

**Prevention Planning Group & Patient Care Planning Group Combined
Meeting Minutes Summary
May 13, 2015
Embassy Suites Downtown-Tampa**

Federal and State Policy Update

Michael Ruppal, The AIDS Institute

Michael Ruppal provided a Federal and State Policy Update that included Ryan White, Appropriations, Health Reform and State Policy Update as well as the 2015 Federal Budget. A copy of the presentation was provided to the members.

HIV/AIDS Section Update

Marlene LaLota, MPH, Program Administrator

Marlene LaLota provided the following HIV/AIDS Section update via PowerPoint presentation. A copy was provided to the members.

- 3rd largest state in the nation by population in 2014: 19.6 million, racial breakdown is 57% White, 15% Black, 24% Hispanic, & 4% Other
- Newly diagnosed HIV infections in 2014—5,821 (1st in the nation in 2013), not good news
- Newly diagnosed AIDS cases in 2014—2,309 (1st in the nation in 2013)
- The Continuum of HIV Care-Florida
- Budget for Florida HIV/AIDS-\$228 million dollars, effective 4/1/15
- Center for AIDS Research at the University of Miami-local competition process to fund other local researchers throughout South Florida-\$1million, research for a cure—fighting to get that money back, not in the Governor's budget, but hopeful we get the money back.
- Dade and Broward continually increase; the rest of the state goes down in the next five years. FLDOH has agreed to hold the areas harmless and make cuts at Headquarters. Since the epidemic is increasing in those areas, the funding does not match. We are very concerned about the funding for that.
- Would like to do an analysis of all of our statewide Testing sites, maybe conduct a cap on testing sites in regards to those providing rapid testing.

Jeff Allen commented that in 2008, he was using social media to address MSM. He sent follow-up to the department about the work they were doing and the response was that they had to send it to legal. It is 2015, and the department is only using Twitter and Facebook. They really need to listen to the community about using social media.

Marlene responded that there are barriers in the department of health. They have identified other ways including the \$1.3 million contract with Anston Stoner. In addition, they have funded a large amount of ASO's/CBO's to use social media tools.

Jeff commented that there are examples out there to provide to legal at the state. He explained that you could use the advisory groups to get the voice out.

Joey commented that we need that energy at FHAAN to make concrete recommendations. He agreed to revisit the issues.

Ken Bargar commented that he understands the barriers, but when the FL DOH communications director cannot publish anything that even says "gay". That is a huge barrier.

Marlene discussed the new competitive process in 2017 and CDC may conduct a reallocation of areas regarding funding.

John Curry asked whether there have been guidelines that determine whether sites could conduct rapid testing or not.

Marlene said she is working with the key advisory groups to ensure they were working on that.

Janelle Taveras commented on the robust testing program. One indicator would be identifying new cases or finding positives, before saying this is a crisis, a further analysis should be conducted by looking at increases and rates. It may be a result of identifying new cases based on our testing programs.

Marlene commented that our surveillance system is one of four in the country that meets or exceeds surveillance systems. She agreed that more information needs to be examined, a further analysis. There are real increases going on based on the great systems we have here.

A question was raised in regards to “How does Florida compare to the national Continuum of Care?” Marlene responded that we are better than the national Continuum and when we look at the Continuum for ADAP, the last bar: nationally 28/29%, For Florida, it is 90%. Other large providers of care; will say similar, among their patient populations, however much higher for all.

Additional Updates:

HIV/AIDS Section/Table of Organization

- Tracy Smith, Marlene’s Assistant
- Nita Harrelle, Operations Coordinator-ensure programs within section work well together.
- John-Mark Schacht-Research/Policy
- Debbie Norberto-HAPC Liaison/COOP Coordinator
- Becky Grigg-Surveillance
- Joe May-Patient Care
- Kellie Wilcox-Budget Management and Operational Support
- Mara Michniewicz-Prevention
- Melinda Waters-Data Integration
- Jeff Beal/Debbie Taylor-Medical
- Ron Henderson-Statewide Minority AIDS Coordinator-pulled out of HIV/AIDS section works in the Bureau level across other issues.

