MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Meeting Housekeeping and Rules	Dr. Diego Shmuels
III.	Introductions	All
IV.	Floor Open to the Public	Dr. Diego Shmuels
V.	Review/Approve Agenda	All
VI.	Special Presentation: HIV Epidemiology In Miami-Dade County, 2021	Dr. Anthoni Llau
VII.	Review/Approve Minutes of January 12, 2023	All
VIII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
	• Medical Care Subcommittee Report	Marlen Meizoso
	• Partnership Report to Committees (reference only)	Dr. Diego Shmuels
IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

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Meeting Housekeeping

Updated January 10, 2023

Miami-Dade County Main Library Version

Behavioral Science Research

Miami-Dade HIV/AIDS Partnership

Miami-Dade County

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.

Resources

- 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.*

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

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 . . .

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.

General Reminders

- All attendees must sign in to be counted as present.
  - ❖ *Members! Please check your contact information.*
- Masking is requested of all attendees.
- Only voting members and applicants should sit at the meeting table.
  - ❖ *You may move your chair if concerned about social distancing.*
- Place cell phones on mute or vibrate.
  - ❖ *If you must take a call, please excuse yourself from the meeting.*
- Have your Cultural Center Parking Garage ticket validated at the Library front desk to receive a reduced parking rate.
- Partnership and Committee members of the affected community should see staff for a voucher at the end of the meeting.

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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 line for statements to be read into the record. No statements were received.”

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HIV Epidemiology In Miami-Dade County, 2021

DEPARTMENT OF HEALTH

Anthoni Llau, PhD
Senior Human Services Program Manager
Florida Department of Health

Data as of 6/30/2022

Acronyms

- **HIV:** Human Immunodeficiency Virus
- **AIDS:** Acquired Immune Deficiency Syndrome
- **IDU:** Injection Drug Use
- **MMSC:** Male-to-Male Sexual Contact
- **MSM:** Men Who Have Sex with Men

Acronyms, continued

- **PWH**: Persons with HIV
- **PWID**: Persons Who Inject Drugs
- **STI**: Sexually Transmitted Infection
- **VL**: Viral Load

Technical Notes

- Data for 2020 and 2021 should be interpreted with caution due to the impact of COVID-19 on HIV testing, care-related services, and case surveillance activities in state and local jurisdictions.

- Unless otherwise noted, all data in this presentation are as of 6/30/2022.

Technical Notes, continued

- Each year, the HIV data for the previous calendar year and all prior years back to 1979 are finalized and frozen for reporting purposes on June 30. The frozen data are used in all data reports until the following June 30, when the continuously deduplicated HIV/AIDS data set will be finalized and frozen again.

- Unless otherwise noted, population-related data (such as rates) are provided by FLHealthCHARTS as of 6/30/2022.

Technical Notes, continued

- HIV-Related deaths represent persons with an HIV diagnosis in the CDC's electronic HIV/AIDS Reporting System (eHARS) who resided in Florida at death and whose underlying cause of death was HIV, regardless of whether their HIV status was reported in Florida.

- STI data are derived from the Surveillance Tools and Reporting System (STARS) and provided by the STD Prevention and Control Section as of 7/01/2022.

Technical Notes, continued

- HIV diagnoses by year represent persons whose HIV was diagnosed in that year, regardless of AIDS status at time of diagnosis.

- AIDS and HIV diagnoses by year are not mutually exclusive and cannot be added together.

Technical Notes, continued

- HIV prevalence data represent PWH living in Florida through the end of the calendar year, regardless of where they were diagnosed.

- For diagnosis data over time, sub-geographical area data exclude Florida Department of Corrections (FDC) and Federal Correctional Institution (FCI) diagnoses. For prevalence data, area and county data include FDC and FCI data.

Technical Notes, continued

- Adult diagnoses represent people ages 13 years and older; pediatric diagnoses represent people under the age of 13 years.
  - For data by year of diagnosis, age is by age at diagnosis.
  - For prevalence data, age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.

Technical Notes, continued

- Unless noted, White and Black people are non-Hispanic/Latino, and Other (which may be omitted in some graphs due to small numbers) represents American Indian/Alaska Native, Asian/Pacific Islander, or multi-racial.

- Transgender people include:
  - Transgender women (assigned male at birth).
  - Transgender men (assigned female at birth).

Definitions of Mode of Exposure Categories

- **MMSC:** Male-to-male sexual contact; these data exclude transgender persons.
- **IDU:** Injection drug use.
- **MMSC/IDU:** Male-to-male sexual contact and injection drug use; these data exclude transgender persons.
- **Transgender Sexual Contact:** Sexual contact resulting in a transgender person acquiring HIV.

Definitions of Mode of Exposure Categories, continued

- **Heterosexual:** Heterosexual contact with person(s) who received an HIV diagnosis or had a known HIV risk; these data exclude transgender persons.
- **Other Risk**: Includes recipients of clotting factor for hemophilia or other coagulation disorders, recipients of HIV-infected blood or blood components other than clotting factor or of HIV-infected tissue, perinatal and other pediatric risks, or other confirmed risks.

Florida's Four Key Components Plan To Eliminate HIV Transmission and Reduce HIV-Related Deaths

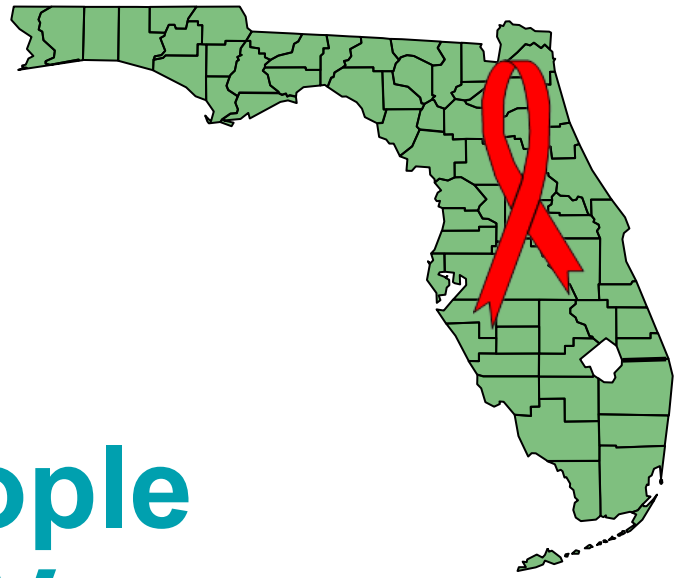
- Implement routine HIV and STI screening in health care settings and priority testing in non-health care settings.

- Provide rapid access to treatment and ensure retention in care (Test and Treat).

Florida's Four Key Components Plan To Eliminate HIV Transmission and Reduce HIV-Related Deaths, Continued

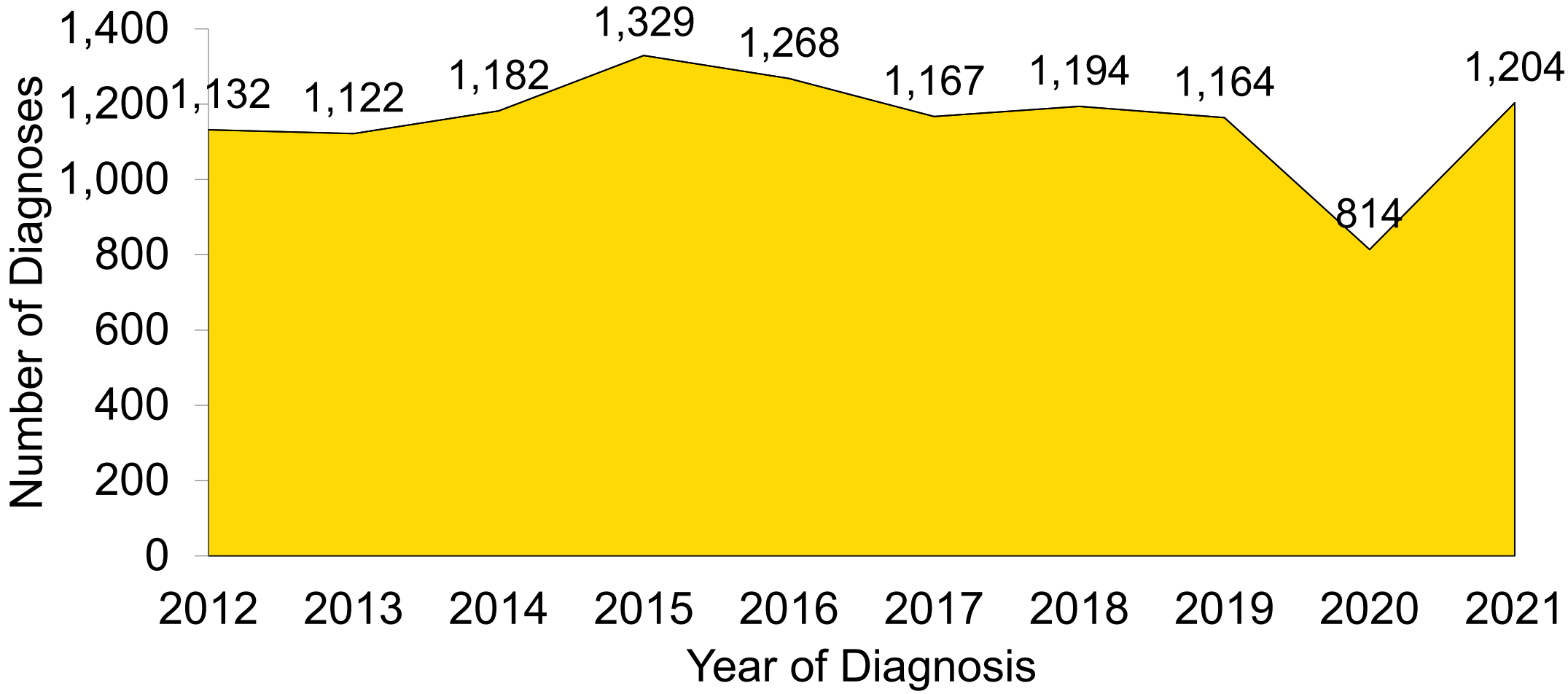
- Improve and promote access to antiretroviral PrEP and nPEP.

- Increase HIV awareness and community response through outreach, engagement, and messaging.

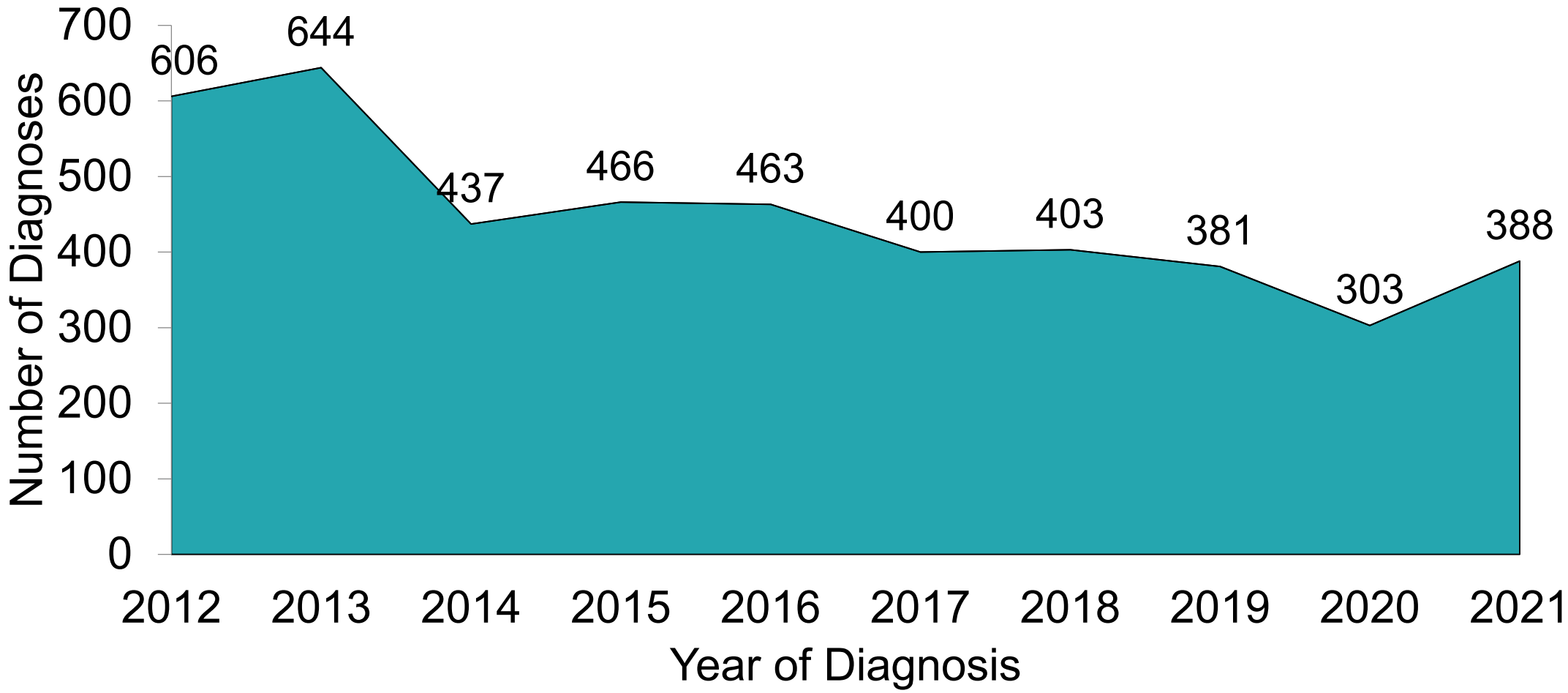


Demographics of People Diagnosed with HIV

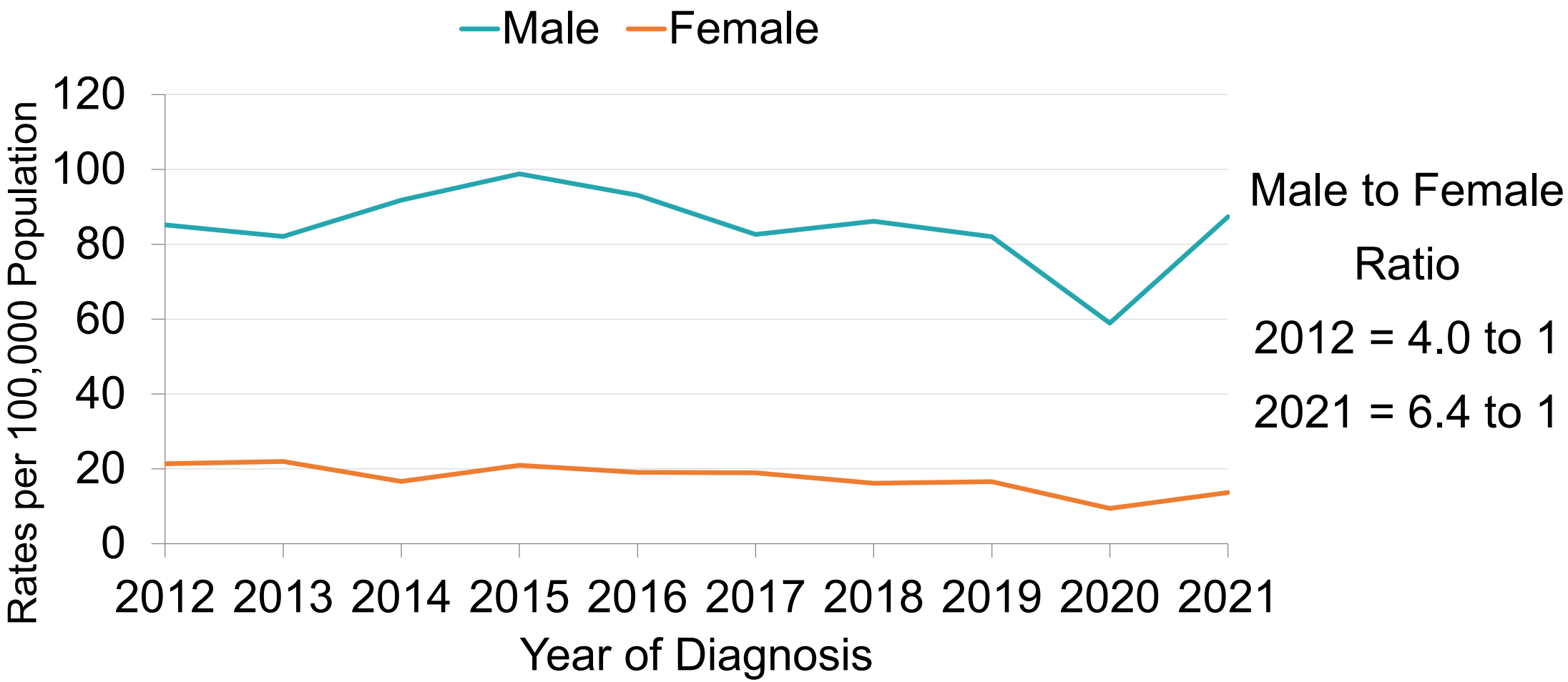
Diagnoses of HIV, 2012–2021, Miami-Dade County



Diagnoses of AIDS, 2012–2021, Miami-Dade County



Adult HIV Diagnosis Rates by Sex at Birth, 2012–2021, Miami-Dade County



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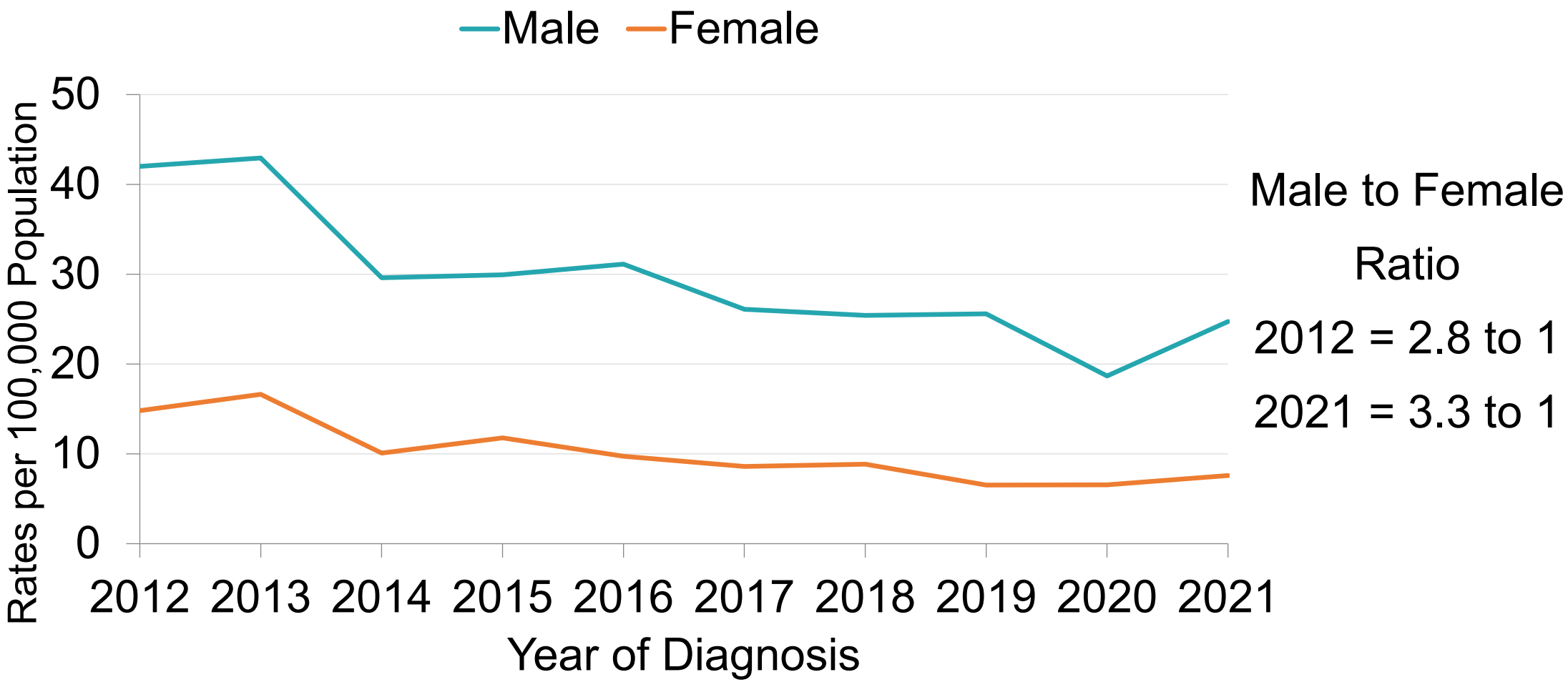
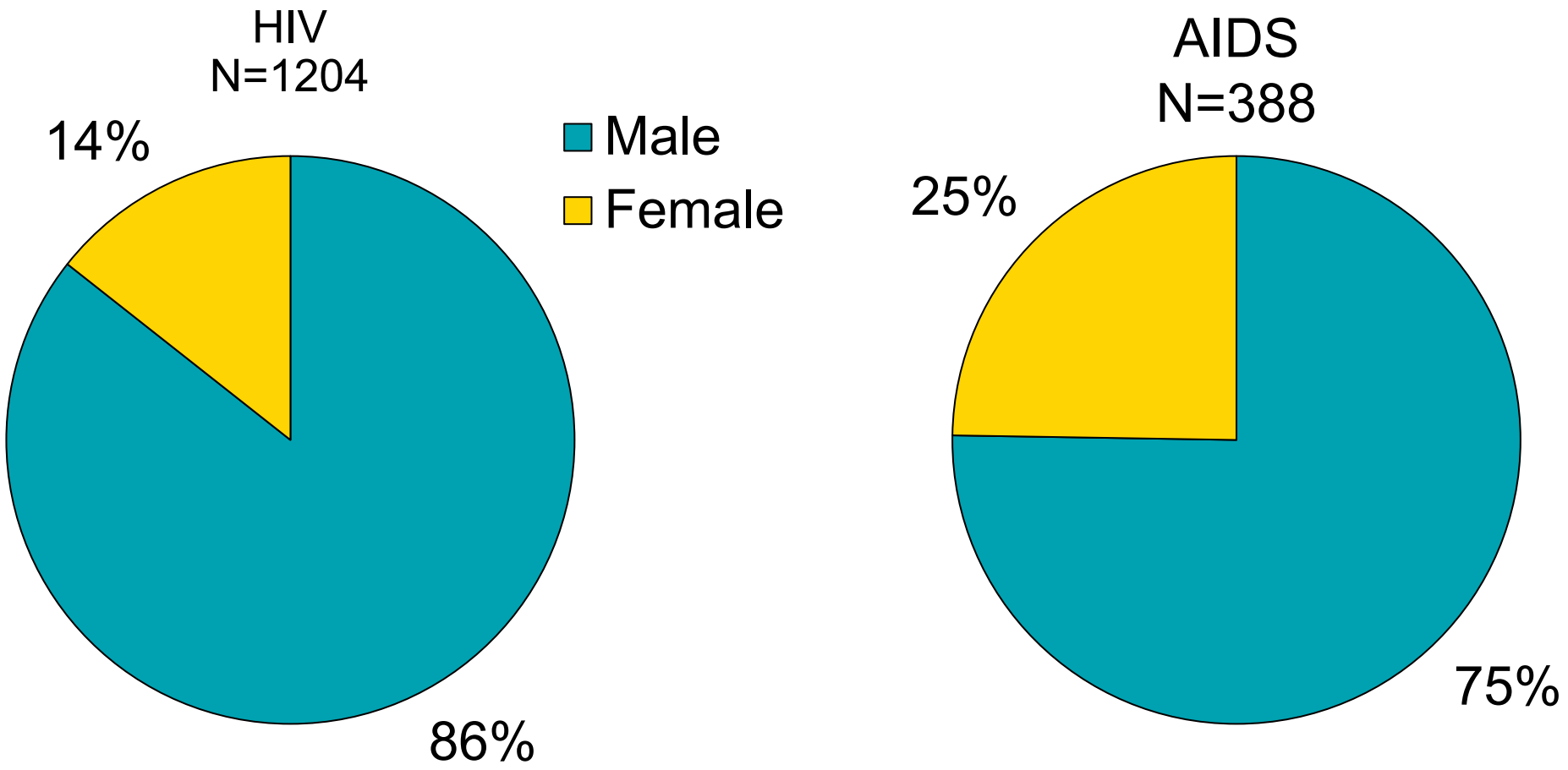
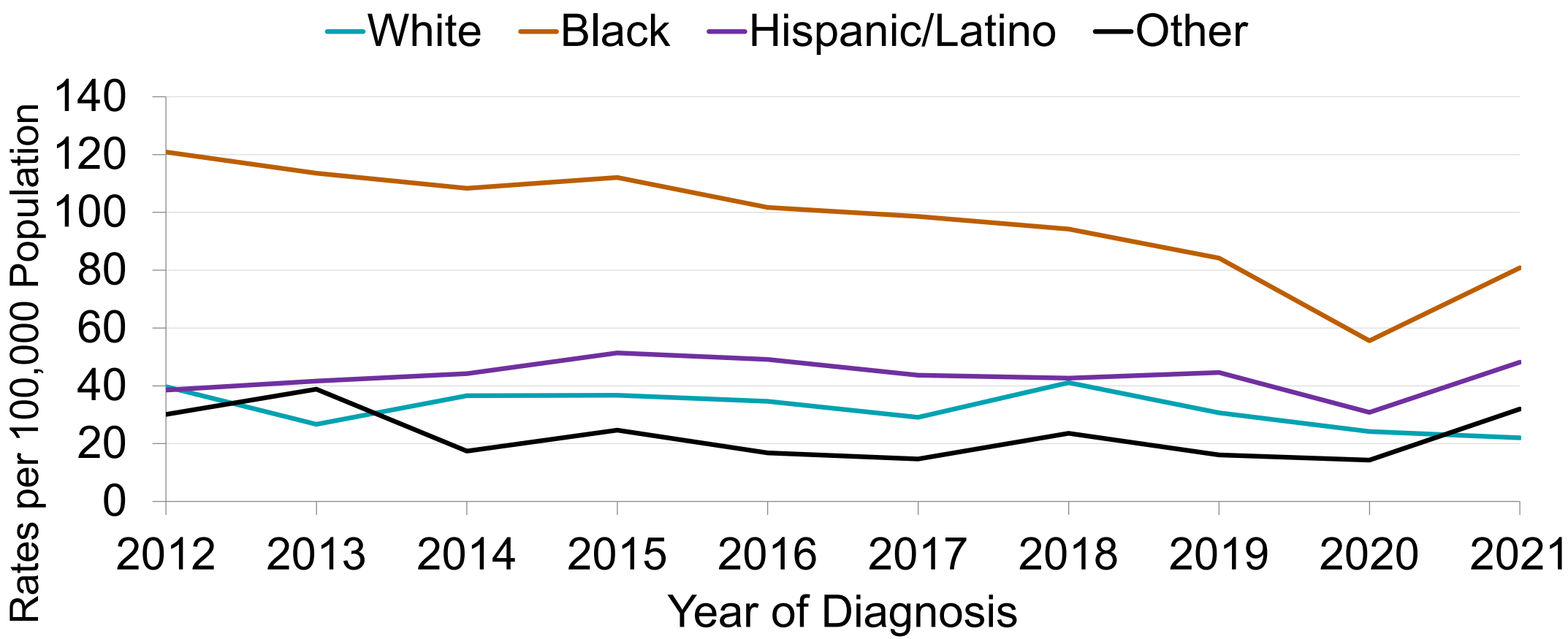


