MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, November 19, 2021

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Coral Gables, FL 33134 and Zoom

AGENDA

I.	Call to Order	Dr. Robert Goubeaux
II.	Meeting Rules and Housekeeping	Marlen Meizoso
III.	Roll Call and Introductions	Dr. Robert Goubeaux
IV.	Floor Open to the Public	Dr. Robert Goubeaux
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of October 22, 2021	All
VII.	Reports	
	• Membership Vacancies	Marlen Meizoso
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	• ADAP Program	Dr. Javier Romero
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	• ADAP formulary additions and RWP review	All
	• Primary Medical Care Standards	All
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	• Continuous Glucose Monitoring Devices	All
	• Potential Needs of Aging Population	All
	• Elections 2022	Marlen Meizoso
X.	Announcements	All
	• Atripla brand discontinuation	
XI.	Next Meeting: **January 26, 2022** at **BSR**	Dr. Robert Goubeaux
XII.	Adjournment	Dr. Robert Goubeaux

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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Partnership Meeting Housekeeping

Hybrid Meetings
(In-Person and Zoom at BSR)

Updated November 11, 2021

www.aidsnet.org

Behavioral Science Research

Miami-Dade HIV/AIDS Partnership

Miami-Dade County

Disclaimer & Code of Conduct

- This meeting – including audio, Zoom video and Chat Box input – is being recorded and will become part of the public record.

- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business in a fair and equitable manner.

Resource Persons

- Behavioral Science Research Corp. staff are the Resource Persons for this meeting.
  - *Will BSR staff please identify themselves?*
  - *Please see staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.*

General Reminders – In Person Attendees

- Masks are requested to be worn at meetings.
- Place cell phones on mute or vibrate.
  - ❖ *If you must take a call, please excuse yourself from the meeting.*
- Only voting members should be seated at the meeting table.
  - ❖ *You may move your chair if concerned about social distancing.*
- Please identify yourself by name before speaking.
- When speaking project your voice towards the camera or move closer to the camera.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.
- Please ensure you entered your car tag number on the sign-in sheet to have your parking validated.

General Reminders – Zoom Attendees

- Please remain on mute until called on by the Chair.
- Place cell phones on mute and turn off external devices (TVs, radios)
- Use the Chat Box to:
  - Record your name for the Roll Call
  - Make or second a motion (members only)
  - Vote in opposition to a motion (members only)
  - Ask a question
  - Ask to be recognized by the Chair to speak

Attendance

- All members are expected to arrive on time and remain throughout the entire meeting.
  - ❖ *If you expect to arrive late or leave early, please notify staff in advance of the meeting as this may impact quorum.*

- In-Person Attendees must **SIGN IN** to be counted as present.

- Zoom Attendees must **CHAT YOUR NAME** to be counted as present.

Meeting Participation

- All speakers must be recognized by the Chair.
  - ❖ *Raise your hand or chat to be recognized or added to the queue.*
  - ❖ *The Chair will call on speakers in order of the queue.*
- Discussion should be limited to the current Agenda topic or motion.
- Speakers should not repeat points previously addressed.
- Any attendee may be permitted to address the board as time allows and at the discretion of the Chair.

- Important!
  - *Please raise your hand or chat if you need clarification about any terminology or acronyms used throughout the meeting.*

Resources

- Today's presentation and supporting documents are online at http://aidsnet.org/meeting-documents/.

- Follow the Partnership on Facebook and Instagram!

Thank you for attending today's meeting!

www.aidsnet.org

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HIV/AIDS PARTNERSHIP

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to be counted as present.

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Zoom Attendees must

CHAT YOUR NAME

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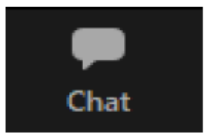

Contact staff after the meeting
if you are not able to chat.

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Floor Open to the Public

"Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

"BSR has a dedicated phone line and email for statements to be read into the record. No statements were received."

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Medical Care Subcommittee Meeting
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 230, Coral Gables, FL 33134 and Zoom
October 22, 2021

#	Members	Present	Absent	Guests	
1	Baez, Ivet		x	John McFeely*	
2	Bauman, Dallas	x		Brad Mester*	
3	Cortes, Wanda	x		Karen Poblete	
4	Dougherty, James	x			
5	Goubeaux, Robert		x		
6	Palacios, Carlos	x			
7	Pinero, Carmen		x		
8	Romero, Javier	x*			
9	Thornton, Darren		x		
10	Torres, Johann	x			
11	Valle-Schwenk, Carla		x		
12	Vasquez, Silvana		x	**Staff**	
Quorum: 5		***virtual attendance**		Marlen Meizoso	

Note that all documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at www.aidsnet.org/meeting-documents.

I. Call to Order

Carlos Palacios, the Chair, called the meeting to order at 9:59 a.m. He introduced himself and welcomed everyone.

II. Meeting Rules and Housekeeping

Mr. Palacios reviewed the meeting rules and housekeeping presentation (copy on file), which provided the ground rules and reminders for the meeting. He also identified Behavioral Science Research (BSR) staff as resource persons for the meeting. If anyone had any questions, they could speak to BSR after the meeting.

III. Roll Call and Introductions

Mr. Palacios requested members introduce themselves around the room. Staff introduced those members participating via Zoom.

IV. Floor Open to the Public

Mr. Palacios read the following: *"Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns."*

"BSR has a dedicated phone line and email for statements to be read into the record. No statements were received."

There were no comments, so the floor was closed.

V. Review/Approve Agenda

The Subcommittee reviewed the agenda. Marlen Meizoso indicated that there was no Ryan White Recipient report.

Motion to accept the agenda as presented.
Moved: Dallas Bauman **Second: James Dougherty** **Motion: Passed**

VI. Review/Approve Minutes of September 24, 2021

Members reviewed the minutes of September 24, 2021 and accepted them with no changes.

Motion to accept the minutes of September 24, 2021.
Moved: Dallas Bauman **Second: Dr. Johann Torres** **Motion: Passed**

VII. Reports

- **Membership Vacancies** *All*

Mrs. Meizoso referenced the membership vacancy report (copy on file) and reviewed the vacancies on the Subcommittee. Attendees were encouraged to direct any persons interested in joining the Subcommittee to contact staff.

- **Partnership Report (informational)**

Mrs. Meizoso indicated that there was no written report for this meeting, but the Partnership approved three new members for the Mayor's review, approved the Administrative Mechanism report, and retroactively approved the letter of assurance for the grant.

- **Ryan White Program** *Ana Nieto*

Ana Nieto was not present but Mrs. Meizoso indicated there was no updated October Recipient report.

- **ADAP Program** *Dr. Javier Romero*

Dr. Javier Romero referenced the September 2021 report (copy on file). He reviewed the number of clients enrolled and expenditures for both ADAP Pharmacy and Premium Plus. The figures are down which may be due to clients receiving 60-90 days of medications at a time, reducing the numbers of clients seen in any given month. There are 36 clients on Cabenuva. In 2022, eligibility for ACA insurance premium reimbursement will be expanded for clients between 75%-99% FPL. Clients must be documented and have a valid Social Security number. The lower FPL levels will likely only add a small number of clients. There have been some changes to the ADAP formulary, with 54 new medications added and 5 ARVS being removed. The ADAP formulary is available on the State ADAP website.

VII.. Standing Business

- **Conclusion of Cabenuva Barriers Discussion** *All*

Mrs. Meizoso reviewed the replies submitted to date including those provided at the last meeting (copy on file). The Subcommittee decided to postpone finalizing the document to see if there are any changes regarding billing with the recent introduction of a new J-code. Two additional issues were identified at the meeting and will be added:

- CVS canceled delivery because appointment at healthcare center could not be confirmed
- Issues regarding confirmation of lead in medication from other pharmacy

The two additions and any other changes will be brought to the next meeting.

- **ADAP formulary additions and Ryan White Program (RWP) review** *All*

The Subcommittee reviewed the Ryan White Program review of ADAP formulary additions (copy on file). The list was divided among the pharmacists on the Subcommittee to provide comments and pricing. The Subcommittee wanted additional data, including conversion of all pricing to 340B, inclusion of a column to identify if a medication was on the General Revenue formulary, and another column identifying if there were any similar medications on the current Ryan White formulary. These additions will be made and presented at the next meeting.

- **Primary Medical Care Standards** *All*

The full draft of the Primary Medical Care Standards was shared and reviewed page by page (copy on file). The only comments were:
On pg. 3, capitalizing PREP throughout the page.
On pg. 5, striking option from 14. The language was updated but may need additional changes pending recommendations from the ANCHOR Study's publication. There was also an email requesting additional information, but this would need to be addressed at the next meeting when County staff and additional medical personnel are present.
On pg. 7, item 21 statement "For those patients…" makes no sense. Staff will verify accuracy of the verbiage of the item. And an "r" is missing in computer on item 25.
On pg. 9, capitalizing ART on item 29 and removing magenta highlighted items on items 32 and 33.

Staff will make the recommended changes and bring the document back to the next meeting.

- **Service Descriptions-Outpatient Ambulatory and AIDS Pharma** *All*

The service delivery descriptions for AIDS Pharmaceutical Assistance and Outpatient Ambulatory Health (copy on file) were reviewed and edits suggested. Aside from updating the date and priorities, a few changes were suggested:

- Deleting discontinued letters of medical necessity note on pg. 29 for next year.
- Adding "a. New to Care Clients" and "b. Limitation on Specialty Testing" on pg. 84 to make them easier to locate.
- Changing "program-eligible people with HIV (clients)" to "program-eligible clients".
- All items highlighted in yellow need updating for 2022; and
- Changing "Miami-Dade RN/AIDS Partnership's "to "Miami-Dade HIV/AIDS Partnership's".

Motion to accept the changes to the AIDS Pharmaceutical Assistance and Outpatient Ambulatory Health service descriptions as discussed.
Moved: Dr. Johann Torres **Second: Dallas Bauman** **Motion: Passed**

VIII. New Business

- **2022 Meeting Dates** *All*

The meeting dates for 2022 were reviewed (copy on file) and the Subcommittee decided to keep the meetings at BSR at the current time of 9:30 a.m., since the Subcommittee is not at full capacity and the acoustics are better at BSR.

IX. Announcements

All announcements are posted online; however, the press release regarding the ANCHOR study mentioned at the last meeting (copy on file) was included in the meeting materials.

X. Next Meeting

The next Subcommittee is scheduled for November 19, 2021, which will feature oral health care items the first half of the meeting.

XI. Adjournment

Motion to adjourn.
Moved: James Dougherty **Second: Wanda Cortes** **Motion: Passed**

Mr. Palacios adjourned the meeting at 11:13 a.m.

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

November 11, 2021

The Miami-Dade HIV/AIDS Partnership

The official Ryan White Program Planning Council in Miami-Dade County and Advisory Board for HIV/AIDS to the Miami-Dade County Mayor and Board of County Commissioners

Opportunities for People with HIV

People with HIV who receive one or more Ryan White Program Part A services and who are not affiliated or employed by a Ryan White Program Part A funded service provider are invited to join the Partnership as a Representative of the Affected Community.

9 available seats / *1 application pending approval*

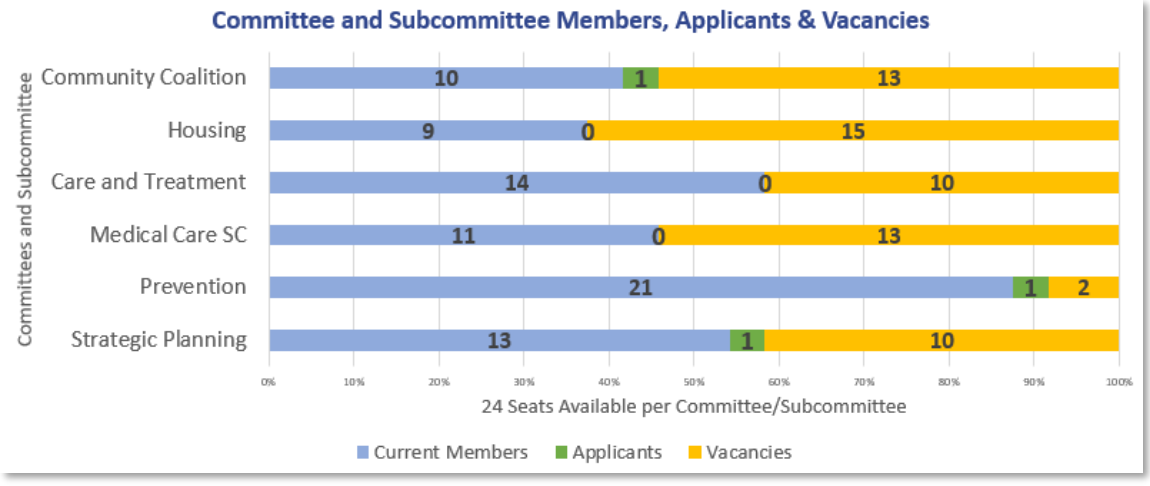
General Membership Opportunities

These Partnership positions are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the knowledge, skills and expertise relevant to these positions:

Former Inmate of Local, State, or Federal Prison Representative *1 application pending approval*
Representative Co-infected with Hepatitis B or C
Hospital or Health Care Planning Agency Representative
Other Federal HIV Program Grantee Representative (SAMHSA)
Federally Recognized Indian Tribe Representative
Mental Health Provider Representative
Miami-Dade County Public Schools Representative
Non-Elected Community Leader, not an HIV Provider

Partnership Committees

Committees are accepting applications for new members. People with HIV are encouraged to apply.



