Fort Lauderdale/Broward County EMA
Broward County HIV Health Services Planning Council
An advisory board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100 • Hollywood, Florida 33020 954-561-9681 • FAX 954-561-9685

Quality Management Committee Meeting

AGENDA

Date: March 15, 2021 at 12:30 p.m.
Location: WebEx Virtual Meeting Platform
Chair: Vacant **Vice Chair:** Bisiola Fortune-Evans

Facilitator: CQM Support Staff
quality@brhpc.org
(954) 561-9681 ext. 1343

QMC Purpose: To ensure quality, comprehensive care, and to positively impact the health of people with HIV at all stages of illness.

1. **Call to Order**
2. **Welcome & Public Record Requirements**
   a. Welcome
   b. Review Meeting Ground Rules, Public Comment and Public Record Requirements (Statement of Sunshine)
   c. Council Member, Guest, and Phone Introductions
   d. Moment of Silence
3. **Approvals**
   a. Meeting Agenda 03/15/2021
   b. Last Meeting Minutes 06/15/2020
4. **Public Comment (10 minutes)**
5. **Standard Committee Items**
   I. **CQM Work Plan Progress Review (Handouts A1-A2)**
   Work Plan Activity 4.1: Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.
   ACTION ITEM: Review QMC's FY2020 CQM Work Plan progress & approve the FY2021 Work Plan.
6. **Unfinished Business**
   None.
7. **Meeting Activities/New Business**
   I. **Non-Medical Case Management (NMCM) Service Delivery Model (Handout B)**
   Work Plan Activity 2.1: Review Service Delivery Models as part of the system-wide QIP and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.
   ACTION ITEM: Review and approve updates to the NMCM Service Delivery Model.

II. **Centralized Intake and Eligibility Determination (CIED) Service Delivery Model (Handout C)**
Work Plan Activity 2.1: Review Service Delivery Models as part of the system-wide QIP and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.
ACTION ITEM: Review and approve updates to the CIED Service Delivery Model.

III. **Disease Case Management (DCM) Service Delivery Model (Handout D)**
Work Plan Activity 2.1: Review Service Delivery Models as part of the system-wide QIP and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.
ACTION ITEM: Review and approve updates to the DCM Service Delivery Model

IV. **Integrated Primary Care & Behavioral Health (IPCBH) Service Delivery Model (Handout E)**
Work Plan Activity 2.1: Review Service Delivery Models as part of the system-wide QIP and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.
ACTION ITEM: Review and approve updates to the IPCBH Service Delivery Model.

8. **Recipient's Report**

9. **Public Comment (10 minutes)**

10. **Agenda Items/Tasks for Next Meeting**

a. Next Meeting Date: April 19, 2021 at 12:30 p.m. via WebEx Videoconference

b. Next Meeting Agenda Items

11. **Announcements**

12. **Adjournment**

FOR A DETAILED DISCUSSION ON ANY OF THE ABOVE ITEMS,
PLEASE REFER TO THE MEETING MINUTES.
Meeting Packets are available at: The HIV Planning Council Website
(http://www.brhpc.org/programs/hiv-planning-council/)

Please complete your meeting evaluations here
Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

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Meeting Minutes

Committee: Quality Management Committee
Date/Time: Monday, June 15, 2020, at 12:30 pm **Location:** Webex Virtual Meeting
Chair: Vacant **Vice Chair:** Fortune-Evans, B.

Attendance						
#	**Members**	**Present**	**Absent**		**Guests**	**Recipient Staff**
1	Barnes, B.	**X**			Biggs, V.	Walker, N.
2	Fortune-Evans, B. *V Chair*	**X**			Butler, T.	
3	Katz, H. B.	**X**			Mester, B.	
4	Markman, N.	**X**			Shamer, D.	**Support Staff**
5	Muneton, Z.	**X**				Guice, M
6	Simpson, R.		**X**			Cestaro-Seifer, D.
7.	Hensley, G.	**X**				Seitchick, J.
	Quorum = 5	**6**				

1. CALL TO ORDER:

The Vice-Chair called the meeting to order at 12:42 pm. The Vice-Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present for reference. The Vice-Chair, committee members, Recipient staff, CQM support staff, and HIVPC support staff introductions were made by roll call. Guests made self-introductions.

2. APPROVALS:

Motion #1 To approve the 6/15/20 meeting agenda
Proposed by: Barnes, B. **Seconded by:** Katz, H.B.
Action: Passed Unanimously

Motion #2 To approve minutes were taken at the 1/27/20 meeting
Proposed by: Markman, N. **Seconded by:** Muneton, Z.
Action: Passed Unanimously

3. STANDARD COMMITTEE ITEMS

None

4. Unfinished Business

Unfinished business from the 2/24/20 QMC meeting will be addressed during the July meeting.

5. MEETING ACTIVITIES/NEW BUSINESS

I. **3 Year CQM Plan FY 2020-2022:** CQM support staff provided a brief overview of the 3 Year CQM plan and answered questions from attendees.

Motion #3 To approve the 3 Year CQM Plan FY 2020-2022
Proposed by: Barnes, B. **Seconded by:** Hensley, G.
Action: Passed Unanimously

II. CQM Workplan for FY2020: CQM support staff provided a brief overview of the annual workplan.

Motion #4 To approve the CQM Workplan for FY2020
Proposed by: Barnes, B. **Seconded by:** Katz, H.B.
Action: Passed Unanimously

III. Service Delivery Model Review- Universal Service Delivery Model: CQM support staff provided a brief overview of the proposed changes to the Universal Service Delivery Model (detailed in the meeting packet). Attendees discussed the meaning and impact of these changes. The document was approved with the recommended changes.

Motion #5 To approve the Universal Service Delivery Model
Proposed by: Hensley, G. **Seconded by:** Muneton, Z.
Action: Passed (5 members in favor, 1 opposed)

IV. Service Delivery Model Review- Health Insurance Continuation Program (HICP) Service Delivery Model: CQM support staff provided a brief overview of the proposed changes to the HICP Service Delivery Model (detailed in the meeting packet).

Motion #6 To approve the HICP Service Delivery Model
Proposed by: Markman, N. **Seconded by:** Katz, H.B.
Action: Passed (5 members in favor, 1 opposed)

V. Service Delivery Model Review- Legal Services Service Delivery Model: CQM support staff provided a brief overview of the proposed changes to the Legal Services Service Delivery Model (detailed in the meeting packet).

Motion #7 To approve the Legal Services Service Delivery Model
Proposed by: Katz, H.B. **Seconded by:** Muneton, Z.
Action: Passed (5 members in favor, 1 opposed)

VI. Service Delivery Model Review- Oral Health Service Delivery Model: CQM support staff provided a brief overview of the proposed changes to the Oral Health Service Delivery Model (detailed in the meeting packet).

Motion #8 To approve the Oral Health Service Delivery Model
Proposed by: Katz, H.B. **Seconded by:** Hensley, G.
Action: Passed (5 members in favor, 1 opposed)

VII. FY 2019-2020 Broward EMA Data Overview Presentation: CQM support staff provided a brief overview of the FY 2019-2020 Broward EMA Data. Due to time constraints,

attendees were encouraged to ask questions at the July QMC meeting or contact the CQM support staff.

6. PUBLIC COMMENT

None.

7. RECIPIENT'S REPORT

The Recipient shared that the Broward EMA received $915,000 in Coronavirus Aid, Relief and Economic Security (CARES) Act funding to assist in continuity of care during the Coronavirus emergency. The Recipient's contract office is in the process of developing procedures to disperse these funds. Funds can be used retroactively for allowable uses from January 20, 2020. The Recipient also noted new staff members and vacancies within the Recipient office, including the new Health Care Services Administrator Juanita Gonzalez-Chalot.

8. AGENDA ITEMS/TASKS FOR NEXT MEETING (7/20/20)

- Housing Status Definitions
- Clients with Highly Detectable Viral Loads Follow-Up (Discussion of key takeaways from Dr. Hidalgo's presentation of clients with highly detectable viral loads on 2/24/20)
- Setting the Aim for FY2020 QI Activities (Determine the overall QI goal for viral suppression within the EMA for FY2020)

9. ANNOUNCEMENTS

Brad Barnes announced that the Poverello Live Well Center will be holding a virtual "Member/Client Summertime Chat" each Friday at 1 pm using the WebEx platform. The June 19, 2020 presentations will include discussion of "Eat Well, Live Well, and Be Well in the Summer of 2020" with speakers Alden Bergeron RD, Shanel Pamphile, Frank Young III, and Brad Barnes. The event flyer is attached.

