic females is nearly 2 times higher than white females.

HIV cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age group with the highest percent of HIV cases, recent estimates show that among males, 34% of HIV cases occur among those aged 20-29, whereas among females, 28% of HIV cases occur among those aged 50 and older.

Black males represent the highest proportions for age groups 13-19 and 20-29. Hispanic males represent the highest proportions for age groups 30-39 and 40-49. White males comprise the largest proportion of cases for those 50 and older.

Black females represent the highest proportions of HIV cases for all age groups.

Among males, men who have sex with men (MSM) was the highest risk (77%) for HIV cases in 2016, followed by heterosexual contact and injection drug use (IDU). Among females, heterosexual contact was the primary mode of exposure (91%).

**HIV Co-Morbidity Data**

Infectious syphilis has been rising steadily since 2007, increasing by 163% over the past ten years. HIV has been increasing steadily since 2013, increasing by 14% since that time. Men who have sex with men (MSM) comprised 95% of the HIV/Syphilis co-infection cases.

HIV/Chlamydia co-infected cases have experienced the greatest increase since 2007 at 239% with cases increasing by 18% in the last year alone.

Of the 114,772 living adult (age 13+) HIV cases in Florida in 2016, approximately 5% were reported to be co-infected with HIV/HBV (Hepatitis B Virus). Among males co-infected with HIV/HBV, 66% of cases had MSM as the mode of exposure. Among females co-infected with HIV/HBV, 76% of cases had heterosexual contact as the primary mode of exposure. Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

Approximately 9% were reported to be co-infected with HIV/HCV. Among adults co-infected with HIV/HCV, 27% of males and 48% of females have a documented IDU-related risk.

National estimates by the Centers for Disease Control and Prevention (CDC) are that about 25% of PLWH are co-infected with HCV, (80% in HIV/IDUs).

**HIV Prevalence and Care in Florida**

One-In-Statements for Adults (Age 13+) Living with HIV in Florida, Year-end 2016

- One in 150 adults in Florida were known to be living with HIV
- One in 284 Whites were living with HIV
- One in 47 Blacks were living with HIV
- One in 181 Hispanics were living with HIV

- **HIV Care in Florida**
  - Primary Barriers to Care in Florida
    - Stigma
    - Low Socio-Economic Status
      - Homelessness, Poverty
      - Self Care is a Lower Priority
    - Transportation
  - Other Considerations
    - Psycho-Social Factors
    - Education and Awareness
    - Structural/Systemic

- **Florida HIV-related Deaths**
  - Caveats
    - Resident HIV deaths due to HIV represent persons who resided in Florida and whose underlying cause of death was HIV, regardless if they were reported with HIV in Florida or not. (Source: Death certificate data from the Florida Department of Health, Bureau of Vital Statistics)
    - HIV case deaths are known cases of HIV, regardless of AIDS status, reported in Florida and are known to be dead, regardless of the cause or residence at death. (Source: Florida HIV Reporting System, eHARS from the Florida Department of Health, Bureau of Communicable Diseases)
  - The number of HIV-related deaths in 2016 decreased by 1% from the previous year. Since 2007, deaths have maintained a downward trend and have decreased by 43% over the past ten years.
  - HIV Resident deaths among blacks have decreased by 53% over the past ten years, (32.9 in 2007-15.5 in 2016). However, racial/ethnic disparities continue to be evident in the death rate data, where blacks continue to have the highest death rate.
  - In 2016, black males were 5 times more likely than white males to die of HIV disease. The HIV disease death rate among black females was over 15 times greater than the rate among white females. Rates among Hispanic males and females were slightly higher than the rate among their white counterpart.
  - **Deaths Due to HIV Among Persons Aged 25 to 44 (2016)**
    - HIV is the seventh leading cause of death overall (down from sixth in 2015)
    - HIV is the eighth leading cause among males (down from sixth in 2015)
    - HIV is the sixth leading cause among females (down from fifth in 2015)
    - HIV is the ninth leading cause among Whites (same since 2014)
    - HIV is the fifth leading cause among Blacks (down from fourth in 2015)
    - HIV is the ninth leading cause of death among Hispanics (down from eighth in 2015)
Summaries

- Florida’s Top-Nine Priority Populations for Primary HIV Prevention
  - Hispanic MSM, Black heterosexual men and women, Black MSM, White MSM, Hispanic heterosexual men and women, White heterosexual men and women, White IDU, Black IDU, Hispanic IDU
- Florida’s Top-Nine Priority Populations for Secondary HIV Prevention
  - Black heterosexual men and women, White MSM, Hispanic MSM, Black MSM, Hispanic heterosexual men and women, Black IDU, White heterosexual men and women, White IDU, Hispanic IDU

Lorene agreed to seek clarification on the categories listed on slides related to death data.

ADAP and Insurance Transition Update

Jimmy LLaque, ADAP Program Manager, Jeffrey Beal, M.D., Medical Director, and Joe May, Patient Care Manager

Jimmy LLaque presented an update on transitioning clients from the uninsured program to the insured program.