Scan the QR code with your phone's camera for membership applications!

MEMBERSHIP

Are you a Member?

Thank you for your service to people with HIV!
Be sure to bring a Ryan White client to your next meeting!

Do You Qualify for Membership?

If you answer "Yes" to these questions, you could qualify for membership!

Are you a resident of Miami-Dade County?

Are you a registered voter in Miami-Dade County?
Note: Some seats for people with HIV are exempt from this requirement.

Can you volunteer three to five hours per month for Partnership activities?

Committee Activities

Work with a dedicated team of volunteers on these and more Partnership activities to better serve people with HIV in Miami-Dade County!
People with HIV are encouraged to join!

- Allocate more than $27 million in Ryan White Program funds with the **Care and Treatment Committee**
- Develop an Annual Report on the State of HIV and the Ryan White Program in Miami-Dade County with the **Strategic Planning Committee**
- Recruit and train new Partnership members with the **Community Coalition**
- Work with the City of Miami Housing Opportunities for Persons with AIDS Program to address housing challenges for people with HIV/AIDS with the **Housing Committee**
- Oversee updates and changes to medical treatment guidelines for the Ryan White Part/ MAI Program with the **Medical Care Subcommittee**
- Set priorities for Ryan White Program HIV health and support services in Miami-Dade County with the **Care and Treatment Committee**
- Share a meal and testimonials at Roundtable Luncheons with the **Community Coalition**
- Develop and monitor the official HIV Prevention and Care Integrated Plan with the **Strategic Planning Committee** & **Prevention Committee**
- Develop your leadership skills and be a committee leader with the **Executive Committee**
- Oversee updates and changes to the Ryan White Prescription Drug Formulary with the **Medical Care Subcommittee**
- Develop and monitor local Ending the HIV Epidemic activities with the Florida Department of Health in Miami-Dade County with the **Prevention Committee** & **Strategic Planning Committee**
- Be in the know about the latest HIV activities of the Prevention Mobilization Workgroups with the **Prevention Committee**

Visit aidsnet.org/membership for the complete list of applications and details on Partnership and committee membership opportunities. Contact us at hiv-aidsinfo@behavioralscience.com or 305-445-1076 for assistance.

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XI.	Next Meeting: **January 26, 2022** at **BSR**	Dr. Robert Goubeaux
XII.	Adjournment	Dr. Robert Goubeaux

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RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **September 2021**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A
Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	19	133	19	124
Health Insurance Premium and Cost Sharing Assistance	3	750	3	748
Medical Case Management	3,427	10,925	3,301	6,953
Mental Health Services	6	68	6	63
Oral Health Care	350	1,888	350	1,629
Outpatient Ambulatory Health Services	924	4,663	920	3,649
Substance Abuse Outpatient Care	0	6	0	6
Support Services				
Food Bank/Home Delivered Meals	283	760	283	503
Medical Transportation	134	489	134	391
Other Professional Services	31	434	10	23
Outreach Services	3	68	3	67
Substance Abuse Services (residential)	3	27	3	24
TOTALS:	5,183	20,211		

Total unduplicated clients (month): 3,877

Total unduplicated clients (YTD): 7,611

REPORT COMPILED ON: 11/02/2021

Part A

RYAN WHITE PART A GRANT AWARD (BU033101)
FY 2021 (YR 31) EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE
FORMULA AND SUPPLEMENTAL FUNDING
Per Resolution # R-1192-20 AND R-246-20

This report includes YTD paid reimbursements for FY 2021 Part A service months up to September 2021, as of 11/2/2021. This report reflects reimbursement requests that were due by 10/20/2021 and have been paid thus far. Pending Part A reimbursement requests that have been received and are in process total $6,149,272.94.

PROJECT: BU033101	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount Formula	15,689,960.00	FORMULA	
Grant Award Amount Supplemental	7,877,731.00	SUPPLEMENTAL	Award - W/out CO
Grant Award Amount FY'19 Supplemental	261,718.00	PY_SUPPLEMENTAL	$23,829,409.00
Carryover Award FY'20 Formula	709,256.00	CARRYOVER	
Total Award	**$ 24,538,665.00**		

CONTRACT ALLOCATIONS/ FORMULA & SUPPLEMENTAL AWARDS

DIRECT SERVICES:

Priority Ranking #	Core Medical Services	Allocations		
2	Outpatient/Ambulatory Health Svcs	8,430,785.00		
9	AIDS Pharmaceutical Assistance	88,255.00		
4	Oral Health Care	3,088,975.00		
6	Health Insurance Services	442,447.00		
3	Mental Health Therapy/Counseling	132,385.00		
1	Medical Case Management	5,632,466.00		
7	Substance Abuse - Outpatient	44,128.00	17,859,441.00	
	Support Services	**Allocations**		
5	Food Bank	1,238,795.00		
13	Other Professional Services	154,449.00		
10	Medical Transportation	150,688.00		
11	Outreach Services	264,696.00		
8	Substance Abuse - Residential	1,887,656.00		
12	Emergency Financial Assistance	0.00	3,696,284.00	
	DIRECT SERVICES TOTAL:		**$ 21,555,725.00**	

Total Core Allocation	17,859,441.00	
Target at least 80% core service allocation	17,244,580.00	
Current Difference (Short) / Over	**$ 614,861.00**	
Recipient Admin. (OMB-GC, PC, GTL)	**$ 2,382,940.00**	
Quality Management	**$ 600,000.00**	
(+) Unobligated Funds / (-) Over Obligated:		
Unobligated Funds (Formula & Supp)	$ -	
Unobligated Funds (Carry Over)	$ -	2,982,940.00
		24,538,665.00

Core medical % against Total Direct Service Allocation (Not including C/O):
Cannot be under 75% — **82.85%** — **Within Limit**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **2.45%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **9.71%** — **Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

ACCOUNT	Core Medical Services	Expenditures	Carryover Expenditures		
5606610000	Outpatient/Ambulatory Health Svcs	1,154,897.77			
5492120000	AIDS Pharmaceutical Assistance	614.06			
5216100000	Oral Health Care	174,962.80			
5223550000	Health Insurance Services	104,402.28			
5114040000	Mental Health Therapy/Counseling	25,187.50			
5211100000	Medical Case Management	1,042,055.45			
5216120000	Substance Abuse - Outpatient	0.00			2,502,119.86
ACCOUNT	**Support Services**	**Expenditures**	**Carryover Expenditures**		
5492250000	Food Bank	529,484.80	0.00	529,484.80	
5212100000	Other Professional Services	50,985.00			
5602400000	Medical Transportation	9,621.18			
5224700000	Outreach Services	12,799.60			
5224130000	Substance Abuse - Residential	225,750.00			
5224300000	Emergency Financial Assistance	0.00			828,640.58
	TOTAL EXPENDITURES DIRECT SVCS & % :			**$ 3,330,760.44**	**15.45%**

Formula Expenditure %	**27.34%**		
Recipient Administration	**1,111,037.53**		
Quality Management	**300,000.00**	1,411,037.53	
Grant Unexpended Balance	**19,796,867.03**		
Total Grant Expenditures & %		**$ 4,741,797.97**	**19.32%**

Core medical % against Total Direct Service Expenditures (Not including C/O):
Cannot be under 75% — **75.12%** — **Within Limit**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **1.26%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **4.66%** — **Within Limit**

FY 2021 Part A/MAI Total Unduplicated Client Count, through September 2021 service month billing; as of 11/2/2021 = 7,611* clients (*subject to change)

Printed on: 11/2/2021

NOTE: 17 of 18 contracts (direct services, CQM, & Staff Support) are executed; the final one had been with the agency for signatures since mid-September and is now awaiting final County signatures. Expected to be executed on 11/3/2021.

RYAN WHITE PART A GRANT AWARD (BU033101)
FY 2021 (YR 31) EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE
MINORITY AIDS INITIATIVE (MAI) FUNDING
Per Resolution # R-1192-20 AND R-246-20

MAI

This report includes YTD paid reimbursements for FY 2021 MAI service months up to September 2021, as of 11/2/2021. This report reflects reimbursement requests that were due by 10/20/2021 and have been paid thus far. Pending Part A reimbursement requests that have been received and are in process total $426,139.39.

PROJECT: BU033102		AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI		2,603,486.00	MAI
Carryover Award FY'20 MAI		97,997.00	MAI_CARRYOVER
Total Award	**$**	**2,701,483.00**	

MAI CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Ranking #	Core Medical Services	Allocations	
2	**Outpatient/Ambulatory Health Svcs**	1,362,753.00	
	AIDS Pharmaceutical Assistance		
	Oral Health Care		
	Health Insurance Services		
3	**Mental Health Therapy/Counseling**	18,960.00	
1	**Medical Case Management**	903,920.00	
4	**Substance Abuse - Outpatient**	8,058.00	2,293,691.00

	Support Services	Allocations	
	Food Bank		
	Other Professional Services		
6	**Medical Transportation**	7,628.00	
5	**Outreach Services**	39,816.00	
	Substance Abuse - Residential		
7	**Emergency Financial Assistance**	0.00	47,444.00

DIRECT SERVICES TOTAL:		**$**	**2,341,135.00**
Total Core Allocation			2,293,691.00
Target at least 80% core service allocation			1,872,908.00
Current Difference (Short) / Over		**$**	**420,783.00**
Recipient Admin. (OMB-GC)		**$**	**260,348.00**
Quality Management		**$**	**100,000.00**
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (MAI)		**$**	**-** 360,348.00
Unobligated Funds (Carry Over)		**$**	**-**

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**97.97%**	**Within Limit**

Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.84%**	**Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**10.00%**	**Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

ACCOUNT	Core Medical Services	Expenditures	Carryover Expenditures		
5606610000	Outpatient/Ambulatory Health Svcs	168,801.11	0.00	168,801.11	
5492120000	AIDS Pharmaceutical Assistance				
5216100000	Oral Health Care				
5223550000	Health Insurance Services				
5114040000	Mental Health Therapy/Counseling	0.00			
5211100000	Medical Case Management	12,152.70			
5216120000	Substance Abuse - Outpatient	0.00			180,953.81

ACCOUNT	Support Services	Expenditures	Carryover Expenditures		
5492250000	Food Bank				
5212100000	Other Professional Services				
5602400000	Medical Transportation	0.00			
5224700000	Outreach Services	0.00			
5224130000	Substance Abuse - Residential				0.00
5224300000	Emergency Financial Assistance	0.00			

TOTAL EXPENDITURES DIRECT SVCS & %:			180,953.81	**7.73%**
Recipient Administration	**2,615.82**			
Quality Management	**49,999.98**		52,615.80	
Grant Unexpended Balance	**2,467,913.39**			
Total Grant Expenditures & % (Including C/O):		**$**	**233,569.61**	**8.65%**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**100.00%**	**Within Limit**

Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**1.92%**	**Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**0.10%**	**Within Limit**

Printed on: 11/2/2021

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, November 19, 2021

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Coral Gables, FL 33134 and Zoom

AGENDA

I.	Call to Order	Dr. Robert Goubeaux
II.	Meeting Rules and Housekeeping	Marlen Meizoso
III.	Roll Call and Introductions	Dr. Robert Goubeaux
IV.	Floor Open to the Public	Dr. Robert Goubeaux
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of October 22, 2021	All
VII.	Reports	
	• Membership Vacancies	Marlen Meizoso
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
VIII.	Standing Business	
	• Conclusion of Cabenuva barriers discussion	All
	• ADAP formulary additions and RWP review	All
	• Primary Medical Care Standards	All
	• Service Descriptions -Mental Health and Substance Abuse	All
IX.	New Business	
	• 2022 Draft Workplan	All
	• Continuous Glucose Monitoring Devices	All
	• Potential Needs of Aging Population	All
	• Elections 2022	Marlen Meizoso
X.	Announcements	All
	• Atripla brand discontinuation	
XI.	Next Meeting: **January 26, 2022** at **BSR**	Dr. Robert Goubeaux
XII.	Adjournment	Dr. Robert Goubeaux