10. ADJOURNMENT

The meeting was adjourned at 2:30 pm.

Quality Management Committee Attendance CY2020

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	27	C	C	C	C	15							
0	1	0		Caraballo, J.	X	Z - 2/12											
0	0	0	**2**	Fortune-Evans, B. V. Chair	X					X							
1	1	0	**3**	Katz, H.B.	E					X							
0	0	1	**4**	Simpson, R.	X					A							
0	1	0	**5**	Barnes, B.	X					X							
0	0	0	**6**	Markman, N.	X					X							
0	0	0	**7**	Hensley, G.	X					X							
0	0	1	**8**	Muneton, Z.	A					X							
				Quorum = 5	6	0	0	0	0	6	0	0	0	0	0	0	

Legend:	
X - present	N - newly appointed
A - absent	Z - resigned
E - excused	C - canceled
NQA - no quorum absent	W - warning letter
NQX - no quorum present	Z - resigned
CX - canceled due to quorum	R - removal letter

Broward EMA CQM Annual Work Plan FY 2020-2021- Updated 3/8/21

HANDOUT A1

Goals and Objectives	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Responsible Party
Goal 1: Use client-level demographic, clinical, and utilization data to assess quality of care, identify health disparities, and client satisfaction.													
1. Analyze and report on performance measures including client demographic and utilization data, HHS/HAB measures, and locally adopted outcomes and indicators.	X			X			X			X			CQM Staff, QMC, Quality Network
2. Review findings from the annual needs assessment, client and provider survey, and client satisfaction surveys.		X											CQM Staff, QMC, Quality Network
3. Identify health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC Committees and Networks to address findings.													CQM Staff, QMC, Networks
Goal 2: Implement quality improvement activities that enhance systemwide service delivery and improve client care, health outcomes, and satisfaction.													
1. Review Service Delivery Models and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.													CQM Staff, QMC, Networks
2. Determine annual CQM Program goals and identify strategies to achieve goals.												X	CQM Staff, QMC
3. Identify and conduct systemwide quality improvement activities and strategies.													CQM Staff, QMC
4. Ensure the development, implementation, and evaluation of at least one quality improvement project per agency during the fiscal year.	X			X			X						CQM Staff, Quality Network
5. Organize and conduct evidence-based trainings for providers and the QMC to expand knowledge on health disparities, HIV treatment and care, and quality improvement strategies.	X			X			X			X			CQM Staff
6. Provide technical assistance to providers as needed.													CQM Staff
Goal 3: Communicate CQM Program updates, data, and activities to the QMC, Networks, and community stakeholders.													
1. Disseminate Ryan White Part A Program data and activities to the HIVPC and Committees, providers, and community stakeholders.	X			X			X			X			CQM Staff
2. Provide Network updates to the QMC and gather feedback/suggestions for Networks.	X			X			X			X			CQM Staff
3. Publish the annual CQM Program Report.		X	X										CQM Staff
4. Provide routine CQM Program updates to the HIVPC.	X			X			X			X			CQM Staff
5. Hold an annual Networks Retreat and celebrate accomplishments.												X	CQM Staff
Goal 4: Routinely evaluate the CQM Program and identify areas for improvement.													
1. Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.												X	CQM Staff, QMC
2. Review CQM Program performance measures for efficacy and relevance and make changes as needed.												X	CQM Staff, QMC, Networks
3. Conduct surveys of all meetings and make suggested improvements.	X	X	X	X	X							X	CQM Staff
4. Review agency-specific quality management plans to ensure compliance with HRSA CQM Program guidelines.					X								CQM Staff
5. Survey efficacy of CQM Program communication methods.												X	CQM Staff

X = goal for objective completion

= in progress

= completed

= planned

Broward EMA CQM Annual Work Plan FY 2021-2022

HANDOUT A2

Goals and Objectives	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Responsible Party
Goal 1: Use client-level demographic, clinical, and utilization data to assess quality of care, identify health disparities, gaps in care, and integration of services.													
1. Analyze and report on performance measures including client demographic and utilization data, HHS/HAB measures, and locally adopted outcomes and indicators.	X			X			X			X			CQM Staff, QMC, Quality Network
2. Review and analyze findings from the annual needs assessment including focus groups, client and provider surveys, and network member evaluations and recommendations.				X			X			X			CQM Staff, QMC, Quality Network
3. Identify and analyze health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC Committees and Networks to address findings.	X			X			X			X			CQM Staff, QMC, Networks
Goal 2: Implement quality improvement activities that enhance systemwide service delivery and improve client treatment, care, health outcomes, and satisfaction.													
1. Review Service Delivery Models as part of the system-wide QIP and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.												X	CQM Staff, QMC, Networks
2. Determine annual CQM Program goals and identify and leverage strategies to achieve goals.											X		CQM Staff, QMC
3. Identify and conduct systemwide quality improvement activities and operationalize strategies to evaluate outcomes.	X			X			X			X			CQM Staff, QMC
4. Ensure the development, implementation, and evaluation of at least one quality improvement project per agency during the fiscal year.	X			X			X			X			CQM Staff, Quality Network
5. Organize and conduct evidence-based trainings for providers, staff, the QMC, and the SOC to enhance knowledge on health disparities, HIV treatment and care, person-centered care, client access to eligible services, and quality improvement strategies.			X			X		X			X		CQM Staff
6. Provide technical assistance to providers as needed.	X			X			X			X			CQM Staff
Goal 3: Communicate CQM Program updates, data, and activities to the QMC, Networks, and community stakeholders.													
1. Distribute the annual CQM Program Report.		X											CQM Staff
2. Disseminate Ryan White Part A Program data and activities to the HIVPC and Committees, providers, and community stakeholders.	X				X			X			X		CQM Staff
3. Provide Network updates to the QMC and gather feedback/suggestions for the Quality Network.			X			X			X			X	CQM Staff
4. Provide routine CQM Program updates to the HIVPC.	X				X			X			X		CQM Staff
5. Plan and implement an annual Network Member Education and Appreciation Week focused on virtual learning and celebration of agency accomplishments.								X					CQM Staff
Goal 4: Routinely evaluate the CQM Program and identify areas for improvement.													
1. Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.												X	CQM Staff, QMC
2. Review CQM Program performance measures for efficacy and relevance and make changes as needed.													CQM Staff, QMC, Networks
3. Conduct surveys of all meetings and make suggested improvements.						X						X	CQM Staff
4. Collaborate with the Recipient following their review of the agency-specific quality management plans for compliance with HRSA CQM Program guidelines and provide TA when indicated to agencies that require assistance in developing a compliant quality management plan.				X									CQM Staff
5. Survey efficacy of CQM Program communication methods.						X						X	CQM Staff
Goal 5: Examine current patient satisfaction strategies and initiate a new evaluation system that will allow for consistent review of the patient experience in receiving Ryan White Part A services.													
1. Review consumer feedback data from 2019-present looking for strengths and weaknesses of current evaluation system.													CQM Staff
2. Research best practices in obtaining consumer feedback about patient experience.													CQM Staff
3. Plan, initiate, and implement a client satisfaction/client experience plan and provide training as indicated.													CQM Staff

X = goal for objective completion

= in progress

HANDOUT B

Broward County Ryan White Part A Program

Non-Medical Case Management (NMCM) Service Delivery Model

Summary of Recommended Changes

(Last Updated September 24, 2020)

CHANGES MADE TO KEY SERVICE COMPONENTS & ACTIVITIES

- Language has been added to underscore the utilization of 30% of all NMCM personnel funds provided under the RW Part A Program for Peer Counseling services
- Support of clients in achieving and maintaining viral suppression was added

BROWARD COUNTY RYAN WHITE PART A PROGRAM

Non-Medical Case Management Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

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

Local Definition

NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

II. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Peer Counseling

Peer counseling is a required component of NMCM services. Providers of NMCM services must utilize at least 30% of all NMCM personnel funds provided under the Ryan White Part A Program for Peer Counseling services. Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Support clients in achieving and maintaining viral suppression
- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Management Information System (MIS).
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV MIS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's barriers to primary medical care, medication adherence, and service needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV MIS and include, at minimum, the following components:

- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Support service needs, including financial, support groups, legal assistance, food bank, vocational, and transportation
- Risk assessment, including knowledge of HIV and STD testing, prevention, and treatment
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

Relevant Areas of Concern

Following the completion of the assessment or reassessment, the designated HIV MIS generates a list of the clients "Relevant Areas of Concern." Providers must utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan
Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals. The action plan must be documented in the designated HIV MIS and contain, at minimum, the following components:

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)
    - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
    - Specified interventions to achieve the goal statement
    - Date goals are established
    - Target date for goal completion

Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress, assistance provided, and communication with clients in the designated HIV MIS, including phone calls, mail, face-to-face, and electronic communication. Checking lab reports (trending viral load and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. On a monthly basis, Case Management supervisors must review a sample of open client action plans to identify opportunities for improvement. All completed action plans must be reviewed, signed, and dated by Case Management supervisors.