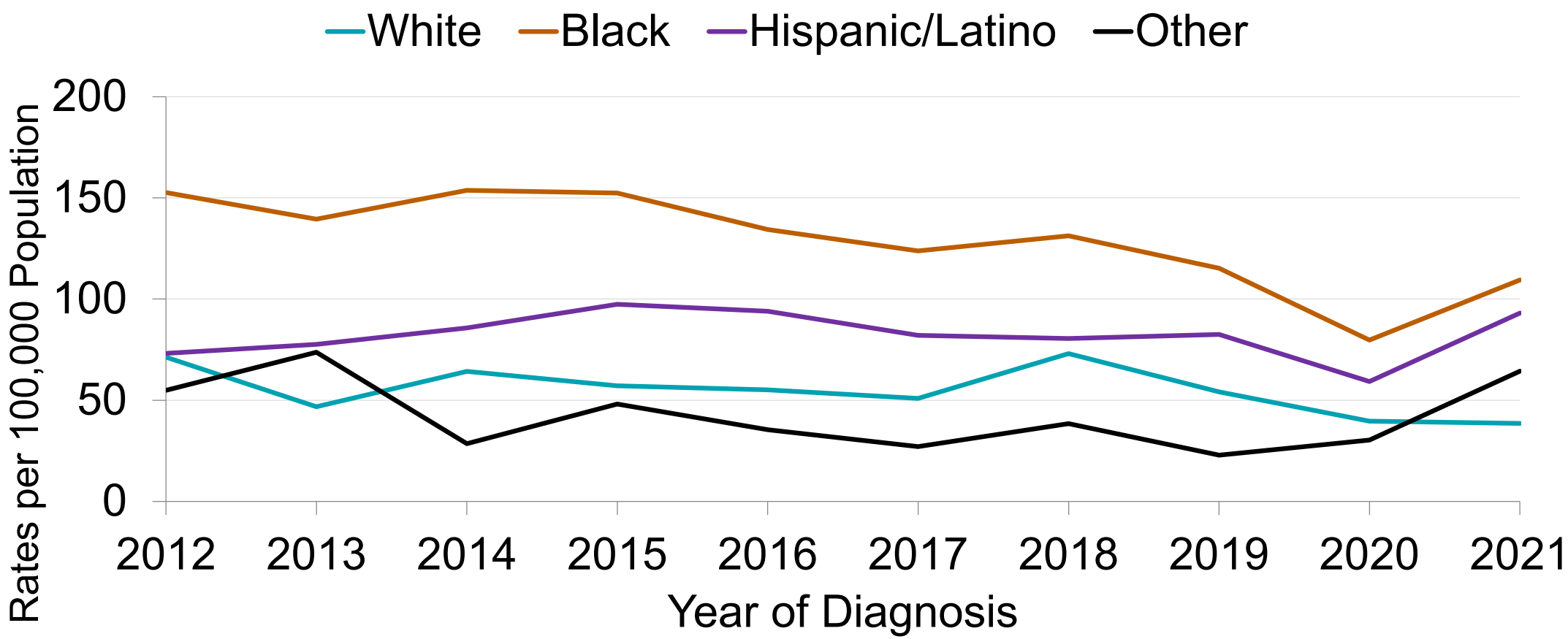
Adult HIV and AIDS Diagnoses By Sex at Birth, 2021, Miami-Dade County



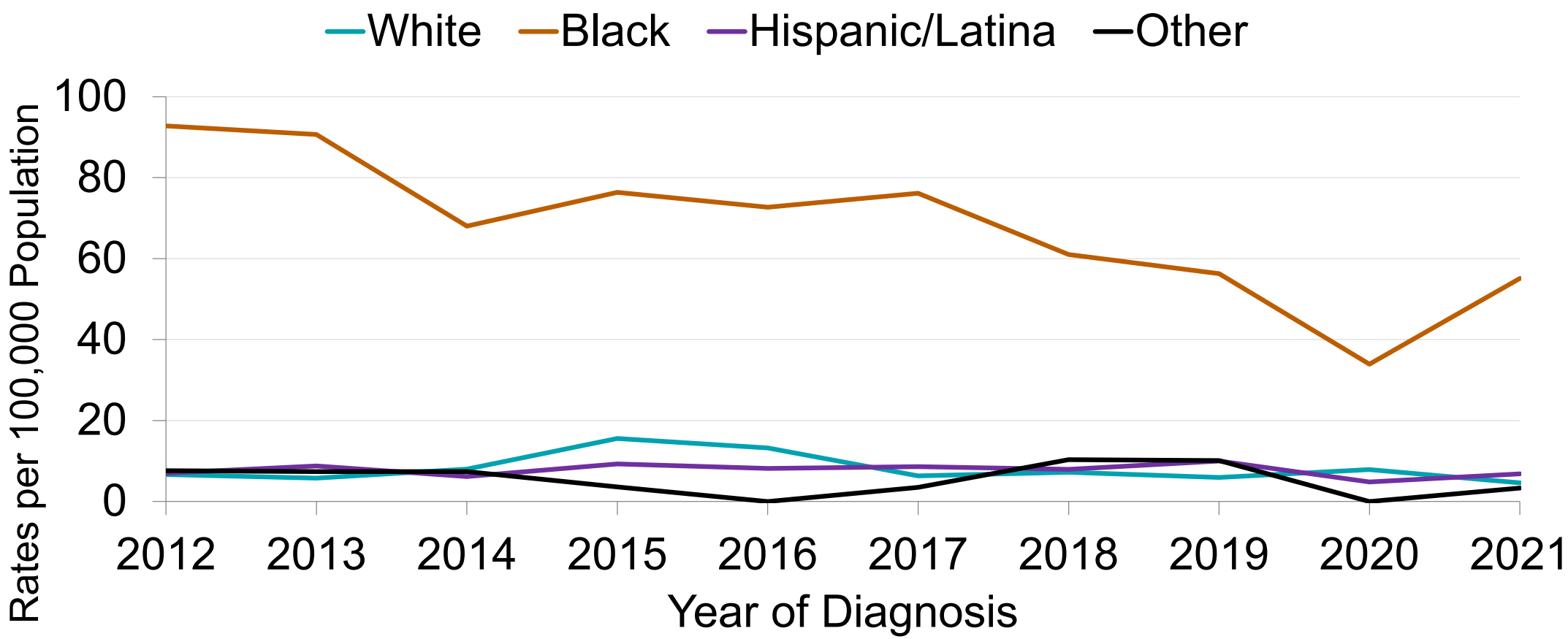
Adult HIV Diagnosis Rates
By Race or Ethnicity, 2012–2021, Miami-Dade County



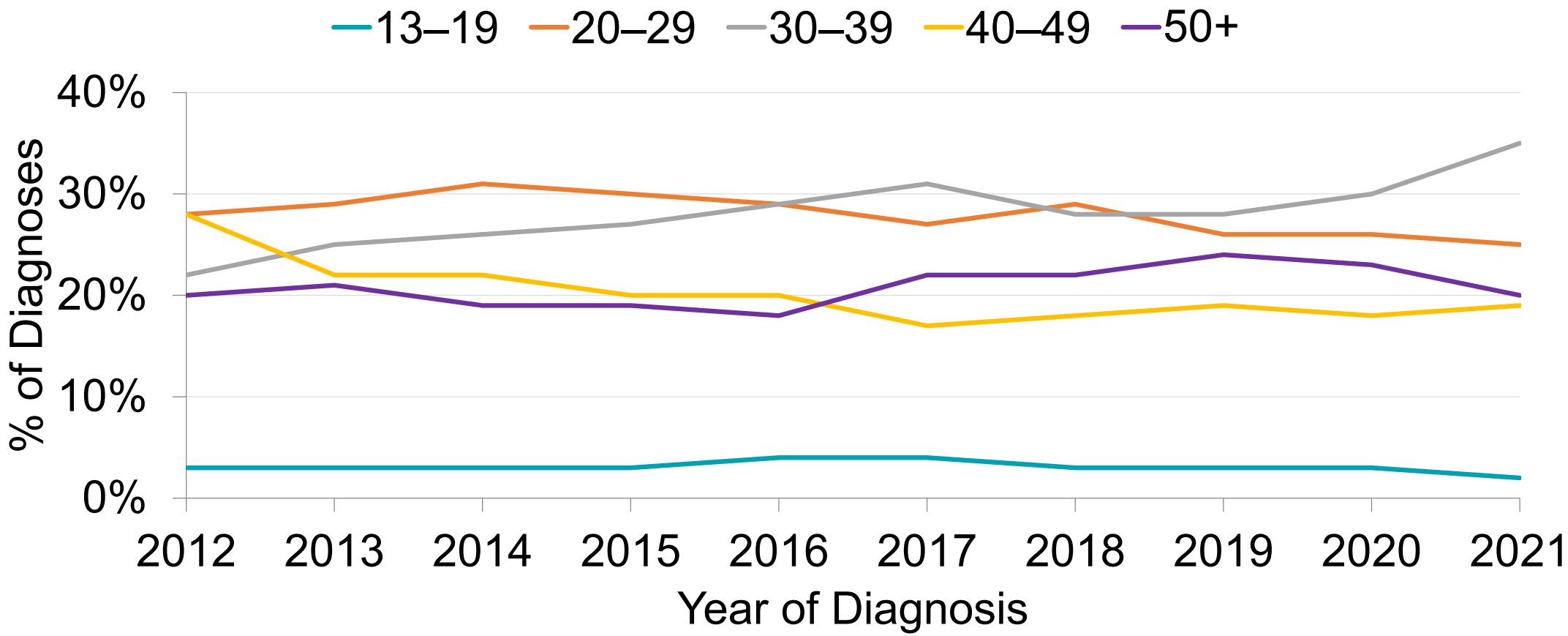
Adult Male HIV Diagnosis Rates By Race or Ethnicity, 2012–2021, Miami-Dade County



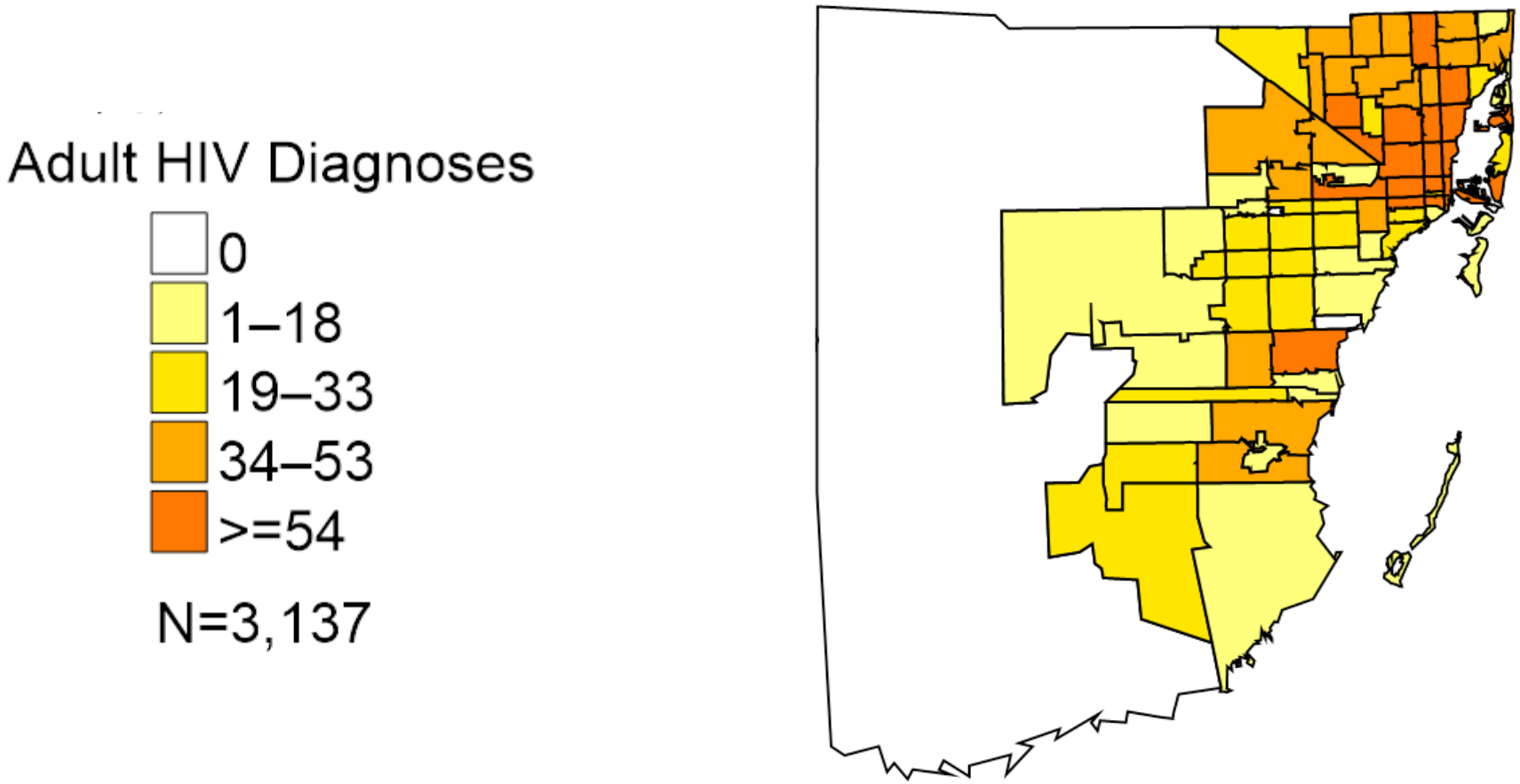
Adult Female HIV Diagnosis Rates By Race or Ethnicity, 2012–2021, Miami-Dade County



Adult HIV Diagnoses by Age At Diagnosis, 2012–2021, Miami-Dade County

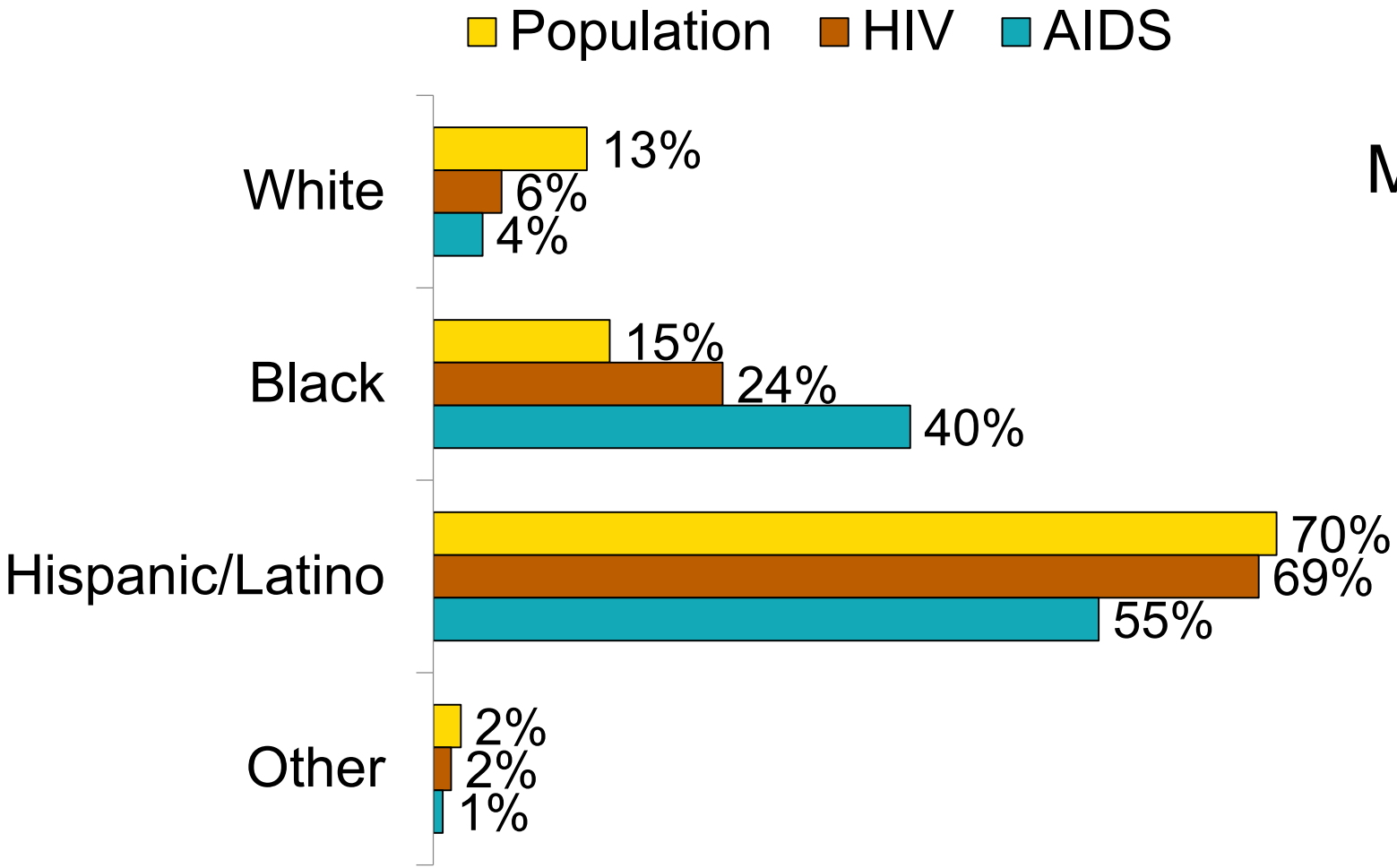


Adult HIV Diagnoses by ZIP Code of Residence At Diagnosis, 2019–2021, Miami-Dade County



County map boundaries include agricultural and/or conservation areas, which may not be populated.

Adult HIV and AIDS Diagnoses and Population by Race or Ethnicity, 2021, Miami-Dade County



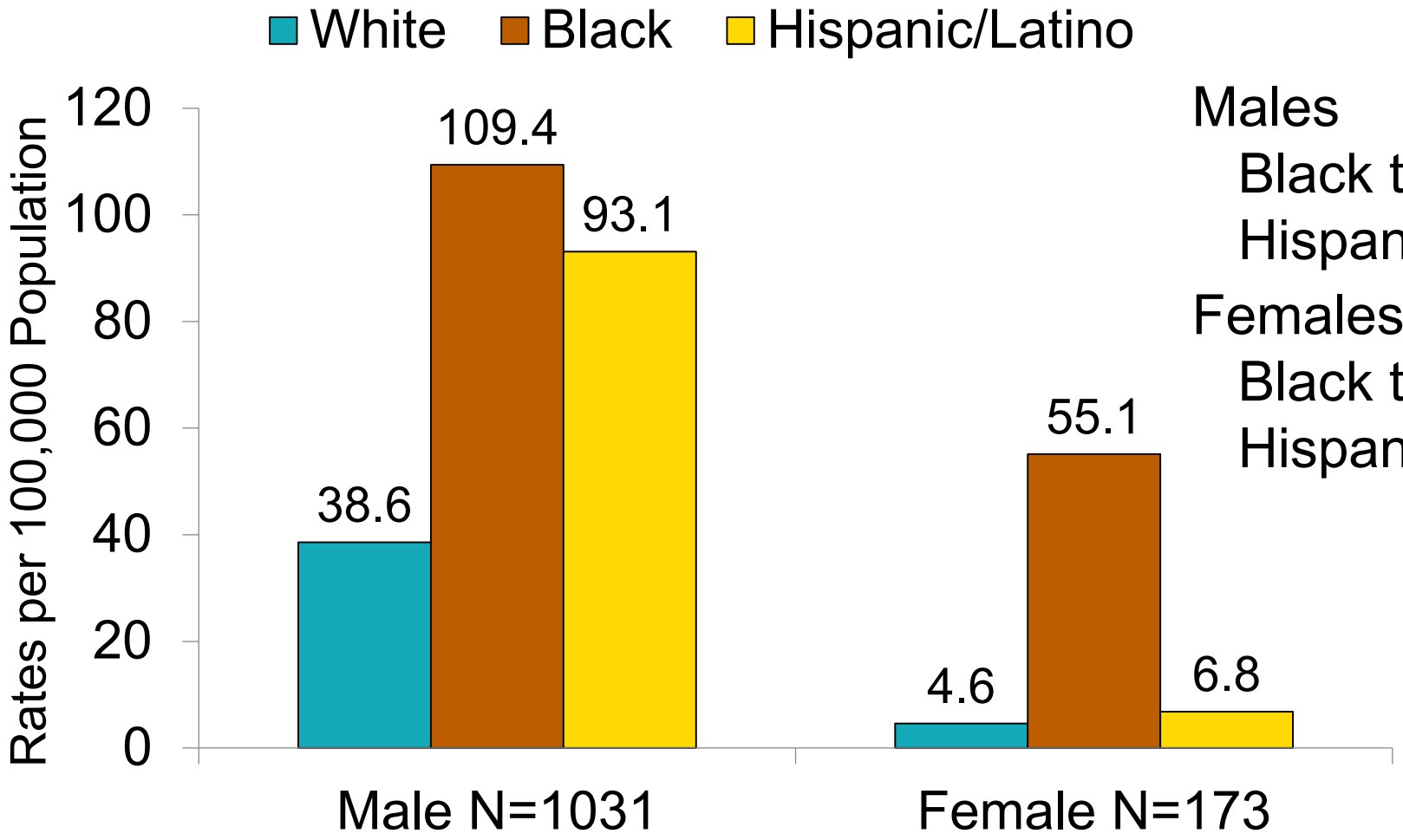
Miami-Dade County Adult Population Estimate
N=2,444,510

HIV
N=1204

AIDS
N=388

Rounding may cause percentages to total more or less than 100.

