MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, September 23, 2022

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	Dr. Robert Goubeaux
II.	Meeting Housekeeping and Rules	James Dougherty
III.	Introductions	Dr. Robert Goubeaux
IV.	Floor Open to the Public	James Dougherty
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 22, 2022	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Marlen Meizoso
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
IX.	New Business	
	• Subcommittee Composition Changes	All
	• Minimum Primary Care Standards Items #1-15	All
	• PHQ2: Behavioral Health Assessment in O/AHS Setting	All
	• Allowable Medication Conditions-Breast Cancer and Neutropenia	All
	• Ketamine for Substance Use Disorder	All
X.	Announcements	All
XI.	Next Meeting**: October 28, 2022** at **BSR**	James Dougherty
XII.	Adjournment	Dr. Robert Goubeaux

Please turn off or mute cellular devices – Thank you

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Meeting Housekeeping

Miami-Dade HIV/AIDS Partnership, Committees, and Subcommittee

Updated June 21, 2022
BSR Version

Disclaimer & Code of Conduct

- Audio of this meeting 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.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

Language Matters!

In today's world, there are many words that can be stigmatizing.

Here are a few suggestions for better communication.

Remember **People First** Language . . .

People with HIV, ***People*** with substance use disorders, ***People*** who are homeless, etc.

Please don't say **RISKS** . . .

Instead, say **REASONS.**

Please don't say, **INFECTED with HIV** . . .

Instead, say **ACQUIRED HIV, DIAGNOSED with HIV,** or **CONTRACTED HIV.**

Please **do not** use these terms . . .

Dirty . . . Clean . . . Full-blown AIDS . . . Victim . . .

Resource Persons

- Behavioral Science Research Corp. (BSR) 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

- Per County mandate, masks are no longer required to be worn in County buildings but because meeting attendees maybe immunocompromised, attendees are asked to wear a mask at all meetings. While masking cannot be enforced, we hope you will respect the health concerns of members and guests and choose to wear a mask for the duration of each meeting. Mask are available from staff.
- Place cell phones on mute or vibrate.
  - ❖ *If you must take a call, please excuse yourself from the meeting.*
- Only voting members and applicants should be seated at the meeting table.
  - ❖ *You may move your chair if concerned about social distancing.*

Meeting Participation

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

- All speakers must be recognized by the Chair.
  - *Raise your hand 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.

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.*

- Please **SIGN IN** to be counted as present at the meeting.

Parking

- *Please write your car tag (license plate) number on the **SIGN IN** sheet to have your parking validated.*

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

Behavioral Science Research

Miami-Dade HIV/AIDS Partnership

Miami-Dade County

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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. 240
Coral Gables, FL 33134
July 22, 2022

#	Members	Present	Absent	Guests	
1	Baez, Ivet		x	Ana Nieto	
2	Bauman, Dallas		x	Carla Valle-Schwenk	
3	Cortes, Wanda	x		Christhian A. Ysea	
4	Dougherty, James	x			
5	Friedman, Lawrence		x		
6	Goubeaux, Robert	x			
7	Romero, Javier	x			
8	Miller, Juliet		x		
9	Thornton, Darren	x			
10	Torres, Johann	x			
11	Vasquez, Silvana		x	**Staff**	
Quorum: 5				Marlen Meizoso	Robert Ladner

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

I. Call to Order

Dr. Robert Goubeaux, the Chair, called the meeting to order at 9:46 a.m. He introduced himself and welcomed everyone.

II. Meeting Rules and Housekeeping

James Dougherty reviewed the meeting rules and housekeeping presentation (copy on file), which provided the ground rules and reminders for the meeting. He identified Behavioral Science Research (BSR) staff as resource persons for the meeting. If anyone had any questions, BSR would be available to answer them after the meeting.

III. Roll Call and Introductions

Dr. Goubeaux requested members and guests introduce themselves around the room.

IV. Floor Open to the Public

Mr. Dougherty 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 and accepted it as presented.

Motion to accept the agenda as presented
Moved: Dr. Johann Torres **Second: James Dougherty** **Motion: Passed**

VI. Review/Approve Minutes of June 26, 2022 and July 5, 2022

Members reviewed the minutes of June 26, 2022 and accepted them as presented.

Motion to accept the minutes of June 26, 2022, as presented.
Moved: Dr. Johann Torres **Second: James Dougherty** **Motion: Passed**

Members reviewed the minutes of July 5, 2022 and accepted them as presented.

Motion to accept the minutes of July 5, 2022, as presented.
Moved: Dr. Johann Torres **Second: James Dougherty** **Motion: Passed**

VII. Reports

- **Ryan White Program** *Carla Valle-Schwenk*

Carla Valle-Schwenk referenced the final expenditures for FY 2021, clients served in FY 2021, and clients served to date in FY 2022 (copies on file). Contracts are still being worked on with the hope to have all out by the end of next week. Once contracts have been executed, payments can be made. A FY 2022 expenditure report should be available next month. The Partnership approved several of the motions from the Subcommittee. The service delivery guidelines for this year have been released but the updated allowable conditions list is pending release. The eligibility check list is being updated and a draft will be forwarded to Dr. Romero. Several DOH advisory sheets have been distributed including a monkeypox fact sheet. Vaccines are available to providers via FL Shots and administration can be charged to the program.