Action Plan Review
An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV MIS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV MIS.

Standard	Measure
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV MIS.
4. Case Management supervisors review a sample of open client action plans each month to identify opportunities for improvement.	4.1. Open action plans in the designated HIV MIS. 4.2. Documentation of monthly reviews and identified opportunities for improvement.
5. Completed action plans are reviewed by Case Management supervisors.	5.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV MIS.
6. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV MIS.

HANDOUT C

Broward County Ryan White Part A Program

Central Intake and Eligibility Determination (CIED) Service Delivery Model

Summary of Recommended Changes

(Last Updated October 23, 2014)

CHANGES MADE THROUGHOUT THE CIED SDM

- Instead of having a "Protocol" section, contents of this section are now included in the "Key Service Components & Activities" section.
- Eligibility Verification, Target Population, Client Intake, Service Caps, Access to Primary Medical Care, Retention in Primary Medical Care, Documentation, Continuous Quality Improvement, Payor of Last Resort, Responsibilities of Staff, Professional Requirements and Training sections were either consolidated or removed to eliminate duplication from the Ryan White Part A Universal SDM, individual contracts, and provider handbook.

CHANGES MADE TO CIED DEFINITIONS

Description of Change	Justification
Language change in local definition.	New language more accurately describes activities conducted in CIED.

CHANGES MADE TO CIED OUTCOMES AND INDICATORS

Description of Change	Justification
Outcome 1 is now, "Increase access, retention, and medical adherence to primary medical care."	Standardization among new Service Delivery Models.
Indicator 1.2 has been added: "80% of clients will not experience a lapse in Ryan White Part A eligibility."	Increasing process efficiency.
Outcome 2 has been removed: "Provide access to benefits for which client is eligible."	This activity is detailed in the Assessment section of the Service Delivery Model.
Removal of columns, "Inputs," "Strategies," and "Data Source."	Fields offer unclear information in data collection of outcomes.
Columns now titled, "Outcomes," "Indicators," and "Measure."	Standardization among new Service Delivery Models.

CHANGES MADE TO CIED STANDARDS FOR SERVICE DELIVERY

Description of Change	Justification
Standards 1 & 2 were combined into *Standard 1*.	Client eligibility profile standards were merged to increase efficiency in the Service Delivery Model.
Standard 4 has been expanded to *Standards 5 & 6.*	This provides more detail regarding provider standards.
Standards 5 & 6 were combined into *Standard 4*.	Increasing efficiency in the Service Delivery Model.
Removal of "Indicator" Column and rename "Data Source" column to "Measure.	Standardization among new Service Delivery Models.
Standard 7 including methods of communication between clients and providers was added.	This outlines the different options for client engagement.

Standard 8 indicating an online recertification option was added.	This indicates the availability of the online Ryan White Part A Client Recertification Portal.

CHANGES MADE TO KEY SERVICE COMPONENTS & ACTIVITIES

- References were inserted to link providers to adherence of the Universal Service Delivery Model, the Broward County Provider Handbook for Contracted Services, and state, local, and federal standards.
- Services must be provided at centralized offices and with staff stationed at Ryan White Part A core medical and support service sites.
- Clients must be oriented to the Broward Ryan White Part A system of care. This activity was added to encourage clients' use of available services and improve engagement & retention in care.
- Community Outreach through an annual marketing plan was added to improve community knowledge of the Ryan White Part A Program and available services.

BROWARD COUNTY RYAN WHITE PART A PROGRAM

Centralized Intake and Eligibility Determination Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definition

Centralized Intake and Eligibility Determination (CIED) is a standalone intake service, which determines initial client eligibility for Ryan White Part A services, recertifies eligibility for Ryan White Part A services, identifies third-party payers for services and other community resources, and provides information and referrals to eligible clients for needed services. The provider must document the minimum eligibility requirements for clients accessing Ryan White Part A services.

II. Key Service Components & Activities

In addition to the CIED Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of CIED services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

CIED services must be provided at centralized offices and with staff stationed at Ryan White Part A core medical and support service sites. There must always be a dedicated live telephone operator during business hours. Routine service hours must include evening hours (after 5:00 pm) and weekends to accommodate the needs of clients, including those hospitalized to coordinate services upon discharge. CIED services must also include the provision of home visits for clients who have difficulty ambulating.

Client Orientation

CIED services must ensure that clients are oriented to the Broward Ryan White Part A system of care. This includes providing clients with information regarding Ryan White Part A services and other community resources that the client is eligible for and making referrals when needed. The provider must maintain an updated list of Ryan White Part A providers and service locations to distribute to clients.

Community Outreach

As a part of continuous community outreach, the provider must establish an annual marketing plan detailing specific activity utilized to promote Ryan White Part A services. These activities include hosting and/or attending community resource fairs, community meetings, hosting virtual workshops, etc.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increase access, retention, and adherence to primary medical care.	1.1. 95% of Part A clients who have not had a primary medical care visit within the last six months at the time of recertification shall have a primary medical care or disease case management appointment scheduled within one business day.	1.1.1. Client appointment record in designated HIV Management Information System (MIS). 1.1.2. Progress notes in designated HIV MIS. 1.1.3. Referral record in designated HIV MIS.

	1.2. 80% of clients will not experience a lapse in Ryan White Part A eligibility.	1.2.1. Client appointment record in designated HIV MIS.

IV. Assessment

The provider must develop and implement a documented policy for verifying and documenting client's Ryan White Part A eligibility, screening for duplication of services, and ensuring Ryan White is the payer of last resort. If a client is eligible for third-party benefits, the provider must assist them in applying for those benefits and develop a benefits service plan. The service plan will ensure that there is follow-up on outstanding benefits applications, steps are taken to resolve benefits issues, and clients have the appropriate referrals in place.

CIED services must schedule Ryan White Part A core medical and support services appointments for new clients within one business day. Emergency transportation services must be available, including bus passes, to ensure engagement in care.

Initial Eligibility Determination

During the initial intake appointment, clients must complete a benefits assessment, including initial eligibility determination for Ryan White Part A services and other third-party benefits. The provider must complete all required fields of the client profile in the designed HIV MIS at the time of intake and include any third-party benefits received. Clients must have a signed and dated Plan of Care Information System (PCIS) Consent Form and Broward County Ryan White Part A Program Client Rights and Responsibilities Agreement Form in the designated HIV MIS. Clients deemed eligible for Ryan White Part A services must have the following dated eligibility documentation and related progress notes documented in the designated HIV MIS:

1. HIV status (proof of HIV diagnosis) (once) OR Rapid Test Documentation (30-day provisional)
2. Income level (to determine client's federal poverty level and whether they are uninsured or underinsured) (every 6 months)
3. Residency within the County (every 6 months)
4. Insurance eligibility with third party payers (to determine whether client is eligible for Medicaid, Medicare, or has private insurance) (every 6 months)

Recertification

Clients must complete recertification for Ryan White Part A services every six months after initial eligibility determination is completed, or sooner if determinants of eligibility change. The provider must contact clients to schedule their six-month recertification appointment date at least 45-days prior to their eligibility expiration date. Recertification appointment date reminders must be made via text, email, or telephone to clients both two weeks prior and 24-hours prior to their scheduled recertification date, at minimum.

The provider must offer clients the option to recertify through the online Ryan White Part A Client Recertification Portal. The provider will set up user accounts for clients and provide technical assistance as needed. A user guide for using the Ryan White Part A Client Recertification Portal can be found here: Recertification Portal User Guides (English, Spanish, & Creole).