HCV Pilot Screening/Linkage Project

In 2014, the Florida legislature appropriated \$200,000 for a hepatitis C screening/linkage program

- Funds were designated as non-recurring
- Managed by the HIV/AIDS Section

Needed a new approach

Purchased OraQuick HCV rapid test kits

- Linkage to care for those testing positive is essential
- HIV/AIDS Section matched funds

Implementation

- Collaborative effort between the HIV/AIDS Section and STD Section/Hepatitis Program
- All counties polled to gauge interest in participation
- Counties selected based on interest, capacity, testing history
- Working with 14 counties
 - Testing mainly in outreach settings (drug treatment, homeless shelters, mobile unit, etc.)
 - Provide training and rapid tests
 - Readiness varied by county
 - 9/14 already trained and providing rapid testing on some level
 - Some had firm linkage process in place, others had no linkage plan
 - Working with counties to capture linkage process information and providing technical assistance

The Data (to date)

- Testing started in February
- 120 tests, 22 reactive (18.3%)
- Of the reactive tests:
 - 13 of 22 (59.1%) linked to care (medical visit)
 - 13 of 22 (59.1%) male; 9 of 22 (40.9%) female
 - 19 of 22 (86.4%%) white, non-Hispanic; 3 of 22 (13.6%) white, Hispanic
 - Age range 19 – 58 (Mean age = 34)
 - Most common risks:

- Tattoos: 18 of 22 (81.8%)
- Jail: 16 of 22 (72.7%)
- IDU: 21 of 22 (95.5%)

Hot Topics

- Structure/organizational/culture changes – adapting and evolving
- ADAP/Marketplace – shifting thousands
- High-Impact Prevention – does it work?
- Data – better, more, integrated, faster
- Continuum of Care – raising the bars
- Integrated HIV/AIDS Plan – tying it all together
- Linkage, Linkage, Linkage – what about retention, adherence and suppression?
- Perinatal HIV – getting to zero
- Partnerships – STD, viral hepatitis, substance abuse, mental health, corrections, faith, business, family health, healthcare providers, community leaders, others
- What's Missing? – PrEP, nPEP, syringe exchange, what else?

Patient Care Update

Joe May, Program Manager

Joe May provided the following Patient Care update via PowerPoint presentation. A copy was provided to the members.

HRSA Part B Grant

- NOA for entire award issued on 3/25/15
- Lost ADAP Supplemental funds - \$6.7 million
- ADAP Emergency Relief Funds – received \$8.9 million down from \$11 million
- Other Ryan White Part B funding pots stable
- \$25 million in Rebate funds compensate for decreases
- Formula \$ 30,387,962 ↓\$138,579
- ADAP \$ 85,677,240 ↑\$183,706
- MAI \$ 1,327,506 ↑\$163,395
- EC \$ 489,052 ↓\$ 1,015
- TOTAL \$117,881,760 ↑\$207,507

- Part B Supplemental FOA expected
- Finalizing 2014-15 Part B Grant Closeout
- Rebate dollars required to be drawn down fully before grant funds
- This requirement and timing of rebates contributed to an estimated \$18-\$20 million carryover
- Total grant was \$124 million
- Because of required drawdown of rebate dollars, HRSA will allow a carryover request greater than 5% of grant award
- HRSA expected to release revised 340-B Program Guidance in June
- Expected to impact collection of 340-B rebate dollars
- HRSA Site Visit – June 29-30, 2015
- Follow-up to 2013 ADAP visit
- Focus on ADAP and progress made to restructure program and shift person to Marketplace
- HRSA Policy Clarification Notice 15-01 Treatment Costs Under the 10% Administrative Cap

Patient Care Program Updates:

- Welcome Susan Barrows – new Community Program Supervisor effective April 10
- Patient Care Structure Being Reviewed
- Community Programs -one position reassigned to bureau; one position reassigned to ADAP; working to establish a 1FTE contract position to address need
- ADAP Unit – with assumption of additional Insurance Marketplace/AICP administrative responsibilities working to re-class two positions to include supervisory responsibilities
- Want to insure our structure fully supports and wraps around the movement of clients into the Insurance Marketplace
- T/A for Quality Improvement Activities – NQC assigned consultant
- Working to quantify staffing needs to implement revised QI program - potential of additional expert guidance