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

Dr. Javier Romero reviewed the June 2022 report (copy on file). The report reflects expenditures of $2,561,946.62 for uninsured clients and $2,797,011.67 for insured clients. Expenditures are up from last year with $60 million spent in quarter 1. Graphs reflect the differences between 2021 to 2022. Magellan started as the new pharmacy benefits manager October 1. The State will be releasing the names of the pharmacies participating (as of the end of quarter). There has been a high number of requests for monkeypox vaccinations, and these requests are handled by the Epi Department at FDOH located at 1350 NW 14th Street. The Epi Department handles distribution of the national stockpile. The department can be reached at 305-470-5660 or by calling the main line at DOH, 305-324-2400 and requesting to be contacted to the Epi Department. If there are any written protocols to access the vaccine or medications, Ms. Valle-Schwenk requested these be forwarded to her for distribution to providers.

- **Membership Vacancies** *Marlen Meizoso*

Marlen Meizoso referenced the membership vacancy report (copy on file) and indicated there were 13 vacancies on the Subcommittee. If anyone knows of interested individuals, they may contact staff. The Executive Committee is looking into reducing the number of seats on the committees to possible a total of 16 seats. If the Subcommittee size is reduced some seats may need to be reassigned.

- **Partnership Report (reference only)** *Dr. Robert Goubeaux*

Dr. Goubeaux indicated the Partnership Report (copy on file) detailed the items approved at the July 18 Partnership meeting including sweeps, the approval of the letter on gender affirming care, and the dental implant items. Any questions can be directed to staff.

VIII. Standing Business

- **Remaining HIV and aging topics** *All*

The last five topics (depression, eyesight/hearing diminishes, cardiovascular disease, liver disease and STIs) were discussed along with two articles from HRSA on HIV and Aging (copies on file). Substance Abuse and Mental Health are two underutilized service categories which need to be better promoted. Underutilization may be due to lower reimbursement rates. In addition, there is a shortage of mental health providers and psychiatrists who work with the program, so wait times are often very long for clients. For depression specifically, there are few medications on the formulary and revising the mental health formularies may be in order. For eyesight or hearing diminishment, there is less of direct connection between HIV and the conditions, particularly for hearing loss, although clients who have uncontrolled HIV or an additional STI may have problems with eyesight. Resources for glasses and hearing, as available, should be shared. Cardiovascular disease does have a documented connection to HIV and some new medications that have dual function may be advisable to add to the formulary. Additional cardiac conditions may need to be added to the conditions list. STIs are still an issue with those aging, as are long term complicators of HIV treatment. Staff will compile the results to share at the upcoming Needs Assessment meeting. With the problems identified, the next step is to find solutions, such as updating the standards to make a notation on aging, revising the allowable conditions list, as applicable, and reviewing the formulary to see if any medications should be added. Ms. Valle-Schwenk will seek clarification from the HRSA project officer as to what is allowable to address the HIV and aging topics.

- **August meeting** *Marlen Meizoso*

Mrs. Meizoso indicated that the August 26, 2022, meeting is on the last day of the Ryan White Conference. The next item the Subcommittee will be working on is the Minimum Primary Care Standards. The draft standards, IDSA update, and CDC Immunization guidelines were shared with the Subcommittee (copies on file). If the Subcommittee decided to cancel the meeting, items #1-15 could be reviewed with comments forwarded for the September meeting. Mrs. Meizoso also indicated she would forward the information electronically along with the DHHS guidelines. The Subcommittee indicated that they were amenable to canceling the meeting.

Motion to cancel the August 26, 2022, meeting.
Moved: Wanda Cortes **Seconded: James Dougherty** **Motion: Passed**

IX. New Business

Addition to ADAP Formulary *All*

Mrs. Meizoso shared a communication from ADAP indicating the addition of two new pneumococcal conjugate vaccines PDV15 and PCV20 to the ADAP formulary (copies on file). Vaccines are allowable under the Part A program under the outpatient ambulatory health category, but Ryan White is the payor of last resort. So, for those clients on ADAP, the vaccines must be accessed via ADAP. Dr. Romero indicated that the SAME DAY card could be used to access the vaccines at approved local pharmacies.

X. Announcements

Dr. Goubeaux indicated that any announcements should be forwarded to staff for posting online. All members are urged to RSVP for the September meeting. Mrs. Meizoso indicated two flyers (copies on file) are included in the

meeting materials and additional copies are available and should be shared with others. The first flyer announces a monthly symposium (June-September) presented by FIU/BSR on research conducted on the Ryan White Program. The second flyer promotes the Community Coalition Roundtables which this month is being hosted at Jessie Trice. The Ryan White Conference is scheduled for August 23-26, 2022, online but registration closes August 9. The Executive Committee revised the Code of Conduct. Members were provided a copy (copy on file) and requested to sign the attestation.

XI. Next Meeting

The next Subcommittee meeting will be held Friday, September 22, 2022, at 9:30 a.m. at BSR.