- In 2012, ADAP started to transition clients from the direct dispense uninsured program.
- The first two enrollment periods targeted individuals who were between 100-250% of the federal poverty level (FPL).
- To date there are 5,200 clients that receive some level of insurance assistance through ADAP statewide.
- In 2016, ADAP expanded the qualification criteria to 100-400% of the FPL. The result was an increase in enrollment from 1,900 to 3,300 clients supported through the federally facilitated exchange
- The open enrollment period is November 1- December 15, 2017. The goal is to retain all 3,300 enrollees in the Affordable Care Act (ACA) who are supported through ADAP.
  - Also working to identify additional eligible clients who have had issues over the past three enrollment cycles who have decided not to enroll or refused services
- Over the summer key messages were sent to ADAP staff to give them the tools necessary to ensure that clients would be retained in programs. For example, they were instructed to tell clients that if they had changes in their financial household, they should make those changes immediately and not wait until open enrollment. Also, they reminded clients to open all mail to check for important messages.

Plan selection for 2018

- The plans that ADAP will support for 2018 were shared with the group. The AIDS Institute distributed the list of plans to FCPN Representative and Alternates as well as guests who attended the meeting.
  - Three Florida Blue plans will not be available this year. Clients (n=182) enrolled in those plans have been identified and notified. If the client does nothing, Florida Blue will automatically enroll them into a plan that they feel is similar. It may or may not be one of the plans that ADAP supports. In an effort not to disrupt care, ADAP will continue to pay premiums on those plans.
  - Humana has also decided not to continue in the marketplace either.
- Selection criteria
  - Grew from 11 plans to 33 plans with 5 carriers.
  - Some plans are maintained due to the number of clients enrolled with the goal of maintaining care even though the inclusion might not be selected due to cost-benefit analysis alone.

How a client enrolls

- Clients may choose to use an ACA navigator, marketplace counselor, insurance broker, or self-enroll. Options are given so that clients can make an informed decision on the plan that they enroll in.
  - If a client chooses to enroll on their own or use an ACA navigator, they must printout the information from the marketplace website as well as provide documentation from the insurance company to the ADAP office.
Marketplace counselors can advise clients on what the best plan is for them. Problems arose when the client actually enrolled for their plan because there were errors in selecting a plan other than the one recommended by the marketplace counselors.

An insurance broker can advise and acts as an agent for the client. Brokers receive most of the information that the client would otherwise receive at home. With the client’s consent ADAP can reach out directly to the broker to get the necessary information.

- American Exchange will serve as a broker for ADAP statewide. FDOH does not endorse or require clients to use this entity. Local areas may have other agreements (e.g. required in Miami-Dade).
- There is a HIPAA business associate agreement in place with the FDOH and a data sharing agreement between American Exchange and Groupware Technologies (developer of PROVIDE).
  - American Exchange sends the ADAP office a file every night and information is available in real time in the PROVIDE system.

Members emphasized the importance of including Lead Agencies and other entities who are involved in providing services for ADAP clients on all correspondence as it relates to messaging. This will help ensure that messaging is consistent and reinforced at every level.

**Q: Do those outside of FDOH have access to PROVIDE?**
**A: Currently there is no access. We are looking at the possibility of having “read-only” access for external agencies.**

There were concerns about the inclusiveness of those outside of the county health departments when making decisions that affect clients. Members emphasized the need for case managers to be utilized to help with the transfer of information regarding enrollment. Questions arose about why a third party, for-profit entity (American Exchange) received a HIPAA business associate agreement when local community partners are still not able to access electronic records. Joey Wynn agreed to send a follow-up email to DOH regarding these issues.

**Q: Do the 3,300 clients that you referenced include the 700 enrolled in Miami-Dade?**
**A: No.**

It was suggested that the entire ADAP enrollment system be automated to eliminate the burden on the clients.

Dr. Jeffrey Beal announced that the ADAP Workgroup will be disbanded. The HIV/AIDS Section asked the FCPN to consider the addition of a Medication Access Committee. Ideally the membership would include FCPN members and other stakeholders such as representatives from Medicaid, Medicare, pharmaceutical industry, commercial pharmacies, and consumers. Example of committee activities include:

- Addressing issues of access to medications and therapeutics for the treatment of HIV/AIDS
- Addressing issues of stigma and access
- Annual review the ADAP formulary to make recommendations for additions and deletions
- Review and monitoring of patient assistance programs (PAPs)
- Increasing ease of access for non-occupational post-exposure prophylaxis across the state
- Addressing issues in the ADAP program dealing with ACA access
- Review of Emergency Plans

The FCPN Co-Chairs agreed to form the Medication Access Committee. Ken Bargar announced that members and guests interested in participating should sign-up with The AIDS Institute staff. Once the membership has been established, **The AIDS Institute will consult with the HIV/AIDS Section and poll the membership to determine meeting dates and times.**
Robert’s Rules of Order  
Alelia Munroe, MPH, Health Planner, Orange County Health Services Department  
Alelia provided the group with an overview of parliamentary procedures and reviewed the key points of Robert’s Rules of Order. FCPN Representatives and Alternates were given a handout that will serve as a quick reference guide.

Call for nominations for Patient Care Community Co-Chair  
A list of eligible members for the position of Patient Care Community Co-Chair was included in the meeting packets. Valerie Mincey opened the call for nominations.