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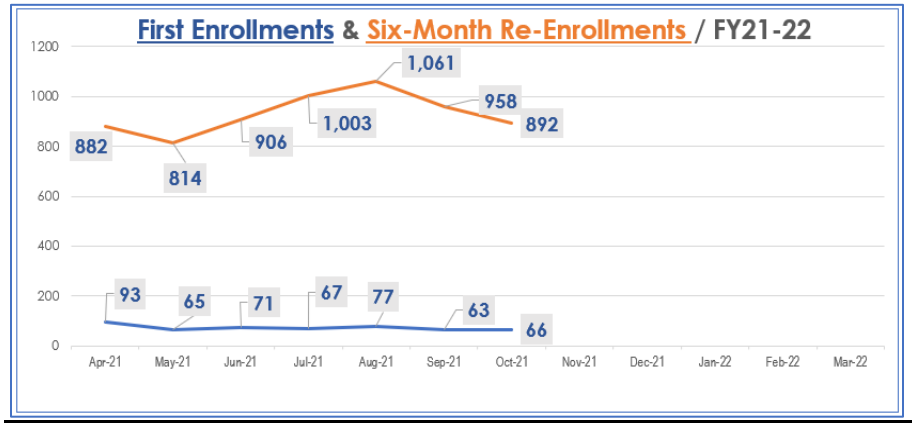
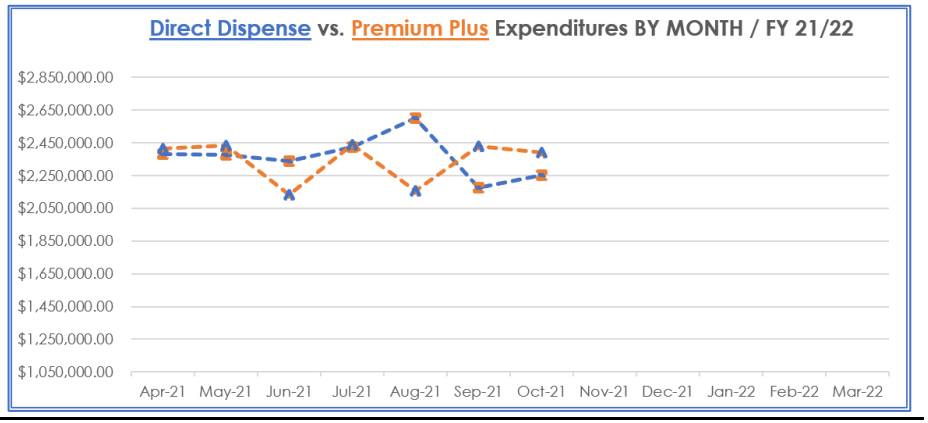
November 3, 2021

ADAP Miami-Dade / Summary Report – OCTOBER 2021

FY 21/22	First Enrollments	6-mo. Re-Enrollments	TOTAL OPEN	CHD Pharmacy Expenditures	RXs	Patients	RX/Pt	Premium Payments	Number of Premiums	Average Premium
FY20/21 >>	**795**	**10,979**	**5,766**	**$32,843,354.32**	**52,678**	**17,944**	**2.9**	**$23,115,161.17**	**25,395**	**$ 910.22**
Apr-21	93	882	5,921	$2,379,896.89	3,824	1,285	3.0	$2,413,106.07	2,366	$1,019.91
May-21	65	814	5,935	$2,376,870.79	3,856	1,289	3.0	$2,435,148.77	2,392	$1,018.04
Jun-21	71	906	5,915	$2,337,952.33	3,997	1,313	3.0	$2,131,887.00	1,917	$1,030.20
Jul-21	67	1,003	5,879	$2,423,002.81	4,396	1,356	3.2	$2,436,296.66	2,403	$1,013.86
Aug-21	77	1,061	5,686	$2,602,360.80	4,490	1,456	3.1	$2,157,974.33	1,973	$1,093.75
Sep-21	63	958	5,755	$2,176,932.46	3,788	1,319	2.9	$2,430,671.29	2,395	$1,014.89
Oct-21	66	892	5,777	$2,250,009.28	4,235	1,413	3.0	$2,391,647.63	2,353	$1,016.42
Nov-21										
Dec-21										
Jan-22										
Feb-22										
Mar-22										
TOTAL	**502**	**6,516**	**5,777**	**$16,547,025.36**	**28,586**	**5,915**	**3.0**	**$ 14,005,084.12**	**13,446**	**$1,041.58**

SOURCE: Provide - DATE: 10/09/21 - Subject to Review & Editing - West Perrine: NOT INCLUDED. (Estimate ~450 clients ~$6+ million/TBC).





PROGRAM UPDATE

11/01	2022 ACA-MP Open Enrollment	New ADAP Income limit 75-400 % FPL	New 75-99%: ~620 pts. *(222/36% No SSN; 398/64% SSN)*
11/05	Cabenuva utilization	ADAP Miami clients	RESULTS: 43 clients. 20 Direct Dispense *(47%)*; 23 Premium Plus *(53%)*.

For additional information: www.ADAPMiami.com or ADAP.FLDOHMDC@flhealth.gov

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Cabenuva Barriers Discussion

Items identified at the July meeting:

- Issues with pharmacy authorizations
- Medication not being approved yet on the Jackson formulary
- Misperceptions that any pharmacy can fill the Cabenuva prescriptions
- Issues with insurance plans (some bill medication as a pharmacy benefit others bill under medical services e.g., Medicare, private insurance
- Patients are being denied because they were receiving the medication originally via a study.

Query Results

A query with three questions was sent to a contact at provider agencies in August, the results of replies are below. Additional discussion from September has been included in this section.

1. **How many clients have you transitioned to Cabenuva?**

   1) 11
   2) 9**,** these nine clients have either started an oral lead in or received a subsequent injection. Seven clients are in the process of enrolling in Cabenuva.
   3) 23 currently

2. **Have you faced any barriers? If so, were these related to any of the following reasons:**

   a. Enrollment process.

   1) Coordinating the completion of the enrollment with a provider and patient signature: The nurse is messaged stating the patient is interested in Cabenuva.
   2) For tele health visits, the nurse must contact patient to answer any questions and explain how the enrollment process works for Cabenuva.
   3) Once a patient leaves an in-office visit, or disconnects from a tele health visit, it becomes more challenging to contact a patient and coordinate the completion of the enrollment form.
   4) The patient can present to clinic to sign the form or do so electronically. When completed electronically, there is usually a processing time of 3-5 business days before receiving a summary of benefits.
   5) We are currently collecting provider signatures for enrollment forms of Cabenuva to decrease delays in the patient receiving their medication.
   6) Yes, enrollment with ViiV can cause delays.

   b. Ordering the medication.

   1) Several calls to ViiV connect are required to order and schedule deliveries of the oral leading dose.
   2) We need to remind providers not to place oral leads of Cabenuva or injections themselves. Doing so bypasses the enrollment process to determine if the medication is covered by insurance and the need to determine the payor.

3) We are also not able to send prescriptions electronically under a pharmacy benefit. Ticket has been placed, but no solution to date.
4) Yes, ordering with specialty pharmacies has caused delays.

c. Delays in receiving the medication.

1) Yes, the oral leading dose.
2) Delays have occurred in shipment of the medication.
3) Delays in receiving medication at doctor's office.
4) Clinical trial client told to call 10 days in advance of need, but medication was not delivered (medications don't ship Friday for Monday).
5) Issue with getting orders on time either through FL Blue or ADAP (CVS Specialty).

d. Issues with authorizations, if so, for pharmacy or medical office?

1) One Pharmacy denial from private insurance stated that there was no indication that patient had difficulty maintaining compliance with daily antiretroviral therapy". However, federally approved medical practice guidelines for HIV/AIDS recommend these therapies for populations consistently engaged in care, similar to the ones enrolled in clinical trials.
2) Prior authorizations pending by the medical and or pharmacy office for approval of Cabenuva. The time commitment it takes to complete the required prior authorizations and the length of time is takes before the patient receives the oral lead in is often significant. By the time the PA is completed, we often check in with patient to determine if they still have interest in transitioning to Cabenuva.
3) Medical authorizations have been very challenging as Medical Prior Authorizations is not typical for them. Also, we have had two denials on a prior authorization for a new start from the pharmacy side.

e. Billing the medication.

1) Meetings and trainings held to discuss properly billing for the medication. Initial issues with J codes and training staff on using the correct code under buy and bill acquisition and or not properly billing for each injection since Cabenuva consists of two injections per visit – Rilpivirine and Cabotegravir.
2) Billing Medical Insurance has been an issue as it may take a month or longer to know if there will be reimbursement.
3) Billing through buy and bill process offers poor reimbursement, this maybe issue with either the insurance or health center.

f. Providing the injection at the office.

The only known issue is correctly billing for the injection at the clinic, see above.

g. Compliance with appointments by clients.

Patients have been compliant. If any appointments have been missed, patients have come in appropriately the following day.

h. Other, please detail.

1) Issues with applications process, applications are incomplete.
2) Communication with CVS specialty is unreliable close to 2 hours to review 3 patients.
3) Some clients signed up but are not aware the medication is injectable or that would require regimen change.
4) Some clients still picked up medications from ADAP while taking Cabenuva. It was suggested that the pharmacy calls ADAP to ensure they discontinue dispensing other medications since ViiV is not contacting ADAP.
5) New J-code (J0741) should go into effect after October1 which may improve billing reimbursement.
6) CVS canceled delivery because appointment at healthcare center could not be confirmed
7) Issues regarding confirmation of lead in medication from other pharmacy

3. **Any other issues you wish to share regarding accessing Cabenuva?** No replies

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Florida AIDS Drug Assistance Program (ADAP) Formulary
September 2021 Additions
Estimated Cost Analysis

	Generic Name	Therapeutic Classification	Pharmacologic Classification	Estimated 340B Cost (per unit or monthly cost)	On General Revenue?	Ryan White Options	Notes/Comments
1	**semaglutide**	Antidiabetic	Glucagon-like peptide-1 receptor agonist (GLP-1 RA)	Rybelsus (oral): $11.19 per unit/$353.73 per month; Wegovy (SC) $186.57 per unit/$746.36 per month	no	Antidiabetic options (non-insulin): biguanide, sulfonylurea,	
2	**dulaglutide**	Antidiabetic	Glucagon-like peptide-1 receptor agonist (GLP-1 RA)	$60.47 per unit/$241.86 per month	no		
3	**liraglutide**	Antidiabetic	Glucagon-like peptide-1 receptor agonist (GLP-1 RA)	Victoza: $0.03 per month/$0.06 per unit; Saxenda: $629.24 per month; $125.84 per unit	yes		
4	**canagliflozin**	Antidiabetic	Sodium-glucose co-transporter 2 (SGLT2) inhibitor	$0.29 per month/$0.01 per unit	yes		
5	**dapagliflozin**	Antidiabetic	Sodium-glucose co-transporter 2 (SGLT2) inhibitor	$0.29 per month/$0.01 per unit	no		
6	**empagliflozin**	Antidiabetic	Sodium-glucose co-transporter 2 (SGLT2) inhibitor	$0.01 per month/$0.29 per unit	yes		
7	**allopurinol**	Antigout	Xanthine oxidase inhibitor	$0.30 per month/$0.01 per unit	yes	no	
8	**sofosbuvir/velpatasvir**	Anti-infective	Hepatitis C antiviral	Brand: $4859.40 per month/$173.55 per unit	no	no	
9	**sofosbuvir/velpatasvir/voxilaprevir**	Anti-infective	Hepatitis C antiviral	$17737 per month/$633.46 per unit	no	no	
10	**naltrexone ER/bupropion ER**	Anti-obesity	Anoretic agents	$16.04 per month/$0.13 per unit	no	no	
11	**orlistat**	Anti-obesity	Gastrointestinal lipase inhibitor	$0.86 per month/$0.01 per unit	no	no	
12	**apixaban**	Blood formation and coagulation	Anticoagulant	$28.21 per month/$0.47 per unit	yes	Epoetin/Procrit/Neupogen,Coumadin, Ferrous sulfate, Feosol, FeroSul, FerrouSul	
13	**dabigatran**	Blood formation and coagulation	Anticoagulant	$0.57 per month/$0.01 per unit	yes		
14	**rivaroxaban**	Blood formation and coagulation	Anticoagulant	$0.29 per month/$0.01 per unit	yes		
15	**hydralazine**	Cardiovascular	Antiangina	0.0100 to 0.6700 per tablet 340B;	yes	benzepril, enalapril, eprosartan,	Indication: Hypertension. Heart failure with reduced ejection fraction. Class: Peripheral Vasodilator

Florida AIDS Drug Assistance Program (ADAP) Formulary
September 2021 Additions
Estimated Cost Analysis