Adult HIV Diagnosis Rates by Sex And Race or Ethnicity, 2021, Miami-Dade County



Rate Ratios

Males

Black to White: 2.8 to 1

Hispanic/Latino to White: 2.4 to 1

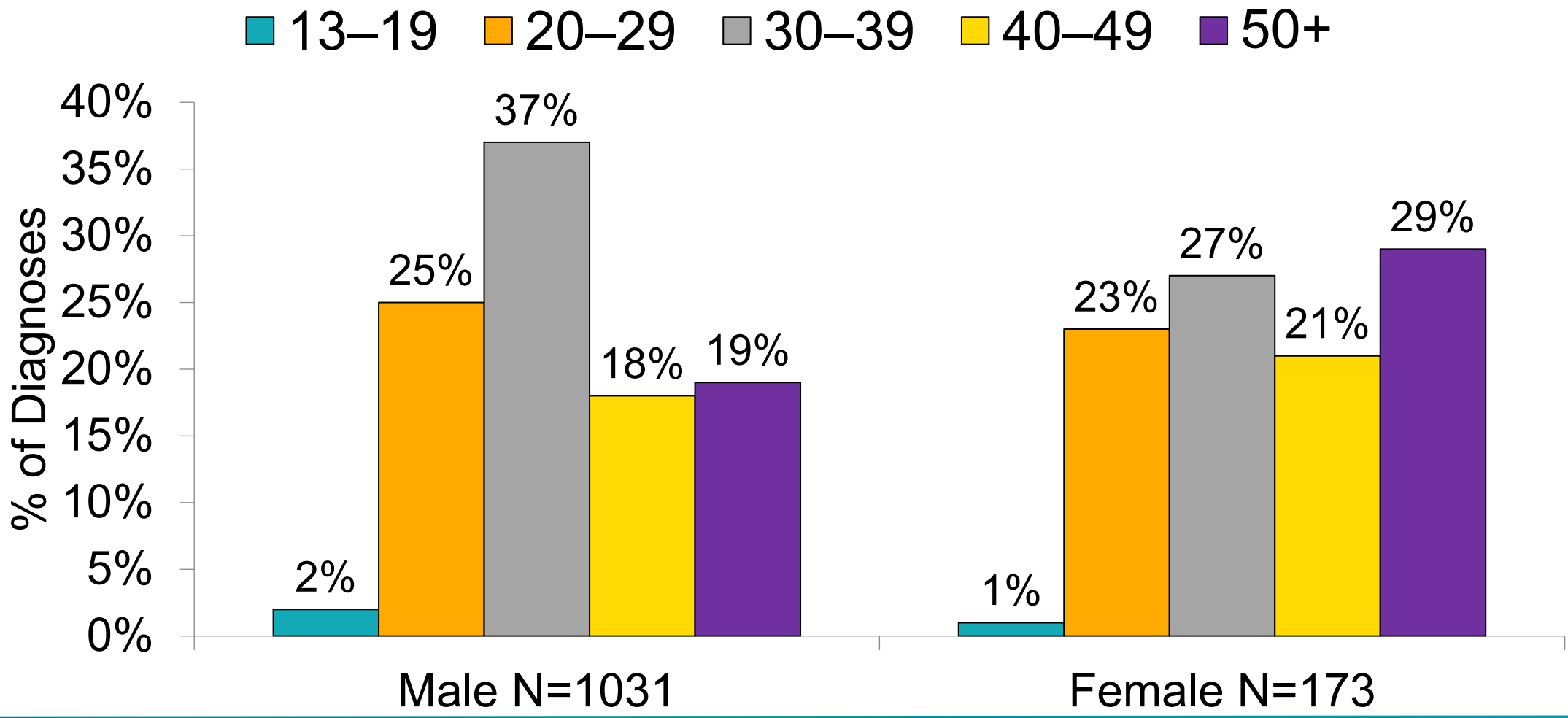
Females

Black to White: 12.0 to 1

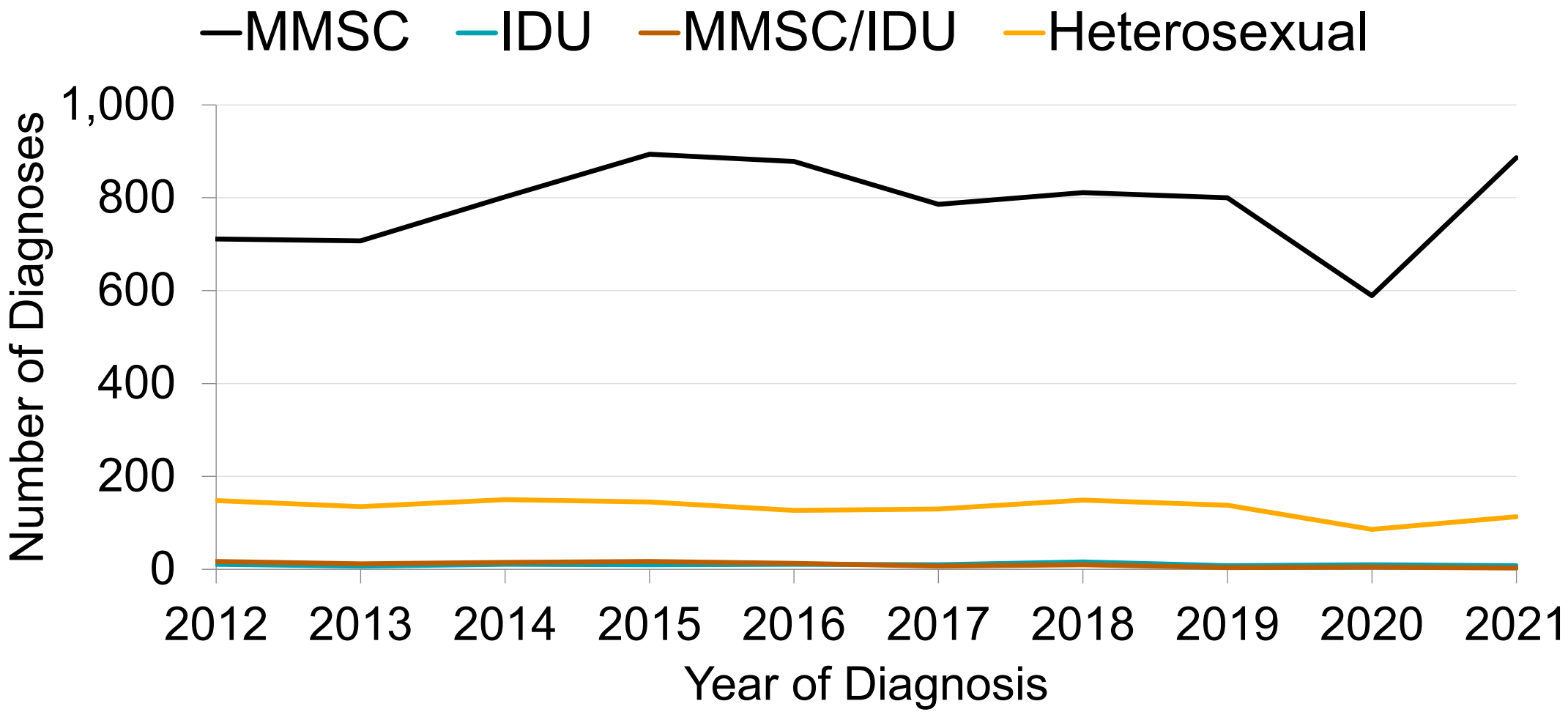
Hispanic/Latina to White: 1.5 to 1

Rounding may cause percentages to total more or less than 100.

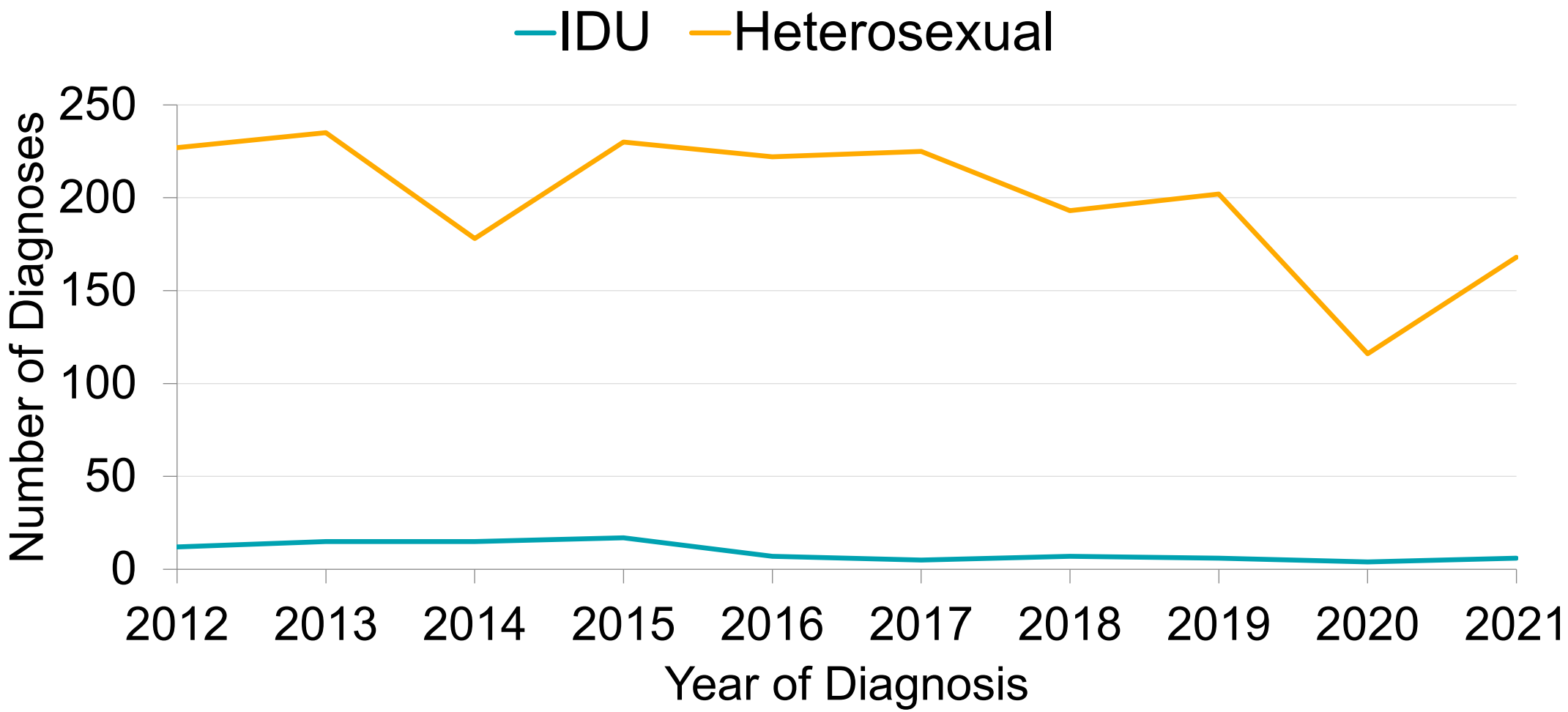
Adult HIV Diagnoses By Sex and Age at Diagnosis, 2021, Miami-Dade County

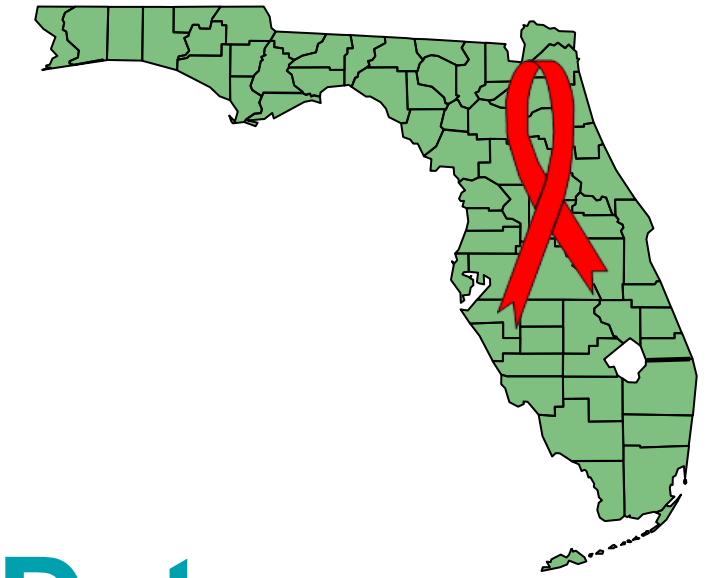


Adult Male HIV Diagnoses by Mode of Exposure, 2012–2021, Miami-Dade County



Adult Female HIV Diagnoses by Mode of Exposure, 2012–2021, Miami-Dade County



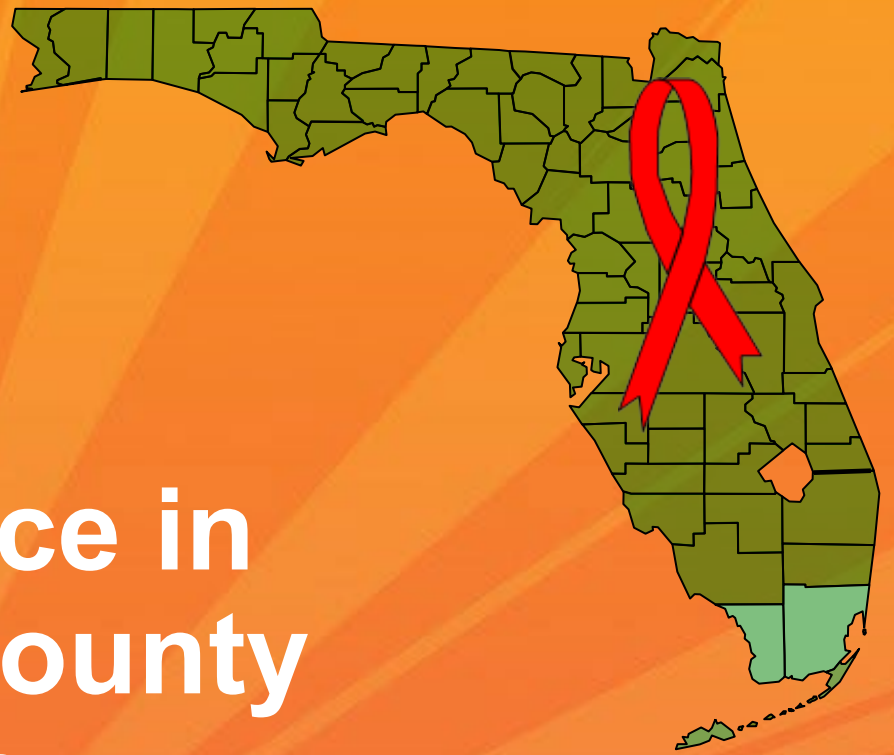


HIV Co-morbidity Data

PWH with a Co-occurring Diagnosis of an STI by Type and Year of STI Report, 2017–2021, Miami-Dade County

Year of STI Report	HIV/ Early Syphilis[1]	HIV/ Chlamydia	HIV/ Gonorrhea
2017	724	611	595
2018	928	803	806
2019	1,000	955	1,034
2020	1,096	837	953
2021	1,248	1,202	1,188
Percentage Change	72%	97%	100%

[1]Primary, secondary and early non-primary, non-secondary syphilis.

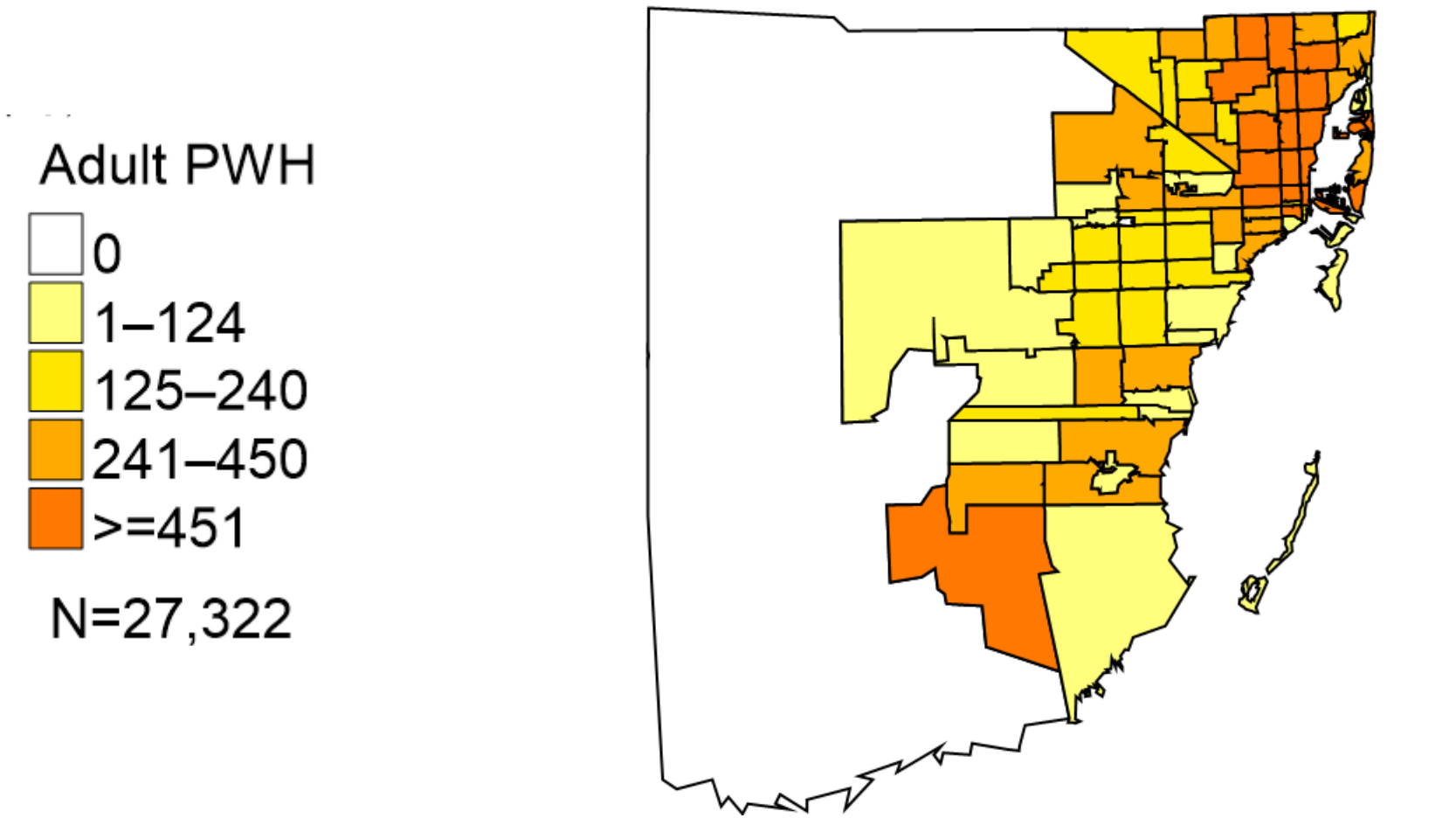


HIV Prevalence in Miami-Dade County

Florida Department of Health

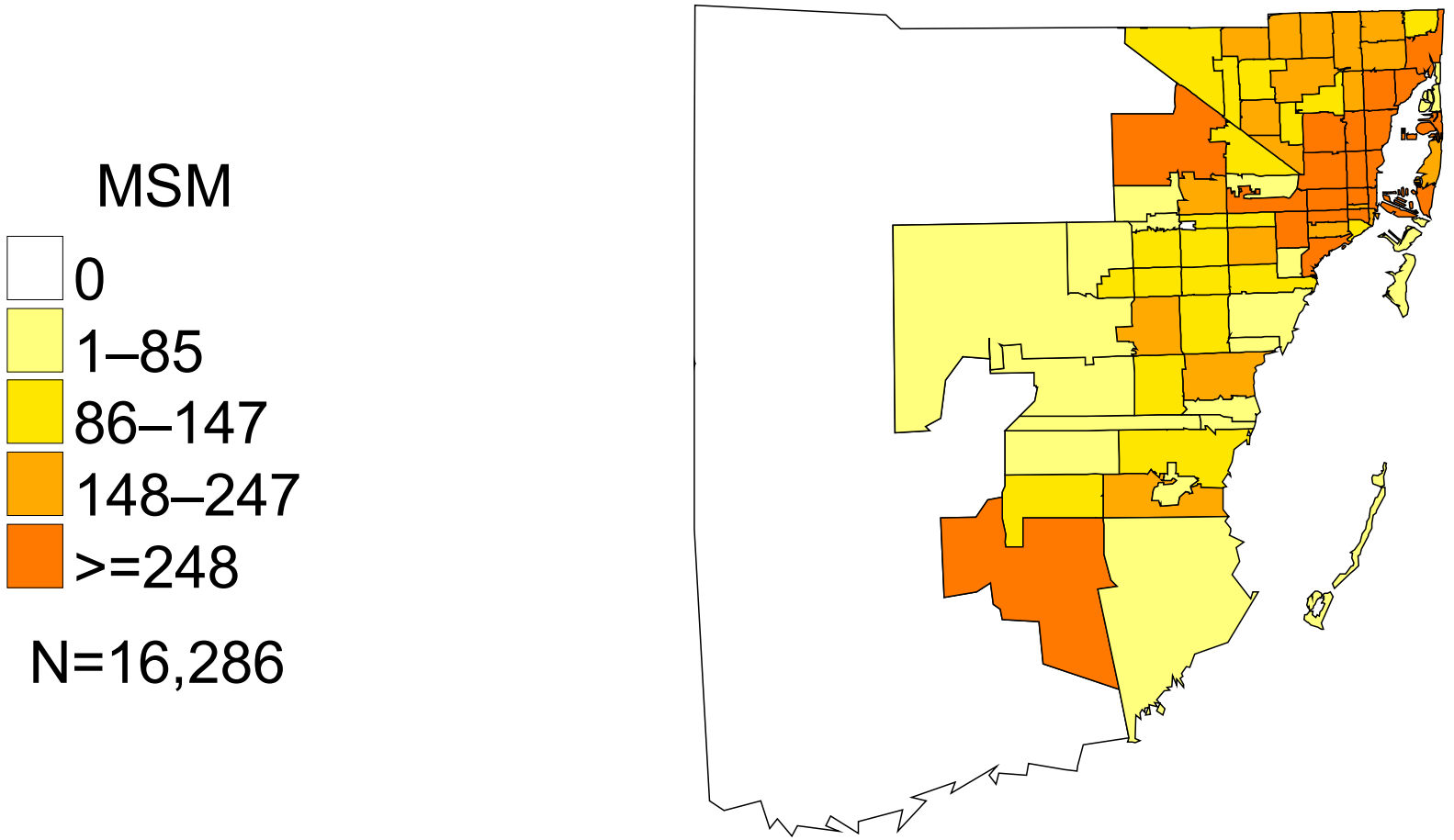
Florida HEALTH

Adult PWH by ZIP Code of Residence,[1] 2021
Living in Miami-Dade County



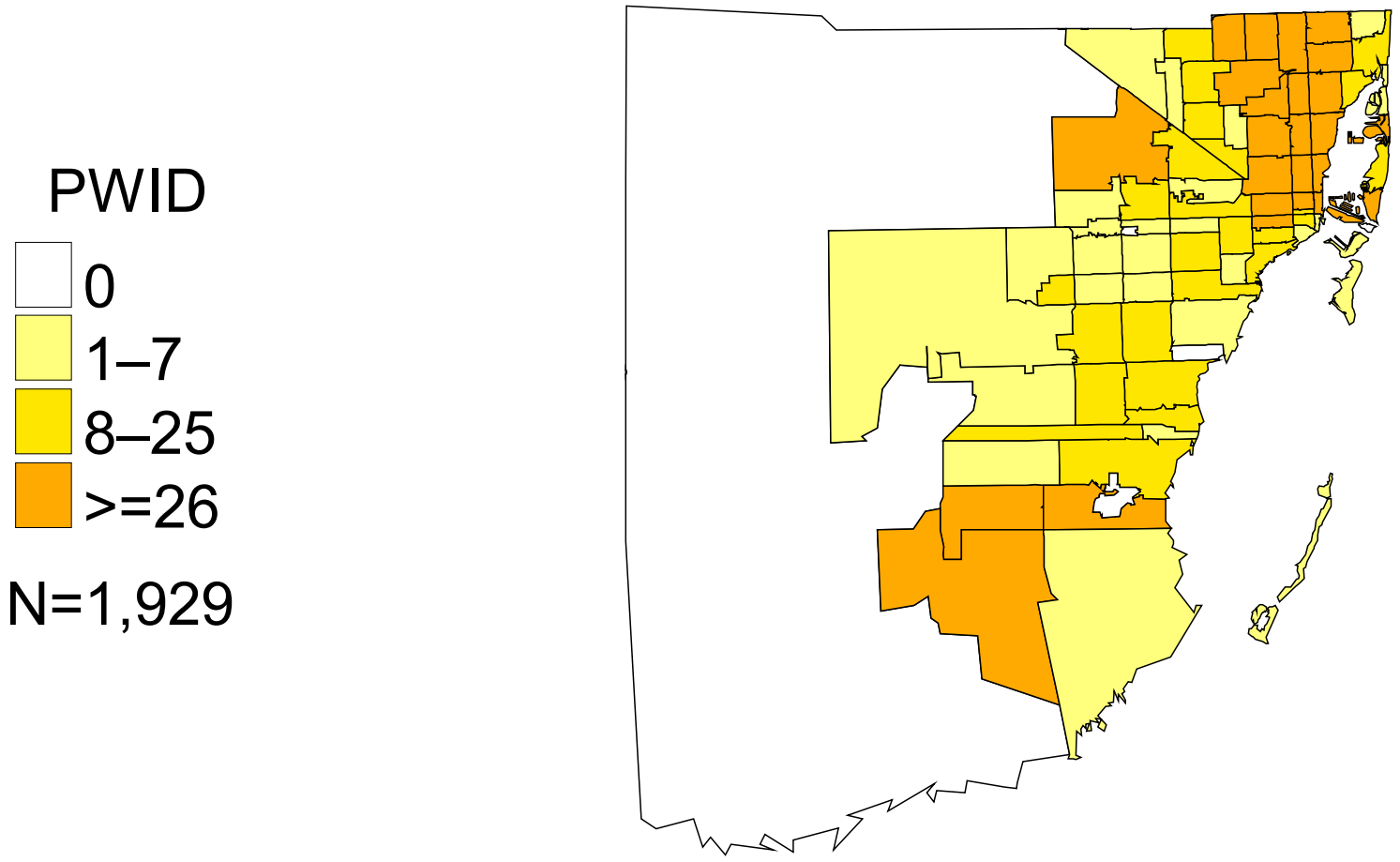
[1]Excludes homeless persons and persons with unknown ZIP codes.