V. Standards for Service Delivery

Table 2. CIED Standards for Service Delivery

Standard	Measure
1. Provider completes client profile in the designated HIV MIS and collects required forms at initial intake appointment.	1.1. Client profile completed in the designated HIV MIS. 1.2. PCIS Form signed and dated by client in the designated HIV MIS. 1.3. Broward County Ryan White Part A Program Client Rights and Responsibilities Agreement Form signed and dated by client in the designated HIV MIS.
2. Client completes a benefits assessment, including initial eligibility determination for Ryan White Part A services and other third-party benefits.	2.1. Dated eligibility documentation in the designated HIV MIS. 2.2. Documentation of third-party benefits eligibility in the designated HIV MIS.
3. Each client is informed about Ryan White services, third-party benefits, and other community resources, and is referred as applicable.	3.1. List of Ryan White Part A providers and service locations distributed to client. 3.2. Referral record in the designated HIV MIS.
4. Provider assists clients eligible for third-party benefits in applying for those benefits and develops a benefits service plan.	4.1. Documentation of third-party benefits eligibility in the designated HIV MIS. 4.2. Benefits service plan and progress notes in the designated HIV MIS.
5. Client completes recertification for Ryan White Part A services every six months after initial eligibility determination is completed, or sooner if determinants of eligibility change.	5.1. Dated eligibility documentation in the designated HIV MIS.
6. Provider schedules six-month recertification appointments at least 45-days prior to client's eligibility expiration date.	6.1. Client appointment record in the designated HIV MIS.
7. Provider conducts recertification appointment date reminders via text, email, or telephone to clients both two weeks prior and 24-hours prior to their scheduled recertification date, at minimum.	7.1. Client progress notes in the designated HIV MIS.
8. Provider offers client the option to recertify through the online Ryan White Part A Client Recertification Portal.	8.1. Client progress notes in the designated HIV MIS.

HANDOUT D

Broward County Ryan White Part A Program

Disease Case Management (DCM) Service Delivery Model

Summary of Recommended Changes

(Last Updated March 23, 2017)

CHANGES MADE THROUGHOUT THE DCM SDM

- Rather than having a "Protocol" section, contents of this section are now included in the "Key Service Components & Activities" and "Assessment and Individual Care Plan" Sections.
- Access to Service, Eligibility Verification, Client Intake, Service Provision, Case Closure, Access to Primary Medical Care, Documentation, Continuous Quality Improvement, Physical Plant Safety, Payer of Last Resort, and Professional Requirements sections were either consolidated or removed to eliminate duplication from the Ryan White Part A Universal SDM, individual contracts, and provider handbook.

CHANGES MADE TO DCM DEFINITIONS

Description of Change	Justification
Addition of HRSA Definition.	Standardization among Service Delivery Models and a reference to national HRSA guidance for the service category.
Language change in local definition.	New language more accurately describes Ryan White Part A Legal Services offered in Broward.

CHANGES MADE TO DCM OUTCOMES AND INDICATORS

Description of Change	Justification
Removal of columns "Inputs" and "strategies".	Fields offer unclear information in data collection of outcomes.
Columns now titled "Outcomes", "Indicators", and "Measure".	Standardization among new Service Delivery Models.
Outcome 1 was updated to increased access, retention, and adherence to primary medical care.	Language in the Broward Outcomes and Indicators have been updated.
Indicator 1.1 was updated to 85% of clients achieve (1) or more action plan goals by the target resolution date.	Setting DCM goals with patients is an important process in helping clients to become successful in making health improvements. Goals should be person-centered, measurable, time sensitive, attainable and reflect a coordinated approach to care.
Indicator 1.2 was updated to 90% of clients are retained in primary medical care.	Indicator supports outcome to increase client access, retention and adherence to primary medical care.

CHANGES MADE TO DCM STANDARDS FOR SERVICE DELIVERY

Description of Change	Justification
Removal of "Indicator" Column and rename "Data Source" column to "Measure.	Standardization among new Service Delivery Models.

Removal of previous *Standard 12, Standard 18,* and *Standard 20*.	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Combination of previous *Standard 1, Standard 2, Standard 3, Standard 4, Standard 5, Standard 6, and Standard 7* to *Standard 1* in the new DCM SDM.	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Standard 1 is now the completion of a CHA with each client by the provider within 14 days of their initial visit.	DCM Network members requested to have a comprehensive health assessment placed in PE to support the work they do.
Combination of previous *Standard 8, Standard 9, Standard 13,* and *Standard 14* to *Standard 2* in the new DCM SDM.	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Standard 2 is now the development of an ICP within 30 days of completing the initial CHA.	Timeline for ICP completion was shortened to be in alignment with State of Florida Medical Case Management standards.
Combination of previous *Standard 10* and *Standard 11* to *Standard 3 in the new DCM SDM.*	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Standard 3 is now the completion of a reassessment every six months after the completion of the initial CHA.	Addition of CHA requires modifications to support the use of the CHA by medical case managers.
Standard 4 is now the client's assessment and reassessment using the Acuity Scale.	New management levels require specific medical case management-client points of contact.
Standard 5 is now contact with the provider at the frequency specified by the client's management level in the Acuity Scale.	This is a best practice of the Disease Case Management Services and was not previously reflected in the Disease Case Management service standards.
Combination of previous *Standard 15* and *Standard 16* to *Standard 6* in the new DCM SDM.	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Standard 6 is now conducting healthcare monitoring as specified by the ICP.	This is a best practice of the Disease Case Management Services and was not previously reflected in the Disease Case Management service standards.
Standard 7 (previously *Standard 19*) is now coordinating medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Standard 8 (previously *Standard 17*) is now conducting adherence counseling to support treatment regimens and medical care.	Language in the previous standards were reallocated to other standards in the new Disease Case Management SDM.
Standard 9 (previously *Standard 21*) now stipulates that assistance must be documented in client file within three business days.	Ensures documentation of Disease Case Management services provided.
Standard 10 (previously *Standard 22*) now stipulates that providers will follow up with clients	This is a best practice of the Disease Case Management Services and was not previously

in two business days of the client's requested communication.	reflected in the Disease Case Management service standards.
Standard 11 (previously *Standard 23*) now stipulates that documentation must support the client's management level in accordance with the Acuity Scale.	New management levels require specific details of management services and the alignment of the services with components of disease case management such as referral, follow-up and reassessments. Medical chart reviews safeguards performance of best practices in supporting clients at the four levels of case management.
Standard 12 is now scheduling and holding client case management conferences in accordance with the client's management level as outlined in the Acuity Scale.	New management levels require delineation of client case management conferences that support client progress towards health outcome goals.

CHANGES MADE TO KEY SERVICE COMPONENTS & ACTIVITIES

- References were inserted to link providers to adherence of the Universal Service Delivery Model, the Broward County Provider Handbook for Contracted Services, and state, local, and federal standards.
- Key service component language is now more concise.

CHANGES MADE TO ASSESSMENT AND INDIVIDUAL CARE PLAN

- Assessment process and components are more clearly defined; the DCM Assessment Model flow chart was also added (Appendix A).
- Language has been added to detail the components of client individual care plans.
- Addition of a Comprehensive Health Assessment (CBA) that is conducted at the time of referral and is updated annually or more frequently when patients experience unmet needs and/or new physical and behavioral health conditions.
- Addition of an Acuity Scale that is informed by the Comprehensive DCM Assessment. The acuity scale ratings provide Disease Case Managers with client contact and service parameters to assist in working with clients to development their Individual Care Plan or ICP that is focused on chronic disease management needs.
    - The Acuity Scale point range is 24-96 points that categorize four levels of DCM.
    - Level 1 is the HIV self-management level where the client is able to manage their medications without any assistance and completes all scheduled medical appointments. The client who is at Level 1 is virally suppressed.
    - Level 4 is the level of highest need. Clients at Level 4 require intensive management and are in need of wrap around services and assistance with medication adherence and medical appointment adherence.

- Level 2 is Basic Management and clients receiving this level of DCM service are medically stable and need minimal assistance to manage their HIV.
- Clients is Level 3 are virally suppressed. Clients receiving Level 3 services require Moderate Assistance and they are at risk of becoming medically unstable without DCM assistance. Clients at Level 3 have documented viral loads or they are at risk for becoming detectable.