Bobby Davis nominated Kim Saiswick and Ken Bargar seconded the nomination.

There were no other nominations.

By acclimation, members voted to re-elect Kim Saiswick as the Patient Care Community Co-Chair for a second term (2017-2019).

Day One of the meeting was adjourned at 5:36pm.
Thursday, November 2, 2017

Ken Bargar, Prevention Community Co-Chair, Jim Roth, Department of Health Prevention Co-Chair, Kim Saiswick, Patient Care Community Co-Chair, and Kira Villamizar, Department of Health Patient Co-Chair, facilitated the meeting.

The meeting was called to order at 8:35 AM by Kim Saiswick. Roll Call was conducted by Kim Saiswick and quorum was established. Community members and guests introduced themselves.

Laura Reeves announced that the FDOH would be providing regular updates to the FCPN on marketing activities at all future meetings. Laura spoke briefly about the Minority AIDS Media Campaign – knowyourhivstatus.com. Mara Michniewicz reviewed the items currently being distributed by the FDOH and encouraged individuals to visit the FDOH’s exhibit table to pick up samples to take back to their local areas. Mara highlighted the Business Response to AIDS (BRTA), Faith Response to AIDS (FRTA), Targeted Outreach for Program for Women with AIDS (TOPWA) and the Perinatal Prevention Program.

Ken Bargar requested a moment of silence for all those who have been affected by HIV/AIDS.

The minutes from the May 2017 Combined Patient Care and Prevention Planning Group Meeting were reviewed. With no changes noted, the minutes were approved by consensus.

Housing Opportunities for Persons with AIDS (HOPWA)
Craig Reynolds, FCCM, State HOPWA Coordinator

Craig Reynolds provided an update of the HOPWA Program

- Established by the AIDS Housing Opportunity Act of 1990, and revised under the Housing and Community Development Act of 1992, to provide housing assistance and related supportive services for low-income persons living with HIV/AIDS and their families.
- The HOPWA program provides states and localities with resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of low-income persons with acquired immunodeficiency syndrome (AIDS) or related diseases and their families.
- States with more than 1,500 cumulative AIDS cases (in areas outside the EMAs) are eligible to receive HOPWA formula grants.
- Florida received its first state HOPWA grant in 1993 which is administered by the FDOH, HIV/AIDS Section, Patient Care Program. Florida has 11 area Project Sponsors, covering 52 counties. In addition, 6 EMAs area funded directly by HUD and administered by the largest city in their area.
- The Objectives of the Florida State HOPWA Program are as follows:
  - Establish or better maintain a stable living environment.
  - Improved access to HIV treatment and other healthcare support.
  - Reduce the risk of homelessness among people living with HIV/AIDS and their families.
  - Coordination with Ryan White Part B: The program places EMPHASIS on the connection between housing assistance and appropriate supportive services available through HOPWA and other funding sources (i.e., Ryan White Part B and state general revenue). This emphasis highlights FDOH’s commitment to ensure that those support services that contribute to stable housing are readily available to our clients.
- The Florida State HOPWA Program provides the following to qualified individuals:
  - Transitional housing (short-term supported housing)
  - Permanent Housing Placement (PHP)
  - Short-Term Rent, Mortgage, and Utility assistance (STRMU)
  - Tenant-Based Rental Assistance (TBRA)
  - Resource identification services
  - Housing case management
  - Other supportive services including, but not limited to, nutritional services, mental health, drug and alcohol treatment; and assistance in gaining access to local, state, and federal government benefits and services.
  - The recent addition of TBRA completes the state’s housing continuum thus allowing for a point of entry for our clients experiencing a variety of housing issues.
- Program Eligibility Requirements*:
A current Patient Care Notice of Eligibility (Rule 64D-4)
*Certification/Recertification completed every six months

Program Qualifications:
- At least one person with HIV in household
- 80% Median Income
- Proof of Florida Residency
- Enrollment through a Case Manager
- Verifiable Documentation of Need

Outcomes: The Florida State HOPWA Program adheres to Housing and Urban Development’s (HUD) reporting guidelines and tracks program outcomes according to the following national performance measures:
- Increase the percentage of qualified clients/households able to establish or better maintain suitable stable housing.
- Reduce the risk of homelessness among individuals and families living with HIV/AIDS.

Florida’s outcomes for FY 16 included:
- Of the 1,229 clients served, 501 (41%) are in permanent, stable housing and 593 (49%) are temporarily stable with a reduced risk of homelessness. 90% of qualified clients were able to establish or better maintain suitable, stable housing.
- 8 chronically homeless are currently in a more stable housing arrangement. This number is significantly down from the 32 identified in FY 2015.
- 44 clients obtained an income-producing job

Next Steps
- Update the Florida State HOPWA Program Policies and Procedures
- Provide guidance on how HOPWA and Ryan White housing services will further our housing and care continuum
- Conduct regularly scheduled state-wide calls
- Coordinate a state-wide meeting to include HUD and HRSA staff
- TBRA Expansion
- Working to integrate data systems across the FDOH systems as well as partnering with other HIV program providers to bridge the gap in data integration

Q: Are there any rebate funds being used for HOPWA?
A: Yes. There are also procurement issues that prevent the addition of funds to contracts that are acquired through a request for proposal (RFP) process. No additional funds may be added to RFP contracts. In addition, it should be noted that funding for HOPWA increased from $5.5 million to $6.2 million.