	Generic Name	Therapeutic Classification	Pharmacologic Classification	Estimated 340B Cost (per unit or monthly cost)	On General Revenue?	Ryan White Options	Notes/Comments
16	carvedilol	Cardiovascular	Beta-blocker	0.0100 to 0.8270 per tablet 340B	yes	metoprolol, atenolol	Indication: Heart Failure with reduced ejection fraction, Hypertension. Class: Alpha/Beta Adrenergic Blocker
17	labetalol	Cardiovascular	Beta-blocker	0.0100 to 0.1516 per tablet 340B	yes		Indication: Hypertension. Chronic hypertension and Hypertensive emergency in pregnancy. Class: Alpha/Beta-Adrenergic Blocker
18	propranolol	Cardiovascular	Beta-blocker	0.0100 to 0.1709 per cap/tab 340B	yes		Indication: Angina pectoris (chronic), Cardiac Dysrhythmia, Hypertension, Idiopathic hypertrophic cardiomyopathy, Migraine (prophylaxis), Pheochromocytoma. Class: Beta-Adrenergic Blocker (Nonselective), Cardiovascular Agent
19	clopidogrel	Cardiovascular	Platelet inhibitor	0.0276 to 0.4901 per tablet 340B	yes	rosuvastatin, atorvastatin, pravastatin	Indication: Acute coronary syndrome, Myocardial infarction, ischemic stroke, or peripheral atherosclerotic disease. Class: Antiplatelet Agent, Thienopyridine, P2Y12 Antagonist
20	prasugrel	Cardiovascular	Platelet inhibitor	0.0300 to 0.2583 per tablet 340B	yes		Indications: acute coronary syndrome, percutaneous coronary intervention, thrombosis. Class: ADP- induced aggregation Inhibitor, Platelet aggregation Inhibitor, Thienopyridine; P2Y12 Antagonist
21	chlorthalidone	Cardiovascular	Thiazide-like diuretic	0.0100 to 0.1899 per tablet 340B	yes	HCTZ	Indication: Edema (refractory), Hypertension. Class: Thiazides, Diuretic.
22	benztropine	Central nervous system	Anticholinergic	0.0100 to 0.0442 per tablet 340B	yes	no	Indication: Parkinsonism, extrapyramidal disease. Class: Anticholinergic, Antiparkinsonian
23	topiramate	Central nervous system	Anticonvulsant	0.0100 to 0.652 per tablet 340B	yes	valproic acid, divalproex sodium, phenytoin, lamotrigine	Indication: Migraine Prophylaxis, Seizure. Antipsychotic-induced weight gain; Binge eating disorder. Class: Anticonvulsant, Central Nervous System Agent
24	frovatriptan	Central nervous system	Antimigraine	0.0089 to 4.5033 per tablet 340B	no	no	Indication: Acute treatment of Migraine. Class: Antimigraine, Serotonin Receptor Agonist (5HT1)
25	naratriptan	Central nervous system	Antimigraine	0.1644 to 6.4978 per tablet 340B	no	no	Indication: Migraine. Class: Antimigraine, (5HT1)
26	rizatriptan	Central nervous system	Antimigraine	0.1975 to 2.47 per tablet	yes	no	Indication: Migraine. Class: Antimigraine, (5HT1)
27	sumatriptan	Central nervous system	Antimigraine	0.0100 to 4.9222 per tablet	yes	no	Indication: Migraine. Class: Antimigraine, (5HT1)
28	buspirone	Central nervous system	Anxiolytic	0.0138 to 0.1326 per tablet 340B	yes	lorazepam, clonazepam, temazepam	Indications: GAD, Anxiety. Class: Anxiety, Azaspirodecanedione

Florida AIDS Drug Assistance Program (ADAP) Formulary
September 2021 Additions
Estimated Cost Analysis

	Generic Name	Therapeutic Classification	Pharmacologic Classification	Estimated 340B Cost (per unit or monthly cost)	On General Revenue?	Ryan White Options	Notes/Comments
29	**baclofen**	Central nervous system	Muscle relaxant	0.0100 to 0.1135 per tablet 340B	yes	no	Indication: Spasticity. Class: Skeletal Muscle Relaxant
30	**cyclobenzaprine**	Central nervous system	Muscle relaxant	0.0100 to 0.8242 per tablet 340B	yes	no	Indication: Muscle spasm. Class: Skeletal Muscle Relaxant
31	**dicyclomine**	Gastrointestinal	Antispasmodic	*10mg = $2.37 per 100ct 20mg = $2.12 per 100ct ; 10mg/5ml = $43.19 per 473ml	yes	no	GR; No similar agents in formulary
32	**sucralfate**	Gastrointestinal	Gastric acid buffer	*1 gm tabs(brand) = $0.92 per 100ct.	no	no	Significant drug interactions; Similar agents: ranitidine, omeprazole
33	**calcium polycarbophil**	Gastrointestinal	Laxative, bulk-forming	*625mg = $1.89 per 60 ct.	yes	no	OTC; GR; products like Fibercon; no equivalent in RW formulary
34	**methylcellulose**	Gastrointestinal	Laxative, bulk-forming	*500 mg = $13.37 per 100ct.	yes	no	OTC; GR; products like Citrucel; no equivalent in RW formulary
35	**psyllium**	Gastrointestinal	Laxative, bulk-forming	*3.5gm = $12.55 per 30 pkt.	yes	no	OTC; products like Metamucil; no equivalent in RW formulary
36	**bisacodyl**	Gastrointestinal	Laxative, stimulant	*10mg supp = $5.83 per 50ct. ; 5mg tab = $0.90 per 100ct.	yes	no	OTC; GR; products like Dulcolax; no equivalent in RW formulary
37	**docusate sodium**	Gastrointestinal	Laxative, stool softener	*100 mg = $1.03 per 100ct.	yes	no	OTC; GR; products like Colace; no equivalent in RW formulary
38	**oxybutynin**	Genitourinary	Bladder antispasmodic	*5mg = $1.80 per 100 ct ; *10mg = $2.98 per 100 ct; *15mg = $3.02 per 100ct	yes	no	GR
39	**fexofenadine**	Respiratory	Antihistamine	*60mg = $9.69 per 100ct ; *180mg = $8.83 per 100ct	yes	cyproheptadine	OTC; GR; similar agent in formulary Benadryl
40	**montelukast**	Respiratory	Leukotriene receptor antagonist	*4mg = $0.82 per 30ct ; *5mg = $0.61 per 30 ct ; *10mg = $0.65 per 30ct	yes	no	GR
41	**hydroxyzine**	Respiratory or CNS	Antihistamine or anxiolytic	*10mg = $1.11 per 100ct; *25mg = $1.49 per 100ct; *50mg = $0.92 per 100ct	yes	no	GR
42	**disulfiram**	Substance abuse	Alcohol deterrent	*250mg = $17.82 per 100ct.	yes	no	GR
43	**nicotine**	Substance abuse	Nicotine replacement	*7mg(patch) = $9.75 per 14ct ; 14mg(patch) = $10.17 per 14 ct ; 21mg(patch) = $10.05 per 14 ct.	yes	smoke cessation:varencicline	GR, Varenicline in RW formulary; usually used in addition to varenicline for smoking cessation with better results.
44	**naltrexone (oral)**	Substance abuse	Opiate antagonist	*50mg = $9.72 per 30 ct ; *380mg(vial) = $543.78 per 1 package	yes	no	GR

Florida AIDS Drug Assistance Program (ADAP) Formulary
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	Generic Name	Therapeutic Classification	Pharmacologic Classification	Estimated 340B Cost (per unit or monthly cost)	On General Revenue?	Ryan White Options	Notes/Comments
45	**ammonium lactate**	Topical	Humectant	*12% lotion = $3.07 per 226gm	yes	no	GR
46	**magnesium oxide**	Vitamin	Vitamin	*400mg = $2.02 per 100ct.	yes	multivitamin (OTC)	GR, OTC

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, November 19, 2021

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Coral Gables, FL 33134 and Zoom

AGENDA

I.	Call to Order	Dr. Robert Goubeaux
II.	Meeting Rules and Housekeeping	Marlen Meizoso
III.	Roll Call and Introductions	Dr. Robert Goubeaux
IV.	Floor Open to the Public	Dr. Robert Goubeaux
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of October 22, 2021	All
VII.	Reports	
	• Membership Vacancies	Marlen Meizoso
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
VIII.	Standing Business	
	• Conclusion of Cabenuva barriers discussion	All
	• ADAP formulary additions and RWP review	All
	• Primary Medical Care Standards	All
	• Service Descriptions -Mental Health and Substance Abuse	All
IX.	New Business	
	• 2022 Draft Workplan	All
	• Continuous Glucose Monitoring Devices	All
	• Potential Needs of Aging Population	All
	• Elections 2022	Marlen Meizoso
X.	Announcements	All
	• Atripla brand discontinuation	
XI.	Next Meeting: **January 26, 2022** at **BSR**	Dr. Robert Goubeaux
XII.	Adjournment	Dr. Robert Goubeaux

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Miami-Dade County Ryan White Program
Minimum Primary Medical Care Standards

Drafted and Reviewed by the Medical Care Subcommittee
and Approved by the
Miami-Dade HIV/AIDS Partnership

Statement of Intent: *All local Ryan White Program-funded practitioners are required by contract to adhere, at a minimum, to the Public Health Service (PHS) Guidelines.*

Requirements

1. **Requirements for New Practitioners** (Physicians, Advance Practice Registered Nurse, and Physician Assistants):

   - New practitioners should be linked to existing Ryan White Program providers, AETC or through an AAHIVM specialist to support the new provider.
   - New providers will receive a chart review within 6 months by supervising physician, medical director or agency team.
   - When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits

   Requirements for All Practitioners (Physicians, Advance Practice Registered Nurse, and Physician Assistants):

   - Practitioner must be a Physician (MD or DO), Nurse Practitioner, or Physician Assistant with current and valid license to practice medicine within the State of Florida
   - Practitioners must have a minimum experience treating 20 HIV+ clients over the past two years or currently working and under supervision of a practitioner meeting these qualifications.
   - Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two years.
   - Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
     a. DHHS Clinical Guidelines
        https://clinicalinfo.hiv.gov/en/guidelines
     b. US Preventive Taskforce
        https://www.uspreventiveservicestaskforce.org/uspstf/
     c. American Cancer Society Guidelines for the Early Detection of Cancer
        http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp
     d. European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV
        https://www.eacsociety.org/guidelines/eacs-guidelines/
     e. ACC/AHA Guideline on the Treatment of Blood Cholesterol
        https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625
     f. CDC Recommended Adult Immunization Schedule
        http://www.cdc.gov/vaccines/schedules/hcp/adult.htlm

g. Incorporating Recommendations for HIV Prevention with Adults and Adolescents with HIV in the US
http://stacks.cdc.gov/view/cdc/26062
h. Although not paid for by the Ryan White Program, below are PrEP, nPEP and PEP guidelines:
https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf
https://www.cdc.gov/hiv/clinicians/prevention/prep-and-pep.html
https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf
i. National HIV Curriculum
https://www.hiv.uw.edu/alternate
j. American Association for the Study of Liver Diseases
https://www.aasld.org/publications/practice-guidelines-0
k. HIV Drug Interactions University of Liverpool
https://hiv-druginteractions.org/
l. HEP Drug Interactions University of Liverpool
https://www.hep-druginteractions.org/
m. American Medical Association Telehealth Quick Guide
https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
n. Miami-Dade County Ryan White Program Telehealth Policy
https://www.miamidade.gov/grants/library/ryanwhite/telehealth.pdf
o. Miami-Dade County Ryan White Program Test and Treat / Rapid Access (TTRA) Protocol
https://www.miamidade.gov/grants/library/ryanwhite/section-XIV-test-treat-rapid-access-protocol.pdf
https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

- Follow an action plan to address any areas for performance improvement that are identified during quality assurance reviews.

Minimum Standards by Which Practitioners Will Be Measured

Assessments and Referrals

2. **Initial** - At initial visit:
   a. If enrolled as Test and Treat/Rapid Access (TTRA) client (patient), follow TTRA protocol for visit
   b. Comprehensive initial history
   c. Mental health and substance abuse assessment
   d. Physical examination, including review of systems
   e. Vital signs, including weight, BMI, height (no shoes) This may not happen on first visit due to COVID and telehealth but should be scheduled for inhouse appt ASAP
   f. Gynecological exam per guidance for females-need consent pursuant to FL Statues.
   g. Wellness exam for females
   h. Rectal examination and stool guaiac testing-not done usually (FIT or GI referral for colonoscopy); Need consent pursuant to FL Statutes
   i. Sexually transmitted infection assessment as appropriate including at a minimum GC, Chlamydia at anatomical sites of potential exposure, RPR, and for females trichomoniasis NAAT of vaginal secretions.
   j. Age appropriate cancer screening
   k. Adherence to medications

l. Risk reduction
m. Safer sex practices-discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
n. Pregnancy Planning:
   1) Preconception counseling for men and women
   2) Contraceptive counseling for men and women including assessment and type of birth control method
o. Targeted initial history and physical examination with expectation that a complete history and physical examination will be completed within 3 months.
p. Education that they should never run out of ARV medications and need to call the FDOH-MDC clinic if they cannot obtain ART.