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Disease Case Management
Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities undertaken in this service category may be provided by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication), as well as activities taken on behalf of the client (e.g., multidisciplinary case conferences, referrals to other personnel or agencies).

Key activities include:

- Initial assessment of service needs
- Develop a comprehensive, individualized care plan (ICP)
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ICP
- Re-evaluate the ICP plan at least every six months, with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of service utilization

In addition to providing the medically oriented activities above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. Such programs may include Florida Medicaid Managed Care Organizations (MCOs), Medicare Part D, Florida AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's Patient Assistance Programs (PAPs), other state or local healthcare and supportive services, and insurance plans through the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), Marketplaces/Exchanges.

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) funds the Disease Case Management (DCM) model of MCM. DCM provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications stemming from co-morbid chronic disease conditions. DCM includes assessment of client needs, development of a coordinated plan of care, and care coordination. Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments
- Coordinating essential medical and support services and making referrals when indicated

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Providing adherence counseling to treatment regimens and healthcare, and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

II. Key Service Components and Activities

In addition to the DCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. DCM providers must refer to their individual contract for service-specific client eligibility requirements. DCM providers must comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Coordination of Medical and Healthcare Improvement Services

Providers must ensure coordination of medical and healthcare improvement services to support clients in meeting their ICP goals and maintaining their engagement in care. Case coordination and case conferencing includes communication, information sharing, and collaboration that occurs regularly with case management and other providers serving the client within and between agencies in the community. Coordination includes, but is not limited to:

- Managing HIV and co-morbid condition (chronic and acute) treatments
- Communicating with the client's primary care and behavioral health providers and other service providers to support client adherence, understanding, motivation, access to services and optimal engagement in care to include case coordination and case conferencing activities
- Coordinating medical and support service use within the RWHAP system of care, addressing barriers to obtaining services, and linking the client to services
- Coordinating specialty medical services outside the RWHAP system of care

Case conferences include multi-disciplinary service providers, including providers within the agency and those from other agencies when possible and relevant. Case conferences must be face-to-face or via conference call and must be held at routine intervals or during significant care changes or transitions. High acuity levels established by the Acuity Scale informs the frequency of case conferences. The client and their family members, significant others, or designated caregiver(s) should also be included in case conferences when possible and appropriate. These activities must be recorded in the client's progress notes in the designated HIV Management Information System (HIV MIS). Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals
- Resolve conflicts or strategize solutions

Adherence Counseling to Support Medical Care and Treatment

DCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions
- Documenting all adherence counseling activities in the designated HIV MIS

Client-Centered Education and Training on HIV Self-Management

DCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression
- Retention in HIV and primary medical care, including health promotion activities
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning
- Recognizing the signs of stress, distress, anxiety, and depression and strategies to access emotional support services
- Adequate nutrition, regular exercise, and the benefits of stress reduction and self-care.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicator(s)	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one (1) or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV MIS.
	1.2. 90% of clients are retained in primary medical care.	1.1.2. Client appointment record in designated HIV MIS.

IV. Assessment and Individual Care Plan

Comprehensive Health Assessment

DCMs must assess client needs by conducting a CHA within 14 days of the client's initial visit. The CHA must be completed within the designated HIV MIS. The CHA is used to evaluate each client's access to medical care, health status, health maintenance, health knowledge, treatment

adherence, behavioral health needs, and environment. Assessment findings are used to inform the acuity scale component.

Acuity Scale

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. DCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

Table 2: Acuity Scale Scoring and DCM Management Levels

Management Level	Points	Health Status/ Medical Condition	Client Contact Frequency	Chart Review Frequency
Self-Management	24-34 Points	Medically stable without need of DCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up at least once every six months for reassessment	Once every six months
Basic Management	35-49 Points	Medically stable with minimal DCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months	Every 3 months
Moderate Management	50-73 Points	At risk of becoming medically unstable without DCM assistance including documented detectable viral load or risk for viremia	Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month	Every 3 months
Intensive Management	74-96 Points	Medically unstable and in need of comprehensive DCM assistance with an accompanying detectable viral load	Face-to-face at least once a month with phone contact weekly	Monthly

Reassessment

Reassessments provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous timeframe of activities. Providers must reevaluate the client's unmet needs and related barriers by conducting reassessments every six months after completion of the initial assessment, or sooner if the client's circumstances change significantly. Reassessment findings are used to update the ICP.

Individual Care Plan (ICP)
Providers must develop an ICP within 30 days of completing the initial client visit. DCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The DCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. DCMs must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV MIS.

V. Standards for Service Delivery

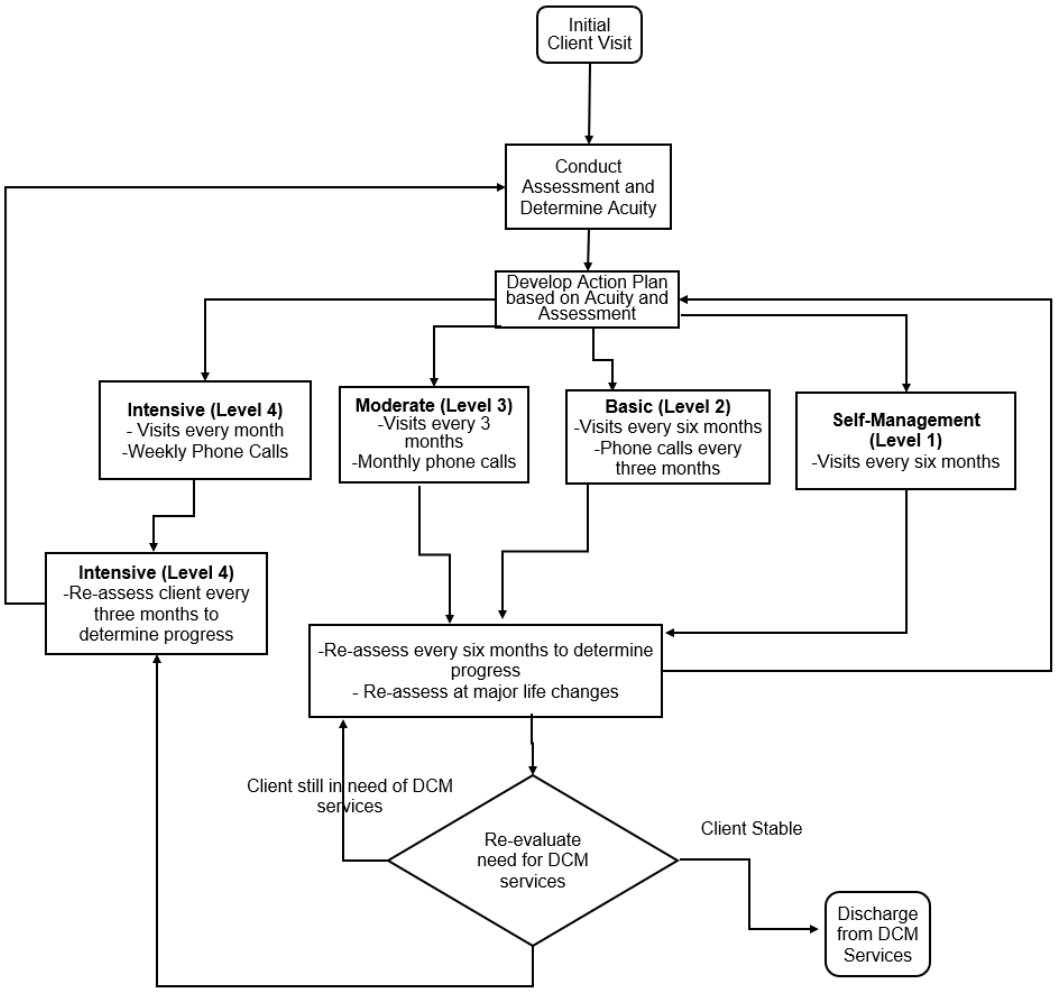
Table 3. DCM Standards for Service Delivery

Standard	Measure
1. Provider completes a CHA with each client within 14 days of their initial visit.	1.1. Completed CHA in the designated HIV MIS.
2. Provider develops an ICP with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client.	2.1. ICP signed and dated by the provider and client in the designated HIV MIS.
3. Provider completes a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change.	3.1. Completed CHA in the designated HIV MIS. 3.2. Progress notes in the designated HIV MIS.
4. Client health needs are assessed and reassessed using the Acuity Scale as outlined in *Appendix A*.	4.1. Acuity Scale completed and scored in the designated HIV MIS.
5. Client has contact with the provider at the frequency specified by client's management level as detailed in *Appendix A*.	5.1. Documentation of client communication in the designated HIV MIS.
6. Provider conducts healthcare monitoring as specified by the ICP.	6.1. Documentation of the ICP and progress notes in the designated HIV MIS.
7. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	7.1. Documentation of the ICP and progress notes in the designated HIV MIS.
8. Provider conducts adherence counseling to support treatment regimens and medical care.	8.1. Documentation of the ICP and progress notes in the designated HIV MIS.