- With new supervisor and creation of new contract FTE, movement of QI project expected
- RFA for lead agency services being prepared now
- Effective date for contracts under RFA is April 1, 2016
- Procurement and contracting processes lengthier and require substantial lead times
- Researching/dialoging with HRSA concerning future changes in service delivery system and possible shift away from lead agency structure
- Economic sustainability; shift to insurance
- Any change years away

Much discussion ensued in regards to the Ryan White Program and what it would like in future years to come.

Patient Care-HOPWA

- 2015-16 HOPWA contract documents posted 4/13; completed documents due 4/30
- Like lead agency contract, 4th and final cycle under 2012-13 competitive process
- 2016-17 competitive process to start soon
- Consolidated Plan for 2015-2020 is underway. It covers 4 housing programs in Florida and the Dept. of Economic Opportunity has lead
- HOPWA Technical Assistance is underway and moving quickly ☺
- TA provider by HUD Contractor Collaborative Solutions
- Weekly calls underway until the completion of the revised and expanded HOPWA Policy and Procedures Manual
- Will include Tenant-Based Rental Assistance (TBRA)
- TBRA will be allowable service for 2016-17 contract cycle

James Talley asked if TBRA would be available in the upcoming RFA?

Joe responded that yes, it will be made available.

- TA Guidelines timeline to include provision of trainings with target date of mid-late June
- Statewide housing needs assessment has been delayed to ensure focus on completion of manual and trainings
- Integrated Disbursements and Information System (IDIS)
 - Web-based application that provide financial disbursements, tracking, performance reporting for CPD grants
 - IDIS being re-engineered to ensure funds are committed to activities and drawn for services rendered are linked back to specific grant
 - Grant drawdown process changing – FIFO out
 - Grant year 2015 and beyond – all current year activities must draw current year funds
- Pre-2015 grant dollars will be lumped together as single consolidated funding pot
- HUD will allow 3 years to commit remaining funds
- Funds will facilitate incorporation of TBRA services

Patient Care-Reporting

- RSR reporting season was a success - all agencies met the HRSA 90% data completeness requirement, with the exception of one agency that went out of business
- Completeness threshold for 2015 is 95% for all required data elements on the RSR
- Working with the Data Integration team and HMS Informatics staff to create an HIV template in HMS
- The goal is to get 100% of the necessary RSR data from HMS for all CHDs that participate in the data download/upload process to reduce duplicate data entry

David Brakebill asked where we were in the eligibility rule process.

Joe responded if it were not finalized in a certain amount of time, we would have to start over. There is much discussion in the general counsel office. No timeline on completion of discussion.

David asked for guidance from the department on legality of marriage and people getting married and getting coverage. Our current eligibility materials is not specific, the assumption is made but it would be

helpful to have the HIV/AIDS section provide guidance as to the ‘consequences of marriage’, in particular to ADAP.

Valerie Mincey asked a question in regards to the RFA: will Ryan White and HOPWA be separate, they won't be consolidated, correct?

Joe responded that there will not be a consolidation and that they will be separate.

Valerie asked about the monthly area calls and if they are looking to re-implement them.

Susan Barrows responded that they are looking to revisit them on at least a quarterly basis depending on when people are available.

Robert Bobo commended the staff on the RSR and their work and timeliness to complete the reports.

Ken Bargar asked about the possibility of hosting a Florida All Parts/All Titles Meeting again?

Joe responded that the days of having statewide meetings have passed.

Marlene responded about the HIV/AIDS Section applying for a grant to put on large public health conferences. The thinking is that it will be a large public health conference, not HIV specific. However, they are more optimistic now than before.

Valerie thanked Marlene for the response and wanted to suggest the inclusion of Substance Abuse and Mental Health.

ADAP, AICP, and Insurance Update

Lorraine Wells, Program Manager

Lorraine Wells provide an overview of the ADAP, AICP and Insurance Premium Plus via PowerPoint presentation. A copy was provided to the members.