MSM[1] with HIV by ZIP Code of Residence,[2] 2021 Living in Miami-Dade County



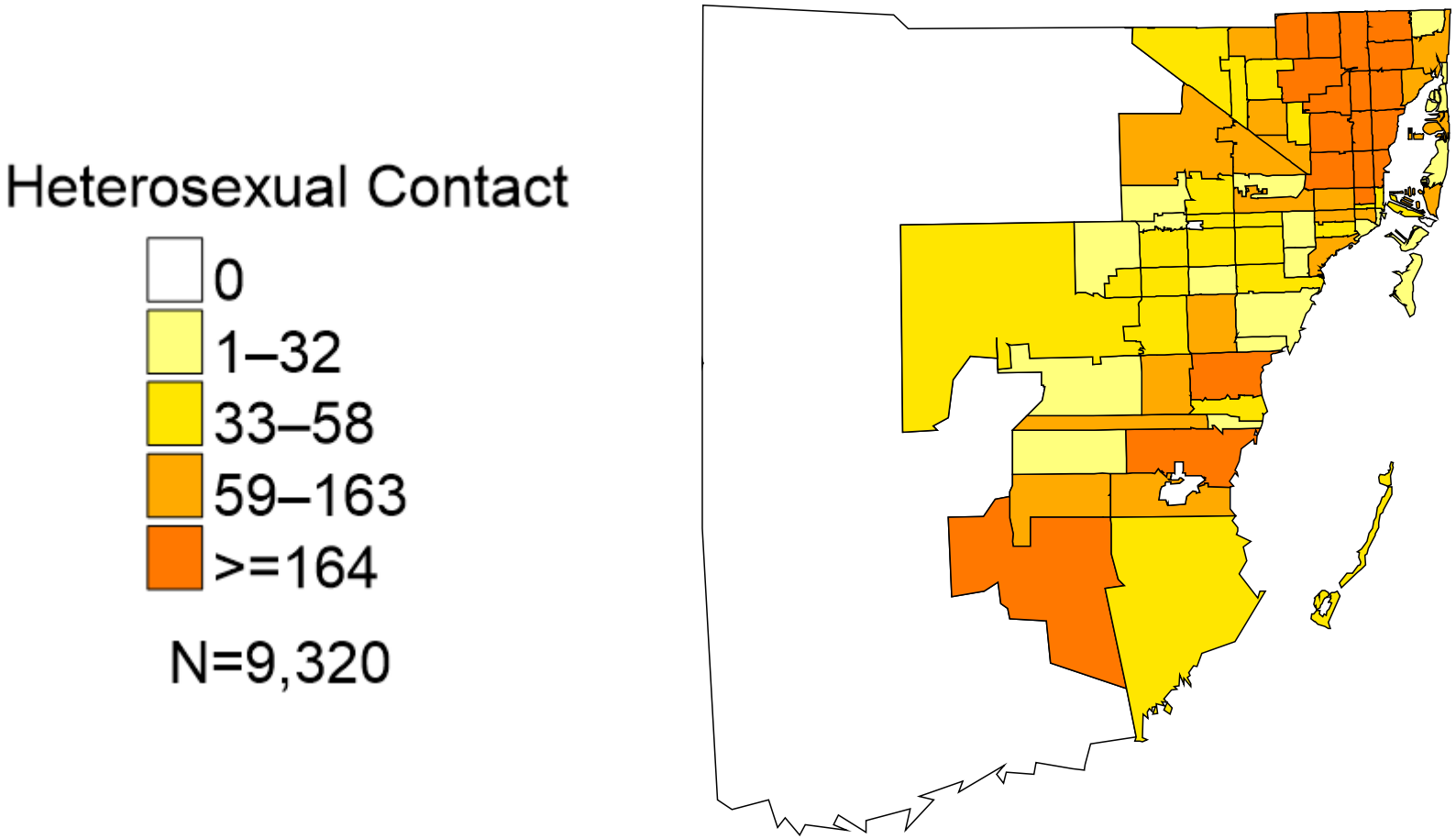
[1]Data includes MSM/PWID and excludes transgender persons.
[2]Excludes homeless persons and persons with unknown ZIP codes.

PWID[1] with HIV by ZIP Code of Residence,[2] 2021 Living in Miami-Dade County



[1]Data includes MSM/PWID.
[2]Excludes homeless persons and persons with unknown ZIP codes.

Persons with Heterosexual Contact with HIV by ZIP Code of Residence,[1] 2021, Living in Miami-Dade County

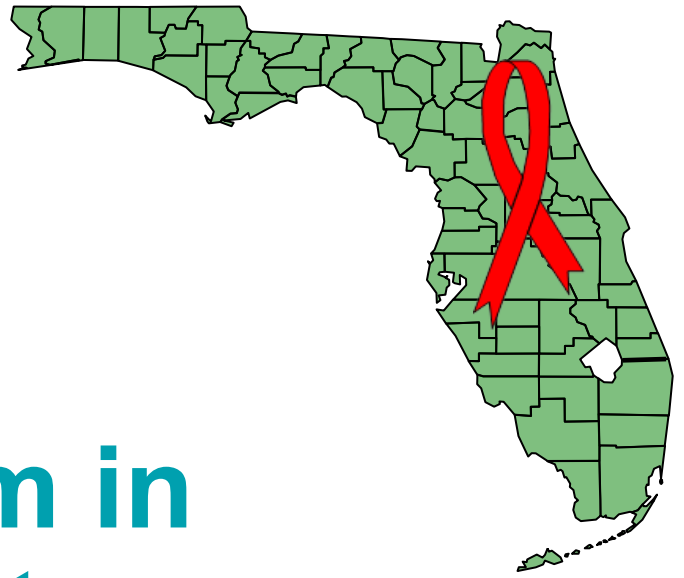


[1]Excludes homeless persons and persons with unknown ZIP codes.

Adults with HIV, 2021, Living in Miami-Dade County

		Male #	%	Female #	%	Total #	%
Race/ Ethnicity	White	2,481	11.7%	275	4.2%	2,756	9.9%
	Black	6,453	30.4%	4,443	67.9%	10,896	39.2%
	Hispanic/Latino	12,016	56.6%	1,745	26.7%	13,761	49.6%
	Other	267	1.3%	82	1.3%	349	1.3%
Age Group	13-19	36	0.2%	15	0.2%	51	0.2%
	20-29	1,414	6.7%	325	5.0%	1,739	6.3%
	30-39	3,811	18.0%	880	13.4%	4,691	16.9%
	40-49	3,995	18.8%	1,338	20.4%	5,333	19.2%
	50+	11,961	56.4%	3,987	60.9%	15,948	57.4%
Mode of Exposure	MMSC	15,870	74.8%	0	0.0%	15,870	57.2%
	IDU	811	3.8%	532	8.1%	1,343	4.8%
	MMSC/IDU	637	3.0%	0	0.0%	637	2.3%
	Heterosexual Contact	3,663	17.3%	5,838	89.2%	9,501	34.2%
	Transgender Sexual Contact	96	0.5%	3	0.0%	99	0.4%
	Other risk	141	0.7%	172	2.6%	313	1.1%

Rounding may cause percentages to total more or less than 100.



HIV Care Continuum in Miami-Dade County

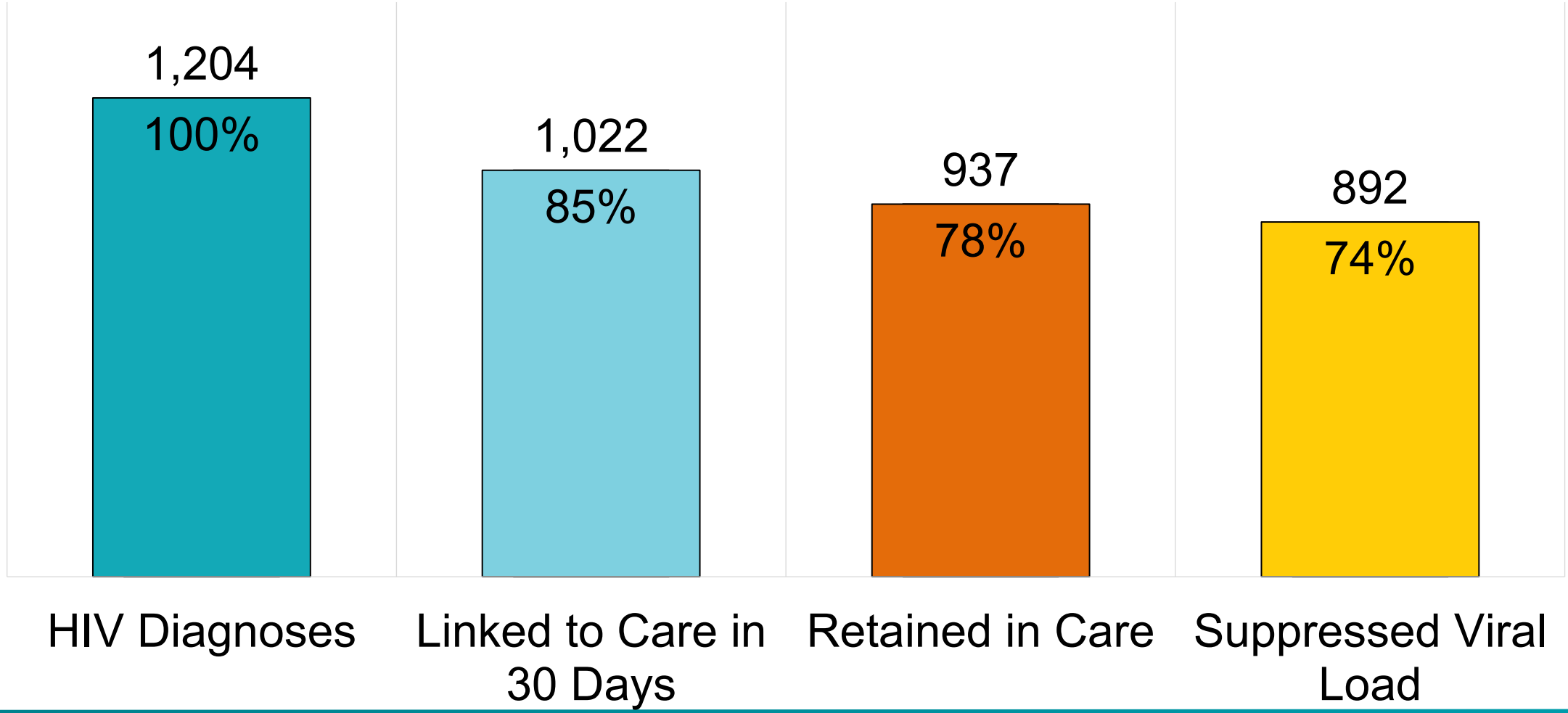
HIV Care Continuum Definitions

- **PWH:** Persons with HIV living in Florida at the end of 2021.
- **In Care:** PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2021 through 3/31/2022.
- **Retained in Care:** PWH with two or more documented VL or CD4 labs, medical visits or prescriptions at least three months apart from 1/1/2021 through 6/30/2022.

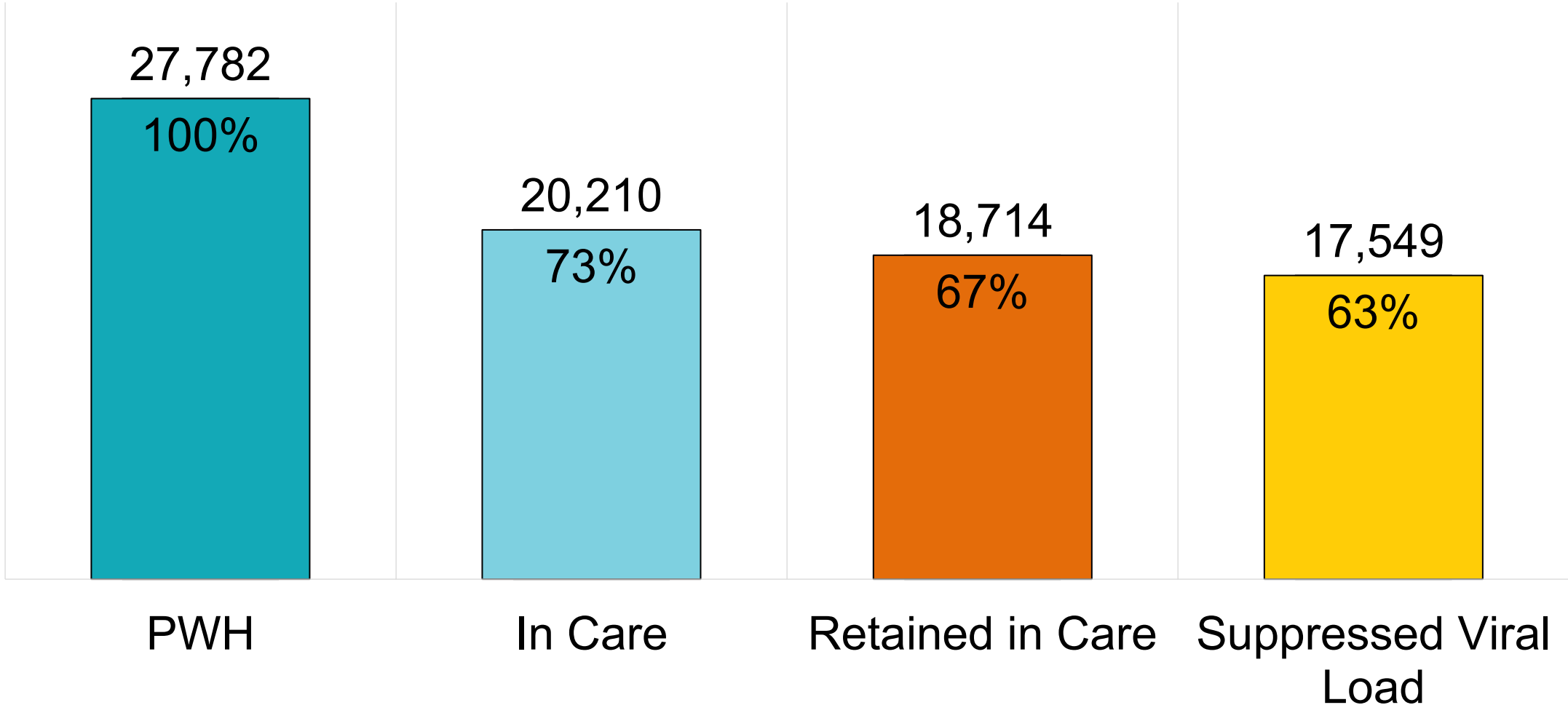
HIV Care Continuum Definitions, continued

- **Suppressed Viral Load**: PWH with a suppressed VL (<200 copies/mL) on their last VL lab from 1/1/2020 through 3/31/2022.
- **Not in Care:** PWH with no documented VL or CD4 lab, medical visit or prescription from 1/1/2021 through 3/31/2022.
- **Linked to Care**: PWH with at least one documented VL or CD4 lab, medical visit, or prescription following their first HIV diagnosis date.

Persons Who Received an HIV Diagnosis Along the HIV Care Continuum in 2021, Miami-Dade County



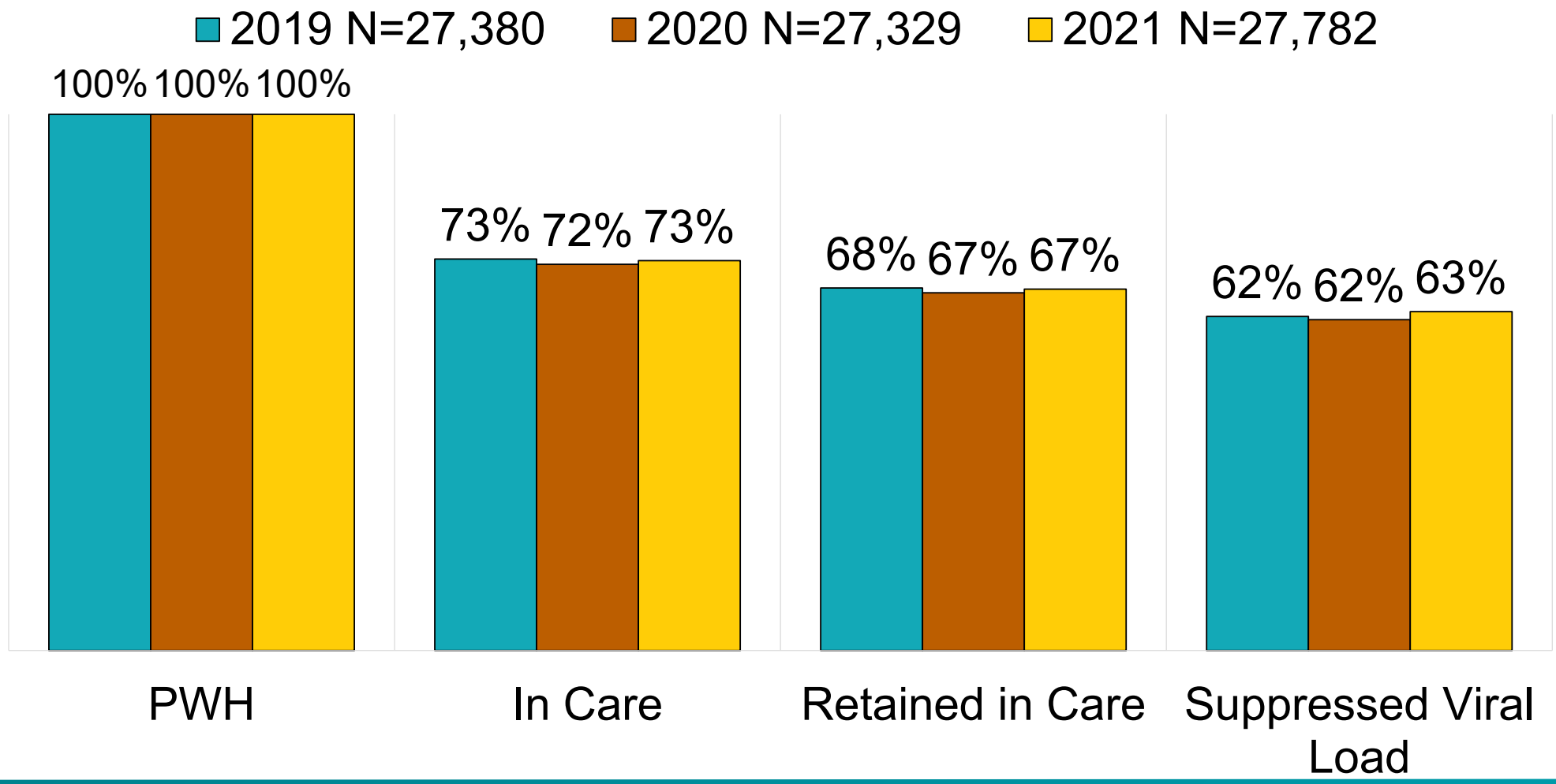
PWH Along the HIV Care Continuum in 2021, Living in Miami-Dade County



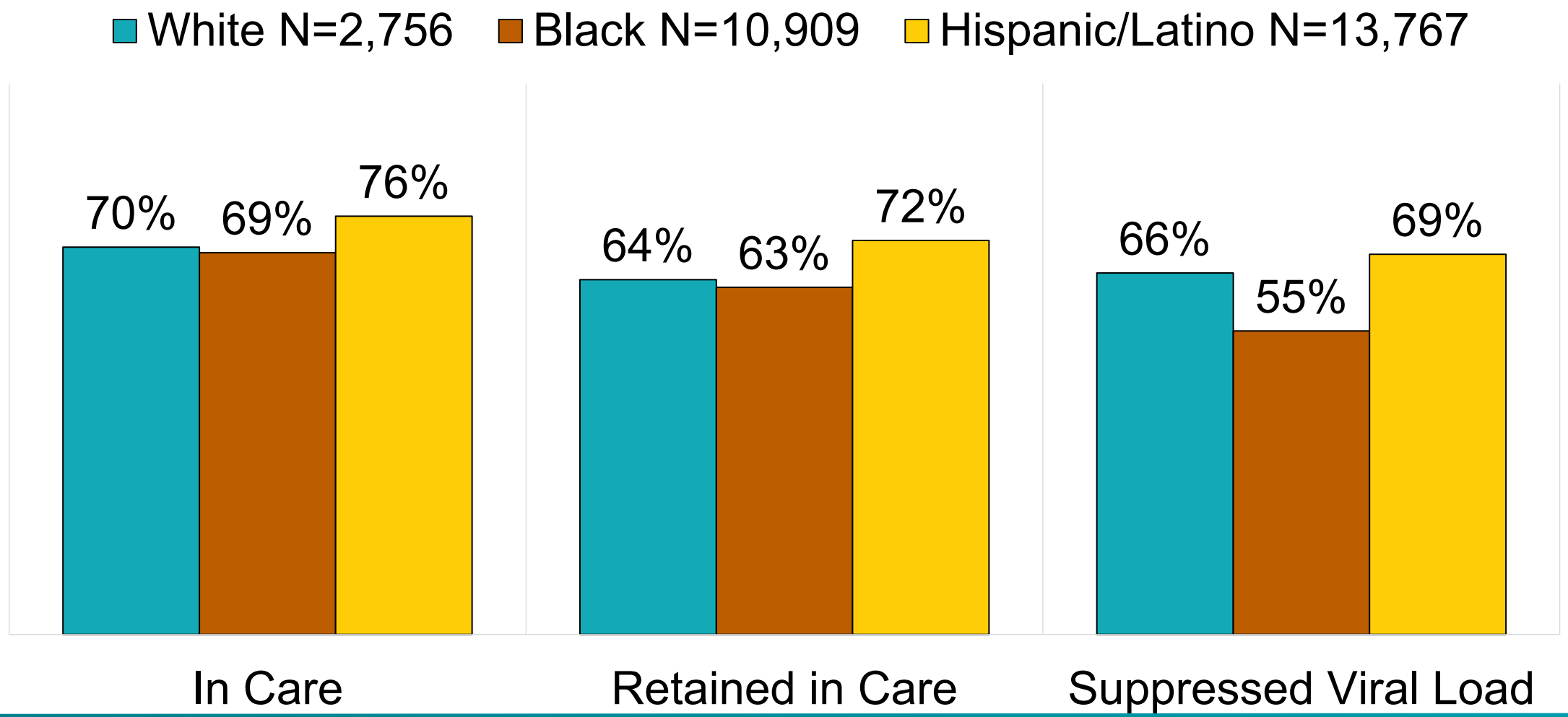
Florida HEALTH

Note: 89% of persons retained in care had a suppressed viral load.