Standard	Measure
9. Assistance provided to client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client.	9.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV MIS.
10. Provider follows up with clients within two business days of the client's requested communication.	10.1. Documentation of client communication in the designated HIV MIS.
11. Provider conducts medical chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in *Table 2.*	11.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV MIS.
12. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 2.*	12.1. Documentation of client case management conference in the designated HIV MIS.

VI. Appendix A

The DCM Assessment Model



HANDOUT E

Broward County Ryan White Part A Program

Integrated Primary Care & Behavioral Health (IPCBH) Service Delivery Model

Summary of Recommended Changes

(Last Updated February 9, 2018)

CHANGES MADE THROUGHOUT THE IPCBH SDM

- Instead of having a "Protocol" section, contents of this section are now included in the "Key Service Components & Activities" section.
- Eligibility Verification, Target Population, Client Intake, Service Caps, Access to Primary Medical Care, Retention in Primary Medical Care, Documentation, Continuous Quality Improvement, Payor of Last Resort, Responsibilities of Staff, Professional Requirements and Training sections were either consolidated or removed to eliminate duplication from the Ryan White Part A Universal SDM, individual contracts, and provider handbook.

CHANGES MADE TO IPCBH DEFINITIONS

Description of Change	Justification
Update to HRSA Definition.	HRSA Definition for Outpatient Ambulatory Health Services updated to reflect most recent definition.
Language change in Local Definition.	New language more accurately describes activities conducted in Integrated Primary Care & Behavioral Health.

CHANGES MADE TO IPCBH OUTCOMES AND INDICATORS

Description of Change	Justification
Removal of Columns, "Inputs," "Strategies," and "Data Source."	Fields offer unclear information in data collection of outcomes.
Columns now titled, "Outcomes," "Indicators," and "Measure."	Standardization among new Service Delivery Models.
Outcome 1 is now, "Increased access, retention, and adherence to primary medical care."	Standardization among new Service Delivery Models.
Indicators 1.1 is now, "85% of clients are retained in Integrated Primary Care and Behavioral Health services."	Changed from 95% of clients are prescribed antiretroviral therapy, which was an indicator that was being met routinely for all clients in the EMA and the strengthening of the Test and Treat Program to focus on client connection to IPCBH services and the ultimate goal of viral suppression. PWH connected to medical care are more likely to be virally suppressed per the literature.
Indicators 1.2 has been updated.	Increase from 85% to 90% to "move the needle on viral suppression" to occur within 6 months of starting antiretroviral (ARV) medication. PWH are more likely to experience better health and quality of life including fewer co-morbidities if they attain and maintain viral suppression. This indicator is also in alignment with HRSA's End the HIV Epidemic (EHE) initiative.

CHANGES MADE TO IPCBH STANDARDS FOR SERVICE DELIVERY

Description of Change	Justification
Removal of "Indicator" Column and rename "Data Source" column to "Measure.	Standardization among new Service Delivery Models.
Standards have been separated into "Primary Medical Care Standards of Service Delivery" and "Behavioral Health Standards for Service Delivery."	Integrated Primary Care Standards and Behavioral Health Standards are displayed separately for improved clarity.
Standard 1 has been updated.	This standard was updated to person-first language.
Standards 2-14 have been combined into *Standard 2* of the Primary Medical Care Standards of Service Delivery.	Laboratory testing standards have been outlined in the Key Service Components and Activities section of the Service Delivery Model.
Standard 5 of the Primary Medical Care Standards of Service Delivery was added.	Clients often forget clinical appointments especially when there may be stigma attached to the service as there often is with Behavioral Health and the word "Counseling." Reminding patients about their appointments cannot be overemphasized as an important intervention to support client follow through.
Standard 16 of the Primary Medical Care Standards of Service Delivery was added.	This standard was included in addition to improve client oral health care outcomes.
Standard 23 requiring an annual Tuberculosis test was removed.	Laboratory testing standards have been outlined in the Key Service Components and Activities section of the Service Delivery Model.
Standard 27 which states that clients attend 2 or more medical visits annually has been removed.	This is reflected in *Standard 2* of the Primary Medical Care Standards of Service Delivery.
Standards 30, 31, & 35 regarding Care Assessments have been removed.	These standards are now outlined under Key Service Components & Activities.
Standards 6-8 of the Behavioral Health Standards for Service Delivery were added.	These standards provide standards for documenting Behavioral Health Service Delivery in client charts.
Clients complete a Patient Health Questionnaire (PHQ-9) at every primary medical care visit.	In the 2017 version, clinical screening tools were to be administered as indicated. Research demonstrates that PWH are most likely to experience at least one episode of depression during their lifetime. This added standard supports early detection and treatment of depression in PWH.
Clients whose score on the PHQ-9 is greater than 11 are referred to Behavioral Health Services.	Mild depression is defined by a score of 5-p on the PHQ-9. Moderate depression is defined by a score of 10-14 and 15-19 moderately severe with 20-27 indicating severe depression. Mild depression does not warrant an Assessment, but does require monitoring by the primary care provider. A score over 11 warrants immediate referral to a Behavioral Health Specialist for an Assessment to rule out major depressive disorder.

CHANGES MADE TO KEY SERVICE COMPONENTS & ACTIVITIES

- References were inserted to link providers to adherence of the Universal Service Delivery Model, the Broward County Provider Handbook for Contracted Services, and state, local, and federal standards.
- Modifications were made to primary medical care and behavioral health services to that ensure the services align with evidence-based practices documented in the U.S. Department of Health and Human Services (HHS) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV.
- The development of a Behavioral Health Treatment Plan was described and the minimal components of the treatment plan outlined with the request for measurable goals and objectives. Guidelines for the Behavioral Health Treatment Plan review were updated as well.
- Referral processes for behavioral health services and specialists were expanded to highlight the importance of behavioral and mental health assessments and treatment for PWH.
- Medical Care Comprehensive Assessment was updated to align treatment and care services with most current HHS treatment guidelines and U.S. Preventative Services Taskforce Recommendations (USPSTF).
- Updates to screening requirements were made to support the integration of behavioral and mental health, nutritional and vision and hearing health. Minimum screening standards were specified as the execution of the following measures:
    - clinical depression (PHQ-9 at a minimum)
    - Nutritional health screening
    - Psychosocial screening, including alcohol and substance use, domestic violence and housing status
    - Tobacco use screening
    - Vision and hearing screenings as indicated by need and/or transition to age-friendly health services
- Behavioral Health Treatment Plan Review is added to the Service and justified with a more comprehensive description of minimum requirements to support the integration of behavioral and mental health with medical care. Components of the Treatment Plan and the expectations of the Treatment Plan Review process are delineated.

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RYAN WHITE PART A PROGRAM
Integrated Primary Care & Behavioral Health Service Delivery Model

BROWARD COUNTY
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Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Outpatient/Ambulatory Health Services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable OAHS activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Local Definition

Integrated Primary Care and Behavioral Health (IPCBH) is the systematic coordination of outpatient/ambulatory medical care and behavioral health care services. This includes the provision of professional diagnostic, therapeutic services, behavioral health services rendered by a physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse provider, psychiatrist, psychologist, licensed clinical social worker, or other mental health professional licensed or authorized within the State of Florida to render such services in an outpatient setting. Settings include clinics, medical offices, mobile clinics, and telehealth. Emergency department and urgent care services are not considered outpatient settings.