Q: Are there any health outcomes you could report on? Specifically, how does stable housing effect health outcomes.
A: The report components are part of the annual HUD progress report. The data fields are fixed. No additional data is available at this point. We are working on some data integration that might be able to answer these questions. Local areas have done some tracking of this information. In areas where it is being tracked, health outcomes are better for those with stable housing.

For additional questions, please contact Craig Reynolds, 850-901-5704, craig.reynolds@flhealth.gov or Cheryl Urbas, 850-901-6707, Cheryl.urbas@flhealth.gov

Updates and Discussion on Activities from Statewide Advisory Groups
Representatives from Statewide Advisory Groups
- Florida Gay Men’s Workgroup - Ken Bargar, Co-Chair
  - The group will be meeting November 8, 2017 for the Florida Gay Men’s Workgroup Consultation at the Embassy Suites – 17th St. Fort Lauderdale, FL.
- Consumer Advisory Group (CAG) – David Brakebill, Co-Chair
  - CAG members received training from the TARGET Center to develop Peer Training Programs.
  - The group reviews and provides feedback on the client-level needs assessment activities administered by the HIV/AIDS Section.
  - Members of the group also serve on the Community Advisory Board (CAB) for the Medical Monitoring Project (MMP).
The group is available to review policies and procedures that will affect clients. Past activities include review of the medical case management guidelines.

- Florida Latino AIDS Advisory Group (FLAAG)
  - Currently needs a new leader at the HIV/AIDS Section level

- Transgender Community Workgroup
  - Participation and activity has dwindled
  - FCPN At-Large Transgender Representative, Riley Johnson and Alternate, Morgan Mayfaire volunteered to chair this workgroup if it is deemed necessary.

- Allocation Methodology Workgroup
  - The HIV/AIDS Section is currently preparing a report for the legislature on the allocation methodology that is used to distribute funds.
  - It was agreed that this group should be revived. **HIV/AIDS Section staff agreed to locate and distribute original charter for this workgroup.**

- Educational Material Review Panel
  - Meets twice a year (virtual or in person)
  - Reviews all educational and promotional material.

- Case Management Workgroup (Shelley Taylor-Donahue)
  - Review updates to the Medical Case Management standards of care

- Black Women’s Consultation
  - **HIV/AIDS Section staff to distribute summary of the consultation to the membership.**

It was emphasized that all Statewide Advisory Groups need to develop a charter with a defined purpose and timeline. Laura Reeves would like to align the meetings of these groups to the PCPPPG meetings as appropriate.

**Medical Update**

**Jeffery Beal, MD, Medical Director**

**Test and Treat**

- **Rationale**
  - Antiretroviral (ART) as early as possible after acquiring HIV infection → better health outcomes, reducing HIV-related morbidity or mortality
  - ART → ↓ viral load → ↓ HIV transmission to the uninfected sexual partner in HIV-discordant couples
  - Results of mathematical models support universal and repeated HIV testing followed by immediate ART could substantially ↓ HIV incidence at the population level

- **Goal** – reduce time from HIV diagnosis or returning to care to initiation of ART and achievement of an undetectable HIV viral load

- **Test and Treat guidance available to all clinics**

- **Two-phased approach**
  - 1st phase - Eligible Metropolitan Areas (EMA’s) and County Health Department (CHD) clinics
    - Broward, Duval, Hillsborough, Miami-Dade, Palm Beach, Orange
  - 2nd phase - Expansion to CHD contracted community HIV clinics
    - Broward, Miami Dade, Lee

- **CHD’s with in-house HIV clinics participating:**
  - Alachua, Bay, Columbia, Citrus, Clay, Flagler, Hernando, Indian River, Jackson, Lee, Marion, Martin, Okaloosa, Pasco, Polk, Sarasota, Osceola, Hendry, Seminole

- **CHD’s with in-house HIV clinics not yet participating:**
  - Baker, Collier, DeSoto, Highlands, Lake, Monroe, Okeechobee, Putnam, St. Johns, Sumter

- **CHD’s with no in-house HIV clinic participating:**
  - Calhoun, Gulf, Hamilton, Holmes, Leon, Liberty, Nassau, St. Lucie, Washington, Volusia

- **As of September 2017 statewide 915 Test and Treat patients**

- **Thirty day starter packs:**
  - dolutegravir (DTG, Tivicay®) + tenofovir alafenamide/emtricitabine (TAF/FTC, Descovy®) once daily with or without food*,1
o darunavir/cobicistat (DRV/COBI, Prezcobix®) + tenofovir alafenamide/emtricitabine (TAF/FTC, Descovy®) once daily with food

o elvitegravir (EVG) + TAF/FTC + COBI (Genvoya®) once daily with food*

o Proposed to add: raltegravir (RAL) HD (Isentress HD®) + TAF/FTC once daily with or without food*

* DHHS Recommended Initial Regimens for Most People with HIV

* Recommended Initial Regimens in Certain Clinical Situations

- Miami-Dade Test and Treat Program
  - Reduce time of testing to time of treatment from 3 months to less than 7 days.
  - 97% retention rate
  - 38 of 50 patients with a suppressed viral load.