Lorraine agreed to send Michelle an update of the insured, uninsured and the program updates. Lorraine discussed the structure of the program. She explained that AICP has not gone away. The services that have been provided are under the insurance continuation services. The marketplace and the waivers were discussed as well.

Dan Wall asked if there was no duplication between the numbers shown between the uninsured and insured.

Lorraine responded that you are correct. However, the majority of the population has remained the same.

Lorraine acknowledged the workgroups, Part A's and other community members who were involved in the process to ensure a seamless transition.

Lorraine address some issues with the insurance carriers cashing the checks and not applying the payment to the client. The major offender was Blue Cross, Blue Shield. Then they sent clients cancellation letters. The department worked to address these issues with the office of insurance regulations.

The department has worked on a plan for future enrollment.

A question was made in regards to the Hispanic section as it relates to the Race/Ethnicity and if they are not the same. Lorraine responded that she believes if they check Hispanic, they are.

Lorraine agreed to ensure it is clear on the updated slide.

Lorraine reported the following updates as to where we are;

- She explained that we have huge emerging issues and that we can set up new workgroups to address the upcoming workplace enrollment and set up policies to address these issues.
- Change of status issues; retroactively go back –clients are noticed. A premium can go from \$24 to \$597.
- Lorraine continued and addressed that we need help talking about education. We need to host forums and empower clients with information.

- Environment has changed dramatically. Clients need to be responsive and involved in their care. For example, with the tax forms-clients had challenges, did not file, etc. One of the key pieces is that insurance and reporting is essential. Several areas we need to look at are changes in Federal Poverty Level (FPL) Kaiser News: 50% are projected to receive an overpayment, generate a tax liability.
- HRSA-we deal with a tax credit, but many of our clients are not filing taxes.
- Looking at other states, for example in Arizona, they have a form that if you do not file taxes, you will not be enrolled.
- Referred to Joey's suggestion to use FHAAN to get the word out and educate clients.

Much discussion ensued in regards to the person navigating the system. Comments were made that that the zero explanation is not reaching the community. The community is entirely frustrated.

Jason King commented that AHF would advocate for town halls being conducted throughout the state. Navigators, certified application counselors, etc. need to be involved in the process.

Joey Wynn commented on the following key points.

- He attended 3 of 4 AICP calls
- He attended both of the town hall meetings held in Broward.
- There has been an ongoing conversation in Area 10 regarding transition, but did not have local health department staff to respond or address the issues.

Joey agreed to put comments/points in an email to Lorraine after the meeting.

Joey Wynn's compilation of issues (from Areas 10 & 11a) raised during the meeting submitted via email on 5/19/15 for inclusion in the minutes:

- The ADAP / ACA Transition process included an open & participatory process for many agencies, advocates & people working within the local service delivery areas of Florida. We commend you for such a long, thoughtful process that took many hours and help from people both at the statewide headquarters as well as the people working at the local level. It was difficult, time consuming & required dedication, but it was well worth it.
- Creating the "ADAP Capsule" newsletter was the right thing to do; it helped us at the local level allay concerns & fears from clients worried about all the changes happening to our healthcare delivery system. In a time filled with changes and avoided many disruptions, as well as provide a level of safety & security. These tools were used widely in south Florida.
- Unfortunately, the AICP conversion in to the ADAP Premium Plus program was not handled in the same fashion. It was filled with uncertainty, little to no explanation in writing, and no preparation for the providers that would end up dealing with the clients that were falling through the cracks.
- The Dept. requires Viral Load results (and CD4 counts) for eligibility into the program: this requires a doctor visit, and labs drawn. These required activities should have the commensurate financial support for those who qualify. AICP does not equal ADAP; the program has state general revenue funds, and has the ability to have a more flexible scope of service than its more narrowly defined ADAP requirements for pharmacy equivalency. The program should address allowing for co pays for these costs, possible requiring documentation that the local level area is not able to cover the client, or some other mechanism to address this so there is no gap in provisions of service for clients to remain on their insurance coverage.
- There is a clear need for more guidance, in writing, explaining the ADAP Premium Plus program, the scope of service, eligibility and how clients can navigate the program, for both the consumers of the service, as well as the providers that will help some of the clients access & maintain the service ongoing. This will help to greatly reduce the fear & stress in the community, which is a leading cause of people losing coverage & dropping out of care for this particular subgroup of our clients that does not access the majority of our Ryan white system of care.