XII. Adjournment

Dr. Goubeaux adjourned the meeting at 11:20 a.m.

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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: **July 2022**

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)	22	136	22	96
Health Insurance Premium and Cost Sharing Assistance	29	1,434	20	633
Medical Case Management	6,879	35,697	3,304	6,361
Mental Health Services	34	295	18	65
Oral Health Care	638	3,785	486	1,545
Outpatient Ambulatory Health Services	1,775	10,617	1,095	3,186
Substance Abuse Outpatient Care	1	18	1	10
Support Services				
Food Bank/Home Delivered Meals	1,367	6,901	522	692
Medical Transportation	113	1,562	105	418
Other Professional Services	55	356	17	50
Outreach Services	76	363	22	65
Substance Abuse Services (residential)	57	681	6	22
TOTALS:	11,046	61,845		

Total unduplicated clients (month): 4,083

Total unduplicated clients (YTD): 7,104

REPORT COMPILED ON: 08/30/2022

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **July 2022**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	22	136	22	96
Health Insurance Premium and Cost Sharing Assistance	29	1,434	20	633
Medical Case Management	6,202	31,789	3,041	6,128
Mental Health Services	34	284	18	58
Oral Health Care	638	3,785	486	1,545
Outpatient Ambulatory Health Services	1,703	10,069	1,058	3,147
Substance Abuse Outpatient Care	1	12	1	6
Support Services				
Food Bank/Home Delivered Meals	1,367	6,901	522	692
Medical Transportation	109	1,539	101	405
Other Professional Services	55	356	17	50
Outreach Services	75	351	21	53
Substance Abuse Services (residential)	57	681	6	22
TOTALS:	10,292	57,337		

Total unduplicated clients (month): 3,913

Total unduplicated clients (YTD): 7,002

REPORT COMPILED ON: 08/30/2022

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **July 2022**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	677	3,908	363	722
Mental Health Services	0	11	0	7
Outpatient Ambulatory Health Services	72	548	53	231
Substance Abuse Outpatient Care	0	6	0	4
Support Services				
Medical Transportation	4	23	4	14
Outreach Services	1	12	1	12
TOTALS:	754	4,508		

Total unduplicated clients (month): 393

Total unduplicated clients (YTD): 893

REPORT COMPILED ON: 08/30/2022

PART A

RYAN WHITE PART A GRANT AWARD (Grant #: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR32

FORMULA AND SUPPLEMENTAL FUNDING

Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2022 Part A service months up to July 2022, as of 8/30/2022. This report reflects reimbursement requests that were due by 8/20/2022 and have been paid thus far. Pending Part A reimbursement requests that have been received and are in process total $6,323,387.50. Several contracts are still pending completion/execution.

Project #: BURW3201	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount Formula	16,141,380.00	FORMULA
Grant Award Amount Supplemental	4,121,835.00	SUPPLEMENTAL
Grant Award Amount FY'20 Supplemental	4,268,879.00	PY_SUPPLEMENTAL
Carryover Award FY'17 Formula		CARRYOVER
Total Award	**$ 24,532,094.00**	

CONTRACT ALLOCATIONS/ FORMULA & SUPPLEMENTAL AWARDS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	
4	AIDS Pharmaceutical Assistance	84,492.00	
6	Health Insurance Services	335,776.00	
1	Medical Case Management	5,815,461.00	
3	Mental Health Therapy/Counseling	132,385.00	
5	Oral Health Care	3,088,975.00	
2	Outpatient/Ambulatory Health Svcs	8,577,172.00	
9	Substance Abuse - Outpatient	44,128.00	18,078,389.00

	Support Services	Allocations	
11	Emergency Financial Assistance	9,853.00	
8	Food Bank	766,083.00	
10	Medical Transportation	194,149.00	
13	Other Professional Services	154,449.00	
12	Outreach Services	264,696.00	
7	Substance Abuse - Residential	1,969,744.00	3,358,974.00

DIRECT SERVICES TOTAL:		**$**	**21,437,363.00**
Total Core Allocation	18,078,389.00		
Target at least 80% core service allocation	17,149,890.40		
Current Difference (Short) / Over	**$ 928,498.60**		
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,453,209.00**		
Quality Management	**$ 641,522.00**		
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (Formula & Supp)	$ -		
Unobligated Funds (Carry Over)	$ -	3,094,731.00	24,532,094.00

Core medical % against Total Direct Service Allocation (Not including C/O):	
Cannot be under 75%	**84.33%** **Within Limit**
Quality Management % of Total Award (Not including C/O):	
Cannot be over 5%	**2.62%** **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	
5606970000	AIDS Pharmaceutical Assistance	0.00		
5606920000	Health Insurance Services	0.00		
5606870000	Medical Case Management	11,043.65		
5606860000	Mental Health Therapy/Counseling	0.00		
5606900000	Oral Health Care	0.00		
5606610000	Outpatient/Ambulatory Health Svcs	89,323.90		
5606910000	Substance Abuse - Outpatient	0.00		100,367.55