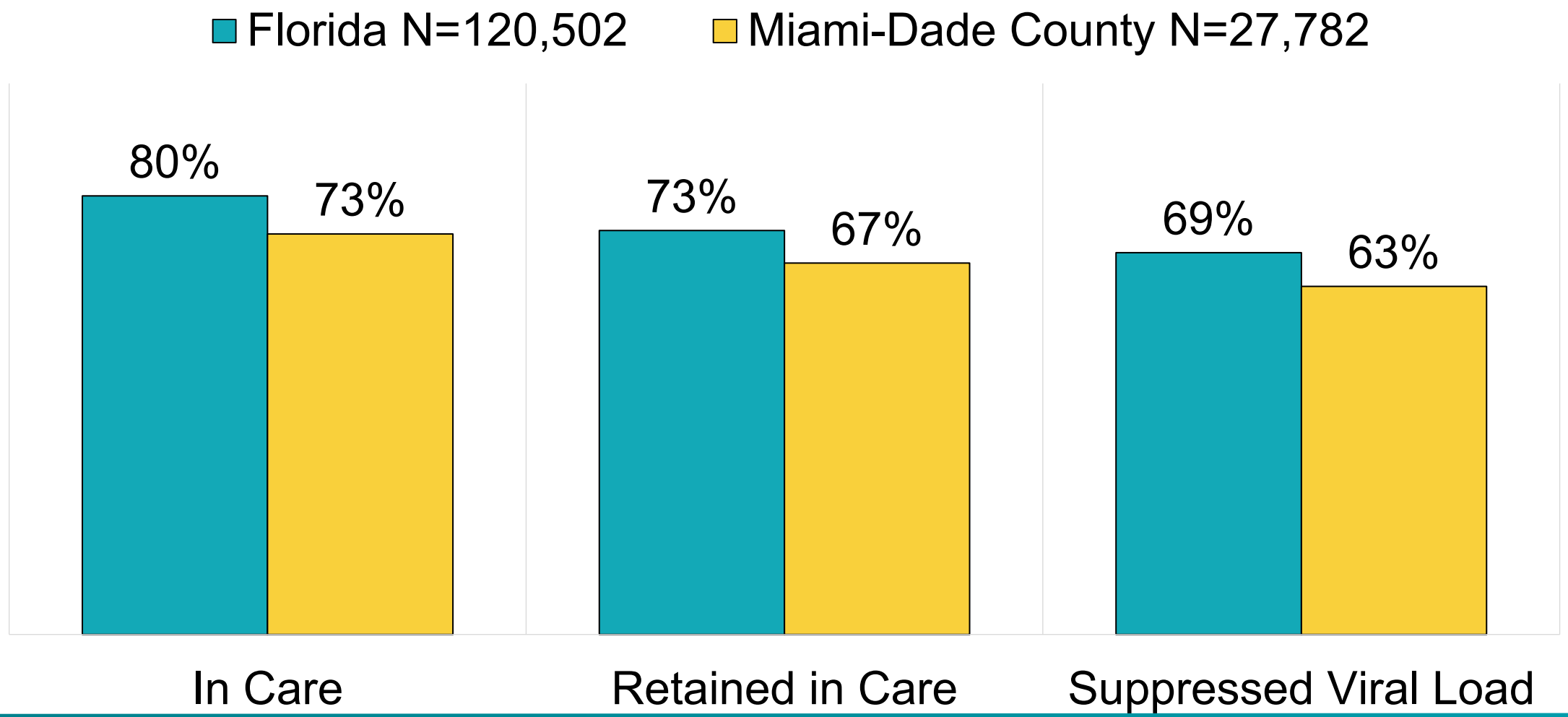
PWH Along the HIV Care Continuum, 2019–2021
Living in Miami-Dade County



PWH by Race or Ethnicity Along the HIV Care Continuum In 2021, Living in Miami-Dade County



PWH Along the HIV Care Continuum in 2021 Living in Florida Compared to Miami-Dade County

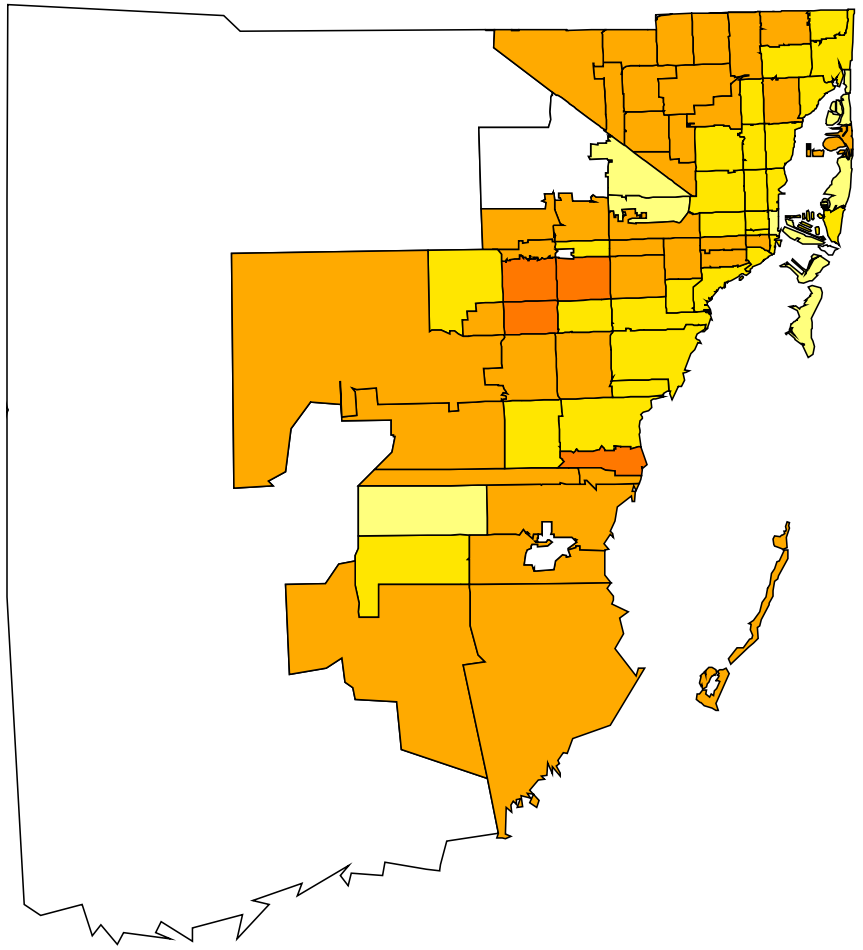


Percentage of PWH Who Were Retained in Care by ZIP Code of Residence[1] in 2021, Living in Miami-Dade County

Retained in Care

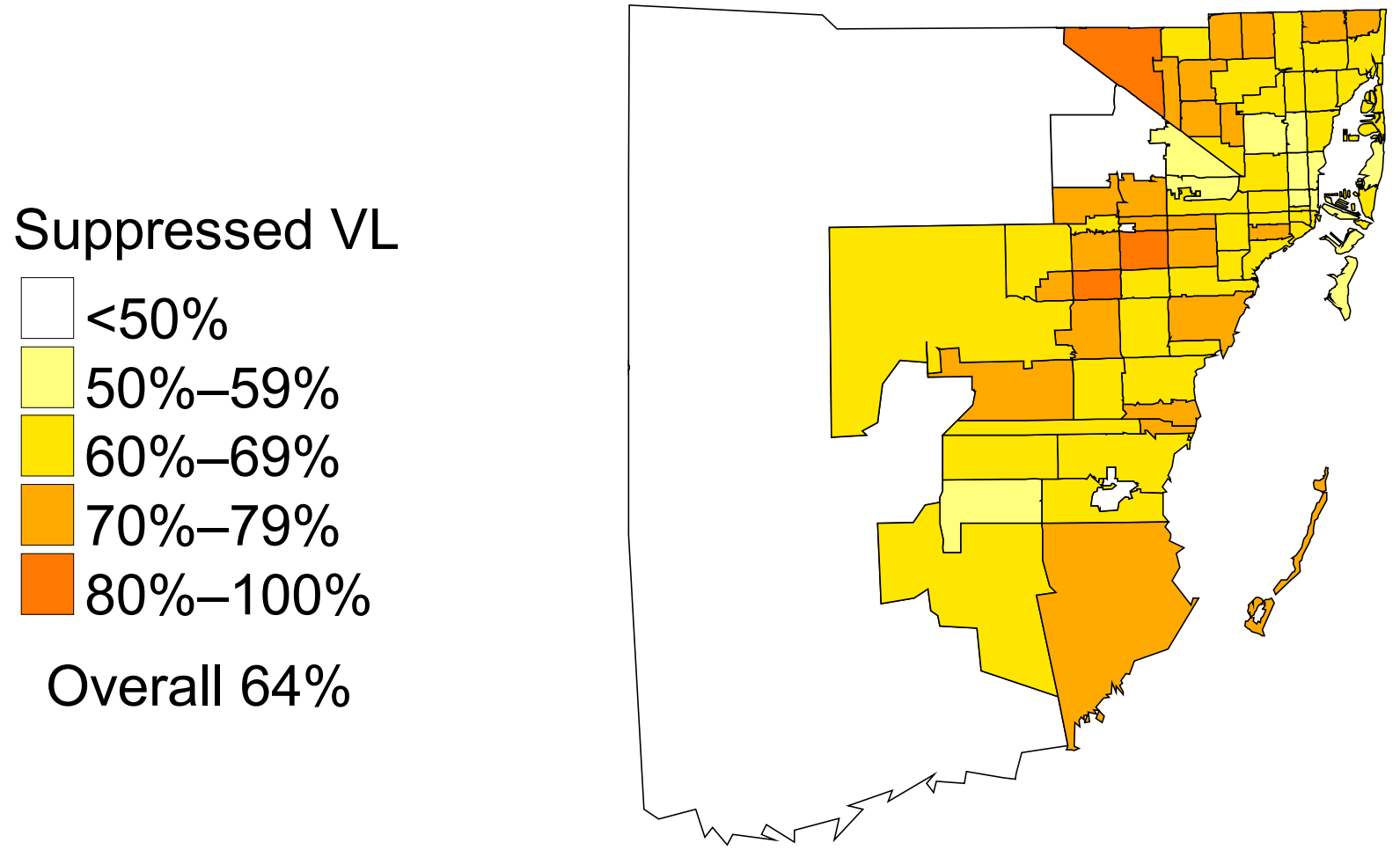
- <50%
- 50%–59%
- 60%–69%
- 70%–79%
- 80%–100%

Overall 68%



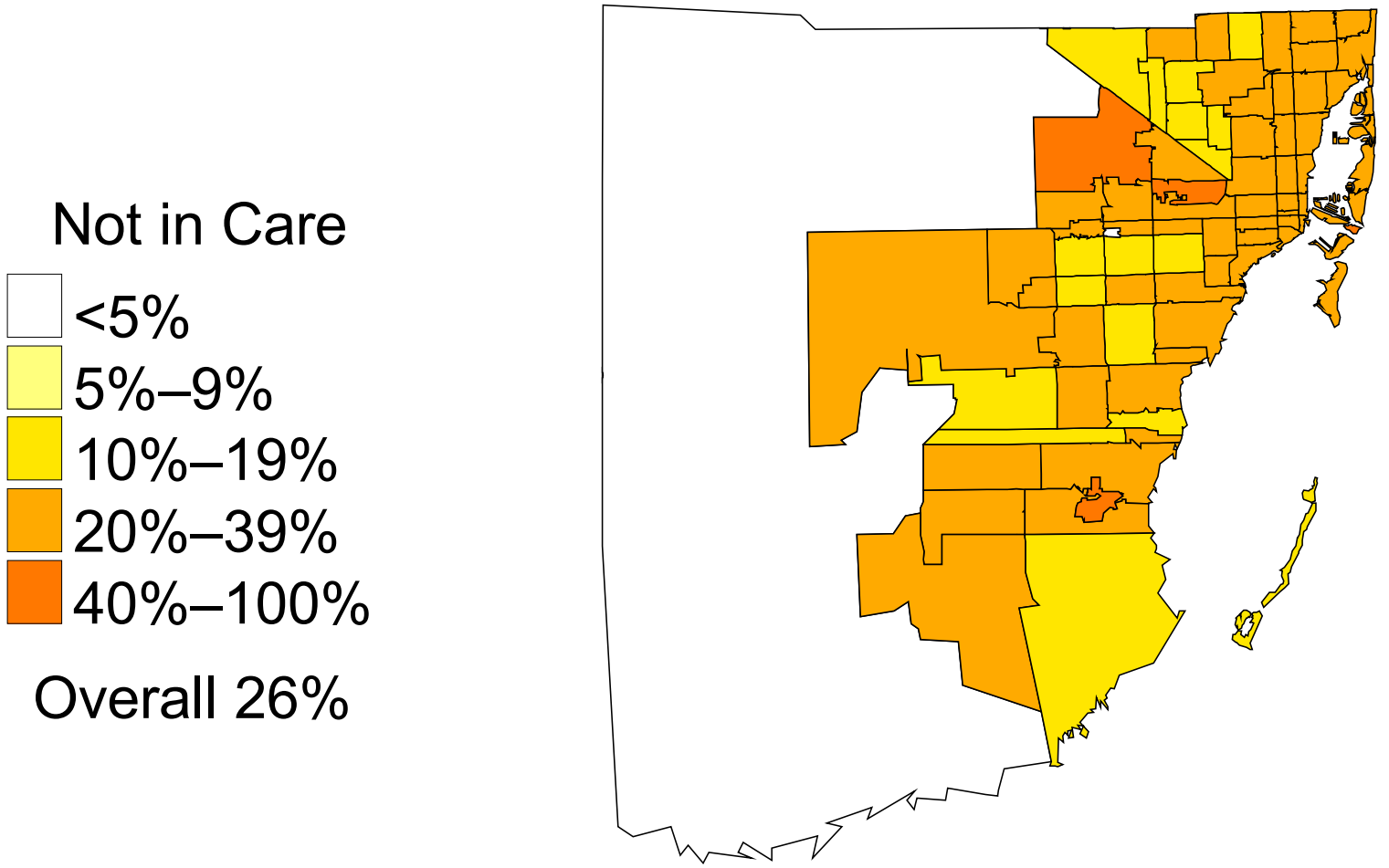
[1]Excludes data from homeless persons and persons with unknown ZIP codes.

Percentage of PWH Who Had a Suppressed VL by ZIP Code of Residence,[1] 2021, Living in Miami-Dade County

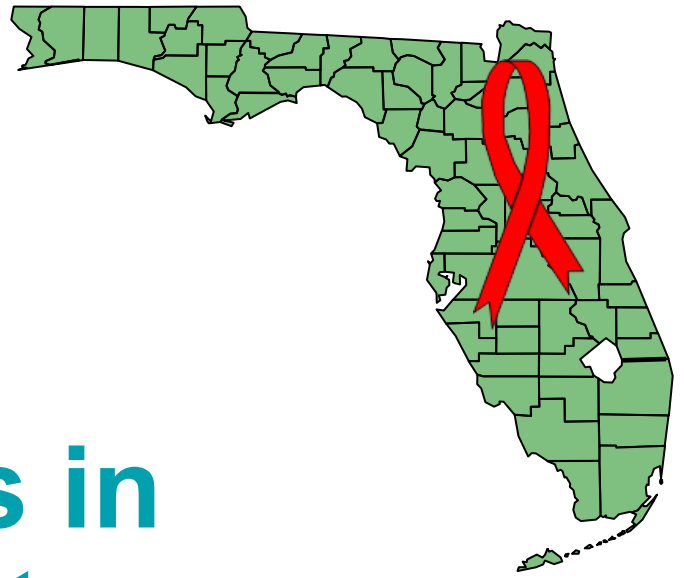


[1]Excludes data from homeless persons and persons with unknown ZIP codes.

Percentage of PWH Who Were Not in Care by ZIP Code of Residence[1] in 2021, Living in Miami-Dade County

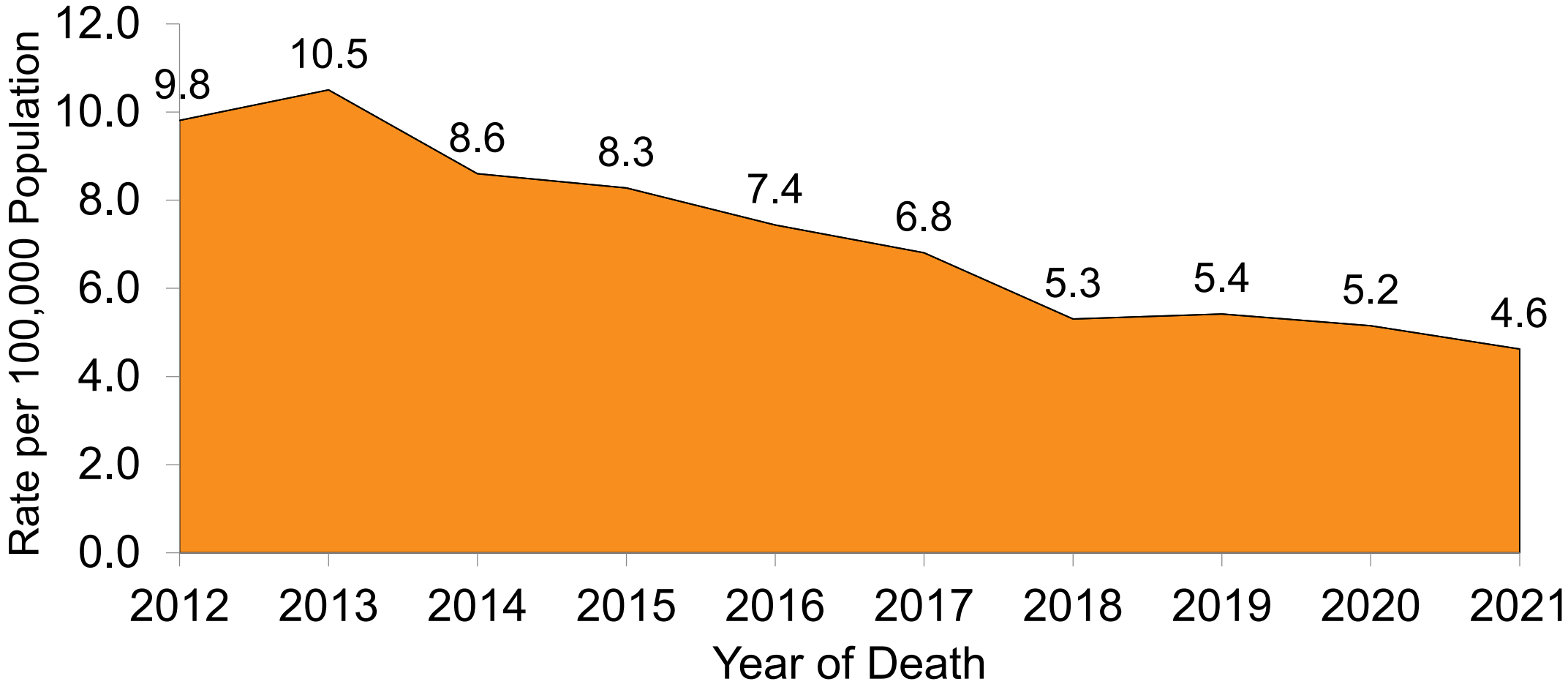


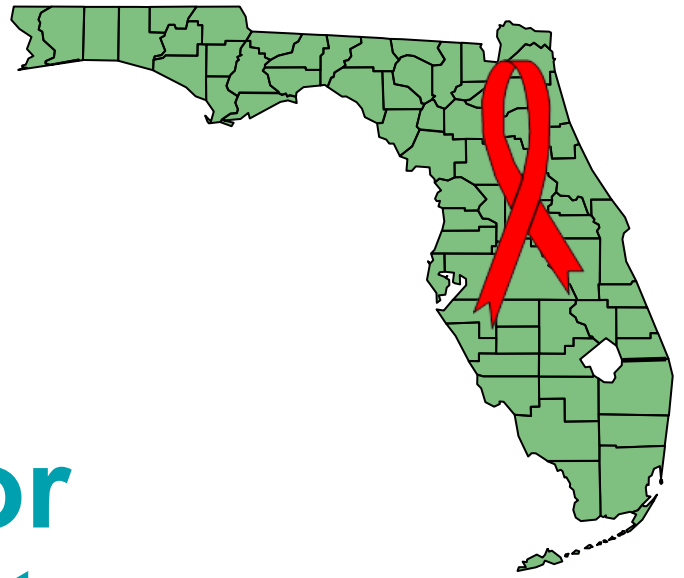
[1]Excludes data from homeless persons and persons with unknown ZIP codes.



HIV-Related Deaths in Miami-Dade County

Rate of HIV-Related Deaths
2012–2021, Miami-Dade County





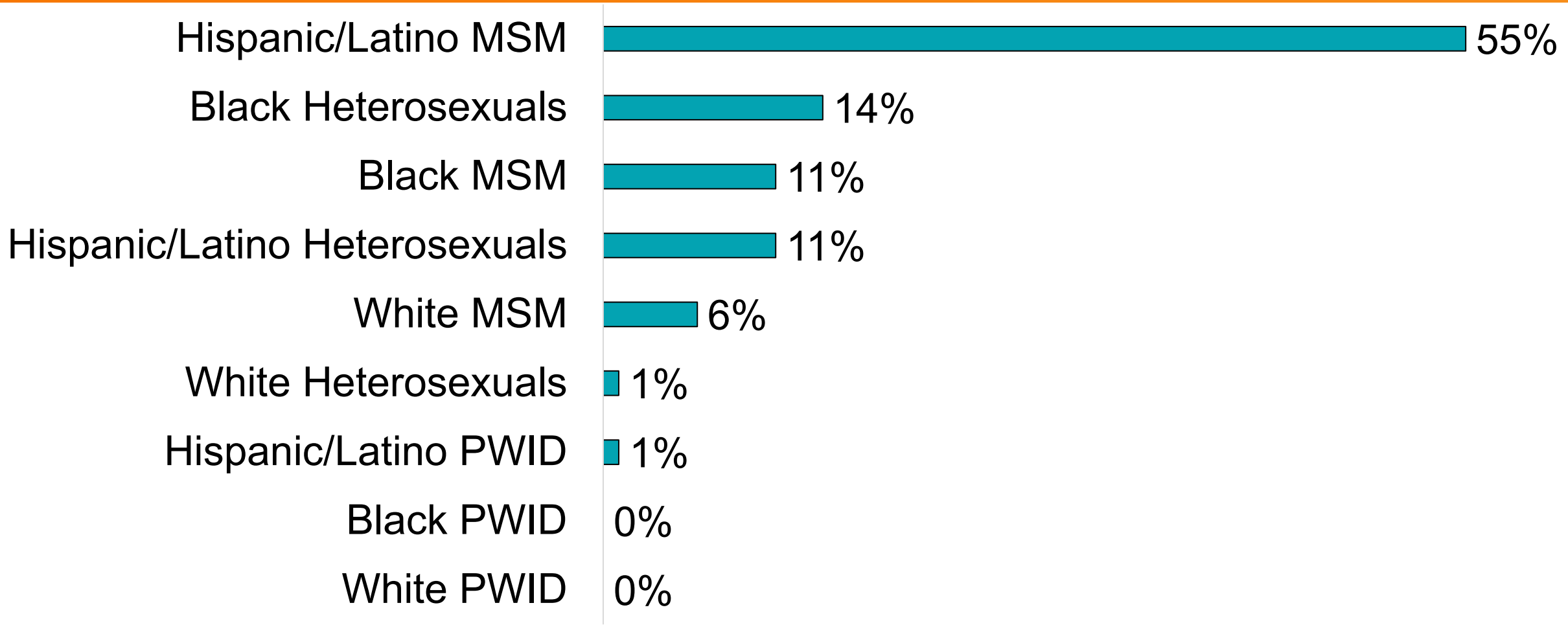
HIV Prevention for Miami-Dade County

Priority Populations for Primary HIV Prevention

- These data were calculated from HIV diagnoses 2019–2021 and represent the proportion of each race or mode of exposure group to the total diagnoses.

- These data are used to identify and prioritize testing, PrEP and other HIV prevention services to those at greatest risk for acquiring HIV in Florida.