- Broward Test and Treat Program
  - Rapid HIV Test Site Locations – 12 locations
  - Ryan White Medical Clinic Providers – 6 locations
  - Test and Treat started May 1, 2017
  - Total number of patients enrolled through September 27, 2017 = 440
  - has 440 patients involved in the Test and Treat Initiative since May 2017

ADAP Hepatitis C Medication
- Currently on the ADAP Formulary
  o Harvoni (ledipasvir/sofosbuvir) Genotype 1, 4, 5, or 6
  o Ribavirin (ribavirin)
  o Viekira Pak (paritaprevir/ritonavir /ombitasvir; dasabuvir) Genotype 1
  o Technivie (ombitasvir/paritaprevir/ritonavir) Genotype 4
  o Zepatier (elbasvir/grazoprevir) Genotype 1,4
  o Daklinza (daclatasvir) Genotype 1,3

- New Hepatitis C Drugs to be added to the formulary (approval is routing through the Pharmacy and Therapeutics (P&T) Committee.)
  o Mavyret (glecaprevir/pibrentasvir) All genotypes
  o Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets) All Genotypes.

- ADAP formulary continues to be expanded to provide Ryan White patients with access to most medications necessary for primary care wellness.

For additional questions please contact: Jeffery Beal, Medical Director, 850-519-3734, jeff.beal@flhealth.gov; Debra Taylor, RN, 850-245-4334 ext. 4488, Debbie.taylor@flhealth.gov; or Roselyn Jasmin, Admin Asst., 850-245-4334 ext. 2514, Roselyn.jasmin@flhealth.gov

State and Federal Update
Michael Ruppal, Executive Director, The AIDS Institute

Michael Ruppal provided an overview of state and federal policy. The AIDS Institute (TAI) remains bipartisan and non-political, which helps to maintain access to information. TAI has 6 full-time policy staff members dedicated to HIV and multi-disease issues, with one member focusing specifically on hepatitis. Michael presented the following key points:

- Communicating with the Health Staffers on the Hill is the best way to get information to the Chief Health staff and congressional members.
- A lot of advocacy work has focused on preventing the repeal of the Affordable Care Act (ACA)
- The Health and Human Services (HHS) Secretary has resigned and has not been replaced.
  o List of potential replacements include Florida Governor Rick Scott.
- The AIDS Institute recently held a Patient Advocacy Summit on lung health. Advocates in Lung Health want to learn from the high level of advocacy in HIV healthcare. Many of the same issues exist such as medication access issues and provider shortages.
- Presidential Advisory Council on HIV/AIDS (PACHA) has been renewed for two more years (through 2019). Seats on the Council are being hand-picked, after 6 committee members left abruptly over the summer.
- There are continued threats to repeal Medicaid expansion and give control of Medicaid to the States.
- No evidence that healthcare coverage will be increased for people in the US.
- Alexander/Murray Legislation
On 10/25/17 the Congressional Budget Office released its score of the Bipartisan Health Care Stabilization Act by Senators Alexander and Murray. The goal is to restore, for two years, the payments to insurance companies that President Trump cut off. Experts predict that doing so would save the government money.

- The office of HIV/AIDS Policy will continue with the potential to be expanded. If it is expanded, it will likely be restructured as the Office of Infectious Diseases.

The following handouts were distributed to participants:
- AIDS Budget and Appropriations Coalition (ABAC) Chart
- ABAC FY 18 Conference Letter
- Prevention and Treatment Dashboards
- Opioid Data
- TAI Federal Hepatitis C Virus (HCV) Update
- TAI Capital Update

Michael invited individuals to join the Florida HIV/AIDS Advocacy Network (FHAAN) distribution list to receive regular policy updates. Members may join by contacting the FHAAN co-chairs Ken Bargar (rw2001president@aol.com) or Joey Wynn (jwynn@empower-u-miami.org).

Hepatitis Update

Tom Bendle, Hepatitis Program Manager

Tom Bendle provided an update on hepatitis (refer to PowerPoint presentation).

A funding snapshot for hepatitis for grant year 2016 was provided:
- Centers for Disease Control and Prevention (CDC)
  - Prevention - $97,462
  - Surveillance - $189,016
  - Total - $286,478
- State Funding
  - Prevention and Surveillance - $1,333,066

Viral Hepatitis Program Structure
- Four Staff in Tallahassee
  - Program Manager
  - Field Services Coordinator
  - Health Educator
  - Surveillance Coordinator

- Support for County Health Departments
  - Hepatitis A & B vaccines provided to all 67 CHDs
  - Chronic hepatitis testing provided through Department public health laboratories
  - Printed educational materials