Item to be covered by subrecipient staff: Documented HIV education, including: transmission, reduction of morbidity/mortality with ART; resistance; compliance with ARV and office visits and lab monitoring; life expectancy; divulging HIV status and state statute

3. **Interim Monitoring and Problem-Oriented visits** - At every visit:
   a. Vital signs, including weight/BMI-may not occur every time with telehealth
   b. Physical examination related to specific problem, as appropriate
   c. Interval changes in vital signs addressed, especially trend in weight over time
   d. Adherence to medications and lab and office visits for monitoring
   e. Risk reduction
   f. Safer sex practices-discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
   g. Interval risk for acquiring STD and screening as indicated
   h. In women of childbearing age, assessment of adequate contraception

4. **Annual** - At each annual visit:
   a. Update comprehensive initial history, as appropriate
   b. Physical examination, including review of systems
   c. Vital signs, including weight, BMI, height (no shoes)-may not occur every time with telehealth. Annual exams should be done in office and include the above.
   d. Interval changes in vital signs addressed, especially trend in weight/BMI over time
   e. Mental health and substance abuse assessment
   f. Gynecological exam per guidance for females -may need to be scheduled if done by telehealth, should be done in office.
   g. Wellness exam for females
   h. Rectal examination and stool guaiac testing-not done usually (FIT or GI referral for colonoscopy)
   i. Sexual transmitted infection assessment
   j. Age appropriate cancer screening
   k. Adherence to medications
   l. Risk reduction
   m. Safer sex practices-discussions may include PrEP, PEP, nPEP, for sexual partners and should include condom usage
   n. Preconception counseling for men and women

Assess and document health education on:
   o. Nutritional assessment/care
   p. Oral health care

q. Mental Health assessment (particularly clinical depression)/care
r. Exercise
s. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
t. Domestic violence
u. Birth control
v. Advance Directives (completion or review)

Item to be covered by subrecipient staff: If client knows of others who need PrEP or Test and Treat / Rapid Access, information and referral are offered.

5. **Additional Charting/Documentation at least annually:**
   a. Problem list complete and up-to-date
   b. Medications list complete with start and stop dates, dosages
   c. Allergies list complete and up-to-date
   d. Immunization list complete and up-to-date

6. **Telehealth**

   Telehealth may be used in place or conjunction with an office visit. Necessary assessments will be conducted as needed and follow-ups will be scheduled as appropriate.

Assessments to be included at Incremental Visits

HIV Specific

7. **CD4 cell count** [i] - Entry into care; at ART initiation or modification; every 3-6 months during the first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm^3; every 12 months after 2 years on ART with consistently suppressed viral load, CD4 count 300-500 cells/mm^3, if CD4 count >500 cells/mm^3: CD4 monitoring is optional; if ART initiation is delayed monitor every 3-6 months; if treatment failure or if clinically indicated. *In accordance with the HRSA HAB performance measures, the local program defines consistently suppressed viral load as <200 copies/ml.*

8. **HIV viral load** [i] - Entry into Care; at ART initiation or modification; 2-8 weeks after ART initiation or modification if HIV RNA is detectable at 2-8 weeks, repeat testing every 4-8 weeks until viral load is suppressed to <200 copies/mL. Thereafter, repeat testing every 3-6 months; every 3 to 6 months or every 6 months, in patients on ART, viral load typically is measured every 3-4 months. More frequent monitoring may be considered in individuals who are having difficulties with ART adherence. However, for adherent patients with consistently suppressed viral load and stable immunologic status for more than 2 years, monitoring can be extended to 6-month intervals; if ART initiation is delayed, repeat testing is optional; treatment failure or if clinically indicated.

9. ***ARV therapy is recommended and discussed*** [i, iv]- Risks and benefits are discussed including reduced morbidity and mortality and prevention of HIV transmission to others and if treatment initiated, follow-up with adherence. If refused, document in record and refer to ARTAS and or Department of Health Treatment Adherence Specialist.

10. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** [ii] - Specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis jirovecii pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines.

11. **Resistance Testing** [i] - Entry into care; at ART initiation or modification; if ART initiation is delayed; treatment failure or clinically indicated. Based on current rates of transmitted drug resistance to different ARV medications, standard genotypic drug-resistance testing in ARV-naïve-persons should focus on testing for mutations in the reverse transcriptase and protease genes. If transmitted INSTI resistance is a concern or if a person presents with viremia while on an INSTI, providers should also test for resistance mutations to this class of drugs. In ART-naïve patients who do not immediately begin ART, repeat testing before initiation of ART is optional if resistance testing was performed at entry into care. In patients with virologic suppression who are switching therapy because of toxicity or for convenience, viral amplification will not be possible; see the DHHS section on Drug Resistance Testing for discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior resistance testing can be helpful in constructing a new regimen.

12. **HLA-B*5701** [i] - If considering start of abacavir (ABC) at ART initiation or modification and document in record carrying data forward to most current volume. *(Currently not paid for by the Ryan White Program due to payer of last resort restrictions; must access ViiV sponsored testing directly through labs. For LabCorp, HLA-AWARE HLA-B*5701 ViiV code #006940 and for Quest Diagnostic ViiV HLA-B*B5701 test code #19774)*

13. **Tropism testing** [i] - If considering use of CCR5 antagonist (requires plasma HIV RNA level ≥ 1000 copies/mL) in ART initiation or modification, or for patients experiencing virologic failure on a CCR5 antagonist-based regimen or if clinically indicated. If performed, record carried forward to most current volume.

STI Screenings

14. **Anal Dysplasia Screening** [iii] -For all patients with HIV ≥35 years old, regardless of HPV vaccine status, clinicians should: inquire annually about anal symptoms, such as itching, bleeding, palpable masses or nodules, pain, tenesmus, or a feeling of rectal fullness; perform a visual inspection of the perianal region; provide information about anal cancer screening and engage the patient in shared decision-making regarding screening, including anal cytology prior to digital anorectal examination (DARE); recommend and perform DARE to screen for anal pathology; perform DARE if anal symptoms are present. For MSM, transgender women, women, and transgender men with HIV clinicians should perform or recommend annual anal pap testing to identify potentially cancerous cytologic abnormalities. Evaluate any patient with HIV who is <35 years old and presents with signs or symptoms that suggest anal dysplasia. Clinicians should conduct or refer for high resolution anoscope (HRA) and histology (via biopsy) any patient with abnormal anal cytology and refer patients with suspected anal cancer determined by DARE or histology to an experienced specialist for evaluation and management. Additional information at https://www.hivguidelines.org/hiv-care/anal-dysplasia-cancer/.

15. **Bacterial STIs (Syphilis**, **N. gonorrhoeae** (GC), **C. trachomatis** (Chlamydia) and **parasitic STIs (Trichomoniasis)** [iv]- At the initial HIV care visit, providers should test all sexually active persons with HIV infection for curable STDs (e.g., syphilis, gonorrhea, and chlamydia) and perform testing at least annually during the course of HIV care. Specific

testing includes syphilis serology and NAAT for N. gonorrhoeae and C. trachomatis at the anatomic site of exposure, as the preferred approach. Women with HIV infection should also be screened for trichomonas at the initial visit and annually thereafter. Women should be screened for cervical cancer precursor lesions by cervical Pap tests per existing guidelines. More frequent screening for curable STDs might be appropriate depending on individual risk behaviors and the local epidemiology of STDs. Many STDs are asymptomatic, and their diagnosis might indicate risk behavior that should prompt referral for partner services and prevention counseling. USPSTF recommends high-intensity behavioral counseling for all sexually active adolescents and for adults at increased risk for STDs and HIV. The following are recommended annual for sexually active MSM, syphilis serology, testing for urethral infection with N. gonorrhoeae and C. trachomatis in men who have had insertive intercourse during the preceding year, test for rectal infections with N. gonorrhoeae and C. trachomatis for men who have receptive anal intercourse during the preceding year and test for pharyngeal infection with N. gonorrhoeae in men who have had receptive oral intercourse during the preceding year. More frequent STD screenings at 3-6-month intervals is indicated if risk behaviors persist. Additional information at https://www.cdc.gov/std/tg2015/tg-2015-print.pdf.

General Health including Labs

16. **ALT, AST, Total Bilirubin** [i] - Entry into care; ART initiation or modification; 2-8 weeks after ART initiation or modification; every 6 months; or if ART initiation is delayed, every 6-12 months, or if clinically indicated.

17. **Basic chemistry** [i,v] - Entry into care; ART initiation or modification; 2-8 weeks after ART initiation or modification; every 6 months; if ART initiation is delayed every 6-12 months, or if clinically indicated. Serum Na, K, HCO_3, Cl, BUN, creatinine, glucose, and creatine-base glomerular filtration rate. Serum phosphorus should be monitored in patients with chronic kidney disease who are on TDF(tenofovir)-containing regimens. Consult the Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America for recommendations on managing patients with renal diseases. More frequent monitoring may be indicated for patients with evidence of kidney diseases (e.g. proteinuria, decreased glomerular dysfunction) or increased risk of renal insufficiency (e.g. patients with diabetes, hypertension). Additional information at https://academic.oup.com/cid/article/59/9/e96/422813

18. **CBC w/ differential** [i] - Entry into care; ART initiation or modification; every 3-6 months when monitoring CD4 cell count; perform CBC cell count and CD4 concurrently; every 12 months when no longer monitoring CD4 cell count; if ART initiation is delayed, every 3-6 months, or if when clinically indicated. CBC with differential should be done when a CD4 count is performed. When CD4 count is no longer being monitored, the recommended frequency of CBC with differential is once a year. More frequent monitoring may be indicated for persons who are receiving medications that potentially cause cytopenia [e.g. ZDV (zidovudine), TMP-SMX (trimethoprim-sulfamethoxazole)].

19. **Random or Fasting Glucose** [i,vi] - Entry into care; ART initiation or modification; every 12 months; if ART initiation is delayed but if normal at baseline, annually, or if clinically indicated. If random glucose is abnormal, fasting glucose should be obtained. HbA1C is no longer recommended for diagnosis of diabetes in person with HIV on ART, see ADA guidelines. Additional information at https://care.diabetesjournals.org/content/43/Supplement_1.

20. **Random or Fasting Lipid Profile** [i,vii] - Entry into care; ART initiation or modification; every 12 months; if ART initiation is delayed but if normal at baseline, annually, or if clinically indicated. If random lipids are abnormal, fasting lipids should be obtained. Consult the 2018 Guideline on the Management of Blood Cholesterol for diagnosis and management of patients with dyslipidemia. Additional information at https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/28/2018-guideline-on-management-of-blood-cholesterol.

21. **Urinalysis** [i,v] - Entry into care; ART initiation or modification; every 6 months in patients on a tenofovir-containing regimen (TDF). , every 12 months or if clinically indicate. Consult the Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Disease Society of America for recommendations on managing patients with renal disease. More frequent monitoring may be indicated for patients with evidence of kidney disease (e.g., proteinuria, decreased glomerular dysfunction) or increased risk of renal insufficiency (e.g., patients with diabetes, hypertension). Urine glucose and protein should be assessed before initiating tenofovir alafenamide (TAF)-or tenofovir (TDF)-containing regimens and monitored during treatment with these regimens.
Additional information at https://academic.oup.com/cid/article/59/9/e96/422813

22. **TB Testing** [ii] - QuantiFERON TB Gold, T-SPOT, or Tuberculin Skin Test (TST), placed by the Mantoux method, should be performed as close to diagnosis of HIV infection and annually thereafter. If tested when CD4 < 200, repeat after CD4 increases to above 200. Annual TB test is recommended if patient is deemed high risk (repeated or ongoing exposure to known active TB, after incarceration, after living in congregate setting, active drug user or other risk factor for TB). If TB test is positive or has had active Tuberculosis documented with adequate treatment, annual chest X-ray should be performed. If chest X-ray cannot be afforded, cough screen questionnaire may be used as suggested by David Ashkin, MD.

23. **Bone Densitometry** [viii, ix] - Age 40-50 calculate FRAX to determine earlier screening and use "secondary causes" check box when using FRAX calculator. FRAX calculator**:** http://www.shef.ac.uk/FRAX/. All greater than or equal to age 50 men and postmenopausal women need DEXA. Additional information at http://hivinsite.ucsf.edu/InSite?doc=md-ward86-osteoporosis&page=md-ward86-index[v]

24. **Colon and Rectal Cancer Screening** [x] - Colorectal cancer screening recommended for individuals between 45-75 years of age. For ages 76-85 screening should be based on personal preference, life expectancy, overall health, and prior screening history. Those over 85 years old should no longer get colorectal cancer screening. Discussion should take place earlier (1) for those with a personal history of colorectal cancer or certain types of polyps, (2) for those with a family history of colorectal cancer, (3) for those with inflammatory bowel disease (ulcerative colitis or Crohn's disease), (4) for those with confirmed or suspected hereditary colorectal cancers syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC), or for those for with a personal history of getting radiation to the abdomen (belly) or pelvic area to treat a prior cancer.