Priority Populations for Primary HIV Prevention in 2021, Miami-Dade County



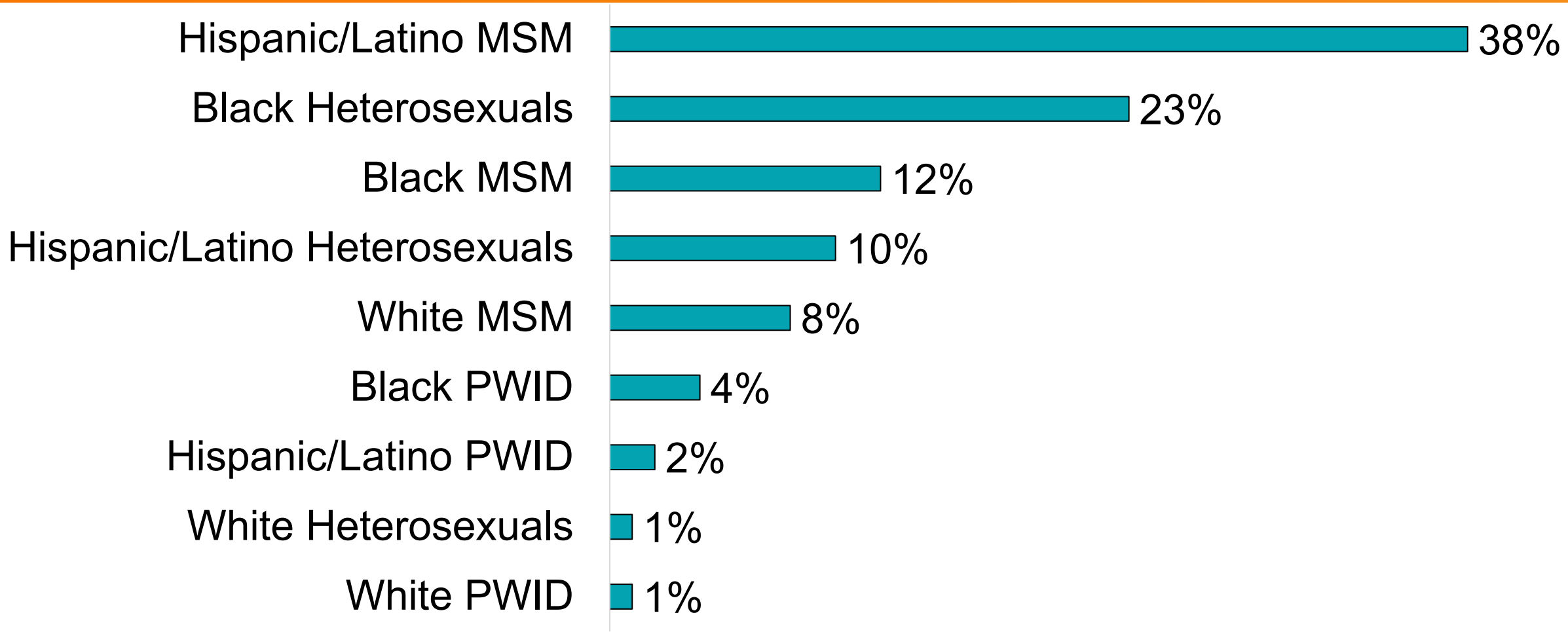
MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Data is for HIV diagnoses 2019–2021. Rounding may cause percentages to total more or less than 100.

Priority Populations for Prevention for PWH

- These data were calculated from PWH living in Florida at year-end 2021 and represent the proportion of each race or mode of exposure group to the total PWH.

- These data are used to prevent further transmission of HIV for those already diagnosed with HIV by providing linkage to care and other services to improve health outcomes and viral suppression to those who need it.

Priority Prevention Populations for PWH In 2021, Living in Miami-Dade County



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive.
Rounding may cause percentages to total more or less than 100.

HIV Testing

Everyone between the ages of 13 and 64 should get tested for HIV at least once. Persons at increased risk for HIV should get tested at least annually. Visit knowyourhivstatus.com for testing options in your area or to order a free at-home testing kit.

Florida law (section 384.31, Florida Statutes) requires all pregnant women to be tested for HIV and other STIs at their initial prenatal care visit, again at 28–32 weeks and at labor and delivery if their HIV status is unknown.

PrEP

PrEP medication, taken as directed, can reduce the risk of acquiring HIV through sexual contact by over 90% and through injection drug use by 70%. Condoms are still important during sex to prevent other STIs and unwanted pregnancy. STIs are increasing in Florida and can increase HIV risk. To find a PrEP provider who can help you decide if PrEP is right for you, visit preplocator.org.

Antiretroviral Therapy (ART)

For PWH, starting ART as soon as possible improves health outcomes and quality of life by reducing viral load and the risk of disease progression. People living with HIV who take antiretroviral medication as prescribed and achieve and maintain an undetectable viral load cannot transmit HIV to their sexual partners. ART is recommended for all PWH, regardless of how long they have had HIV or how well they feel. To find a care provider or to learn more about the resources available to PWH, visit floridaaids.org.

Florida HIV/AIDS Hotline

1-800-352-2437 English
1-800-545-7432 Spanish
1-800-243-7101 Haitian Creole
1-888-503-7118 Hearing/Speech Impaired
211bigbend.org/flhivaidshotline
Text ‘FLHIV’ or ‘flhiv’ to 898211

For more information, email
DiseaseControl@flhealth.gov

Some Useful Links

Department of Health HIV/AIDS Section
floridaaids.org

CDC HIV Surveillance Reports (State and Metro Data)
cdc.gov/hiv/library/reports/hiv-surveillance.html

CDC's Morbidity and Mortality Weekly Report
(Special Articles on Diseases, including HIV)
cdc.gov/mmwr

U.S. Census Data (Available by State and County)
census.gov

Florida HIV/AIDS Surveillance Data
Miami-Dade County Contact

Anthoni Llau
Florida Department of Health in
Miami-Dade County
Phone: 305-470-6984
Email: Anthoni.Llau@flhealth.gov

HIV/AIDS surveillance data are frozen on June 30 for the previous calendar year. These are the same data used for FLHealth CHARTS and all grant-related data.
flhealthcharts.com/charts/CommunicableDiseases/default.aspx

Department of Health

Thank you!

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Meeting Housekeeping and Rules	Dr. Diego Shmuels
III.	Introductions	All
IV.	Floor Open to the Public	Dr. Diego Shmuels
V.	Review/Approve Agenda	All
VI.	Special Presentation: HIV Epidemiology In Miami-Dade County, 2021	Dr. Anthoni Llau
VII.	Review/Approve Minutes of January 12, 2023	All
VIII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
	• Medical Care Subcommittee Report	Marlen Meizoso
	• Partnership Report to Committees (reference only)	Dr. Diego Shmuels
IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment Committee Meeting
Miami-Dade Public Library, Auditorium
101 West Flagler, Miami, FL 33130
January 12, 2023

#	Committee Members	Present	Absent
1	Alcala, Etelvina	X	
2	Downs, Frederick		X
3	Grant, Gena		X
4	Henriquez, Maria	X	
5	Iadarola, Dennis	X	
6	Mills, Vanessa		X
7	Neff, Travis		X
8	Roelans, Ryan		X
9	Siclari, Rick		X
10	Shmuels, Diego		X
11	Trepka, Mary Jo	X	
12	Wall, Dan	X	
Quorum: 5			

Guests	
Goldberg, David	
Mester, Brad	
Staff	
Robert Ladner	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

Dennis Iadarola volunteered to lead the meeting since the Chair had a scheduling conflict. He called the meeting to order at 10:14 a.m.

II. Meeting Housekeeping and Rules

Mr. Iadarola reviewed a Housekeeping and Rules presentation (copy on file), which reviewed the environmental reminders, parking, and meeting decorum for all participants.

III. Introductions

Members and guest introduced themselves around the room.

IV. Floor Open to the Public

Mr. Iadarola read the following:

Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any items 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 line 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 committee reviewed the agenda and made a motion approved it as presented.

Motion to accept the agenda, as presented.
Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed

VI. Review/Approve Minutes of November 3, 2022

The committee reviewed the minutes of November 3, 2022, and accepted them as presented.

Motion to accept the minutes from November 3, 2022, as presented.
Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed

VII. Reports

- *Part A* *Dan Wall*

Dan Wall reviewed the January reports which provided reimbursements through November 2022 (copy on file). Thus far, the program has served 8,030 clients. All contracts have been executed. Over 3,200 clients have been served under TTRA. All reports are up to date. Site visits are being conducted and will be completed by the end of the fiscal year. Provisional award letters will be sent out by January 20, 2023, since a partial award has been received. The County is working on a new Ending the Epidemic (EHE) RFP which has been sent to HRSA for review. The FCPN continues to meet and has requested an extension to submit the joint integrated plan. There is a meeting scheduled face-to-face in Orlando with the participation of Part As. A self attestation form is being developed for the state.

- *Part B* *David Goldberg*

David Goldberg reviewed the September 2022 (copy on file) report. Over 1.6 million dollars has been allocated but only $64,193.32 has been spent (21% of budget). Providers are submitting reports late. Utilization rates are low since providers are using patient assistance programs or using samples. Some edits will need to be made to contracts for next year. The housing component has not been finalized yet but the Department of Health is trying to work with an agency. One of the issues is the program is not a permanent solution, and the program can't pay set-up fees (deposits or utilities).

- *.ADAP* *Marlen Meizoso*

Marlen Meizoso reviewed the December 2022 (copy on file) report. Enrollments, pharmacy and insurance expenditures, program updates and current pharmacy listings. Another expansion of pharmacies joining Magellan is forthcoming.

- *General Revenue* *Marlen Meizoso*

Mrs. Meizoso reviewed the General Revenue report for November 2022 (copy on file) which indicated 1,340 clients were served and $363,296.72 was expended for the month.

- *Vacancies* *Marlen Meizoso*

Mrs. Meizoso reviewed the January 2023, vacancy report (copy on file) which indicated there are four vacancies on the Care and Treatment Committee. Barbara Kubilus, who is currently working with the Part D program at the University of Miami, has submitted an application and wishes to join the committee and will also be joining the Partnership. Ms. Kubilus was not present, but the Committee was familiar with her, and they voted to accept her as a member.

Motion to accept Barbara Kubilus as a member of the Care and Treatment Committee.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

- *Medical Care Subcommittee Report* *Marlen Meizoso*

Mrs. Meizoso reviewed the Medical Care Subcommittee report (copy on file).

The Subcommittee:

Met on November 19, 2021.

Heard updates from the Ryan White Program and the ADAP Program.

Discussed and made a motion restricting Ryan White Oral Health Care formulary to prevent code D5421 (Adjustment to Dentures) and code D5225 (Maxillary partial denture-flexible based [including any clasps, rests, and teeth]) and D5226 (Mandibular partial denture) from being billed together. In some commercial plans, billing of an adjustment code separately is allowable only **after six months** of the initial service.

Motion for D5225 (Maxillary partial denture-flexible based [including any clasps, rests, and teeth] to include adjustments up to 180 days.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Motion for D5226 ((Mandibular partial denture-flexible based [including any clasps, rests, and teeth] to include adjustments up to 180 days.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Motion to restrict D5421 (Adjustment to Dentures) billing within 180 days of D5225 and D5226.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Reviewed the Oral Health Service standards and suggested some updates. The Subcommittee made a motion to accept the revisions. Staff recommended deferring this item to allow staff time to present additional language which may be needed to add and having the Medical Care Subcommittee address a language revision. The Committee concurred with the recommendation and made a motion to defer the item and return the item to the Medical Care Subcommittee.

Motion to defer the Oral Health Services Standards and return it to the Medical Care Subcommittee.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Continued its review and updates to the Primary Medical Care Standards.

Reviewed and made some revisions the Oral Health Care, AIDS Pharmaceutical Assistance, and Outpatient/Ambulatory Health service descriptions. Changes in red indicate suggested changes, and items highlighted in yellow indicate updates that will need to be made for 2022.

Motion to accept the changes to the Oral Health Care services descriptions, as discussed. *(Attachment 2),* the AIDS Pharmaceutical Assistance service descriptions, as presented. *(Attachment 3),* and the Outpatient/Ambulatory Health service descriptions, as presented. *(Attachment 4).*
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Continued work on revisions to the Allowable Conditions, including formatting and additions.

Reviewed and approved their meeting dates and draft workplan for 2023.

The next subcommittee is scheduled for January 27, 2023.

VIII. Standing Business

- *2023 Officer Elections* *All*

Mrs. Meizoso indicated that a memo concerning committee officers had been shared (copy on file). Dr. Shmuels is eligible for a second term as chair of the Care and Treatment Committee, and was interested. Frederick Downs, Jr. indicated that because of health issues he will not pursue a second term. None of the committee members present self-nominated to contest Dr. Shmuels' re-election as chair. The Committee moved to re-elect Dr. Shmuels.

Motion to reelect Dr. Diego Shmuels as chair of the Care and Treatment Committee.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Staff will need to review the membership for qualified and interested candidates for the vice-chair position. An election for the missing officer can be conducted at the next meeting.

IX. New Business

- *Service Descriptions: Medical Case Management, Emergency Financial Assistance, Health Insurance, Food Bank and Outreach* *All*

Staff distributed copies of the service descriptions for Medical Care Management, Emergency Financial Assistance, Health Insurance, Food Bank, and Outreach with updates to years, items, and service ranking in redline. The Committee approved the Emergency Financial Assistance, Health Insurance, and Food Bank service descriptions without additional changes. Under the Medical Case Management service description, the Committee made additional changes for clarity and consistency. They decided to strike language on situational care, since there is no way to distinguish contact.

Motion to strike the statement from the Medical Case Management service description: "Clients limited to only 'situational needs' should not be included in the 'active' caseload count."
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Discussion regarding timely entry and access to data was brought up. Provider systems reporting outpatient medical care activities must interface with the Provide Enterprise Miami system in a timely manner (within 48 hours of service provision, per contract). Timely entry of data is important not only for performance measures but client access to services and is a HRSA expectation. Some providers are only interfacing once a month, but this not acceptable.

Motion to accept the updates to the Medical Case Management, Emergency Financial Assistance, Food Bank, and Health Insurance Assistance service descriptions as presented.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

The Committee reviewed the Outreach service descriptions and there were some questions about access and programing in the Provide Enterprise system. The Committee voted to defer the item to review the issues.

Motion to defer the Outreach service description.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

X. Announcements *All*

Meeting announcements should be forwarded to Staff for distribution through the aidsnet.org website and weekly Community Notices.

Next month distribution of the source of income forms will begin. All forms must be completed before July 1, 2023, to comply with local and state rules.

XI. Next Meeting *Dennis Iadarola*

The next meeting is scheduled for Thursday, February 2, 2023, at the Miami-Dade County Main Library, Auditorium, 101 West Flagler Street, Miami, FL 33130 from 10:00 a.m. to 12:00 p.m.

XII. Adjournment *Dennis Iadarola*

With business concluded, Mr. Iadarola thanked the members for participating in today's meeting. He then requested a motion to adjourn and closed the meeting at 11:37 a.m.

Motion to adjourn.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

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IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

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

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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: **January 2023**

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)	3	241	3	150
Health Insurance Premium and Cost Sharing Assistance	8	3,978	7	1,311
Medical Case Management	9,523	90,821	4,596	7,982
Mental Health Services	44	716	22	99
Oral Health Care	728	8,707	557	2,422
Outpatient Ambulatory Health Services	2,245	28,627	1,177	4,394
Substance Abuse Outpatient Care	2	70	2	22
Support Services				
Food Bank/Home Delivered Meals	2,036	19,741	697	1,072
Medical Transportation	467	4,946	215	710
Other Professional Services	0	703	0	72
Outreach Services	68	777	23	146
Substance Abuse Services (residential)	159	3,920	6	59
TOTALS:	15,283	163,247		

Total unduplicated clients (month): 5,219

Total unduplicated clients (YTD): 8,472

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 03/01/2023

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **January 2023**

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)	3	241	3	150
Health Insurance Premium and Cost Sharing Assistance	8	3,978	7	1,311
Medical Case Management	8,634	81,195	4,279	7,790
Mental Health Services	44	696	22	91
Oral Health Care	728	8,707	557	2,422
Outpatient Ambulatory Health Services	2,208	26,742	1,155	4,326
Substance Abuse Outpatient Care	2	56	2	17
Support Services				
Food Bank/Home Delivered Meals	2,036	19,741	697	1,072
Medical Transportation	457	4,858	205	696
Other Professional Services	0	703	0	72
Outreach Services	67	751	22	121
Substance Abuse Services (residential)	159	3,920	6	59
TOTALS:	14,346	151,588		

Total unduplicated clients (month): 4,979

Total unduplicated clients (YTD): 8,402

REPORT COMPILED ON: 03/01/2023

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **January 2023**

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	889	9,626	446	921
Mental Health Services	0	20	0	8
Outpatient Ambulatory Health Services	37	1,885	30	602
Substance Abuse Outpatient Care	0	14	0	5
Support Services				
Medical Transportation	10	88	10	26
Outreach Services	1	26	1	25
TOTALS:	937	11,659		

Total unduplicated clients (month): 471

Total unduplicated clients (YTD): 1,289

REPORT COMPILED ON: 03/01/2023

Miami-Dade County Ryan White Part A/MAI Program

Service Unit Definitions

Service Categories	Service Unit Definition
Core Medical Services	
AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program; LPAP)	1 filled prescription
Health Insurance Premium & Cost Sharing Assistance	1 health insurance payment (copayment or deductible)
Medical Case Management (MCM; Incl. Treatment Adherence)	1 MCMencounter
Mental Health Services	1 individual or group encounter
Oral Health Care	1 oral health care visit
Outpatient/Ambulatory Health Services	1 medical visit
Substance Abuse Outpatient Care	1 individual or group encounter
Support Services	
Emergency Financial Assistance (limited access)	1 filled prescription
Food Bank	1 bag of groceries
Medical Transportation	1 medical transportation voucher or one-way rideshare trip
Other Professional Services (Legal Assistance & Permanency Planning)	1 hour of legal assistance
Outreach Services	1 individual encounter
Substance Abuse Services-Residential	1 day of residential substance abuse services

NOTE: MAI-funded services are limited to minority clients from priority subpopulations or emerging need subpopulations.

PART A

This report includes YTD paid reimbursements for FY 2022 Part A service months up to January 2023, as of 3/1/2023. This report reflects reimbursement requests that were due by 2/20/2023, and have been paid thus far. Pending Part A reimbursement requests that have been received and are in the review process total $1,460,727.19.

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

Project #: BURW3201	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount Formula	16,141,380.00	FORMULA	
Grant Award Amount Supplemental	4,121,835.00	SUPPLEMENTAL	FY 2022 Award
Grant Award Amount FY'20 Supplemental	4,268,879.00	PY_SUPPLEMENTAL	$24,532,094
Carryover Award FY'21 Formula	4,076,477.00	CARRYOVER	
Total Award	**$ 28,608,571.00**		

Note:
The recipient has reached its budgeted direct services Formula minimum expenditures. Until the end of the current period of performace, only budgeted Administrative and Quality Management expenditures and a carryover allowance will be applied to this funding source in order to surpass the 95% minimum expenditure threshold.

CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover Allocations	
4	AIDS Pharmaceutical Assistance	84,492.00		
6	Health Insurance Services	335,776.00	259,924.00	595,700
1	Medical Case Management	5,826,737.00	400,000.00	6,226,737
3	Mental Health Therapy/Counseling	51,237.00	91,457.00	142,694
5	Oral Health Care	2,864,445.00	1,000,000.00	3,864,445
2	Outpatient/Ambulatory Health Svcs	8,695,763.00	600,000.00	9,295,763
9	Substance Abuse - Outpatient	28,099.00	17,369.00	45,468
	CORE Services Totals:		20,255,299.00	

	Support Services	Allocations	Carryover Allocations	
11	Emergency Financial Assistance	9,853.00		
8	Food Bank	1,660,108.00	1,000,000.00	2,660,108
10	Medical Transportation	209,912.00		
13	Other Professional Services	154,449.00		
12	Outreach Services	178,086.00		
7	Substance Abuse - Residential	1,338,406.00	200,000.00	1,538,406
	SUPPORT Services Totals:		4,750,814.00	
	DIRECT SERVICES TOTAL:		**$ 25,006,113.00**	

Total Core Allocation	17,886,549.00	
Target at least 80% core service allocation	17,149,890.40	
Current Difference (Short) / Over	**$ 736,658.60**	
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)	$ 507,727.00	3,602,458.00

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**83.44%**	**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	3,780.72		
5606920000	Health Insurance Services	242,684.97	0.00	242,684.97
5606870000	Medical Case Management	4,407,305.95	0.00	4,407,305.95
5606860000	Mental Health Therapy/Counseling	51,237.00	7,620.50	58,857.50
5606900000	Oral Health Care	2,529,854.50	0.00	2,529,854.50
5606610000	Outpatient/Ambulatory Health Svcs	6,378,817.89	0.00	6,378,817.89
5606910000	Substance Abuse - Outpatient	4,251.00	0.00	4,251.00
	CORE Services Totals:	13,625,552.53		

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	1,294,421.80	1,000,000.00	2,294,421.80
5606460000	Medical Transportation	91,618.59		
5606890000	Other Professional Services	63,243.00		
5606950000	Outreach Services	48,858.77		
5606930000	Substance Abuse - Residential	844,800.00	0.00	844,800.00
	SUPPORT Services Totals:	3,342,942.16		
	TOTAL EXPENDITURES DIRECT SVCS & % :		**$ 16,968,494.69**	**67.86%**

	Formula Expenditure %	**94.01%**	
5606710000	**Recipient Administration**	**1,579,461.78**	
5606880000	**Quality Management**	**550,000.00**	2,129,461.78

	FY 2022 Award	Carryover	
Grant Unexpended Balance	**6,441,758.03**	**3,068,856.50**	9,510,614.53
Total Grant Expenditures & %		**$ 19,097,956.47**	**66.76%**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**98.47%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**2.24%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**6.44%**	**Within Limit**

Printed on: 3/1/2023

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

MAI

This report includes YTD paid reimbursements for FY 2022 MAI service months up to January 2023, as of 3/1/2023. This report reflects reimbursement requests that were due by 2/20/2023; and have been paid thus far. Pending MAI reimbursement requests that have been received and are in the review process total $25,164.31.