- Treatment for Hepatitis C
  - There are no public health funds allocated to pay for treatment for persons who are mono-infected with HCV
  - Treatment provided free of charge to patients who are co-infected with HIV and eligible for the AIDS Drug Assistance Program
  - Florida Medicaid covers HCV treatment, including physician costs and laboratory tests
    - They require a negative drug screening within 30 days of requesting the authorization
  - Persons infected with HCV are eligible for free vaccinations for hepatitis A and B
  - Some of the larger metropolitan areas (Tampa, Palm Beach, Ft. Lauderdale) have special taxing districts that provide medical coverage to low-income persons. HCV treatment is covered by these plans.
  - Some local health department physicians are prescribing HCV medication and assisting clients in applying to pharmaceutical companies’ patient assistance programs. If possible, they are charging the clients for the necessary laboratory tests or covering the costs through local county funds.
Priority Areas
- Priorities for hepatitis are shifting
  - Past programs focused heavily on educational materials, screening and vaccination
  - Current funding emphasizes targeted screening and linkage to care for those who test positive
  - Outreach to high risk populations
- Need to interview or investigate acute cases of hepatitis B and hepatitis C
  - Not yet a system of tracking re-infected individuals, for those that are treated and cured, and for those that are cured and then re-infected.
  - Nationally we’re seeing that the older population are being re-infected less than the younger populations.

Local Area Highlights
Representatives from even-numbered areas provided updates on key local area activities as they relate to the goals and objectives outlined in the Integrated Plan. Members who presented were asked to submit their updates in writing to the AIDS Institute following the meeting.

Discussion of PS18-1802 Integrated HIV surveillance and Prevention Funding for Health Departments
Mara Michniewicz, MPH, Prevention Program Manager
Mara provided a review of the funding opportunity announcement (FOA) for PS18-1802 and the 11 required strategies. A handout was distributed to members and guests which included strategies and activities, intended short-term outcomes, and intended long-term outcomes. In addition, the following key points were made about items included in the application:
- The FDOH applied for $35.1 million in prevention funds and $5.1 million in surveillance funding
- In the new FOA, the Expanded Testing Initiative (ETI) was eliminated. HIV testing activities will remain in a restructured manner as “testing in healthcare settings” and “testing in non-healthcare settings”.
  - There was increased emphasis on the Frontlines of Communities in the United States (FOCUS) program. This Gilead-sponsored program was created to address systemic and institutional barriers to routine HIV and HCV screening and access to care by building innovative partnerships for the creation of sustainable testing models. The number of testing sites was increased to 9 sites across Florida.
- Molecular HIV surveillance is now being included in FOA. Uses transmission clusters data surveillance to track transmission trends, based on resistance test genotyping.
- State has inventory of OraQuick Advanced, SureCheck, OraSure, small amount of Determin (4th GenRapid) available to providers. FDOH does not want to limit providers to only one type of test. **Mara agreed to develop a one-page protocol for how to request test kits from the FDOH.**

Prevention for Positives
- Promotes early antiretroviral therapy initiation (Test and Treat)
- Activity promoting continuum improvement.

The application included a PrEP component
- The state Surgeon General has mandated that all 67 County HDs offer PrEP within the next 12 months.
- Two full-time telehealth providers (ARNPs) have been hired to assist county health departments who are without PrEP providers. The providers are based out of Duval and Lee counties.
- Inclusion of Perinatal HIV prevention and surveillance. Improving Perinatal HIV exposure reporting and service coordination.
- Included syringe services programs, with the caveat that we are limited by State Legislature.
- Improve health and data systems with more automation. For example, tracking engagement and retention and care.
- Update policies and procedures, data sharing agreements and easier
- Prevention Allocation methodology will be reviewed to ensure funding in the state based on need and improved data.
Open Forum

- Kim Molnar, The AIDS Institute, reviewed the travel protocol for FCPN Members. She reminded the group that only one Prevention Representative or Alternate and one Patient Care Representative or Alternate would be supported per area by TAI to attend face-to-face meetings. Tamara McElroy informed the alternates who applied for travel assistance through the Department of Health that they would be receiving a follow-up email with instructions on submitting receipts.

- The 2017 Patient Needs Assessment was discussed. The survey was contracted out to the University of Florida, and had a very small response rate across the State.
  - Tamara McElroy emphasized that there were more components of the Needs Assessment than just a survey, for example community engagement sessions, focus groups, consultations, and key informant interviews.
  - Joe May agreed that there were lessons to be learned from the most recent Patient Needs Assessment Survey experience including better coordination with local areas on the timing of the administration of the survey.

- It was announced that the USCA Conference will be held September 6-8, 2018 in Orlando.

Spring 2018 Patient Care and Prevention Planning Group Meeting

- Members requested that all national and state meetings be taken into consideration when planning the dates for future FCPN meetings.
- After much discussion, the preferred dates for the next meeting were mid-March or late April 2018.
- Requested that updates be presented via webinar prior to the face-to-face meeting to allow members to come to the meeting prepared to present local issues and questions.
- Suggested agenda items:
  - Showcase best practices
  - Discuss the issue of clients who fall out of care. Create a thinktank of ideas from the group on how to reengage clients.
  - Framework of DOH Website

- Members requested that every committee call summary be distributed to every member of the PCPPG.

- Develop a web portal for the FCPN. This should contain a roster of members, committee meeting dates and times, and call summaries.