25. **Lung Cancer Screening** [xi] -Annually with low-dose computer tomography (LDCT) for patients age 55-80 who have a 20 pack-year smoking history and currently smoke or have

quit within the last 15 years. Screening should be discontinued once a person has not smoked for 15 years, or has developed a health problem that substantially limits life expectancy or ability or willingness to have curative lung surgery.

26. H**epatitis A Screening** [xii] - At initial screening, if non-immune, offer vaccination and after vaccination received do postvaccination serologic testing ≥1 month after completing the hepatitis A vaccine series. See additional recommendations in guidelines.

27. **Hepatitis B Serology (HBsAb, HBsAg, HBcAb total)** [i] - At entry into care; at ART initiation or modification, may repeat if patient is nonimmune and does not have chronic HBV infection; every 12 months, may be repeated if patient is nonimmune and does not have chronic HBV infection, or if clinically indicated, including prior to starting HCV direct-acting antiretroviral (see HCV/HIV Coinfection). If patient has HBV (as determined by a positive HBsAg or HBV DNA test result), TDF(tenofovir) or TAF (tenofovir alafenamide) plus either FTC (emtricitabine) or 3TC (lamivudine) should be used as part other ARV regiment to treat both HBV and HIV infections (HBV/HIV). If HBsAg, HBsAb, and HBcAb test results are negative, hepatis B vaccine series should be administered. Refer to the HIV Primary Care Guidelines and the Adult and Adolescent Opportunistic Infection Guidelines for detailed recommendations. Most patients with isolated HBcAb have resolved HBV infection with loss of HBsAb. Consider performing an HBV viral load test for confirmation. If the HBV viral load test is positive, the patient may be acutely infected (and will usually display other signs of acute hepatitis) or chronically infected. If the test is negative, the patient should be vaccinated. Refer to the HIV Primary Care Guidelines and the Adult and Adolescent Opportunistic Infection Guidelines for detailed recommendations.

28. **Hepatitis C Screening (HCV antibody or, if indicated, HCV RNA)** [i] - At entry into care; every 12 months, for at-risk patients-injection drug users, person with a history of incarceration, men with HIV who have unprotected sex with men, and persons with percutaneous/parenteral exposure to blood in unregulated settings are at risk for HCV infection; or when clinically indicated. The HCV antibody test may not be adequate for screening in the setting of recent HCV infection (defined as acquisition within the past 6 months), or advanced immunodeficiency (CD4 count <100 cells/mm^3). HCV RNA screening is indicated in persons who have been successfully treated for HCV or who spontaneously cleared prior infection. HCV antibody-negative patients with elevated ALT may need HCV RNA testing.

29. **Gynecological Exam** [xiii] (females) - In women and adolescents with HIV, initiation of cervical cancer screening with cytology alone should begin within one year of onset of sexual activity, or if already sexually active, within the first year after HIV diagnosis but no later than 21 years of age. Cervical cancer screenings in women who are infected with HIV should continue throughout a woman's lifetime (i.e. not stopping at age 65 years). In women infected with HIV who are younger than 30 years, if the initial cytology screening result is normal, the next cytology screening should be in 12 months. If the results of three consecutive annual cervical cytology screenings are normal, follow-up cervical cytology screen should be every 3 years. Co-testing (cervical cytology and human papillomavirus [HPV] screening) is not recommended for HIV-infected women younger than 30 years. Women infected with HIV who are 30 years and older can be screened with cytology alone or co-testing. After women screened with cytology alone have had three consecutive annual test results that are normal, follow-up screening can be every 3 years. Women infected with HIV who have one negative co-test results (normal cytology and HPV negative) can have their next cervical cancer screening in 3 years. In women with HIV infection, co-testing

results that are cytology negative, but HPV positive are managed as in the general population. Women with HIV who have cervical cytology results of low-grade squamous intraepithelial lesions or worse should be referred for colposcopy. For women with HIV infection who are 21 years or older and have atypical squamous cells of undetermined significance (ASC-US) test results, if reflex HPV testing results are positive, referral to colposcopy is recommended. If HPV testing is not available, repeat cervical cytology in 6-12 months is recommended, and for any result of ASC-US or worse on repeat cytology, referral to colposcopy is recommended. Repeat cytology in 6-12 months, but not HPV testing, is recommended for HIV-infected women younger than 21 years with ASC-US test results. Although not explicitly stated in the Panel guidelines, women with HIV infection who have ASC-US, HPV-negative results (whether from reflex HPV testing or co-testing) can return to regular screening.

30. **Mammogram (**females) [xiv] - Starting at age 40, screening recommended annually. After age 55 every 2 years or can continue yearly screening. Screenings should continue as long as a woman is in good health and is expected to live at least 10 more years.

31. **Pregnancy test** [i] (For people of childbearing potential)- At entry into care; ART initiation or modification or when clinically indicated.

32. **Annual wellness visit** (females) [xv]- Should include screenings for anxiety, breast cancer, cervical cancer, interpersonal and domestic violence, sexually transmitted infections, urinary incontinence, and contraception. For those who are pregnant, lactation support and screenings for diabetes mellitus, as applicable.

33. **Prostate-specific antigen (PSA) Screening** [xvi] (males) - PSA testing is an individualized decision to be made by clinician and patient based on current guidelines.

Immunizations

Document in medical record carrying data forward to most current volume

34. **Hepatitis A vaccination** [xi, xvii] - Offer vaccination if not immune per guidance. Assess for response 30-60 days after vaccination by performing Hep A IgG antibody or Hep A Total antibody.

35. **Hepatitis B vaccination** [xvii] - Offer vaccination if not immune per guidance. Assess for response 30-60 days after vaccination by performing Hepatitis B surface antibody quantitative (anti-HBs).

36. **Human Papillomavirus (HPV) Vaccine** [xvii] - HPV vaccination as indicate by current guidelines.

37. **Influenza vaccination** [xvii] - Offer IIV or RIV4 annually.

38. **Meningococcal vaccination** [xvii] - Use 2-dose series MenACWY-D (Menactra, Menveo or MenQuadfi)) at least 8 weeks apart and revaccinate every 5 years if risk remains. See vaccination guidelines**.**

39. **Pneumococcal polysaccharide (PPSV23) and Pneumococcal conjugated (PCV13) vaccination** [xvii] - Should receive a dose of PCV13 (Prevnar 13), followed by a dose of PPSV23 (Pneumovax 23) at least 8 weeks later, then another dose PPSV23 at least 5 years

after previous PPSV23; at age 65 or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 year or older).

40. **Tetanus, diphtheria, pertussis (Td/Tdap)** [xvii] - One dose Tdap, then Td or Tdap every 10 years.

41. **Varicella** [xvii] – Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 count <200 cells/mm^3.

42 **Zoster vaccination** [xvii] - Recommended for 50 years and older per guidelines, use RZV.

43. **SARS-CoV-2 vaccination** [xvii] - Vaccinate per CDC guidance.

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[i] Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/tests-initial-assessment-and-follow?view=full. Accessed on July 19, 2021.
[ii] Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/whats-new-guidelines. Accessed July 19, 2021.
[iii] Screening for Anal Dysplasia and Cancer in Patients with HIV. https://www.hivguidelines.org/hiv-care/anal-dysplasia-cancer/. Accessed November 16, 2021.
[iv] Sexually Transmitted Diseases Guidelines, 2015. June 5, 2015. MMWR 2015. vol. 64, no. 3. https://www.cdc.gov/std/tg2015/tg-2015-print.pdf. Accessed July 19, 2021.
[v] Clinical Practice Guideline for the Management of Chronic Kidney Disease in Patients Infect with HIV: 2014 Update by the HIV Medicine Association of the Infectious Disease Society of America. Clinical Infectious Disease, vol. 59, issue 9, November 2014, e96-e138.
[vi] American Diabetes Association. Diabetes Care. January 1, 2020. Vol. 43, Issue supplement 1. https://care.diabetesjournals.org/content/43/Supplement_1. Accessed July 21, 2021.
[vii] 2018 Guideline on the Management of Blood Cholesterol. American College of Cardiology, November 10, 2018. https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/28/2018-guideline-on-management-of-blood-cholesterol. Accessed July 21, 2021.
[viii] Recommendations for Evaluation and Management of Bone Disease in HIV. Clinical Infectious Disease 2015:60; 1242-1251. https://pubmed.ncbi.nlm.nih.gov/25609682/. Accessed September 10, 2021.
[ix] Osteoporosis Screening, Treatment, and Prevention in HIV-Infect Patients. Updated January 2019 http://hivinsite.ucsf.edu/InSite?doc=md-ward86-osteoporosis&page=md-ward86-index. Accessed July 21, 2021.
[x] American Cancer Society Recommendations for Colorectal Cancer Screening. https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html Accessed July 21, 2021.
[xi] Screening for Lung Cancer: US Preventive Services Task Force Recommendation Statement. file:///C:/Users/Marlen/AppData/Local/Temp/lung-cancer-screening-final-recommendation.pdf. Accessed September 10, 2021.
[xii] Prevention of Hepatitis A Virus in the United States: Recommendations of the Advisory Committee on Immunization Practices, 2020. July 3, 2020. MMWR 2020. vol. 69, no. 5. https://www.cdc.gov/mmwr/volumes/69/rr/rr6905a1.htm. Accessed September 10, 2021.
[xiii] Gynecologic Care for Women and Adolescents with Human Immunodeficiency Virus. The American College of Obstetricians and Gynecologist, vol. 128, no. 4, October 2016.
[xiv] American Cancer Society Recommendations for the Early Detection of Breast Cancer. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html. Accessed July 21, 2021.
[xv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines-2019. Accessed September 10, 2021.

[xvi] American Cancer Society Recommendations for Prostate Cancer Early Detection. https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html. Accessed July 21, 2021.
[xvii] Recommended Adult Immunization Schedule for Ages 19 years or older, United States, 2021. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html. Accessed September 10, 2021.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, November 19, 2021

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Coral Gables, FL 33134 and Zoom

AGENDA

I.	Call to Order	Dr. Robert Goubeaux
II.	Meeting Rules and Housekeeping	Marlen Meizoso
III.	Roll Call and Introductions	Dr. Robert Goubeaux
IV.	Floor Open to the Public	Dr. Robert Goubeaux
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of October 22, 2021	All
VII.	Reports	
	• Membership Vacancies	Marlen Meizoso
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
VIII.	Standing Business	
	• Conclusion of Cabenuva barriers discussion	All
	• ADAP formulary additions and RWP review	All
	• Primary Medical Care Standards	All
	• Service Descriptions -Mental Health and Substance Abuse	All
IX.	New Business	
	• 2022 Draft Workplan	All
	• Continuous Glucose Monitoring Devices	All
	• Potential Needs of Aging Population	All
	• Elections 2022	Marlen Meizoso
X.	Announcements	All
	• Atripla brand discontinuation	
XI.	Next Meeting: **January 26, 2022** at **BSR**	Dr. Robert Goubeaux
XII.	Adjournment	Dr. Robert Goubeaux

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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MENTAL HEALTH SERVICES

(Year 31 Service Priorities: #3 for Part A and #3 for MAI)

Mental Health Services are core medical services. These Mental Health Services include the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to people with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the State of Florida to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers (see below for additional allowable professions under the local Ryan White Part A Program).

Mental Health Services require a treatment plan, as noted above. Treatment plans require an assessment and diagnosis which shall be used to inform the treatment goals and objectives and clinical interventions. Mental health providers may use this service category to conduct the assessment and diagnosis steps for the treatment plan. If ongoing mental health services are being provided to a client, it is expected that the client has a mental health treatment plan in place.

Psychiatric treatment that is part of a medical visit or a medication management and evaluation process must be recorded and billed under Outpatient/Ambulatory Health Services.

Mental Health Services are allowable only for program-eligible ~~people with HIV (~~clients~~)~~. This service is not available to non-HIV family members. Ryan White Program funds may **not** be used for bereavement support for uninfected family members or friends.

Mental Health Services reimbursed under Part A or MAI of the Ryan White Program are limited to conditions impacting the treatment of the client's underlying HIV disease (i.e., assessing, diagnosing, and treating a mental health condition that hinders HIV treatment adherence) and treated within the context of the client's HIV or AIDS diagnosis. This service is intended to address HIV-related issues and strengthen coping skills to increase adherence and access to ongoing medical care and treatment. It is important for the Level I or Level II mental health professional to regularly gauge the client's progress and determine if the client is still in need of the service.

- **Mental Health Services (Level I):** This level includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess ***a Doctorate degree*** **in psychology or counseling or related field (PhD, EdD, PsyD), and must be** ***licensed by the State of Florida*** as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.