Account	Support Services	Expenditures	Carryover Expenditures		
5606940000	Emergency Financial Assistance	0.00			
5606980000	Food Bank	529,470.00		529,470.00	
5606460000	Medical Transportation	0.00			
5606890000	Other Professional Services	32,040.00			
5606950000	Outreach Services	0.00			
5606930000	Substance Abuse - Residential	127,260.00			688,770.00

TOTAL EXPENDITURES DIRECT SVCS & % :			**$ 789,137.55**	**3.68%**
Formula Expenditure %	**10.75%**			
5606710000	**Recipient Administration**	**696,085.45**		
5606880000	**Quality Management**	**250,000.00**	946,085.45	
Grant Unexpended Balance	**22,796,871.00**			
Total Grant Expenditures & %			**$ 1,634,855.45**	**6.66%**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**0.386523268**	**Danger!!!!!**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**1.02%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**2.84%**	**Within Limit**

Printed on: 8/30/2022

MAI

RYAN WHITE PART A GRANT AWARD (Grant#: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR32

MINORITY AIDS INITIATIVE (MAI) FUNDING

Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2022 MAI service months up to July 2022, as of 8/30/2022. This report reflects reimbursement requests that were due by 8/20/2022 and have been paid thus far. Pending MAI reimbursement requests that have been received and are in process total $360,847.98. Several contracts are still pending completion/execution.

PROJECT #: BURW3201	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI	1,089,480.00	MAI
Grant Award Amount FY'20 MAI	1,623,771.00	PY_MAI
Carryover Award FY'21 MAI		MAI_CARRYOVER
Total Award	**$ 2,713,251.00**	

CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations		
	AIDS Pharmaceutical Assistance			
	Health Insurance Services			
1	Medical Case Management	903,920.00		
3	Mental Health Therapy/Counseling	18,960.00		
	Oral Health Care			
2	Outpatient/Ambulatory Health Svcs	1,356,661.00		
4	Substance Abuse - Outpatient	8,058.00	2,287,599.00	
	Support Services	**Allocations**		
7	Emergency Financial Assistance	0.00		
	Food Bank			
5	Medical Transportation	7,628.00		
	Other Professional Services			
6	Outreach Services	39,816.00		
	Substance Abuse - Residential		47,444.00	
	DIRECT SERVICES TOTAL:		**$ 2,335,043.00**	

Total Core Allocation	2,287,599.00		
Target at least 80% core service allocation	1,868,034.40		
Current Difference (Short) / Over	**$ 419,564.60**		
Recipient Admin. (OMB-GC)	**$ 271,325.00**		2,713,251.00
Quality Management	**$ 106,883.00**		
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (MAI)	$ -	378,208.00	2,713,251.00
Unobligated Funds (Carry Over)	$ -		

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover Expenditures	
5606970000	AIDS Pharmaceutical Assistance			
5606920000	Health Insurance Services			
5606870000	Medical Case Management	52,191.50		
5606860000	Mental Health Therapy/Counseling	0.00		
5606900000	Oral Health Care			
5606610000	Outpatient/Ambulatory Health Svcs	0.00		
5606910000	Substance Abuse - Outpatient	0.00		52,191.50
Account	**Support Services**	**Expenditures**	**Carryover Expenditures**	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank			
5606460000	Medical Transportation	0.00		
5606890000	Other Professional Services			
5606950000	Outreach Services	0.00		
5606930000	Substance Abuse - Residential			0.00
	TOTAL EXPENDITURES DIRECT SVCS & %:		**$ 52,191.50**	**2.24%**

5606710000	**Recipient Administration**	**43,280.89**		
5606880000	**Quality Management**	**41,666.65**	84,947.54	
	Grant Unexpended Balance	**2,576,111.96**		
	Total Grant Expenditures & % (Including C/O):		**$ 137,139.04**	**5.05%**

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%	**3.94%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**10.00%**	**Within Limit**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**$ 1.00**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**1.54%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**1.60%**	**Within Limit**

Printed on: 8/30/2022

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, September 23, 2022

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

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	• Allowable Medication Conditions-Breast Cancer and Neutropenia	All
	• Ketamine for Substance Use Disorder	All
X.	Announcements	All
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September 1, 2022

ADAP Miami-Dade / Summary Report* – August 2022

Fiscal Year	1st Enrollments	Re-Enrollments	OPEN	CHD Pharmacy	RXs	Patients	RX/Pt	Payments	Premiums	~ Premium
FY20/21 >	795	10,979	6,150	$32,843,354.32	52,678	17,944	2.9	$23,115,161.17	25,395	$ 910.22
FY21/22 >	903	11,308	6,074	$28,342,382.90	49,549	16,381	3.0	$29,915,353.77	27,419	$1,091.04
FY22/23 >YTD	469	4,604		$12,237,829.42	21,092	6,983	3.0	$14,111,120.85	11,833	$1,192.52
Apr-22	113	914	6,143	$2,334,995.84	4,164	1,377	3.0	$2,885,135.63	2,429	$1,187.79
May-22	114	808	6,205	$2,428,021.98	4,295	1,385	3.1	$2,844,770.69	2,374	$1,198.30
Jun-22	85	925	6,205	$2,561,946.62	4,142	1,439	2.9	$2,797,011.67	2,344	$1,193.26
Jul-22	71	875	6,263	$2,393,320.77	4,049	1,342	3.0	$2,807,326.41	2,350	$1,194.61
Aug-22	86	1,082	6,309	$2,519,544.21	4,442	1,440	3.1	$2,776,876.45	2,336	$1,188.73
Sep-22										
Oct-22										
Nov-22										
Dec-22										
Jan-23										
Feb-23										
Mar-23										