Day two of the meeting was adjourned at 4:30pm.
Friday, November 3, 2017
Ken Bargar, Prevention Community Co-Chair, Jim Roth, Department of Health Prevention Co-Chair, Kim Saiswick, Patient Care Community Co-Chair, and Kira Villamizar, Department of Health Patient Co-Chair, facilitated the meeting.

The meeting was called to order at 8:30 AM by Jim Roth. Roll Call was conducted by Jim Roth and quorum was established. Community members and guests introduced themselves.

Ken Bargar reminded members and guests to sign up for one of the standing PCPPG committees.

**Project AIDS Care (PAC) Waiver Update**

*Kimberly Quinn, Government Operations Consultant, Agency for Health Care Administration (ACHA)*

The Project AIDS Care Waiver (PAC) was established to promote, maintain, and optimize the health of people living with AIDS to prevent or delay institutionalization. The waiver was designed to provide home and community-based services to Medicaid eligible people with a documented diagnosis of AIDS. With the advances in HIV/AIDS treatment, the most of individuals do not use the majority of the home and community-based services provided. Case management is the most utilized service under the PAC waiver.

- During 2017 Legislative session, AHCA was instructed to consolidate the PAC waiver, Traumatic Brain and Spinal Cord Injury Waiver and the Adults with Cystic Fibrosis Waiver. Current PAC Waiver recipients will transition to Managed Medical Assistance (MMA) and Medicaid Long-Term Care (LTC) plans. The scheduled date for transition is January 1, 2018.
- All services offered by PAC waiver are being offered through the MMA plans or LTC.
  - Case management
  - Home delivered meals
  - Education and support services
  - Restorative massage
  - Physical therapy and chiropractic services
  - Personal care
  - Specialized medical equipment and supplies
  - Pest Control – Does not have a direct correlation; but is available through home care with LTC
  - Day health care
  - Chore services/home maker services
  - Home accessibility adaptations
  - Skilled nursing
  - Therapeutic management of Substance Abuse
- LTC plan includes additional services not available through PAC waiver
  - Respite
  - Attendant care
  - Occupational therapy
  - Speech therapy
  - Transportation
  - Assisted living
  - Med administration
  - Med management
  - Nutritional assessment
  - Personal emergency response system
  - Respiratory therapy
- Income requirements: remains unchanged: at or below 220% of the federal poverty level
- Pre-notification letters regarding the have already been distributed to clients affected by the change
- Welcome letters will be sent by December 1, 2017
- Recipients transitioning to LTC will have at least 30 days to select a LTC plan
- Patients may change their plans within the first 120 days or during the open enrollment period
- Telephone and in person assistance is being provided through a broker
• Case Management agencies must maintain level of care with the same processes
• Provider Network Adequacy Standards exist to ensure high standard of medical care and service provision. A complete list of all managed care providers is available at www.ahca.myflorida.com/Medicaid/statewide_mc/providers.shtml
• LTC requires quarterly face to face and monthly phone contact
• To apply for LTC moving forward, clients will apply on the Department of Children and Families (DCF) website

For copies of past webinars on Florida Medicaid’s PAC Waiver changes, please visit, http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/PAC_waiver_changes.shtml

Open Forum
Laura Reeves requested additional input on future agenda items for the next face-to-face meeting of the FCPN. The group requested the following:
• A presentation on data integration and ideas on how to better facilitate and automate client-level data.
• **Standing agenda items for all future meetings:**
  - Report on progress towards the goals and objectives outlined in the State of Florida’s Integrated HIV Prevention and Care Plan
  - Items from standing committees that require input from the larger group
  - Best practices from local areas
• **STD Update webinar prior to the next face-to-face meeting**
• Update by Germane Solutions on current activities

The dates of the next meeting were also further discussed. The group narrowed the selection down to mid-March or April 9-20, 2018. The AIDS Institute agreed to administer a Doodle Poll to members to determine the best dates for the majority. It was also requested that other meetings such as the Consumer Advisory Group and Part A meeting be held during the same time period.

Members requested standardization of the committee call summaries to include action items. The AIDS Institute agreed to develop a standardized template to share with the committee co-chairs for future use.

**HIV Continuum of Care Dashboard Review**
*Joey Wynn, Co-Chair, Coordination of Efforts Committee*
Joey Wynn provided an overview of the HIV Continuum of Care Dashboard submissions for 2017. Joey reminded the group that HIV Continuum of Care Dashboard should be populated with 2016-2017 data. Completed dashboards were distributed to Coordination of Efforts Committee members for their review. Committee members are being asked to work with their local HIV/AIDS Program Coordinator (HAPC) to ensure that the information is complete and accurate.

It was noted that dashboard submissions had not been submitted for Areas 2A, 8, 9, and 11B. The HIV/AIDS Section agreed to follow-up with the HAPCs for those areas to establish a timeline for submission.

Other PCPPG Committee Co-Chairs presented updates to the group on their respective committee’s activities.