- **Mental Health Services (Level II):** This level includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess ***a Master's degree*** **in psychology, psychotherapy or counseling or related field (MS, MA, MSW, or M.Ed.), and must be *licensed by the State of Florida*** as a LCSW, LMHC or LMFT to provide such services. **Direct service providers may also be:** 1) Florida registered interns as defined by Florida Statute (F.S.) 491.0045 (Clinical Social Work Intern, Mental Health Counselor Intern, or Marriage and Family Therapy Intern), or 2) a Psychology Intern, Postdoctoral Resident, or Fellow satisfying Rule 64B19-11.005 of the Florida Administrative Code (F.A.C.). Such interns will provide services under the supervision of a licensed State of Florida LCSW, LMHC, LMFT or Licensed Psychologist to provide such services.

Mental Health Service Components:

Level I counseling services include psychosocial assessment and evaluation, testing, diagnosis, treatment planning with written goals, crisis counseling, periodic re-assessments, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Level II counseling services include crisis counseling, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Group Counseling (Levels I and II) refers to a group of individuals [minimum of three (3) Ryan White Program clients, maximum of fifteen (15) total clients] with similar problems meeting under the expert guidance of a trained mental health professional. Members of the group will be selected by the mental health professional in order to maximize the interaction, learning, and benefits derived from a group dynamic. Group counseling provides therapy in a social context, reduces the feeling of isolation many

clients experience, provides an opportunity for clients to share methods of problem-solving, and allows the therapist an opportunity to observe how an individual interacts with others.

A. Program Operation Requirements: Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV+ family members (as defined by the client) only if the program-eligible ~~person with HIV (~~client~~)~~ is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of group counseling participants to counselors may not be lower than 3:1 and may not be higher than 15:1, as described above. One visit is equal to one half-hour counseling session.

Clients who are newly diagnosed with HIV or have returned to care should be offered the opportunity to speak with a mental health provider as a routine component of the services available through the local Ryan White Part A Program. An initial mental health visit could be used to identify, assesses, or verify mental health conditions that may affect a client's treatment adherence. Subsequent or on-going Mental Health Services under the Ryan White Part A Program require a mental health diagnosis documented in the client's chart. To facilitate this process for newly diagnosed or returned to care clients who are following the Test & Treat / Rapid Access (TTRA) protocol, the TTRAMH service code should be used to document the Mental Health Services provided. TTRAMH services are limited to one encounter (all mental health services provided on one day) within 30 days of starting the TTRA protocol, while program eligibility is being determined. For clients following the Newly Identified Client (NIC) protocol, Mental Health Services may be provided with these same limitations when using the NICMH service code.

Tele-mental health services are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

B. Additional Service Delivery Standards: Level I and Level II providers must adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV/AIDS-related illnesses. (Please refer to Section III of this FY 202~~1~~2 Service Delivery Manual for details.)

C. Rules for Reimbursement: Reimbursement for individual and group Mental Health Services will be based on a half-hour counseling session not to exceed $32.50 per unit for Level I individual counseling; $35.00 per unit for Level I group counseling; $32.50 per unit for Level II individual counseling; and $35.00 per unit for Level II group counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are

calculated for the counselor that provided the group counseling (i.e., number of group counseling units per counselor). The TTRAMH and NICMH codes are reimbursable under Level I or Level II individual counseling at $32.50 per unit (i.e., per half-hour session).

Tele-mental health services are reimbursed as follows:

New Code	Description	Flat rate Reimbursement
THMHT1	Tele-Mental Health provided by a Level I provider (individual client only)	$32.50 per 30-minute session
THMHT2	Tele-Mental Health provided by a Level II provider (individual client only)	$32.50 per 30-minute session

D. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group Mental Health Services is a one-half-hour counseling session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level I and Level II Mental Health Services.

E. **Additional Rules for Documentation:** Providers must also maintain certifications and licensure documents of the mental health professionals providing services to Ryan White Program clients and must make these documents available to OMB staff or authorized persons upon request. Client charts **must** include a detailed treatment plan for each eligible client that includes required components and the mental health professional's signature.

F. **Additional Treatment Guidelines and Standards:** Providers of Mental Health Services (Levels I and II) will adhere to generally accepted clinical guidelines for mental health therapy/counseling of people with HIV. The following are examples of such guidelines:

- American Psychiatric Association (APA). HIV Psychiatry - Training and Education, as well as HIV Psychiatry Physician Resources and Publications [e.g., Fact Sheets: HIV and Clinical Depression; HIV and Anxiety; HIV and Cognitive Disorders; HIV and Delirium; HIV and Substance Use; HIV and People with Severe Mental Illness (SMI); Sleep Disorders and HIV; and Pain in HIV/AIDS; Publications (including links to other related books and journals, such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition - DSM-5); and additional web materials.

  Available at:

  https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry and

https://www.psychiatry.org/psychiatrists/search-directories-databases
Accessed 8/5/2021.

- American Psychiatric Association. Latest Published APA Clinical Practice Guidelines, 2020; including but not limited to The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition, 2015.

  Available at:

  https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines and https://psychiatryonline.org/guidelines
  Accessed 8/5/2021.

SUBSTANCE ABUSE OUTPATIENT CARE
AND
SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

(Year 31 Service Priorities: #9~~7~~ for outpatient Part A and #4 for MAI; and #7~~8~~ for Part A residential only)

Two types of substance abuse counseling and treatment services are included in this section: Outpatient and Residential. **Substance Abuse Outpatient Care** is a core medical service. **Substance Abuse Services (Residential)** is a support service. Both of these substance abuse service components shall comply with the following requirements:

A. Program Operation Requirements: Providers are encouraged to provide services that are highly accessible to target populations.

Providers are also encouraged to demonstrate linkages with other service providers relevant to the needs of people with HIV in substance abuse treatment programs. Providers should especially demonstrate linkages with other services relevant to the needs of people in substance abuse treatment programs including housing and shelter programs.

Service must be provided in settings that foster the client's sense of self-control, dignity, responsibility for his/her/their own actions, relief of anxiety, and mutual aid.

Providers are encouraged to offer program services to families to support the family unit. However, substance abuse services may be provided to members of a client's family in an outpatient setting only (i.e., non-HIV family members may not stay in the residential facility), and only if the program-eligible ~~person with HIV (~~client~~)~~ is also being served. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.A. of this service definition on the following page for details). ***IMPORTANT NOTE****: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

Individual treatment plans must be documented in the client's chart and linked to the provision of primary medical care.

Providers must ensure that clients adhere to their treatment plan, including prescription drug regimens.

Providers of substance abuse services must offer flexible schedules that accommodate the client's nutritional needs in order to facilitate client compliance with medication regimens.

Providers are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate.

Residential substance abuse treatment is not a pre-requisite to access Substance Abuse Outpatient Care. However, clients graduating from Substance Abuse Services (Residential) are encouraged to transition to Substance Abuse Outpatient Care.

I. Substance Abuse Outpatient Care

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. This service includes medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a Physician or under the supervision of a Physician, or by other qualified personnel as indicated below. This program provides regular, ongoing substance abuse monitoring and counseling on an individual and/or group basis in a state-licensed outpatient setting.

Services include screening, assessment, diagnosis and/or treatment of substance use disorder. Allowable substance use disorder treatments include: pre-treatment/ recovery readiness programs; harm reduction; behavioral health counseling associated with substance use disorder; outpatient drug-free treatment and counseling; medication assisted therapy; neuro-psychiatric pharmaceuticals; and relapse prevention. Services may offer mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; conflict resolution; anger management; and relapse prevention. All clients receiving this service must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of substance use disorder.

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, it is included in a documented plan. Acupuncture therapy must be provided by an acupuncturist who is licensed in the State of Florida to provide such service.

Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The minimum amount of group participants is three (3) Ryan White Program clients per group and should be no higher than fifteen (15) total persons per group. The ratio of group counseling participants to Counselors should be no lower than 3:1 and no higher than 15:1. One unit is equal to one half-hour counseling session.

Substance Abuse Outpatient Care levels are specific to the education level of the provider of the service, as indicated below, and are not interchangeable:

- **Substance Abuse Outpatient Care (Level I) - Professional Substance Abuse Counseling.** Level I services include *general and intensive* substance abuse therapy and counseling (individual, family, and group) provided by trained mental health or certified addiction professionals. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Direct service providers for Level I must possess at least a *doctorate or postgraduate degree* (PhD or Master's degree) in the appropriate counseling-related field, and preferably be licensed as a *certified addiction professional* (CAP), Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.

- **Substance Abuse Outpatient Care (Level II) - Counseling and Support Services.** Level II services include supportive and crisis substance abuse counseling by trained and supervised Counselors (who may possess Bachelor's degrees or have related experience, and may not be licensed), peers, and facilitators. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Non-certified personnel providing this Level II service will be supervised by professionals with appropriate Level I substance abuse counseling credentials.

- **Tele-substance abuse outpatient care services** are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

B. **Additional Service Delivery Standards:** Providers of these services will also be required to adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. (Please refer to Section III of this FY 2021 Service Delivery Manual for details.)

C. **Rules for Reimbursement:** Reimbursement for individual and group Substance Abuse Outpatient Care will be based on half-hour counseling sessions (i.e., 1 unit) not to exceed $30.00 per unit for Level I individual counseling; $34.00 per unit for Level I group counseling; $27.00 per unit for Level II individual counseling; and $30.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and/or family member(s) receiving the counseling, whereas, reimbursement for group sessions is calculated for the

Counselor that provided the group counseling. Documentation activities are included in the Substance Abuse Outpatient Care unit of service and are not to be billed as a separate encounter. Substance Abuse Outpatient Care may be provided to members of a client's family in an outpatient setting if the program-eligible person with HIV (client) is also being served. The client must be currently receiving such services; and preferably, but not necessarily, the family member may be served on the same day as the client.

Tele-substance abuse outpatient care services are reimbursed as follows:

New Code	Description	Flat rate Reimbursement
THSAC1	Tele-Substance Abuse Outpatient Care provided by a Level I provider (individual client only)	$30.00 per 30-minute session
THSAC2	Tele-Substance Abuse Outpatient Care provided by a Level II provider (individual client only)	$27.00 per 30-minute session

D. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group counseling is a *one half-hour counseling session* provided to the client and the number of unduplicated clients served. Providers must also report, on a monthly basis, the number of group counseling units provided by each Counselor.

E. **Linkage/Referrals:** Providers of Substance Abuse Outpatient Care must document the client's progress through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the client, his/her/their Medical Case Manager, and Primary Care Physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving Medical Case Management services; if not, the provider must seek enrollment of the client in a Medical Case Management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the Medical Case Management provider must be established in order to ensure coordination of services while the client remains in treatment.

IMPORTANT NOTE: referrals from residential substance abuse services to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility, or once the client has completed or left their residential treatment program.

F. **Additional Rules for Documentation:** Providers must submit an assurance to OMB that Substance Abuse Outpatient Care services are only provided in an outpatient setting. Providers must maintain professional certifications and licensure documents as required by the State of Florida for staff providing

residential substance abuse treatment services to Ryan White Program clients and must make these documents available to OMB staff or authorized persons upon request. Providers must also submit to OMB a copy of the staffing structure showing supervision by a Physician or other qualified personnel. Providers must also maintain client charts that include treatment plans with all required elements, including but not limited to measurable goals and timelines for completion. Documentation in the client chart must also clearly indicate that services were provided as allowable under the local Ryan White Program service definition, and include the quantity, frequency and modality of treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. If acupuncture services were provided, a copy of the written referral from the primary health care provider must be in the client chart.

II. Substance Abuse Services (Residential)

This program offers substance abuse, including alcohol addiction and/or addiction to legal and illegal drugs, treatment and counseling, including HIV specific counseling, to program-eligible people with HIV (clients) on a short-term basis. Medication assisted therapy is also covered as part of the residential treatment services. **Substance Abuse Services (Residential)** provides room and board, in a secure, drug-free, state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Detoxification services are allowable, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital). HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license. Proof of the separate license is required for detoxification services.

In accordance with HRSA Policy Clarification Notice #16-02, Substance Abuse Services (Residential), as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, are permitted **only** when the client has received a written referral from a clinical provider. In Miami-Dade County's Ryan White Part A/MAI Program, this requirement shall be met if the client is accessing the service based on a Ryan White Program In Network Referral or Out of Network Referral as a result of a comprehensive health assessment conducted by a Medical Case Manager or other case manager or in response to a court-ordered directive to a residential treatment program. Upon arrival at the residential treatment center and PRIOR TO final enrollment in the treatment program, an assessment MUST be conducted by the residential clinical staff (e.g., Medical Director, Psychologist, Licensed Therapist, etc.) as appropriate using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) assessment tool for diagnosis of a substance use disorder. Services will then be provided by or under the supervision of a Physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State of Florida.

If the client is participating in a residential treatment program, the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in the residential facility with the client during the treatment process. As a reminder, a family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.B. of this service definition on the following page for details).