PROJECT #: BURW3201	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount MAI	1,089,480.00	MAI	FY 2022 Award
Grant Award Amount FY'20 MAI	1,623,771.00	PY_MAI	2,713,251.00
Carryover Award FY'21 MAI	1,212,670.00	MAI_CARRYOVER	
Total Award	**$ 3,925,921.00**		

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**		3,925,921.00
	Quality Management	**$ 106,883.00**		
	(+) Unobligated Funds / (-) Over Obligated:			
	Unobligated Funds (MAI)	$ -	378,208.00	2,713,251.00
	Unobligated Funds (Carry Over)	$ 1,212,670.00		

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover Expenditures	
5606970000	AIDS Pharmaceutical Assistance			
5606920000	Health Insurance Services			
5606870000	Medical Case Management	546,079.50		
5606860000	Mental Health Therapy/Counseling	1,007.50		
5606900000	Oral Health Care			
5606610000	Outpatient/Ambulatory Health Svcs	545,688.46		
5606910000	Substance Abuse - Outpatient	570.00		1,093,345.46
Account	**Support Services**	**Expenditures**	**Carryover Expenditures**	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank			
5606460000	Medical Transportation	5,141.34		
5606890000	Other Professional Services			
5606950000	Outreach Services	0.00		
5606930000	Substance Abuse - Residential			5,141.34
	TOTAL EXPENDITURES DIRECT SVCS & %:		**$ 1,098,486.80**	**47.04%**
5606710000	**Recipient Administration**	**95,174.95**		
5606880000	**Quality Management**	**91,666.63**		186,841.58
	Grant Unexpended Balance	**FY 2022 Award**	**Carryover**	
		1,427,922.62	**1,212,670.00**	2,640,592.62
	Total Grant Expenditures & % (Including C/O):		**$ 1,285,328.38**	**32.74%**

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%	**99.53%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.38%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**3.51%**	**Within Limit**

Printed on: 3/1/2023

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Meeting Housekeeping and Rules	Dr. Diego Shmuels
III.	Introductions	All
IV.	Floor Open to the Public	Dr. Diego Shmuels
V.	Review/Approve Agenda	All
VI.	Special Presentation: HIV Epidemiology In Miami-Dade County, 2021	Dr. Anthoni Llau
VII.	Review/Approve Minutes of January 12, 2023	All
VIII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
	• Medical Care Subcommittee Report	Marlen Meizoso
	• Partnership Report to Committees (reference only)	Dr. Diego Shmuels
IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

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

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Provider Agency Name & Address
FDOH in Miami-Dade County
1350 N.W. 14th St.,
Miami, 33125

Florida Department of Health

Expenditure/Invoice Report

Program Name: Patient Care-Consortia

Contract Name: 2022-2023 Miami CHD Consortia

Area Name:AREA 11A

Month: December

Year: 2022-2023

Report generated on: 02/24/2023

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	December	0	0	$116,720.00	$6,080.18	$62,517.09	54%
Medical Case Management (including treatment adherence)	December	38	38	$175,390.00	$6,848.25	$38,484.75	22%
Mental Health Services - Outpatient	December	4	12	$35,000.00	$390.00	$7,930.10	23%
Emergency Financial Assistance	December	31	31	$713,220.00	$30,266.95	$297,768.50	42%
Housing	December	0	0	$375,000.00	$0.00	$0.00	0%
Non-Medical Case Management Services	December	20	20	$156,572.00	$11,530.80	$112,260.40	72%
Clinical Quality Management	December	0	0	$71,083.00	$5,484.97	$34,790.09	49%
Planning and Evaluation	December	0	0	$36,864.00	$2,744.78	$26,907.99	73%
Totals		**93**	**101**	**$1,679,849.00**	**$63,345.93**	**$580,658.92**	

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend

ADVANCE(S) INFORMATION:

Total Advances	$0.00
Previous Reductions	$0.00
Current Reductions	$0.00
Remaining Advances	$0.00

Total Contract Amount	$1,679,849.00
Minus Expended Y-T-D	$580,658.92
Minus UNPAID Advances	$0.00
Balance To Draw	$1,099,190.08

Total Expenditures this period:	$63,345.93
Less Advance Payback this period:	$0.00
AMOUNT OF FUNDS REQUESTED THIS REPORT:	**$63,345.93**

I certify that the above report is a true, accurate and correct reflection of the activities this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature & Title of Provider Agency Official | **Date** | **Contract Manager Signature** | **Date**

Contract Manager's Supervisor Signature | **Date**

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
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February 6, 2023

ADAP Miami-Dade / Summary Report* – January 2023

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	**818**	**8,381**		**$22,690,810.89**	**38,974**	**12,862**	**3.0**	**$28,547,945.47**	**23,418**	**$1,219.06**
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	80	917	6,352	$2,454,007.19	4,158	1,367	3.0	$2,731,186.36	2,287	$1,194.22
Oct-22	103	945	6,260	$2,188,894.51	3,798	1,237	3.1	$2,726,877.33	2,273	$1,199.68
Nov-22	72	907	6,241	$1,926,172.25	3,227	1,075	3.0	$2,707,404.96	2,252	$1,202.22
Dec-22	94	1008	6,301	$2,011,314.10	3,370	1,129	3.0	$2,715,906.41	2,272	$1,195.38
Jan-23	79	923	6,345	$1,872,593.42	3,329	1,071	3.1	$3,555,449.56	2,501	$1,421.61
Feb-23										
Mar-23										

SOURCE: Provide - DATE: 02/06/23 - Subject to Review & Editing

* *NOTE: West Perrine: 446 clients (02/06/23): DD 259; PP 187. Expenditures not included in this report.*

PROGRAM UPDATE

* Cabenuva ® utilization @ ADAP Miami (02/06/23): 119 patients. Direct Dispense 56 *(47%);* Premium Plus 63 *(53%)*

* Additional pharmacy choices for ADAP Uninsured clients in Miami-Dade *(10/01/22): five additional providers @ 16 pharmacy services*

CURRENT Ongoing CHD Pharmacy **Services**		
1	CHD Pharmacy @ Flagler Street	One Site
2	CHD Pharmacy @ Flagler Street	Mail order
3	ADAP Program @ West Perrine	CVS Specialty Mail Order

ADDITIONAL Pharmacies - Magellan RX PBM 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

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

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
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10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
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General Revenue July 2022 - June 2023

HIV/AIDS Demographic Data for PHT/SFAN

	December -2022			Year To Date Data		
	Unduplicated Client Count	Units	Dollar Amt.	Total Dollar Amt.	Annual Budget	YTD Units
Ambulatory - Outpatient Care	110	217	52,239.44	572,009.92	1,792,649.00	3,018
Drug Pharmaceuticals	98	194	48,418.09	246,790.90	761,622.00	901
Home & Community Base Services	4	122	838.62	1,775.16	2,000.00	124
Home Health Care	-	-	-	-	30,000.00	-
Mental Health Services	43	55	6,796.44	36,327.57	115,854.00	306
Nutrition Counseling	13	15	2,059.05	2,882.67	20,000.00	21
Medical Case Management	-	-	29,105.93	718,345.87	1,309,687.00	7,656
Non-Medical Case Management	281	286	46,673.52	200,543.56	668,338.00	1,833
Other Support Services / Emergency Fin. Assistance	6	7	14,113.82	112,722.14	170,000.00	53
Transportation	141	141	7,931.25	42,702.65	77,250.00	813
Referral for Health Care / Supportive Services	34	105	37,429.61	153,171.32	399,856.00	470
Substance Abuse Residential	8	491	109,468.45	109468.45	428,955.00	491
Residential Care - Adult	17	1,989	85,527.00	85,527.00	204,035.00	1,989
Nursing Home Care	5	136	35,715.08	193,048.50	470,000.00	758
Hospital Services	-	-	-	95,157.02	567,538.00	75
	760	3,758	476,316.30	2,570,472.73	7,017,784.00	18,508

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Meeting Housekeeping and Rules	Dr. Diego Shmuels
III.	Introductions	All
IV.	Floor Open to the Public	Dr. Diego Shmuels
V.	Review/Approve Agenda	All
VI.	Special Presentation: HIV Epidemiology In Miami-Dade County, 2021	Dr. Anthoni Llau
VII.	Review/Approve Minutes of January 12, 2023	All
VIII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
	• Medical Care Subcommittee Report	Marlen Meizoso
	• Partnership Report to Committees (reference only)	Dr. Diego Shmuels
IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

February 22, 2023

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.

11 AVAILABLE SEATS

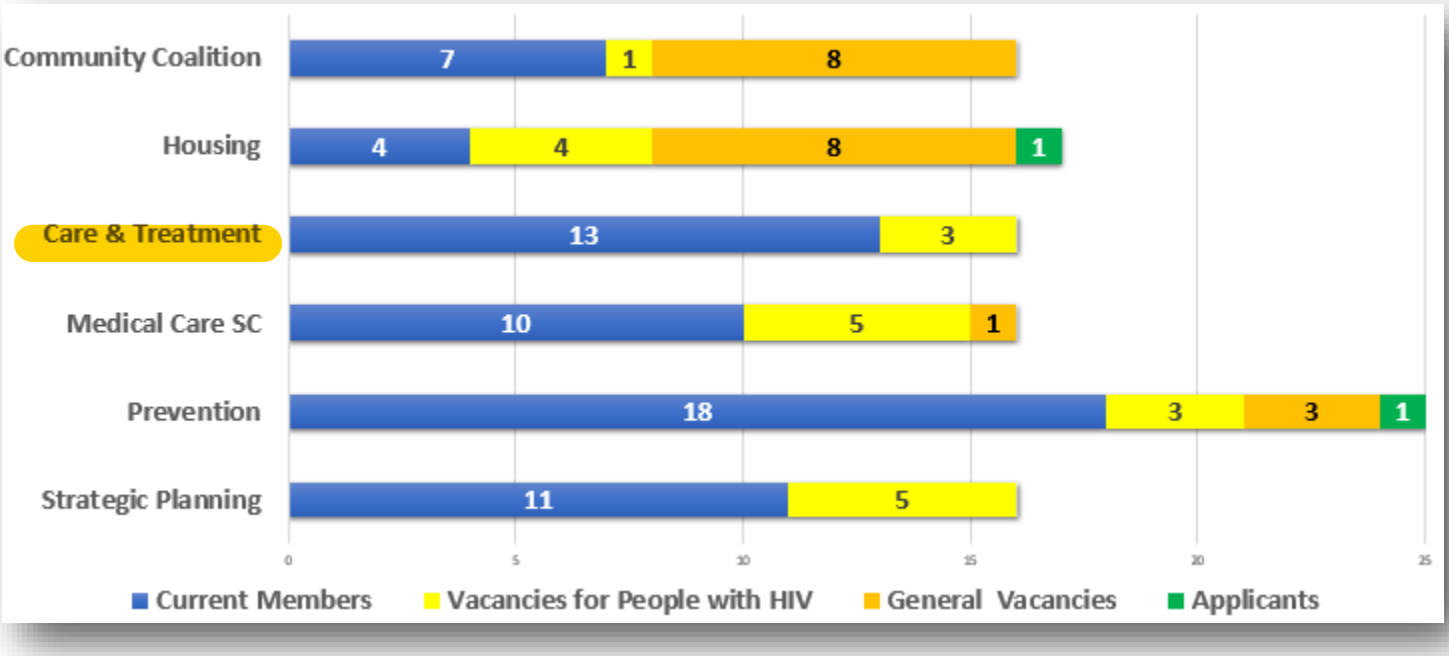
General Membership Opportunities

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.



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Medical Care Subcommittee Meeting for January and February 2023
Report to the Care and Treatment Committee
Presented March 2, 2023

The Medical Care Subcommittee (MCSC):

Met on January 27 and February 24, 2023.

Heard updates from the Ryan White Program and the ADAP Program.

Re-elected Dr. Robert Goubeaux (chair) and James Dougherty (vice-chair).

Welcomed a new member, Cristhian Ysea to the Subcommittee.

Previously reviewed the Oral Health Service standards and suggested additional language. The Subcommittee reviewed the item again and maintained the motion to accept the revisions.

1. Motion to accept the changes to the Oral Health Services Standards, as discussed. *(Attachment 1).*

Concluded its review and updates to the Primary Medical Care Standards.

2. **Motion to approve the Minimum Primary Care Standards, as presented.** *(Attachment 2)*

Reviewed the Mental Health and Substance Abuse. Some revisions are being worked on but the Subcommittee approved the revisions to the Substance Abuse service description. Revisions are in track changes.

3. **Motion to approve the Substance Abuse service description, as presented.** *(Attachment 3)*

Began review of the medications approved on the ADAP formulary. The first 44 were reviewed for pricing, other options or payor sources, medication interactions, and if the medications were either lifesaving or cost effective. The Subcommittee recommended all but nine medications which have been shaded in grey on the attachment. Two medications were restricted to tablets only.

4. Motion to add all the medications included in the December 2022 ADAP formulary additions to the Ryan White Prescription Drug Formulary Items #1-44 sheet to the Ryan White Formulary with the restriction on #18 levonorgestrel and #22 clonidine to tablets only but excluding the following nine items: #2 diclofenac, #3 nepafenac, #10 rifapentine, #20 bempedoic acid, #24 olmesartan, #28 olmestarn/hydrochlorothiazide, #36 ezetimibe/rosuvastatin, #39 evolocumab, and #40 alirocumab. *(Attachment 4)*

Requested data on utilization of four letters of medical necessity which showed very low utilization. The Subcommittee voted to discontinue usage of the four letters to reduce paperwork requirements.

5. Motion to discontinue the Letters of Medical Necessity for 1) Roxicodone and Percocet, 2) Neupogen, 3) Procrit or Epogen, and 4) the (lab test) for the Highly Sensitive Tropism Assay required to prescribe Maraviroc.

Continued work on revisions to the Allowable Conditions including formatting and additions.

The next subcommittee is scheduled for March 24, 2023.

All motions are subject to Partnership approval.

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 1: Oral health care providers shall ensure that all staff has sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population: initial orientation and training for new staff shall be provided and all staff shall participate in ongoing HIV/AIDS trainings.

	Standards of Care	Measure
Standard 1.1	All oral health care staff will possess appropriate licenses, credentials and expertise; experience working with HIV/AIDS clients is desirable.	• Copy of current license for each staff person, with provider number, as required by Florida law: copies of current required operational licenses as required by Florida law. • Documentation of work experience (letters of recommendation, work references, etc.)
Standard 1.2	Policies and procedures.	Written policies and procedures manuals.
Standard 1.3	Newly hired staff will receive orientation within one month of hire, including training on Ryan White Program eligibility and service requirements.	Documentation of completed orientation on file including documentation of training on Ryan White Program eligibility and service requirements.
Standard 1.4	Ongoing annual HIV/AIDS staff training.	Documentation of all completed annual trainings on file.

Standard 2: Clients receiving services meet Ryan White Program eligibility requirements and are informed of their rights per Ryan White Program standards.

	Standard	Measure
Standard 2.1	Ryan White Program client eligibility screening and demographics present.	• Proof of HIV status, financial eligibility, permanent residency in Miami-Dade County OR • Current ~~(not > 6 mos.)~~ Ryan White Program ~~Internal~~ Referral. • Demographics include at a minimum: address, phone number, emergency information, age, race/ethnicity and gender.

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 2.2	Ryan White Program required documents present, signed, and dated.	• Signed and dated ~~*Consent to Release and Exchange Information*~~*Ryan White Consent form* *in the data management information system)* OR current ~~(not > 6 mos.)~~ Ryan White Program ~~Internal~~ Referral • Documentation that *Outreach Consent/Miami-Dade County Notice of Privacy Practices* and *Composite Consent* were provided.
Standard 2.3	General Consent for Treatment	Signed general consent for treatment present.

Standard 3: All clients shall have a completed initial medical history with updates as appropriate; medical conditions and allergies are noted; an oral health history is taken.

	Standard	**Measure**
Standard 3.1	Initial Comprehensive Medical History	• There is an initial comprehensive medical history including medications and conditions affecting diagnosis and management of oral health care. • The initial comprehensive medical history is signed and dated by the client and dentist.
Standard 3.2	Medical History is updated at least once a year.[a]	Medical history is updated every 6 months or at the next appointment after six months.
Standard 3.3.	Medical conditions and allergies are noted.	• Medical conditions and/or medications requiring an alert are flagged. • Allergies/ no known allergies (NKA) are noted.
Standard 3.4	An oral health history is taken and updated at least once a year.[a]	Oral health history is taken that includes problems with or reactions to anesthesia, specific or chief complaints (if any), problems with previous treatment (if any).

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 4: Documentation across providers shall reflect, at a minimum, services provided including procedure codes, treatment plans, examinations, charting grids, informed consents, refusal of treatment, and periodontal maintenance.

	Standard	Measure
Standard 4.1	Treatment assessment and planning developed and/or updated at least once a year. [a]	Completed treatment plan is in the progress notes OR a treatment plan form is completed.* **If clients access oral health services for episodic care only, documentation in treatment notes will reflect clients were advised to return for examination and a treatment planning appointment. If client does not present for this appointment, documentation in client's chart of advice to return for planning may serve as treatment plan.*
Standard 4.2	Documentation reflects services provided.	Documentation, at a minimum, includes: • Date of service • Tooth number, if appropriate • Service description • Procedure code billed • Anesthetic used including strength and quantity • Materials used, if any • Prescriptions or medications dispensed, including name of drug, quantity, and dosage • Education provided • Signature and title

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 4.3	A comprehensive examination is provided*at least annually. *Not applicable for episodic care, follow up, or problem-focused examinations. **OR** A problem-focused oral examination is performed.	Comprehensive Examination includes: • Cavity charting • Complete periodontal exam or periodontal screening record • Documentation of restorations & prosthesis • Full mouth radiographs, as clinically indicated • Pre-existent conditions • Disease presence • Structural anomalies • Oral hygiene instruction • Prescriptions or medications dispensed including name of drug, quantity, and dosage • Education provided Problem-focused examination includes: • Chief complaint is documented • Problem-focused evaluation is performed • Prescriptions or medication dispensed include name of drug, quantity, and dosage • Radiographs as necessary • Specific oral treatment plan • Education provided • Return for further evaluation documented
Standard 4.4	Charting grids are completed as appropriate.	Charting of the examination findings/treatment is completed in the appropriate tooth grids.
Standard 4.5	Informed specific consents are present for each oral surgery procedure.	A signed, informed, specific consent is present for all oral surgery procedures that includes the risks, benefits, alternatives, and consequences of not having the procedure.

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 4.6	Refusal of treatments/radiographs is documented.	• Client refusal for treatment/radiograph is documented (form or in progress note) with dentist (DDS) signature, client signature or initials and date; signature and date of witness are present. • Reason for DDS refusal to perform a requested treatment is documented; signature and date of witness are present.
Standard 4.7	Periodontal screening or examination is done at least once a year.[a]	Charting of the examination findings/treatment is documented in the client record.
Standard 4.8	Periodontal maintenance is regularly performed.* *Not applicable for clients who are "No shows" AND "No show" is documented; not applicable for episodic care.	Periodontal maintenance is performed according to the treatment plan or at the next appointment, if later than six months.
Standard 4.9	Oral health education offered at least once a year.[a]	Education documented in the client record.

Standard 5: Client care and referrals shall be coordinated with other care providers, as appropriate.

	Standard	**Measure**
Standard 5.1	Treatment provided for oral opportunistic infection (when indicated) is coordinated with client PCP.* *Not applicable if no oral opportunistic infection (OI) Dx/treatment documented.	Documentation reflects treatment provided for oral OI and coordination with PCP.
Standard 5.2	Referral and coordination of care.* *Not applicable if no condition documented and no referral made. Tobacco use and referral.* *NA for clients not using tobacco products. Nutritional problems and referral.* *Not applicable when no indication of nutritional problems.	• Documentation in client record of the condition and referral to a specific specialty or ancillary service provider. • Documentation of heavy tobacco use and referral to a tobacco counseling program. • Documentation of nutritional problems and referral to a nutritionist for nutritional counseling.

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 6: Clients shall receive education in preventive oral health practices; tobacco, and nutritional counseling as appropriate.

	Standard	Measure
Standard 6.1	Education will be provided in preventive oral health practices[1] including hygiene, nutritional education[2] as related to oral health care and education, as appropriate, concerning tobacco use[3]. [1]Not applicable for episodic care. [2]Not applicable for episodic care. [3]Not applicable if no indication of tobacco use; not applicable for episodic care.	• Documentation of education in preventive oral health practices including hygiene is provided every six months or at next appointment if later than six months. • Documentation of nutritional education as related to oral health. • Documentation of education, as appropriate, concerning tobacco use.

[a] Reflects Health Resources and Services Administration (HRSA) HIV/AIDS Bureau Core Performance Measures for Oral Health Care

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

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. These standards serve as the minimum standards by which practitioners will be measured.*

I. Requirements

Requirements for New Practitioners (Physicians, Advanced Practice Registered Nurse, and Physician Assistants):

- New practitioners should be linked to existing Ryan White Program providers, AIDS Education and Training Center (AETC) or through an American Academy of HIV Medicine (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, Advanced Practice Registered Nurse, and Physician Assistants):

- 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.

Practitioner must:

- Be a Physician (MD or DO), Advanced Practice Registered Nurse, or Physician Assistant with current and valid license to practice medicine within the State of Florida.
- 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.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
  a. **American College of Cardiology/American Heart Association Guideline on the Treatment of Blood Cholesterol**
  https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625
  b. **Adult Immunization Schedule**
  https://www.cdc.gov/vaccines/adults/index.html
  c. **American Association for the Study of Liver Diseases**
  https://www.aasld.org/practice-guidelines
  d. **American Cancer Society Guidelines for the Early Detection of Cancer**
  https://www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
  e. **American Medical Association Telehealth Quick Guide**
  https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

f. **Department of Health and Human Services (DHHS) Clinical Guidelines**
https://clinicalinfo.hiv.gov/en/guidelines
g. **European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV**
https://www.eacsociety.org/guidelines/eacs-guidelines/
h. **Hepatitis (HEP) Drug Interactions University of Liverpool**
https://www.hep-druginteractions.org/
i. **HIV Drug Interactions University of Liverpool**
https://hiv-druginteractions.org/
j. **HIV Prevention with Adults and Adolescents with HIV in the US**
https://www.cdc.gov/hiv/guidelines/recommendations/personswithhiv.html
k. **Health Resources and Service Administration (HRSA) 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
l. **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/
m. **Miami—Dade County Ryan White Program (including Telehealth Policy and Test and Treat/Rapid Access [TTRA] program)**
https://www.miamidade.gov/global/service.page?Mduid_service=ser1482944607068715
n. **National HIV Curriculum**
https://www.hiv.uw.edu/alternate
o. **PrEP, nPEP and PEP guidelines below (Although not paid for by the Ryan White Program):**
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
q. **United States (US) Preventive Taskforce**
https://uspreventiveservicestaskforce.org/uspstf/home

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

II. Assessments and Referrals

1. **Annual —** At each annual visit:
   a. Adherence to medications
   b. Age-appropriate cancer screening
   c. Behavioral risk reduction
   d. Gynecological exam per guidance for females
   e. Interval changes in vital signs addressed, especially trend in weight/BMI over time

f. Mental health and substance abuse assessment
g. Physical examination, including review of systems
h. Preconception counseling for men and women
i. Rectal examination
j. Safer sex practices — discussions may include PrEP, PEP, nPEP, for sexual partners and should include condom usage
k. Sexually transmitted infection assessment
l. Update comprehensive initial history, as appropriate
m. Vital signs, including weight, BMI, height (no shoes)
n. Wellness exam for females

Assess and document health education on:

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

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

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.

3. **Initial —** At initial visit:
   a. Access to stable housing, food, and transportation
   b. Adherence to medications
   c. Age-appropriate cancer screening
   d. Behavioral risk reduction
   e. Comprehensive initial history
   f. Dates of last: mammogram, bone density, colonoscopy, abnormal aortic aneurysm screening, dental visit, and dilated eye exam
   g. Education that they should never run out of ARV medications and need to call the FDOH—MDC clinic if they cannot obtain ART
   h. Gynecological exam per guidance for females

i. If enrolled as Test and Treat/Rapid Access (TTRA) client (patient), follow TTRA protocol for visit
j. Mental health and substance abuse assessment
k. Physical examination, including review of systems
l. Pregnancy Planning:
   1) Preconception counseling for men and women
   2) Contraceptive counseling for men and women including assessment and type of birth control method
m. Rectal examination
n. Safer sex practices — discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
o. 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.
p. Social supports and disclosure history
q. Targeted initial history and physical examination with expectation that a complete history and physical examination will be completed within 3 months.
r. Vital signs, including weight, BMI, height (no shoes)
s. Wellness exam for females

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

4. Interim Monitoring and Problem-Oriented visits — At every visit:

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

5. 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.

III. Assessments at Incremental Visits

General Health including Labs

1. **ALT, AST, Total Bilirubin** [i] — Entry into care; ART initiation or modification; 4-8 weeks after ART initiation or modification; every 6 months; or if ART initiation is delayed, every 6-12 months; or if clinically indicated.

2. **Annual wellness visit** (females) [iv] — 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.

3. **Basic metabolic panel** [i] — Entry into care; ART initiation or modification; 4-8 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 tenofovir disoproxil fumarate (TDF)-containing regimens. Consult the HIV Medicine Association of the Infectious Diseases Society of America's (HIVMA/IDSA) Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Patients Infected with HIV 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).

4. **Bone Densitometry** [iii] — Baseline bone DEXA should be performed in all greater than or equal to 50 years old postmenopausal women and men.

5. **CBC w/ differential** [i] — Entry into care; ART initiation or modification; every 3-12 months if monitoring CD4 count (if required by lab); or 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 receiving medications that potentially cause cytopenia [e.g., trimethoprim-sulfamethoxazole (TMP-SMX)].

6. **Colon and Rectal Cancer Screening** [v] — 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.

7. **Glucose (Random or Fasting)** [i] — Entry into care; ART initiation or modification; treatment failure; 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 American Diabetes Association Guidelines.

8. **Gynecological Exam** [vi] (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.

9. **Hepatitis A Screening** [ii] — At initial screening, if non-immune, offer vaccination and after vaccination received do postvaccination serologic testing 1 or 2 months or at the next scheduled visit. After the second vaccine to assess for immunogenicity. A repeat vaccine series is recommended in those who remain seronegative.

10. **Hepatitis B Serology (HBsAb, HBsAg, HBcAb total)** [i] — At entry into care; at ART initiation or modification, in patients not immune to hepatitis B (HBV), consider retesting if switching to a regimen that does not contain tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF); as clinically indicated including before starting hepatitis C direct-acting antiviral (HCV DAA). If patient has HBV infection (as determined by a positive HBsAg or HBV DNA test result), TDF or TAF plus either emtricitabine (FTC) or lamivudine (3TC) should be used as part other ARV regiment to treat both HBV and HIV infections. If HBsAg, HBsAb, and HBcAb test results are negative, hepatis B vaccine series should be administered. 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 HIVMA/IDSA's Primary Care Guidance for Person with HIV and the Adult and Adolescent Opportunistic Infection Guideline for detailed recommendations.

11. **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 hepatitis C (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.

12. **Lipid Profile** [i] — Entry into care;4-8 weeks after ART initiation or modification; consider 1-3 months after ARV initiation or modification ; every 12 months if normal at baseline but with cardiovascular risk. If normal at baseline, every 5 years or if clinically indicated. If random lipids are abnormal, fasting lipids should be obtained. Consult the American College of Cardiology/American Heart Association's 2018 Guideline on the Management of Blood Cholesterol for diagnosis and management of patients with dyslipidemia.

13. **Lung Cancer Screening** [iii] — Annually with low-dose computer tomography (LDCT) for patients aged 55-80 who have a 30 pack-year smoking history and currently smoke or have quit within the last 15 years until smoking has been discontinued for 15 years.

14. **Mammogram (**females) [vii] — 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.

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

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

17. **TB Testing** [ii] — Entry into care or anytime there is concern of a recent exposure. 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 tested when CD4 < 200, repeat after CD4 increases to above 200. Testing using either tuberculin skin test or interferon—γ release assay.