SOURCE: Provide - DATE: 09/01/22 - Subject to Review & Editing

* *NOTE: West Perrine: 413 clients (09/07/22): DD 256; PP 157. Expenditures not included in this report.*

PROGRAM UPDATE

* Cabenuva ® utilization @ ADAP Miami (09/01/22): 144 clients. Direct Dispense 76 *(53%);* Premium Plus 68 *(47%)*
* ACA-MP Special Enrollment Period: APTC+=>100% FPL; <150 % FPL. Requirements apply.
* ACA-MP Open Enrollment 2023: November 1st - January 15th. Approved plans pending @ CMS.
* New pharmacy choices for ADAP Uninsured clients in Miami-Dade:

NEW - Magellan RX PBM participating pharmacies in Miami-Dade - 10/01/22		
1	AIDS Healthcare Foundation	Four (4) sites
2	Borinquen Healthcare Center	One (1) site
3	Miami Beach Community Health Center	Three (3) sites
4	WINN DIXIE Stores	Seven (7) sites
5	YOUR PHARMACY @ Care Resource	One (1) site
6	CVS SPECIALTY* / PROCARE PHARMACY DIRECT	Mail Order / Monroeville, PA

SOURCE: FLADAP / FL HIV-AIDS Patient Care Programs; 09/02/22

CURRENT Ongoing CHD Pharmacy Services		
7	CHD Pharmacy @ Flagler Street	One Site (1)
8	CHD Pharmacy @ Flagler Street	Mail order
9	ADAP Program Office @ West Perrine	CVS Specialty Mail Order

TOTAL: seventeen sites + two Mail Order options in Miami-Dade

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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

August 16, 2022

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 |

General Membership Opportunities

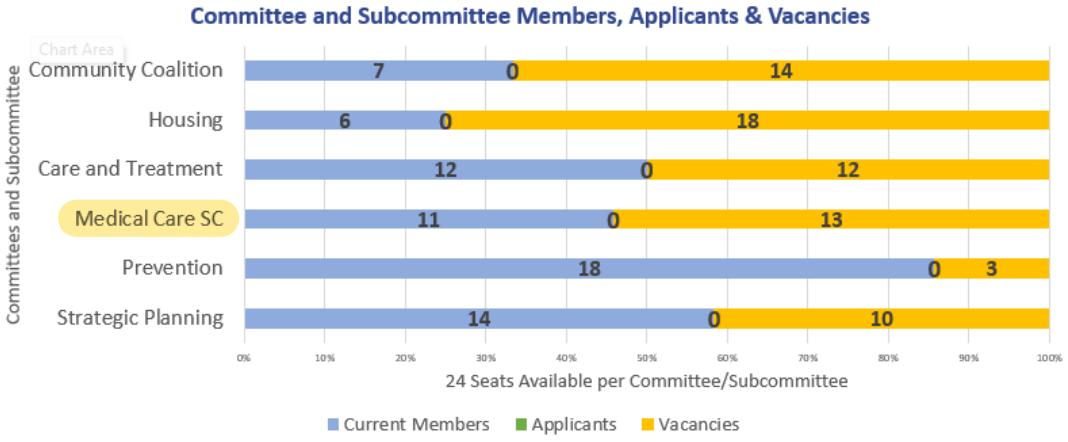
These Partnership positions are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the knowledge, skills and expertise relevant to these positions:

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

Partnership Committees

Committees are now 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?

when you say Yes! good things happen.

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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Proposed Medical Care Subcommittee Seat Assignments

Seat Assignments by Specialty	*Minimum* Seat Assignments	*Current Standing at 24 members*	Suggested Revision based on 16 members
Physicians, ARNP, Physician Assistant	4	5	discuss
ADAP representative	1	1	1
General Revenue representative	1	1	1
Pharmacists	2	1	1
Nurse/Medical Case Manager	2	1	1
Nutritionist	1	1	discuss
Representatives of Affected (RA)	8	0	5
Substance Abuse Treatment Provider	1	1	1
Psychiatrist/Mental Health Provider	1	0	1
General Seats (non-assigned)	as available	0	delete
Total Assigned Seats: *This leaves three vacancies that can be filled in any category.	21	11	16
Notes:		13	11 non-RA/5 RA

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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
        ~~c.~~
        ~~https://www.uspreventiveservicestaskforce.org/uspstf/~~https://uspreventiveservicestaskforce.org/uspstf/home

     ~~d.~~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

     ~~e.~~ European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV
     ~~f. https://www.eacsociety.org/guidelines/eacs-guidelines/~~https://www.eacsociety.org/guidelines/eacs-guidelines/

d.