The following is the schedule of upcoming conference calls and webinars for the PCPPG Standing Committees:

PCPPG Needs Assessment Committee
Standing call day/time: 1st Thursday of every month at 2PM (EST), 1 hour duration
The next call is scheduled for December 7, 2017 at 2PM (EST)

PCPPG Membership, Nominations & Bylaws Committee
Standing call day/time: 2nd Tuesday of every month at 10AM (EST), 1 hour duration
The next call is scheduled for December 12, 2017 at 10AM (EST)
PCPPG Coordination of Efforts Committee  
Standing call day/time: 2nd Wednesday of every month at 1PM (EST), 1 hour duration  
The next call is scheduled for December 13, 2017 at 1PM (EST)

PCPPG Statewide Quality Management Advisory Committee  
Standing call day/time: 2nd Wednesday of every month at 2PM (EST), 1 hour duration  
The next call is scheduled for December 13, 2017 at 2PM (EST)

PCPPG Medication Access Committee  
Meeting dates and times to be determined

The meeting concluded with a discussion of next steps and action items.

### Action Items for Follow-up

<table>
<thead>
<tr>
<th>Summary of Discussion</th>
<th>Action Items</th>
<th>Person(s) Responsible</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Patient Care and Prevention Planning Group (PCPPG) Bylaws</td>
<td>Update the proposed PCPPG Bylaws to reflect the changes approved during the meeting and distribute to PCPPG members</td>
<td>The AIDS Institute/PCPPG Membership, Nominations and Bylaws Co-Chairs</td>
<td>Post Meeting</td>
</tr>
<tr>
<td>Breakdown of Part B Funding</td>
<td>Provide a breakdown of Part B dollars by category for future presentations</td>
<td>HIV/AIDS Section</td>
<td>Future presentations</td>
</tr>
<tr>
<td>Training for medical providers on how to access Ryan White funding</td>
<td>Check on the status of the request for proposal (RFP) to fund this initiative</td>
<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
</tr>
<tr>
<td>HIV-related deaths</td>
<td>Lorene Maddox to seek clarification on death categories listed.</td>
<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
</tr>
<tr>
<td>Medication Access Committee</td>
<td>Recruit and poll members on best meeting dates/times, establish a charter. Hold periodic meetings</td>
<td>HIV/AIDS Section/The AIDS Institute</td>
<td>Post Meeting</td>
</tr>
<tr>
<td>Allocation Methodology Workgroup</td>
<td>Locate and share workgroup charter with the FCPN membership</td>
<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
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<tr>
<td>Black Women’s Consultation</td>
<td>Distribute summary from the recent face-to-face consultation to the FCPN membership</td>
<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
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<tr>
<td>HIV Test Kits</td>
<td>Develop a one-page protocol on how to request test kits from the FDOH</td>
<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
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<tr>
<td>PCPPG Standing Committee calls</td>
<td>Distribute call schedule and registration information to representatives, alternates and guests. Develop a standardized template for call summaries to include action items for each call. Distribute call summaries for all calls to all Representatives and Alternates.</td>
<td>The AIDS Institute/HIV/AIDS Section Staff/PCPPG Executive Committee</td>
<td>Post Meeting</td>
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<tr>
<td>Web portal for FCPN</td>
<td>Develop a web portal for the Florida Comprehensive Planning Network. Include a roster of</td>
<td>HIV/AIDS Section/The AIDS Institute</td>
<td>Post Meeting</td>
</tr>
<tr>
<td>Standing Agenda Items for Future Meetings</td>
<td>All future meetings should include:</td>
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<td>- Report on progress towards the goals and objectives outlined in the State of Florida Integrated HIV Prevention and Care Plan</td>
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<td>- Best practices from local areas</td>
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<td>- Request to hold other meetings during the same time period (e.g. Consumer Advisory Group Meeting, Florida Gay Men’s Workgroup Meeting, Part A Meeting, etc.)</td>
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<tr>
<td>PCPPG Executive Committee/ HIV/AIDS Section</td>
<td>Post Meeting</td>
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<thead>
<tr>
<th>STD Update</th>
<th>Provide a webinar to address increasing STD rates in Florida with an opportunity for discussion.</th>
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<tbody>
<tr>
<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
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<thead>
<tr>
<th>Dates for Spring 2018 FCPN Meeting</th>
<th>Distribute Doodle Poll with possible meeting dates.</th>
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<tbody>
<tr>
<td>The AIDS Institute/HIV/AIDS Section</td>
<td>Post Meeting</td>
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<tr>
<th>HIV Continuum of Care Dashboard</th>
<th>Follow-up to HAPCs from local areas who have not yet submitted their dashboard updates (Area 2A, 8, 9, and 11B).</th>
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<td>HIV/AIDS Section</td>
<td>Post Meeting</td>
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<thead>
<tr>
<th>Presentation follow-up/Red Ribbon Report</th>
<th>PowerPoint presentations and handouts from the meeting will be made available to the members</th>
</tr>
</thead>
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<tr>
<td>The AIDS Institute/HIV/AIDS Section</td>
<td>Post Meeting</td>
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<thead>
<tr>
<th>Part A Representation on the Florida Comprehensive Planning Network (FCPN)</th>
<th>Appoint a Part A Representative and Alternate to the FCPN</th>
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</thead>
<tbody>
<tr>
<td>Part A Group, HIV/AIDS Section/ PCPPG Membership, Nominations and Bylaws Committee</td>
<td>Still pending from the May 2017 Meeting. To be determined at the Part A Meeting on December 6, 2017</td>
</tr>
</tbody>
</table>