Services provided include diagnostic testing, early intervention and risk assessment, preventive care and screening, behavioral health screening, physical examination, medical history, diagnosis and treatment of common physical and mental health conditions, prescribing and managing medication therapy, education and counseling on health, behavioral and mental health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

II. Key Service Components and Activities

All IPCBH service providers must adhere to the minimum requirements stated in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Provision of IPCBH – Primary Medical Care services must align with the U.S. Department of Health and Human Services (HHS) and U.S. Preventative Services Taskforce Recommendations (USPSTF) best practices and recommendations. Provision of IPCBH – Behavioral Health services must be consistent with Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook. Providers of IPCBH are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Primary Medical Care

ART Initiation

The current federally approved medical practice Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV[2] endorse immediate initiation of antiretroviral therapy (ART). Patients who are candidates for rapid ART initiation[3]:

- Have a new reactive point-of-care HIV test result or a new HIV diagnosis (confirmed through the Centers for Disease Control and Prevention HIV testing algorithm[4]) or acute HIV infection (HIV antibody negative and HIV RNA positive) or known HIV, and
- Are treatment-naive, or
- Have a history of limited ART use (e.g., a person who stopped first-line therapy for reasons other than regimen failure), as long as concern for acquired drug resistance is low (requires a case-by-case determination).

Laboratory Tests

Providers are expected to conduct testing in compliance with HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV[2]. The following laboratory tests are included as a standard treatment of care:

Baseline Visit (Initiation of Medical Care)

- HIV-1/2 Antigen and Antibodies, 4th Gen *(if prior HIV serostatus labs not available)*
- Absolute CD4 cell count with percentage CD4
- CBC with differential and platelets
- Resistance Testing *(HIV-1 RNA Quant PCR)*
- Syphilis Antibody w/cascading reflex

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[2]Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf . Accessed 10/9/2020.

[3] This material was accessed on 10/09/2020 on the HIV Clinical Resource website (https://www.hivguidelines.org/antiretroviral-therapy). The HIV Clinical Guidelines Program is a collaborative effort of the New York State Department of Health AIDS Institute and the Johns Hopkins University Division of Infectious Diseases. Copyright © Johns Hopkins University HIV Clinical Guidelines Program 2000-2016.

[4] Centers for Disease Control and Prevention. Laboratory testing for the diagnosis of HIV infection: updated recommendations. https://stacks.cdc.gov/view/cdc/23447

- Comprehensive Metabolic Panel (CMP) *(Basic Chemistry: including ALT, AST, and Total Bilirubin)*
- Hepatitis A Antibody total
- Hepatitis B Serology *(HBsAb, HBsAg, HBcAb total)*
- Hepatitis C Screening *(HCV antibody or, if indicated, HCV RNA)*
- Toxoplasma Antibody (IgG) (*when indicated)*[5]
- Urinalysis
- Chlamydia/Gonococcus, NAAT (*site specific swabs as indicated and urine)*
- Random or Fasting Lipid Profile
- Random or Fasting Glucose
- Resistance Testing *(HIV-1 Genotype)*
- Quantiferon TB Gold *(when indicated)*[5]
- HLA-B*5701 *(when initiating abacavir-containing regimen)*
- Pregnancy test *(for people of childbearing potential)*

Every Six Months

- Basic Chemistry: including ALT, AST, and Total Bilirubin *(when indicated)*
- Absolute CD4 cell count with percentage CD4 *(during first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm^3)*
- CBC with Differential *(when monitoring CD4 cell count; perform CBC cell count and CD4 concurrently)*
- Resistance Testing *(HIV-1 RNA Quant PCR)*
- CMP *(while on Tenofovir containing regimen)*
- Urinalysis (*for clients on tenofovir disoproxil fumarate and tenofovir alafenamide containing regimens)*

Every Twelve Months

- Absolute CD4 cell count with percentage CD4 *(after 2 years CD4 and % CD4 in presence of undetectable viral load and CD4 300-500. If CD4 greater than 500, optional to repeat)*
- CBC with Differential *(when no longer monitoring CD4 cell count)*
- Hepatitis B Serology (HBsAb, HBsAg, HBcAb total) *(May repeat if patient is non-immune and does not have chronic HBV infection)*
- Hepatitis C Screening *(HCV antibody or, if indicated, HCV RNA)*
- Urinalysis
- CMP *(while on Tenofovir containing regimen)*

Viral Load Monitoring [2]

After initiation of ART or modification of therapy because of virologic failure: Plasma viral load (VL) should be measured before initiation of ART and within 2 to 4 weeks, but no later than 8 weeks, after treatment initiation or modification. Repeat VL measurement should be performed at 4- to 8-week intervals until the level falls below the assay's limit of detection.

[5] Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and Adolescents: Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/adult_oi.pdf . Accessed 10/09/2020.

Virologically suppressed patients whose ART was modified because of drug toxicity or for regimen simplification: VL measurement should be performed within 4 to 8 weeks after changing therapy.

Patients on a stable, suppressive ART regimen: VL should be repeated every 3 to 4 months, or as clinically indicated, to confirm continuous viral suppression. Clinicians may extend the interval to 6 months for adherent patients whose VL has been suppressed for more than 2 years and whose clinical and immunologic status is stable.

Patients with suboptimal response: The frequency of VL monitoring will depend on clinical circumstances, such as adherence and availability of further treatment options. In addition to VL monitoring, additional factors, such as patient adherence to prescribed medications, suboptimal drug exposure, or drug interactions, should be assessed. Patients who fail to achieve viral suppression should undergo resistance testing to aid in the selection of an alternative regimen (see Drug-Resistance Testing [6] and Virologic Failure and Suboptimal Immunologic Response [7] sections).

Referral Procedures for Behavioral Health Services

A hallmark of integrated primary medical care includes the use of the Patient Health Questionnaire (PHQ-9) as a part of measurement-based care to improve patient outcomes. The PHQ-9 shall be either provider-administered or self-administered.[8] If a client's score on the PHQ-9 is greater than 11 and/or the client demonstrates or reports signs and symptoms of mental illness or behavioral health concerns, the client must be introduced in person, by phone, or by telehealth platform to a behavioral health professional.[9] If the primary medical care provider is unable to provide the client with an immediate introduction to a behavioral health professional, the provider must immediately schedule an appointment with a behavioral health professional at the client's earliest convenience prior to leaving the facility. The primary medical care provider is required to follow-up via phone with the client to remind them of their first scheduled appointment and identify and discuss any barriers to the client attending the appointment.

If a client scores 5 – 10 on the PHQ-9, indicating mild depression, a plan for follow-up and rescreening must be noted in the medical care and treatment plan.

Specialist Referrals

Providers must refer clients to specialists for diagnostic and treatment services as determined by the client's clinical status. If the client utilizes Disease Case Management (DCM) services, their disease case manager must be contacted to ensure linkage of the specialist referral and conduct follow-up activities, accordingly.

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[6] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf . Accessed 10/09/2020 page C-12.

[7] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf . Accessed 10/09/2020 page I-1.

[8] Gelenberg, A.J. (2017) (J of Clinical Psychiatry), Kroenke, K. et al (2001) (J of General Internal Med) and VA/DoD (2016)

[9] Crane, P. K., Gibbons, L. E., Willig, J. H., Mugavero, M. J., Lawrence, S. T., Schumacher, J. E., Saag, M. S., Kitahata, M. M., & Crane, H. M. (2010). Measuring depression levels in HIV-infected patients as part of routine clinical care using the nine-item Patient Health Questionnaire (PHQ-9). AIDS care, 22(7), 874–885. https://doi.org/10.1080/09540120903483034

Providers may refer eligible clients to Medical Nutritional Therapy (MNT)[10]. Clients who receive an MNT referral must have the diagnosis of diabetes, chronic kidney disease, or have had a kidney transplant within the last 36 months. An MNT referral can also be made when a client reports any of the following concerns and agrees to an MNT referral:

- Physical changes, including weight concerns
- Oral or gastrointestinal symptoms
- Barriers to nutrition such as living environment, functional status, economic and geographic barriers such as living in a food desert
- Changes in diagnosis requiring nutrition intervention

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicators	Measures
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients are retained in Integrated Primary Care and Behavioral Health services.	1.1.1. Client appointment record in the designated HIV Management Information System (MIS).
	1.2. 90% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	1.2.1. Client prescription of ART documented in the designated HIV MIS.

IV. Assessment and Treatment Plan

Primary Medical Care Assessment and Screening Process

The provision of primary medical care assessments and behavioral health screenings must be consistent with the current HHS treatment guidelines and U.S. Preventative Services Taskforce Recommendations (USPSTF). Primary medical care providers must ensure client completion of the PHQ-9 at every primary medical care visit.