~~g.~~e. ACC/AHA Guideline on the Treatment of Blood Cholesterol
~~https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625~~https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625

CDC

~~h.~~f. ~~-~~Recommended Adult Immunization Schedule
http://www.cdc.gov/vaccines/schedules/hcp/adult.htlm

~~i.~~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/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf
https://www.cdc.gov/hiv/clinicians/prevention/prep-and-pep.html
~~https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf~~
https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

~~i.~~ 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~~https://www.aasld.org/practice-guidelines

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* *Formulary*~~
https://www.miamidade.gov/grants/library/ryanwhite/testand-treat-formulary.pdf
Coverage and Expectations Update
https://www.miamidade.gov/grants/library/ryanwhite/test-treat-coverage-and-expectations.pdf
Overview for Medical Professionals
https://www.miamidade.gov/grants/library/ryanwhite/test-treat-rapid-access-overview-medical-practitioner.pdf
~~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~~p. Infectious Disease Society of America Primary Care Guidance for Persons with HIV
https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/

q. HRSA's HIV Care for People Aging with HIV
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf

- 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.
    q. Social supports and disclosure history
    r. Access to stable housing, food, and transportation
    s. Dates of last: mammogram, bone density, colonoscopy, abnormal aortic aneurysm screening, dental visit, and dilated eye exam.

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 (including appetite)
    p. Oral health care
    q. Mental Health assessment (particularly clinical depression)/care, mood, libido, sleep patterns, concentration, and memory)
    r. Exercise
    s. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
    t. Domestic violence
    u. Birth control
    v. Advance Directives (completion or review)
    ~~v.~~w. Frailty assessment, as appropriate
    ~~w.~~x. Neurology and/or neuropsychology referral for assessment of neurocognitive disorders, dementia, and focal neuropathies, as appropriate.

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 before ~~prior to~~ digital anorectal examination (DARE); recommend and perform DARE annually and whenever anal symptoms are present.~~to screen for anal pathology; perform DARE if anal symptoms are present.~~ For HIV clients who are men who have sex with men~~MSM~~, transgender women, women, or~~and~~ transgender men ~~with HIV~~ clinicians should perform or recommend annual anal Pp~~ap~~ testing to identify potentially cancerous cytologic abnormalities. Clinicians should promote smoking cessation for all patients with HIV, especially those at increased risk for anal cancer. 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 LSILs or HSILs or refer as needed. For patients with ~~abnormal~~ anal cytology indicating ASC-Us, clinicians should perform HPV testing. If HPV testing is available and results are negative, repeat anal cytology in 1 year. If HPV testing is available but reflex testing is not available, perform HPV test and follow-up within 6 months. If positive for high-risk HPV or if HPV testing is not available, refer to HRA. ~~and~~ rRefer patients with suspected anal cancer determined by DARE or histology to an experienced specialist for evaluation and management. Discontinue screening for anal cancer when life expectancy is less than 10 years and in individuals with 2 consecutive negative anal cytology specimens who are not currently sexually active. Additional information at ~~https://www.hivguidelines.org/hiv-care/anal-dysplasia-cancer/~~ https://www.hivguidelines.org/hiv-care/anal-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.~~ https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

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.

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://uspreventiveservicestaskforce.org/uspstf/home
     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.0000000000000625CDC
     f. 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-2021.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/practice-guidelines
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) *Formulary*
https://www.miamidade.gov/grants/library/ryanwhite/testand-treat-formulary.pdf
Coverage and Expectations Update
https://www.miamidade.gov/grants/library/ryanwhite/test-treat-coverage-and-expectations.pdf
Overview for Medical Professionals
https://www.miamidade.gov/grants/library/ryanwhite/test-treat-rapid-access-overview-medical-practitioner.pdf
p. Infectious Disease Society of America Primary Care Guidance for Persons with HIV
https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/
q. HRSA's HIV Care for People Aging with HIV
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf

- 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.
q. Social supports and disclosure history
r. Access to stable housing, food, and transportation
s. Dates of last: mammogram, bone density, colonoscopy, abnormal aortic aneurysm screening, dental visit, and dilated eye exam.

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
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   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
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Assess and document health education on:

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u. Birth control
v. Advance Directives (completion or review)
w. Frailty assessment, as appropriate
x. Neurology and/or neuropsychology referral for assessment of neurocognitive disorders, dementia, and focal neuropathies, as appropriate.

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.

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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 before digital anorectal examination (DARE); recommend and perform DARE annually and whenever anal symptoms are present. For HIV clients who are men who have sex with men, transgender women, women, or transgender men clinicians should perform or recommend annual anal Pap testing to identify potentially cancerous cytologic abnormalities. Clinicians should promote smoking cessation for all patients with HIV, especially those at increased risk for anal cancer. 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 LSILs or HSILs or refer as needed. For patients with anal cytology indicating ASC-Us, clinicians should perform HPV testing. If HPV testing is available and results are negative, repeat anal cytology in 1 year. If HPV testing is available but reflex testing is not available, perform HPV test and follow-up within 6 months. If positive for high-risk HPV or if HPV testing is not available, refer to HRA. Refer patients with suspected anal cancer determined by DARE or histology to an experienced specialist for evaluation and management. Discontinue screening for anal cancer when life expectancy is less than 10 years and in individuals with 2 consecutive negative anal cytology specimens who are not currently sexually active. Additional information at https://www.hivguidelines.org/hiv-care/anal-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. Additional information at https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