Residential treatment programs shall comply with the following requirements:

B. **Rules for Reimbursement:** The unit of service for reimbursement of Substance Abuse Services (Residential) is a *client-day* of care up to a maximum amount of $210.00 per day. The final, maximum rate is negotiated between the County's Office of Management and Budget-Grants Coordination division and each funded subrecipient. **Under normal circumstances clients may not be enrolled in any Ryan White Program-funded Substance Abuse Services (Residential) program for longer than 120 calendar days within a twelve-month period. Twelve months begins on the very first day of a client's residential treatment and restarts every 12 months based on that original start date for Ryan White Program-funded residential substance abuse treatment services. NO EXCEPTIONS, unless approved by the Miami-Dade County Office of Management and Budget for extreme circumstances (e.g., public health emergencies such as COVID-19 or extreme weather events such as hurricanes). The length of stay for existing clients will be closely monitored by the County's OMB/Ryan White Program.**

Residential substance abuse treatment providers are strongly encouraged to check the Provide® Enterprise Miami data management system order to determine how many days of residential treatment service have already been billed for the client, and how many days are remaining in the client's 120-day/12-month period. In addition, providers should call or email the client's previous Substance Abuse Services (Residential) provider, if applicable, to inquire if any services are pending to be entered or compiled in the Provide® Enterprise Miami data management system. This will affect the actual number of available days versus those that appear in the Provide® Enterprise Miami data management system.

C. **Additional Rules for Reporting:** Monthly activity reporting (i.e., reimbursement requests) for Substance Abuse Services (Residential) is per *client-day* of care and number of unduplicated clients served. Providers will indicate in the Provide® Enterprise Miami data management system the client's disposition after Substance Abuse Services (Residential) has ended (e.g., treatment completed, client referred to outpatient substance abuse counseling, client withdrew from treatment, etc.). This process is facilitated by the review and managing of the "RSA Disenrollment Report" available in the Provide® Enterprise Miami data management system.

Service providers are required to print this report on a monthly basis and disenroll clients who are no longer in active care. Once all residential treatment disenrollments for the month are completed, a final "RSA Disenrollment Report" must be printed and uploaded along with the monthly reimbursement request that is uploaded in the Provide® Enterprise Miami data management system.

D. **Linkage/Referrals:** Providers of Substance Abuse Services (Residential) must document the client's progress through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the client, his/her/their Medical Case Manager, and the Primary Care Physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving Medical Case Management services; if not, the provider must seek enrollment of the client in a Medical Case Management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the Medical Case Management provider must be established in order to ensure coordination of services while the client remains in treatment. **A client's Ryan White Program-funded Medical Case Manager will receive an automated "pop-up" notification through the Provide® Enterprise Miami data management system upon the client's discontinuance or release from, completion of, and/or relapse in residential substance abuse treatment.**

IMPORTANT NOTE: referrals from residential substance abuse services to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility, or once the client has completed or left their residential treatment program.

E. **Special Client Eligibility Criteria:** A Ryan White Program In Network Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service. Clients receiving Ryan White Program Part A or MAI-funded Substance Abuse Services (Residential) must be documented as having gross household incomes below 400% of the 202~~1~~2 Federal Poverty Level (FPL).

F. **Additional Rules for Documentation:** Providers must also maintain professional certifications and licensure documents as required by the State of Florida for staff providing residential substance abuse treatment services to Ryan White Program clients and must make these documents available to OMB staff or authorized persons upon request. Providers must submit to OMB a copy of the staffing structure showing supervision by a Physician or other qualified personnel, and an assurance that all services are provided in a short-term residential setting. Providers must also maintain client charts that include individual treatment plans with all required elements and document that services were provided as allowable under the Ryan White Program service definition, the quantity, frequency and modality of

treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. If acupuncture services were provided, a copy of the written referral from the primary health care provider must be in the client chart.

III. Additional Standards and Guidelines

Guidelines: Outpatient and residential substance abuse treatment and counseling providers will adhere to generally accepted clinical guidelines for substance abuse treatment of people with HIV. The following are examples of such guidelines:

- American Society of Addiction Medicine. *The ASAM Principles of Addiction Medicine,* Sixth Edition; November 2, 2018.
  Available at: https://www.asam.org/Quality-Science/publications
  Accessed 8/5/2021

- American Society of Addiction Medicine (ASAM). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* Third Edition.
  Available at: https://www.asam.org/Quality-Science/publications
  Accessed 8/5/2021

- American Society of Addiction Medicine. Public policy statements on HIV/AIDS and Addiction, and other policy statements related to the substance abuse treatment of clients living with HIV/AIDS.
  Available at: https://www.asam.org/advocacy/find-a-policy-statement
  Accessed 8/5/2021

- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida's Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.

- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30, Substance Abuse Services Office, of the Florida Administrative Code under the State of Florida Department of Children and Families, as may be amended.

MIAMI-DADE HIV/AIDS PARTNERSHIP

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9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Coral Gables, FL 33134 and Zoom

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XII.	Adjournment	Dr. Robert Goubeaux

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Medical Care Subcommittee
Calendar of Activities 2022

Month	Officer Elections	Conflict of Interest Forms/Financial Disclosure Forms	Outpatient/Ambulatory Medical Care Standards	Allowable Medical Conditions, as needed	Ryan White Prescription Drug Formulary, as needed	Oral Health Care Items	Committee Items (items added as needed)	Notes
	Activities							
January	x	x				x	x	elections, disclosures, oral healthcare issues continuation
February		x					x	utilization of Outpatient, amd AIDS Pharmaceutical
March		x					x	
April						x	x	ohc items, as needed
May							x	
June							x	
July			x			x	x	ohc items, as needed; review standards
August			x				x	continue with medical standards; service descriptions
September			x				x	continue with medical standards and service descriptions
October			x			x	x	ohc items, as needed; continue with medical standards and service descriptions
November			x				x	nominations for officers; finalize medical standard ;review 2023 planning
December	N	N	N	N	N	N	N	

Comments:
N=no meeting

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- Approximately 90 percent of Ryan White HIV/AIDS Program clients aged 50 and older receiving HIV medical care are virally suppressed, which is greater than the national Program average of 84.9 percent.*

Meeting the Health Challenges of Older PLWH Through Patient-Centered Care

Ryan White HIV/AIDS Program providers offer integrated primary medical and non-medical support services delivered by dedicated health care professionals in community health centers, clinics, and other sites. Patient-centered HIV care is implemented by the Program through a team-based, comprehensive approach focused on patient engagement, treatment adherence, and retention in care. The Ryan White HIV/AIDS Program recipients provide core medical services and support services, including the following:

- AIDS Drug Assistance Programs and the AIDS pharmaceutical assistance programs that allow PLWH to gain access to treatment and U.S. Food and Drug Administration-approved medications.
- Health insurance premium and cost-sharing assistance programs to help PLWH obtain health insurance and manage their co-payments.
- Medical case management services, which greatly help PLWH to manage, follow through with, and adhere to their treatment plans.
- Access to food banks or food pantries, transportation to and from medical appointments, and emergency financial assistance.

Ryan White HIV/AIDS Program providers now are caring for HIV patients who are developing age-related chronic diseases and comorbidities, such as diabetes and cardiovascular disease. These diseases are common in the general population as people age; however, older PLWH have more diseases and comorbidities than do adults without HIV. PLWH aged 50 and older particularly are at risk for—[4,5]

Cardiovascular disease (CVD), including high blood pressure: PLWH are at higher risk for coronary artery disease, hypertension, myocardial fibrosis, congestive heart failure, and ischemic stroke. Replacing older ART medications with newer ones may help to reduce CVD risk.

Kidney disease: The risk of chronic kidney disease is increased in all PLWH and is known as HIV nephropathy. Older patients particularly are at risk for kidney disease as a result of declining kidney function with age; use of such medications as tenofovir; and comorbidity of such conditions as diabetes, CVD, and hypertension.

Liver disease: Older PLWH who are co-infected with hepatitis are at higher risk for liver-related complications, including hospitalizations for liver-related diseases, than are younger people living with HIV. Screening for hepatitis A, hepatitis B, and hepatitis C with appropriate vaccination is currently recommended.

Diabetes: The prevalence of type 2 diabetes is reported to be four times higher in PLWH than in adults not living with HIV. These high rates of diabetes may be related to the use of older ART medications, such as protease inhibitors, and increasing age. More than half of new cases of diabetes are in adults aged 45 to 64.[6]

Osteoporosis: PLWH have a higher risk of osteoporosis or bone loss and fractures than do adults not living with HIV. Substance misuse, especially of alcohol, is a comorbidity seen in PLWH and is a risk factor for osteoporosis. Certain ART medications (e.g., protease inhibitors and tenofovir) also contribute to bone loss.

Cancer: While rates of skin and lung cancers are higher in PLWH than in adults not living with HIV, the risk of all cancers among PLWH increases with age, as it does in the general population. Cancer screening is recommended for all adults aged 50 and older as part of general health maintenance, in addition to HIV-specific screenings.

Dementia and other neurocognitive disorders: While ART has dramatically reduced the prevalence of HIV-associated neurocognitive disorders (HAND), about 50 percent of PLWH have some impairment. With aging, the risk of dementia, Alzheimer's disease, and HAND increases. Providers may use such screening tools as the Montréal Cognitive Assessment to assess patients.

Depression: Some studies suggest that adults living with HIV have an increased risk for depression. Side effects of ART and other medications may worsen mood and daily functioning. Some older PLWH may be socially isolated and may not have a support system—either

* Viral suppression among PLWH who had at least one outpatient ambulatory medical care visit and one viral load test during the measurement year is defined as a viral load result of less than 200 copies/mL at the most recent test.

because of stigma or the presence of fewer friends and family members. Such tools as the Geriatric Depression Scale can be used to screen patients for depression.

Polypharmacy: The use of multiple medications (polypharmacy) is common among PLWH. Older PLWH may be taking medications for age-related conditions, as well as for HIV. Both kidney and liver function decrease with age, affecting the clearance of many medications from the body. Ryan White HIV/AIDS Program providers can reduce the risk of polypharmacy and adverse drug interactions by reviewing patients' medications during each medical visit, conferring with treatment team members, carefully selecting antiretroviral agents, and monitoring and adjusting medication doses.

Ryan White HIV/AIDS Program providers are at the forefront of screening their older HIV patients for comorbidities and potential adverse drug interactions and providing the necessary treatments and referrals to optimize their patients' medical care.

AIDS RESOURCE CENTER OF WISCONSIN

As part of providing comprehensive HIV care, the AIDS Resource Center of Wisconsin screens patients with HIV who are older than age 50 with validated tools to identify such neurocognitive or neuropsychiatric issues as depression, as well as substance use disorders. "We integrate screening for substance use disorders and depression during a patient's medical clinic visit," says Dr. Debra Endean, Vice President and Chief Operating Officer, and Dr. Kevin Roeder, Senior Director of Behavioral Services. "All patients are assigned a care team that includes a behavioral health provider—usually a psychotherapist—a mental health and drug/alcohol counselor, a social worker, and a case manager. Provider options are offered according to a patient's needs, and practitioners work with patients to develop coping strategies."

RYAN WHITE HIV/AIDS PROGRAM RECIPIENTS ADDRESS HIV AND AGING

Stories From the Field: Boston Public Health Commission, Ryan White Services Division

The Boston Public Health Commission (BPHC) receives Ryan White HIV/AIDS Program Part A funding and serves 5,200 HIV-positive individuals across seven counties in Massachusetts and three in southern New Hampshire. BPHC is well-established in the community, having been a Ryan White HIV/AIDS Program recipient for more than 27 years. The programs and services provided by the 32 agencies that receive BPHC grants vary. In addition to primary care, case management and psychosocial support are core components of the programs; however, services also may include drug assistance and cost sharing, medical transport, meals, medical nutrition therapy, oral health, and residential treatment for substance abuse.

Approximately 72 percent of the patients BPHC serves are older than age 45. According to Dennis Brophy, Director, Ryan White Services Division for BPHC, "We have a long history of addressing the HIV epidemic, and many our patients are long-term survivors." About 52 percent of BPHC's patients older than age 45 are accessing medical case management services, and approximately 67 percent are accessing psychosocial support services. Mr. Brophy states that at least half of the 32 funded agencies provide psychosocial services to patients older than age 45, and at least two have HIV support groups geared toward long-term survivors. For example, the Justice Resource Institute's long-term survivor support group addresses issues related to aging, such as chronic diseases, medication changes due to effects of aging, stigma, special financial considerations, and relationships. Mr. Brophy notes that it is important for these support groups to be peer-led. He states, "We find that peer learning is important in terms of connecting people to care, being compassionate, and understanding unique concerns."

A key element in ensuring that BPHC meets the needs of patients is the Active Planning Council, whose members provide BPHC with formal feedback and guidance on the needs and concerns of the community. Council members are older themselves—at least 20 of the 30 members are older than age 50—and many have been involved with BPHC and the community for a long time. Mr. Brophy reports that the Council addresses such challenging issues as aging and housing, insurance coverage after retirement, financial issues, and the types of services that

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