Primary Medical Care Comprehensive Health Assessment

The provider must complete an initial comprehensive health assessment within three (3) sessions from the time of a client's initial visit. The purpose of the initial comprehensive health assessment is to evaluate the client's clinical status, social/lifestyle issues, sexual and emotional health, knowledge of HIV, ability to adhere to prescribed medication regimens, immunization records/needs, and prevention needs for recommended health screenings, including but not limited to, prostate-specific antigen (PSA) screening, mammogram and pap smear, colon cancer screening, or Dual-Energy X-ray Absorptiometry (DEXA) Scan.

Clients must be reassessed within six months after completion of the initial comprehensive health assessment or sooner if the client's circumstances change significantly. Thereafter, reassessments

[10] The Los Angeles County Commission on HIV. *MEDICAL NUTRITION THERAPY SERVICES.* Accessible at http://hiv.lacounty.gov/LinkClick.aspx?fileticket=q1l1KKC-ACQ%3d&portalid=22

are conducted, at minimum, every six months. The initial assessment and reassessment must include, at a minimum:

- General medical history, including sexual history
- Medication reconciliation
- Screening for opportunistic infections
- Comprehensive HIV-related history
- Comprehensive physical examination
- Nutritional assessment
- PHQ-9
- Psychosocial screening, including alcohol and substance use, domestic violence, and housing status
- Tobacco use screening
- Additional screenings as clinically indicated, such as vision and hearing

Medical Care and Treatment Plan

Primary medical care providers must develop a medical care and treatment plan with the client's input based on the results of the client's comprehensive health assessment findings. Providers must update medical care and treatment plans at every client visit, at minimum. If a client declines a treatment, such as vaccination, documentation of the client's denial and reason for the denial must be documented. The client medical care and treatment plan must document:

- Chief complaint
- Vital signs
- Presenting symptoms list
- Assessment/diagnosis
- Current medications and adherence
- Vaccinations
- Proposed treatment in accordance with current HHS Treatment Guidelines
- Follow-up protocol and actions to be taken if client does not attend follow-up appointment
- Referrals and recommendations for treatment and/or intervention
- Client decision to accept offers for treatment, referrals, and recommended support services

Behavioral Health Assessment

Clients referred to Behavioral Health services must complete a biopsychosocial assessment within three treatment sessions. The biopsychosocial assessment must be reviewed and signed by a licensed professional and documented in the designated HIV MIS. During the first encounter with a client, the Behavioral Health provider must establish a provisional diagnosis and treatment plan goal. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[11]
- Biological factors
- Psychological factors

[11] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Behavioral Health Treatment Plan[12]

Providers must work with each client to develop a detailed behavioral health treatment plan that directly addresses the primary diagnosis(es) that is(are) consistent with the assessment. The behavioral health treatment plan must be an individualized, structured, and goal-oriented schedule of services with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Behavioral health treatment plans become effective on the date the plan is signed and dated by the licensed behavioral health practitioner and the client.

Behavioral health treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- Modality of treatment to be provided
- A list of the services to be provided to client (behavioral health treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the behavioral health provider for the development of the behavioral health treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month behavioral health treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed behavioral health provider
- A signed and dated statement by the licensed behavioral health provider stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)

Behavioral Health Treatment Plan Review

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any

[12] Agency for Health Care Administration. *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.* 2014.

modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed professional and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed professional who participated in the review of the plan
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. IPCBH - Primary Medical Care Standards for Service Delivery

Standard	Measure
1. Clients have documentation of HIV+ status in their medical record.	1.1. Documentation of HIV+ test and results in the client chart.
2. Client complete initial comprehensive health assessment within three sessions from the time of a client's initial visit, and every six months thereafter.	2.1. Documentation of initial comprehensive health assessment in the client chart.
3. Clients complete a PHQ-9 at every primary medical care visit.	3.1. Documentation of PHQ-9 score in the client chart.
4. Clients whose score on the PHQ-9 is greater than 11 are referred to Behavioral Health services.	4.1. Documentation of PHQ-9 score in the client chart. 4.2. Referral documented in the designated HIV MIS.
5. Providers follow-up via phone with the clients referred to behavioral health services to remind them of their first scheduled appointment.	5.1. Documentation of referral follow up in the designated HIV MIS.
6. Providers develop a medical care and treatment plan with the client's input based on the results of the client's comprehensive health assessment findings.	6.1. Documentation of medical care and treatment plan in the client chart.
7. Clients are offered immunizations in accordance with HHS guidelines, including: • Pneumococcal vaccine and a follow up booster 5 years later	7.1. Documentation of immunizations in the client chart.

Standard	Measure
• Annual influenza immunization • Hepatitis A and B vaccine as clinically indicated.	
8. ART is prescribed as clinically indicated.	8.1. Documentation of prescribed ART in the client chart.
9. Treatment for opportunistic infections and prophylaxis for opportunistic infections is provided when clinically indicated.	9.1. Documentation of treatment in client chart.
10. Female clients receive cervical cancer screenings as clinically indicated. Clients with an abnormal PAP test result or documented cervical lesion present receive a referral to a gynecologist.	10.1. Documentation of screening and results in the client chart. 10.2. Referral documented in the designated HIV MIS.
11. Female clients, starting at age 40, receive a mammogram annually. Clients with an abnormal mammogram are referred to a specialist and have a plan of care.	11.1. Documentation of screening and results in the client chart. 11.2. Referral documented in the designated HIV MIS.
12. Clients receive colon and rectal cancer screenings as clinically indicated.[13]	12.1. Documentation of screening and results in the client chart.
13. Clients are assessed and counseled for medication adherence at every primary medical care visit.	13.1. Documentation of assessment and counseling provided in the client chart.
14. Clients with CD4 T-cell counts below 200 and/or CD4 percentage less than 14% are prescribed PJP prophylaxis as clinically indicated. [14]	14.1. Documentation of laboratory test results in the client chart. 14.2. Documentation of prescription in the client chart.
15. Clients with potential to be pregnant must receive pregnancy test at ART initiation and as clinically indicated be prescribed ART as clinically indicated.	15.1. Documentation of pregnancy screening in the client chart. 15.2. Documentation of ART prescription in the client chart.
16. Clients are referred to oral health care, if not engaged in the last six months.	16.1. Referral documented in the designated HIV MIS.
17. Clients receive an annual oral examination.	17.1. Documentation of oral health examination in the client chart.
18. Clients receive sexual health education annually, including birth control methods, pregnancy planning, discussion of condom use, risk identification, and PrEP for partners.	18.1. Documentation of sexual health education in the client chart.

[13] National HIV Curriculum. *Primary Care Management.* Accessible at National HIV Curriculum, Basic HIV Primary Care, Primary Care Management, Cancer Screening.
[14] National HIV Curriculum. *Opportunistic Infections: Treatment.* Accessible at https://www.hiv.uw.edu/page/qb/topic/co-occurring-conditions/opportunistic-infections-treatment

Standard	Measure
19. Transgender-inclusive healthcare is provided, including: • Documentation of birth sex and self-reported gender. • Routine healthcare clinically appropriate for client' birth sex as anatomically permitted. • Assessment of additional medical and mental health needs, in addition to those inherent in birth sex and incurred from additional anatomical changes.	19.1. Documentation of transgender-inclusive healthcare provided in the client chart.

Table 3. IPCBH – Behavioral Health Standards for Service Delivery

Standard	Measure
1. Client is asked to give expressed and informed consent for treatment.	1.1. Signed informed consent form in the client chart.
2. Providers conduct a biopsychosocial assessment with each client prior to the development of a treatment plan within three treatment sessions.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HIV MIS.
3. Providers conduct additional behavioral health clinical scales, when clinically indicated.	3.1. Completed clinical scales signed by the licensed practitioner in the client chart.
4. Providers work with each client to develop a detailed treatment plan.	4.1. Treatment plan signed and dated by licensed professional and client in the designated HIV MIS.
5. Providers conduct a formal treatment plan review at least every six months.	5.1. Updated treatment plan with signature and date of licensed professional and client in the designated HIV MIS.
6. Assistance provided to clients and progress made toward achieving treatment plan goals is documented in the client chart within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client chart.
7. All client communication is documented in the client chart and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	7.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client chart.
8. Progress notes in the client chart is linked to a treatment plan goal.	8.1. Progress notes in the client chart.