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

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, September 23, 2022

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	Dr. Robert Goubeaux
II.	Meeting Housekeeping and Rules	James Dougherty
III.	Introductions	Dr. Robert Goubeaux
IV.	Floor Open to the Public	James Dougherty
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 22, 2022	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Marlen Meizoso
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
IX.	New Business	
	• Subcommittee Composition Changes	All
	• Minimum Primary Care Standards Items #1-15	All
	• PHQ2: Behavioral Health Assessment in O/AHS Setting	All
	• Allowable Medication Conditions-Breast Cancer and Neutropenia	All
	• Ketamine for Substance Use Disorder	All
X.	Announcements	All
XI.	Next Meeting**: October 28, 2022** at **BSR**	James Dougherty
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

Patient Health Questionnaire-2 (PHQ-2)

Share

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	+1	+2	+3
2. Feeling down, depressed or hopeless	0	+1	+2	+3

PHQ-2 score obtained by adding score for each question (total points)

Interpretation:

- A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cutpoint when using the PHQ-2 to screen for depression.
- If the score is 3 or greater, major depressive disorder is likely.
- Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, September 23, 2022

9:30 a.m. – 11:30 a.m.

Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

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MIAMI-DADE COUNTY RYAN WHITE PROGRAM
ALLOWABLE MEDICAL CONDITIONS LIST

These conditions are related to or exacerbated by HIV, comorbidities related to HIV, and complications of HIV treatment.

This list is intended to address the federal Health Resources and Services Administration's requirement that services provided through outpatient medical care be related to an individual's HIV status. This list was created to assist medical providers with specialty care referrals and to emphasize the importance of documenting the link between an individual's HIV status and the specialty care service to which a client is referred. This list is a sample guideline to be used in Miami-Dade County's Ryan White Part A/Minority AIDS Initiative Program of the most common conditions exacerbated or caused by HIV or its treatment.

Routine medical diagnostic testing (e.g., Pap smear, mammogram, bone density test, colonoscopy, colorectal cancer screening, and ophthalmologic screening) is allowable as long as such testing follows established medical guidelines, such as U.S. Public Health Service (PHS), American Medical Association, Health Resources and Services Administration (HRSA), or other local guidelines, as a standard of care. Please see the most current, local Ryan White Program Service Delivery Manual for more information.

When provided in an outpatient setting, labs, diagnostics and treatments related to HIV, as indicated above, including complications of HIV treatment related to the following conditions may be covered:

BONE AND JOINT DISEASES (E.G., ORTHOPEDICS/RHEUMATOLOGY):
avascular necrosis of hip, knee, etc.
fibromyalgia
HIV-related myopathy/myalgia
HIV-related rheumatic diseases
osteoarthritis
osteopenia/osteoporosis

CARDIOLOGY:
atherosclerosis
coronary artery disease
hyperlipidemia
peripheral artery disease
phlebitis

CHIROPRACTIC/PHYSICAL MEDICINE:
avascular necrosis (Stage 1 or 2 only)
chronic arthralgia, HIV related
chronic myopathy/myalgia, HIV related
fibromyalgia
osteopenia/osteoporosis
peripheral neuropathy
rheumatic diseases

IMPORTANT NOTE: According to CDC, chronic pain is defined as pain having duration of at least three months. Chronic pain is considered a co-morbidity of HIV. This may also contribute to the depression with pain comorbidity complex (DPC). Treatment of acute pain is not covered.

COLORECTAL:
abnormal anal Pap smears
anal cancers
fistulas
hernias

DENTAL (ORAL HEALTH CARE):
dental cancers
giant aphthous ulcers
human papillomavirus associated oral lesions
oral cancers

DERMATOLOGY:
dermatitis (including tinea infections)
eczema/seborrheic dermatitis
eosinophilic folliculitis
herpes simplex virus
impetigo
Kaposi's sarcoma
Methicillin-resistant Staphylococcus aureus (MRSA)
molluscum contagiosum
onychomycosis
photodermatitis
pruritus (as a symptom of undiagnosed xerosis, psoriasis, scabies, lymphoma, etc.)
psoriasis
skin cancers (squamous cell carcinoma, etc.)
skin conditions and symptoms, including skin appendages and oral mucosa
warts

EAR, NOSE AND THROAT (ENT)/OTOLARYNGOLOGY:
chronic sinusitis
dental cancers
oral cancers
oral human papillomavirus

ENDOCRINOLOGY:
diabetes
hormone replacement therapy (for individuals of trans experience)
hypogonadism

GASTROINTESTINAL:
colitis (syphilitic colitis--very rare)
diarrhea
esophageal candidiasis
nausea/vomiting

GENITOURINARY (GU)/ GYNECOLOGY (GYN)/OBSTETRICS (OB):
abnormal Pap smear
cervical human papillomavirus
erectile dysfunction *(IMPORTANT NOTE: the local Ryan White Part A/MAI Program will only pay for evaluation and diagnostics of erectile dysfunction; but, the treatment of erectile dysfunction is not covered by the local Ryan White Part A/MAI Program.)*
gynecological cancers
hematuria (related to neoplasms)
pregnancy
prostate cancer
tinea cruris (jock itch) or scrotal candidiasis
vaginal candidiasis