- Clients of the APP (sub) program need a wider variety of choices of plans to be able to choose from. They should have a broader base of plans to choose from since they are converting from existing policies and COBRA plans.
- We in the HIV community EXPECT more-timely reporting from the program, and want to identify a set of reports to receive on a regular basis. We understand there are already some types of “canned” reports available, and would cause no added burden on the program for dissemination. We would like to see some of the members of the now defunct ASTAC committee to possibly be added to the newly formed ADAP workgroup / P & T committee.
- Many clients have expressed a fear to leave their COBRA plans, they need more time to have one on one explanations and someone to help them walk through the maze of administrative steps to get them eligible and plans paid so we can avoid any disruptions in accessing their healthcare.
- As I read the chart provided in your PowerPoint presentation, it appears to allow clients the choice to select the specialty pharmacy that best meets their needs. Is this correct? You responded yes, there is an option for clients to do so, and that there will be an RFP / procurement process coming up in the next 2 months to address the new PBM contract.

Joey asked when we would see some kind of analysis of what has happened in terms of migration from the traditional ADAP program to the plan sponsored support for ACA plan coverage; especially now that the enrollment period is over? This is time sensitive since open enrollment will begin again in only 5 ½ months from now.

Lorraine commented that they have hired an Actuary and they are working on the trends but the data is still really fresh. In January, they saw a lot of closures and due to the changes in the landscape they also saw a decline in the number of new persons enrolling in the program (once 350 a month, dropped to 250 a month, etc.). The information is very premature that it is difficult to predict right now.

Joey commented that as co-chair of FHAAN, we expect quarterly updates and ongoing reports about this topic and greater participation. The advisory boards are here and need to be engaged actively to assist with regard to the activities and information to identify trends and barriers.

Lorraine commented that it is the goal of their section and they are happy to seek input on how better to communicate with the clients and address policies for the tax issues, etc.

Marlene commented that since she has been in her position, she has found the FHAAN interaction very valuable. She expressed concern for an ongoing conflict with the monthly FHAAN calls and the weekly management team meetings of the HIV/AIDS Section that occur on Monday's at 2PM. She suggested the group looking at the schedule to see if the calls would consider being moved.

Ken Bargar agreed to bring it back to the FHAAN convening group to see if they could change the time of the FHAAN call.

Lorraine agreed that she has worked with FHAAN and that she is encouraged that we can move forward working together.

George Kress, a pharmacy at Walgreens raised concern in regards to client choice for a pharmacy. If they choose another pharmacy, what type of reporting mechanism would you want for adherence or refill history?

Lorraine responded that if they use other pharmacies, we ask them to show medicine “pick up”.

Kim Saiswick asked about the Cascade and our newer clients included (no ADAP clients were included). Are we looking at them by pharmacy benefit or lack of benefit? Is it impacting the Cascade? She suggested that maybe our target or focus is in the right place. Lorraine responded that sure, it could very well impact the cascade.

Prevention Update

Mara Michniewicz, Program Manager

Mara Michniewicz provided a brief Prevention program update via PowerPoint presentation that included high impact funding and other relevant prevention activities. A copy was provided to the members.

Hot topics:

- High Impact Prevention Town Hall meetings
- CMS routine HIV testing recommendations
- Future funding announcements
 - CDC directly funded CBO's, left out larger funded areas decreasing
 - CDC 2 demonstration projects: 1506, 1509, MSM/Transgender, due June 1
- Integrated Planning-interim guidance, look at the outline and get feedback and how do we move forward given what we have. Integrated Plan by September 2016.
- PrEP/nPEP-no funded activities, Demonstration project from CDC, allowable under our funding-identifying or creating tools, training of staff, increasing awareness, implementing screening tools, develop algorithms for offering PrEP, developing capacity to bill for services.
- PrEP/nPEP Statewide Stakeholder's Consultation-June 9-10, 2015, develop a three year plan
- Develop an inventory of who can prescribe for PrEP/nPEP
- Minority AIDS Initiative funding from HRSA-2 new areas listed.
- Billing and reimbursement of HIV testing is important to get more training's on board.
- Linkage, retention and re-engagement are very important. Linkage is good but retention is challenging.
- Field staff should be focused on targeted high impact outreach to maximize their time. Maybe do additional retention or re-engagement instead of doing broad sweep outreach
- "Momma Bear" partnerships are working well for making sure pregnant women are connected to support.
- Disease Intervention Specialists (DIS) are an important part of our statewide network of linkage. State receives about \$600,000 to support staffing around the state.
- Using existing public health strategies for a statewide coordination of "Partnership for Care"—demonstration project
- Social media –roughly half of the funded HIP providers are implementing virtual Internet outreach activities-very innovative

Update and Discussion on Integrated Planning Efforts

Tamara McElroy & Susan Barrows

Tamara McElroy and Susan Barrows reviewed the CDC/HRSA Integrated HIV Statewide Coordinated Statement of Need/Prevention and Care Plan (2017-2021) Guidance Outline and asked the representative and alternates for feedback as they reviewed each section of the outline. Tamara explained that we do not have the official guidance but she explained that they recently met with the co-chairs of both planning groups and it was the consensus that once they receive the guidance, they would contract the work of the integrated plan.

Executive Summary and Introduction section input:

- Needs to be a succinct statewide coordinated statement of need—less than a paragraph versus a 45-50-page document.

Q: How will this relate to the jurisdictional plans and feed into the overall integrated plan?

A: Without seeing the guidance, it may be too premature to comment. Discussion will need to happen as to what that may need to look like across the state.

Section I-SCSN/NA

Epi overview input:

Q: Will they provide a template for the overall plan? Is there a template for the Epi Profile?

A: Not sure that the guidance will actually provide a template, but they will outline exactly the required parts of what you must include.

- It seems like if you want to integrate the two, you need a template to overlay the two. This would assist in laying out the goals, objectives, etc.

- Epi profile is the surveillance and data, broken down by race, ethnicity, demographics, etc. for the entire state of Florida.

HIV Care Continuum input:

- Integrate Prevention, we need to be looking at targeted high risk groups that may not know they are positive
- Need to ensure the HIV Care Continuum is made up of all of the geographic representation throughout the state versus rolling it all up into one.
- Data will come from one source such as Lory Maddox. Therefore if it comes from various jurisdictions the numbers will come out different. A recommendation was made to streamline and standardize as much as you can.
- Consider irregularities in community viral load as it relates to ADAP clients
- Describe any partnerships that were developed to address data gaps? Those are just examples, not the only one. It was suggested to include outreach or church based partnerships.
- Veterans Affairs-don't know if we have access to the data

Resource Inventory input:

- This section is a huge task.
- It was suggested that one way to address the Resource Inventory is through the draft-funding snapshot.
- Unfortunately, some agencies will not tell you how they fund their private services.
- Comment was made that if you have people who are getting funded in your area and are not involved in the planning process, it is difficult to be involved in the process.
- Includes private and government partnerships, etc.
- Comment was made that a 501C3 organization should be able to provide this information, not withhold this information.
- Unfortunately, some Federal agencies have issues with breaking down the information.
- Comment was made about SAMSHA or VA funding and how they determine their total or percentage, by an epidemic percentage and applying it.
- Most of this information is provided; however we would augment it if we have different or additional information.

Assessing Needs, Gaps & Barriers input:

- Comment was made about the timeline to ensure we meet the adequate requirements. For example, the timeline for conducting a comprehensive needs assessment survey.
- Question about "how would you ask to identify the prevention and care service needs of PLWH (both diagnosed and undiagnosed)
- Comment was made about C and not having specific data but possibly using a qualitative format, such as using surveys and gathering comments, etc.
- Suggestion to coordinate the needs assessment with Part A and B, versus using different survey tools to gather data.

Marlene LaLota provided clarification as to the guidance came from HRSA, we were hoping to get feedback in regards to planning. How might we achieve this? What should the plan look like for Florida?