HEMATOLOGY/ONCOLOGY:
anemia
Kaposi's sarcoma
lymphoma
polycythemia vera
thrombocytopenia

INFECTIOUS DISEASE:
herpes simplex infections (1 and especially type 2), varicella zoster infections, non-tuberculous histoplasmosis
leishmaniasis
mycobacterial infections
syphilis
tuberculosis
viral hepatitis (hepatitis B and C)

MENTAL HEALTH SERVICES:
mental health disorder caused or exacerbated by HIV diagnosis or HIV treatment
mental health disorder/condition that significantly hinders a client's HIV treatment adherence

IMPORTANT NOTES:

- *As covered by this local Ryan White Part A Program:*
  - *Services in this general category (other than Psychiatry, see page 6) are not provided under Outpatient/Ambulatory Health Services.*
  - *Mental Health Services include the provision of outpatient psychological and psychiatry screening, assessment, diagnosis, treatment, and counseling services offered to clients who are living with HIV or AIDS. These services may be used by appropriate mental health providers to assess and diagnose a mental health illness.* ***However, a diagnosed mental health illness is required to receive ongoing treatment and counseling under this service category****.*
  - *Services are to be provided by a mental health professional holding a PhD, EdD, PsyD, MA, MS, MSW, or M.Ed. degree, AND be licensed in the State of Florida as a LCSW, LMHC, LMFT, or Licensed Clinical Psychologist. Appropriately supervised interns may also provide such services, as defined in the local Ryan White Program Service Delivery Guidelines, under Mental Health Services.*

NEPHROLOGY:
human immunodeficiency virus-associated nephropathy
renal failure (may be related to coronary artery disease induced by HIV or diabetes mellitus induced by HIV, etc.)

NEUROLOGY:
delirium
HIV associated neurocognitive disorder (HAND) [1, 2]
HIV related encephalopathy
neuropathy
neurosyphilis

[1] National Institute of Mental Health info:
https://www.nimh.nih.gov/about/organization/dar/developmental-and-clinical-neuroscience-of-hiv-prevention-and-treatment-branch/clinical-neuroscience-of-hiv-infection-program

[NOTE: old NIMH web link not accessible. Additional link added below by OMB-GC/Ryan White Program]

[2] UCSF Weill Institute for Neurosciences:
https://memory.ucsf.edu/sites/memory.ucsf.edu/files/wysiwyg/UCSF_HIV%20Dementia_Providers_11-6-17.pdf

NUTRITION:
lipodystrophy
wasting
weight gain
weight loss

OPHTHALMOLOGY/OPTOMETRY:
IMPORTANT NOTE: the local Ryan White Part A/MAI Program will only pay for evaluation and diagnostics for HIV-related eye problems/complications; but, not the filling of prescriptions for corrective lenses.

Clients must also meet at least one of these criteria to access ophthalmology/optometry services:

- Client has a low CD4 count (at or less than 200 cells/mm^3) *currently*
- Client has a comorbidity (e.g. diabetes, hypertension, STI, etc.)
- Client has a prior diagnosis of cytomegalovirus retinitis (CMV)
- Client has Immune Reconstitution Syndrome

Referrals to an optometrist or ophthalmologist must indicate a condition attempting to rule out complications of HIV. Any one of these conditions listed below would apply as examples.

Manifestations due to opportunistic infections:

- acute retinal necrosis
- bacterial retinitis
- candida endophthalmitis
- cryptococcus chorioretinitis
- cytomegalovirus retinitis
- pneumocystis choroiditis
- toxoplasma retinochoroiditis

Visual disturbances to rule out complication of HIV due to:

- cancers of the eye (e.g., squamous cell carcinoma of the eye, Kaposi Sarcoma, etc.)
- cataracts
- dry eyes (sicca)
- glaucoma
- intra-retinal hemorrhages
- reactive arthritis
- trichomegaly or eyelash hypertrichosis (exaggerated growth of the eye lashes found in the later stages of the disease)
- uveitis

History of STI and complications of STI:

- herpes simplex virus
- herpes zoster-varicella visual changes
- syphilis

PODIATRY:

diabetic foot care

foot and ankle pain *(IMPORTANT NOTE: the local Ryan White Part A/MAI Program will only pay for diagnostic evaluation of foot and ankle pain. Conditions such as hammer toes, bunions, heel spurs may be covered if related to neuropathies. Sprains or fractures are not covered unless a direct connection to neuropathies is present.)*

onychomycosis

PSYCHIATRY:

mental health disorder caused or exacerbated by HIV diagnosis or HIV treatment

mental health disorder/condition that significantly hinders a client's HIV treatment adherence

IMPORTANT NOTE:

- *Under this component, a Psychiatrist will assess, diagnose, and treat mental illness in an outpatient/ambulatory health care setting.*

PULMONARY:

mycobacterium

pneumocystis pneumonia

recurrent pneumonia

tuberculosis

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