Data, Access, Sources and Systems input:

- In regards to contracting data sources, if we go with an online process, not everyone has access to technology and may have challenges providing information. May need to include paper access and outreach in the community to gather relevant information.

Section II: Integrated HIV Prevention and Care Plan

Framework and Goals

- Confirmed that the Plan is due September 2016
- Question was raised if the NHAS revision plans in the summer would impact the section?

Collaboration, Partnerships, Stakeholders Involvement input:
No feedback was provided.

PLWH and Community Engagement input:

- It was suggested that BTAN Broward and BTAN Melbourne would fit the community engagement category and be a model for the whole state
- A suggestion was made to conduct a resource Inventory of the existing consortia, merged planning bodies, CPP and other advisory workgroups.
- Once you do the assessment, do the work plan based on NHAS, identify objectives and strategies, how are you going to do it? Simplify it.
- Question was raised as to how different the outline is from the previous PPG and PCPG outlines.
- Many of the elements have been discussed and included in the previous plans.
- Department of health is a critical stakeholder in the plan development, even if the plan gets outsourced.
- It was suggested that we describe the advisory groups, planning groups and information sharing. The PPG Coordination of Efforts committee is working on similar things. NHAS has made us look at things in a different manner, Continuum of Care

Tamara commented that the folks at the table are the ones that will be involved in the PPG Planning Committees or PCPG workgroups. There are opportunities for you to get involved, including leadership and the opportunity to do the work.

Q: What are the next steps?

A: Tamara commented that we are still waiting for the guidance.

It was recommended to at least start engaging in the dialogue with the stakeholders at the local level.

Section III: Monitoring and Improvement

No feedback was provided.

Pre-Exposure Prophylaxis (PrEP) Update

John-Mark Schacht, Policy and Research Consultant

John Mark provided an update in regards to PrEP via PowerPoint presentation. A copy was provided to the members.

Much discussion ensued in regards to PrEP medication monitoring, side effects of Truvada and other adherence issues. Other discussion ensued in regards to PrEP activities around the country.

ADAP Pharmacy Benefits Manager Update

Robert Greenwood, Regional Director, Payer Relations, CVS Caremark

Bob Greenwood provided an update on CVS Health via PowerPoint presentation. A copy was provided to the members. He explained that they recently dropped tobacco products from their stores and their smoking cessation program planning has increased. He shared the following information:

- The Power of CVS Health
- CVS Caremark PBM
- CVS Pharmacy
- Specialty Pharmacy
- Provider Relationships
- MinuteClinic-retail medical clinics in the stores
- Specialty Pharmacy deals with high cost pharmaceuticals with sensitive conditions.
- Serve as the liaison between store and corporate-working with legal counsel on an orientation program. It would start with the client, after they are deemed eligible; then they are introduced to a pharmacy of their choice and begin training program.

Ken Bargar suggested involving a few consumers, especially from a rural area.

Robert Bobo agreed that it would be a great idea. He discussed challenges they experience in Hendry County.

Bob Greenwood commented that they want to be the best at providing services to the clients. Access is definitely part of the discussion.

Valerie Mincey suggested including the Part B providers, to use the linkage people.

James Talley asked about the MinuteClinics, do they have prescribing options?

Bob G. responded yes, it is limited, but they have them.

Joey Wynn commented that they are a 340B provider to the state. Do you currently have any pharmacies in your network that anyone can access?

Lorraine Wells discussed that we have the current structure as such, PBM side for CVS and Bob Greenwood-Retail side. There was some confusion about the state employee and the department of management services, contracted with CVS. The RFP process will offer choice.

Yul Knighten asked a question in regards to the software allowing for the client to be notified for their labs if they have a prescription coming up for renewal.

Bob G. responded yes.

Bob G. referred to the slide regarding the pharmacy software—all retail stores, once they are enrolled in ADAP premium plus, they should be enrolled in the software.

Contact information:

Bob Greenwood-Regional Director, Payer Relations-Southeast Based in the Tampa area

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No further business to discuss, the meeting ended at 5:00PM.