18. **Urinalysis** [i] — Entry into care; or if clinically indicate e.g., in patients with chronic kidney disease (CKD) or diabetes mellitus (DM). HIV Medicine Association of the Infectious

Diseases Society of America's (HIVMA/IDSA) Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Patients Infected with HIV 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 disoproxil fumarate (TDF)-containing regimens and monitored during treatment with these regimens.

HIV Specific

19. **ARV therapy is recommended and discussed** [i] — 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.

20. **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.*

21. **Genotypic Resistance Testing (PR/RT Genes)** [i] — Entry into care; at ART initiation or modification; if ART initiation is delayed; treatment failure or clinically indicated. Standard genotypic drug-resistance testing in ARV-naïve persons should focus on testing for mutations in the PR and RT genes. If transmitted INSTI resistance is a concern, or if a person has a history of INSTI use in PrEP or treatment, or a person presents with viremia while on an INSTI, providers also should test for resistant mutation in the IN gene. In ARV-naïve patient who are not immediately begin ART, repeat testing before initiating of ART is option if drug-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 Drug-Resistance Testing section for a discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior drug-resistance testing should be considered because they can be helpful in constructing a new regimen.

22. **Genotypic Resistance Testing (Integrase Genes)**[i] — Entry into care, if transmitted INSTI resistance is suspected or if there is a history of cabotegravir long acting (CAB-LA) use for PrEP ; at ART initiation or modification, if transmitted INSTI resistance is suspected or if there is a history of INSTI use; treatment failure if there is a history of INSTI use; or clinically indicated, if there is a history of INSTI use. Standard genotypic drug-resistance testing in ARV-naïve persons should focus on testing for mutations in the PR and RT genes. If transmitted INSTI resistance is a concern, or if a person has a history of INSTI use in PrEP or treatment, or a person presents with viremia while on an INSTI, providers also should test for resistant mutation in the IN gene. In ARV-naïve patient who are not immediately begin ART, repeat testing before initiation of ART is option if drug-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 Drug-Resistance Testing section for a discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior drug-resistance testing should be considered because they can be helpful in constructing a new regimen.

23. **HIV viral load** [i] — Entry into Care; at ART initiation or modification; 4-8 weeks after ART initiation or modification if HIV RNA is still detectable, repeat testing every 4-8 weeks until viral load is suppressed to <200 copies/mL. Thereafter, repeat testing every 3-6 months. For patients on ART, viral load typically is measured every 36 months. More frequent monitoring may be considered in individuals having difficulties with ART adherence or at risk for nonadherence. However, for adherent patients with consistently suppressed viral load and stable immunologic status for more than 1 years, monitoring can be extended to 6month intervals; if ART initiation is delayed, repeat testing is optional; or if treatment failure or if clinically indicated.

24. **HLA-B*5701** [i] — At ART initiation or modification if considering start of abacavir (ABC) 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).*

25. **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.

26. **Tropism testing** [i] — At ART initiation or modification if considering use of CCR5 antagonist; or for treatment failure if considering a CCR5 antagonist, or if the patients with virologic failure on a CCR5 antagonist; or if clinically indicated. If performed, record carried forward to most current volume.

Immunizations

Document in medical record carrying data forward to most current volume

27. **Hepatitis A vaccination** [ix] — 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.

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

29. **Human Papillomavirus (HPV) Vaccine** [ix] — HPV vaccination as indicate by current guidelines.

30. **Influenza vaccination** [ix] — Offer IIV or RIV4 annually.

31. **Meningococcal vaccination** [ix] — 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**.**

32. **Mpox vaccination** — Vaccinate per CDC guidance. See https://www.cdc.gov/poxvirus/monkeypox/vaccines/vaccine-basics.html

33. **Pneumococcal vaccination** [ix] — Should receive a dose of PCV15, followed by a dose of PPSV23 or 1 dose PCV20. See vaccination guidelines**.**

34. **SARS-CoV-2 vaccination** [ix] — Vaccinate per CDC guidance.

35. **Tetanus, diphtheria, pertussis (Td/Tdap)** [ix] — One dose Tdap, then Td or Tdap every 10 years.

36. **Varicella** [ix] **—** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CDC 4 count <200 cells/mm^3.

37. **Zoster vaccination** [ix] — Recommended for persons aged 19 or older per guidelines, use RZV. See vaccination guidelines**.**

STI Screenings

38. **Anal Dysplasia Screening** [iii] — For all patients with HIV ≥35 years old, see information at https://www.hivguidelines.org/hiv-care/anal-cancer/.

39. **Bacterial STIs (Syphilis**, **N. gonorrhoeae** (GC), **C. trachomatis** (Chlamydia) and **parasitic STIs (Trichomoniasis)** [ii] — 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. See information at https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

Footnotes

[i] Guidelines for the Use of Antiretroviral Agents in HIV—1 Infected Adults and Adolescents. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines. Accessed on November 10, 2022.

[ii] Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections. Accessed on January 03, 2023

[iii] Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America. https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/. Accessed November 10, 2022

[iv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines-2019. Accessed January 4, 2023.

[v] American Cancer Society Recommendations for Colorectal Cancer Screening. https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html Accessed January 4, 2023.

[vi] Gynecologic Care for Women and Adolescents with Human Immunodeficiency Virus. The American College of Obstetricians and Gynecologist, vol. 128, no. 4, October 2016.

[vii] 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 January 4, 2023.

[viii] American Cancer Society Recommendations for Prostate Cancer Early Detection. https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html. Accessed January 4, 2023.

[ix] Recommended Adult Immunization Schedule for Ages 19 years or older, United States, 2022. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html. Accessed January 4, 2023.

SUBSTANCE ABUSE OUTPATIENT CARE
AND
SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

(Year 3~~2~~3 Service Priorities: #~~9~~ 12 for outpatient Part A and #~~4~~ 8 for MAI; and #~~7~~ 10 for Part A residential only)

~~*Note: Following Florida Department of Children and Families (DCF) terminology, clients are now referred to as individuals served.*~~

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-determination, dignity, responsibility for own actions, relief of anxiety, and peer support.

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 individual served (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 incorporate motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate.

A residential substance abuse episode is not a pre-requisite to access Substance Abuse Outpatient Care. However, clients stepping down from or completing Substance Abuse Services (Residential) are encouraged to transition to Substance Abuse Outpatient Care. Furthermore, providers shall attempt a warm hand off to Substance Abuse Outpatient Care, where appropriate.,

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 disorders; outpatient drug-free treatment and counseling; medication assisted therapy; psychopharmaceutical interventions; substance abuse education; and relapse prevention. Services may also include 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) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) 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 ~~2022~~ 2023 Service Delivery Manual for details, as may be amended.)

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, 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 Treatment (MAT) 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 Service 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 (e.g., ASAM Criteria®, a Level of Care determination tool) for diagnosis of a substance use disorder or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) tools. 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 $25~~1~~0.00 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~~ 180 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). ~~Effective September 1, 2022, the temporary policy allowing more than 120 bed days of residential substance abuse treatment services due to a COVID-19 related issue will come to an end.~~ Override requests may be considered on a case-by-case basis and would be approved or denied at the discretion of Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program (OMB-GC/RWP) management. Please contact the OMB-GC/RWP office for pre-approval ~~prior to~~prior to extending residential care past the 1~~2~~80-day cap. 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~~180-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, 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 Service 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 ~~2022~~ 2023 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/publications-resources/textbooks
  Accessed 6/20/2022.

- 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/publications-resources/textbooks
  Accessed 6/20/2022. (Note: the Fourth Edition is currently in development.)

- American Society of Addiction Medicine. Current and archived public policy statements related to the treatment of substance use disorder.
  Available at: https://www.asam.org/advocacy/public-policy-statements
  Accessed 6/20/2022.

- 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.

~~IV.~~

IV. **Best Practices Compilation Search** provides interventions that improved outcomes: https://targethiv.org/bestpractices/search?keywords=substance%20abuse&page=1

December 2022 ADAP Formulary Additions
Ryan White Prescription Drug Formulary Review
Items 1-44 (Therapeutic/Pharmacological Sort)

	Generic Name	Brand Names	Therapeutic Classification	Pharmacologic Classification	Restrictions
1	tramadol	Ultram	Analgesic	Opioid	
2	diclofenac	Voltaren	Analgesic, Pain Relief	NSAID	
3	nepafenac	Nevanac	Analgesic, Pain Relief	NSAID (Ophthalmic)	
4	cefixime	Suprax	Anti-infective, antibiotic	Antibiotic-cephalosporin (3rd generation)	
5	moxifloxacin	Avelox (oral), Vigamox (opth)	Anti-infective, antibiotic	Antibiotic-Quinolone	
6	voriconazole	Vfend	Anti-infective, antifungal	Azole Antifungal	
7	tinidazole	Tindamax	Anti-infective, antiprotozoal, amebicide	Antiprotozoal, amebicide	
8	famciclovir	Famvir	Anti-infective, antiviral	Antiviral	
9	mupirocin	Bactroban	Anti-infective-antibiotic	Topical antibiotic	
10	rifapentine	Priftin	Anti-infective-antitubercular	Antitubercular	
11	ethinyl estradiol/desogestrel	Apri, Marvelon	Birth Control	Contraceptive	
12	ethinyl estradiol/etonogestrel	NuvaRing	Birth Control	Contraceptive	
13	ethinyl estradiol/levonorgestrel	Aviane, Lessina	Birth Control	Contraceptive	
14	ethinyl estradiol/norethindrone	Junel	Birth Control	Contraceptive	
15	ethinyl estradiol/norethindrone/ferrous fumarate	Junel Fe	Birth Control	Contraceptive	
16	ethinyl estradiol/norgestimate	Sprintec	Birth Control	Contraceptive	
17	ethinyl estradiol/norgestrel	Cryselle	Birth Control	Contraceptive	
18	levonorgestrel	My Way, Plan B, Mirena	Birth Control	Contraceptive	Resticted to tablets only
19	norethindrone	Micronor, Nor-Q-D	Birth Control	Contraceptive	
20	bempedoic acid	Nexletol	Cardiovascular	ACL Inhibitor	
21	prazosin	Minipress	Cardiovascular	Alpha-1 Adrenergic Blocker	
22	clonidine	Catapres	Cardiovascular	Alpha-2 Adrenergic Agonist	Resticted to tablets only
23	irbesartan	Avapro	Cardiovascular	Angiotensin II Receptor Blocker	

	Generic Name	Brand Names	Therapeutic Classification	Pharmacologic Classification	Restrictions
24	**olmesartan**	Benicar	Cardiovascular	Angiotensin II Receptor Blocker	
25	**valsartan**	Diovan	Cardiovascular	Angiotensin II Receptor Blocker	
26	**irbesartan/hydrochlorothiazide**	Avalide	Cardiovascular	Angiotensin II Receptor Blocker/Thiazide Diuretic	
27	**losartan/hydrochlorothiazide**	Hyzaar	Cardiovascular	Angiotensin II Receptor Blocker/Thiazide Diuretic	
28	**olmesartan/ hydrochlorothiazide**	Benicar HCT	Cardiovascular	Angiotensin II Receptor Blocker/Thiazide Diuretic	
29	**valsartan/ hydrochlorothiazide**	Diovan HCT	Cardiovascular	Angiotensin II Receptor Blocker/Thiazide Diuretic	
30	**enalapril/hydrochlorothiazide**	Vaseretic	Cardiovascular	Angiotension Converting Enzyme Inhibitor/ Thiazide Diuretic	
31	**benazepril/ hydrochlorothiazide**	Lotensin HCT	Cardiovascular	Angiotension Converting Enzyme Inhibitor/Thiazide Diuretic	
32	**metoprolol tartrate/ hydrochlorothiazide**	Lopressor HCT	Cardiovascular	Beta-Blocker/Thiazide Diuretic	
33	**atenolol/ chlorthalidone**	Tenoretic	Cardiovascular	Beta-Blocker/Thiazide Diuretic	
34	**amlodipine/benazepril**	Lotrel	Cardiovascular	Calcium Channel Blocker/ Angiotension Converting Enzyme Inhibitor	
35	**amlodipine/atorvastatin**	Caduet	Cardiovascular	Calcium Channel Blocker/HMG-CoA Reductase Inhibitor	
36	**ezetimibe/rosuvastatin**	Ridutrin	Cardiovascular	Cholesterol Absorption Inhibitor/HMG-CoA Reductase Inhibitor	
37	**ivabradine**	Corlanor	Cardiovascular	Hyperpolarization-activated cyclic nucleotide-gated channel blocker	
38	**sacubitril/valsartan**	Entresto	Cardiovascular	Neprilysin Inhibitor/ Angiotensin II Receptor Blocker	
39	**evolocumab**	Repatha	Cardiovascular	PCSK9 Inhibitor	
40	**alirocumab**	Praluent	Cardiovascular	PCSK9 Inhibitor	
41	**spironolactone/ hydrochlorothiazide**	Aldactazide	Cardiovascular	Potassium Sparing Diuretic/ Thiazide Diuretic	
42	**isosorbide dinitrate**	Isordil Titradose, Sorbitrate, Wesorbide	Cardiovascular	Vasodilating Agent	
43	**isosorbide mononitrate**	Imdur,Monoket	Cardiovascular	Vasodilating Agent	
44	**midodrine**	ProAmatine, Orvaten	Cardiovascular	Vasopressor	

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Meeting Housekeeping and Rules	Dr. Diego Shmuels
III.	Introductions	All
IV.	Floor Open to the Public	Dr. Diego Shmuels
V.	Review/Approve Agenda	All
VI.	Special Presentation: HIV Epidemiology In Miami-Dade County, 2021	Dr. Anthoni Llau
VII.	Review/Approve Minutes of January 12, 2023	All
VIII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
	• Medical Care Subcommittee Report	Marlen Meizoso
	• Partnership Report to Committees (reference only)	Dr. Diego Shmuels
IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

Please turn off or mute cellular devices – Thank you

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

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Partnership Report to Committees and Subcommittee
February 21, 2023 Meeting

Supporting documents related to motions in this report are available are online at aidsnet.org/ meeting-documents/, or from staff at Behavioral Science Research Corporation (BSR). For more information, please contact hiv-aidsinfo@behavioralscience.com.

Miami-Dade HIV/AIDS Partnership members heard a Special Presentation: *Tele-Harm Reduction: In Pursuit of Destigmatizing HIV Care for Persons Who Inject Drugs*, by Dr. Hansel Tookes

Members deferred nominations of Officers to their March meeting.

Members heard regular reports and approved the following motions:

Executive Committee

1. Motion to approve Policy and Procedure Manual changes attached to this report.

Community Coalition

2. Motion to recommend to the Mayor of Miami-Dade County the appointment of James Dougherty for the Community-Based AIDS Service Organization Representative seat on the Miami-Dade HIV/AIDS Partnership.

3. Motion to recommend to the Mayor of Miami-Dade County the appointment of Barbara Kubilus for the Representative from Agencies Receiving Grants Under Ryan White Part D, or from Organizations with a History of Providing Services to Children, Youth, and Families seat on the Miami-Dade HIV/AIDS Partnership.

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Memo

To: Care and Treatment Committee Members

From: Marlen Meizoso

Date: February 22, 2023

Re: 2023 Elections

At the next Care and Treatment Committee meeting, we will be holding elections for the Vice-Chair.

The following members are eligible for the officer position: Dr. Mary Jo Trepka, Ryan Roelans, Vanessa Mills, and Barbara Kubilus.

Eligible candidates interested in being on the ballot for the Vice-Chair must contact me **ASAP**.

For details on the qualifications for officers as they relate to this Committee, please see Section 5.1 of the Miami-Dade HIV/AIDS Partnership Bylaws: http://aidsnet.org/wp-content/uploads/2020/07/2020-Bylaws-FinalTAS.pdf.

If you interested in being placed on the ballot, please contact me at 305-445-1076 or by email at marlen@behavioralscience.com.

c/o Behavioral Science Research Corporation
2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134
p (305) 445-1076 | f (305) 448-3325 | www.aidsnet.org

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OUTREACH SERVICES

(Year ~~32~~ 33 Service Priorities: #1~~2~~4 for Part A and #~~6~~10 for MAI)

I. Definition and Purposes of Outreach Services

Ryan White Program **Outreach Services** are support services. Ryan White Part A/MAI Outreach Services in Miami-Dade County will use targeted approaches to locate people with HIV who are in need of assistance accessing HIV care and treatment who are:

- Newly diagnosed with HIV or AIDS, not receiving medical care;
- People with HIV, formerly in care, currently not receiving medical care (lost to care);
- People with HIV, at risk of being lost to care; or
- People with HIV, never in care.

Ryan White Program Outreach Services are directed to those persons known to have HIV and consist of activities to: a) engage and enroll newly diagnosed clients into the system of care; b) assist people with HIV who are lost to care with re-entry into the care and treatment system; and c) assist people with HIV who are determined to be at risk of being lost to care with their retention and access to ongoing medical care and treatment.

Outreach programs must be: 1) conducted at times and in places where there is a high probability that people with HIV and/or persons exhibiting high-risk behavior will be nearby; 2) designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness; 3) planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort; and 4) targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection.

With implementation of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative and in collaboration with the Florida Department of Health in Miami-Dade County's (FDOH-MDC) Early Intervention Program, newly diagnosed clients are the primary focus of service provision for Outreach Workers. Clients testing positive at state-licensed testing and counseling sites who sign an outreach consent form at the time they receive their preliminary reactive test result (Referral/Consent for Outreach Linkage to Care) will be contacted by Part A or MAI Outreach Workers for linkage to care either through Medical Case Management or Outpatient/Ambulatory Health Services. Outreach Workers will enter all demographic and program-related information in the Provide® Enterprise Miami data management system for every client contacted, including those not eligible for Ryan White Program-funded medical care. Thirty (30) and sixty (60) day follow-ups from the date of initial appointment with a medical provider and/or Medical Case Manager must be documented in the outreach progress note and labeled as a 30 and 60 day follow-~~up~~~~will be tracked~~ in the Provide® Enterprise Miami data management system~~.~~

Commented [SM1]: PE does not have a mechanism to track the 30 and 60 day follow-ups. Outreach workers are tracking the dates on their own(outside of PE) and documenting the follow-up contacts in the progress notes in PE.

Once a lost-to-care or at risk of being lost-to-care client is located, or a newly diagnosed and/or never in care person with HIV is located, ~~an outreach referral must be made to a Medical Case Manager or medical provider of the client's~~ choice. ~~.~~ The Outreach Worker may assist the client in obtaining necessary documentation to receive services and may accompany the person to a point of entry into the system of care. Outreach Workers must follow-up on each referral to ensure that the client is enrolled in Medical Case Management and/or Outpatient/Ambulatory Health Services. The outcome (e.g., connection to care or inability to locate the client) must be documented in the Client Profile in the Provide® Enterprise Miami data management system.

Commented [SM2]: Outreach workers cannot generate a referral to an MCM because it is omitted from the referral category list.

IMPORTANT NOTE: Outreach Services may be provided to clients with a rapid test preliminary positive result while a confirmatory HIV test result is pending, for the purpose of rapidly linking the client to care. However, it is still necessary to obtain a confirmatory HIV test result; however, within thirty (30) calendar days, Outreach Services (e.g., connecting a newly diagnosed client to Outpatient/Ambulatory Health Services or Medical Case Management services) may be provided while a confirmatory HIV test result is pending. **Time spent by Outreach Workers with clients who have a preliminary reactive test result and a pending confirmatory HIV test result is limited to a total of up to three (3) encounters within a 30-calendar day period. After which time a confirmatory HIV test result is required to continue serving the client. If the HIV positive status cannot be confirmed or the result is negative, any services provided to the client must be disallowed.**

Referrals to Ryan White Program Part A or MAI-funded Outreach Services from state-licensed counseling and testing sites may only be initiated if there is a valid outreach-specific consent (Referral/Consent for Outreach Linkage to Care) signed by the client and filed in the client's chart or scanned into the Client Profile in the Provide® Enterprise Miami data management system.

IMPORTANT NOTE: Outreach Workers are required to pick up the Ryan White Program Referral/Consent for Outreach Linkage to Care within 24 hours of notice that a signed consent is waiting AND must make an initial attempt to contact the client within 48 hours (i.e., 2 business days) of such notice. During a public health emergency or extreme weather event the process to pick up the consent forms may be altered by the Florida Department of Health and/or the Miami-Dade County Office of Management and Budget-Grants Coordination. In such cases, outreach service providers will be notified in writing.

The Outreach Referral end date is thirty (30) calendar days from the initial referral date. At least one encounter must be provided within this 30-day period. Additionally, an Outreach Episode of Care must be opened in the Provide® Enterprise Miami data management system to coincide with the first date of Outreach Services and the period covered by the related referral. Final Outreach Services must be provided within ninety (90) calendar days of the initial referral date. After the ninety (90) calendar day period, the Outreach Episode of Care must be closed in the Provide® Enterprise Miami data

management system. New and lost to care clients who are served by Ryan White Part A/MAI Program Outreach Workers apart from the FDOH linkage process and are not successfully connected to care within ninety (90) calendar days should have their case closed unless there is a well-documented, reasonable justification for keeping the case open.

Newly diagnosed clients who are referred to the Ryan White Part A or MAI Program through the Florida Department of Health (FDOH) linkage referral process who are not successfully contacted by a Ryan White Program Outreach Worker within thirty (30) calendar days of receiving a signed consent shall be referred to FDOH-MDC Linkage Specialist or Disease Intervention Specialist for appropriate follow up.

A. Newly Diagnosed or Never in Care Person with HIV

1. Linkage agreements form the basis of collaborative relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the eleven (11) key points of entry to the system of care listed below for the purpose of receiving referrals for program-eligible clients identified at key points of entry.

    - Florida Department of Health (FDOH) Miami-Dade County's (M-DC) Sexually Transmitted Disease (STD) clinics
    - FDOH state-licensed HIV counseling and testing sites
    - Hospitals/emergency room departments/urgent care centers
    - Hospital discharge clinics/departments
    - Substance abuse treatment providers/programs
    - Mental health clinics/programs
    - Adult and juvenile detention centers
    - Jail and/or correctional facilities, including, but not limited to, re-entry programs
    - Homeless shelters
    - Detoxification centers
    - Federally Qualified Health Centers (FQHCs)

    Linkage agreements must include the Outreach Worker's contact information, work schedule availability, geographic areas of the County covered, and a description of the Outreach Services offered. Clients referred from a key point of entry will be assisted to obtain necessary documentation for enrollment in the service system, will receive a referral to the primary medical care and/or Medical Case Management service provider of their choice, may be accompanied to the initial appointment and must be followed-up to ensure that they are connected to care. Ryan White Program-funded outreach providers are required to cooperate with the FDOH-MDC's Early Intervention Counseling and Testing sites by supplying outreach/linkage to care workers at "Take Control Miami"

events. Under the EIIHA mandate it is the responsibility of Ryan White Program-funded outreach/linkage to care workers to connect every new positive who has signed a Referral/Consent for Outreach Linkage to Care to Medical Case Management and/or Outpatient/Ambulatory Health Services; this includes connecting clients who are not eligible for Ryan White Program-funded services to appropriate care under other funding sources. The Outreach Worker must provide the client with provider information and track the client to ensure, through 30- and 60-day follow-ups from the date of initial appointment with a medical provider and/or Medical Case Manager, that the client is actually linked to a Medical Case Manager and/or a medical provider.

B. Outreach to People Lost to Care or at Risk of Being Lost to Care

1. Outreach Workers must work with service providers, including Medical Case Managers, to locate people lost to medical care or Medical Case Management and bring them back to care. The Medical Case Manager, or pharmacy staff, after three (3) repeated attempts to contact the client by phone and/or mail without success, may refer the case through a Ryan White Program In Network Referral in the Provide® Enterprise Miami data management system to an Outreach Worker. Jail linkage and prison re-entry coordinators may refer a client to an Outreach Worker if they have a signed document with permission for a Ryan White Program Part A or MAI Outreach Worker to contact them; such documents must be included with the OON referral and the supporting documentation being sent to the outreach provider. There must be clear documentation in the client chart at the referring agency and recorded in the Ryan White Program In Network Referral, of at least three (3) repeated attempts by the Medical Case Manager, pharmacy staff, or jail linkage/prison re-entry coordinator to contact the client and the reason why the case is being referred to an Outreach Worker. A Ryan White Program In Network Referral with last known contact information on the client indicating the reason for the outreach referral must be provided to the Outreach Worker and be maintained in both the Medical Case Management and outreach client charts. In instances where it is clearly documented that a client has a history of non-compliance or clear documentation of extenuating circumstances, such as homelessness, repeated non-compliance with their treatment regimen, mental health issues, and/or a history of substance abuse, referrals to an Outreach Worker may be made after one or two attempts at contacting the client.

2. A Physician, Physician Assistant, or Advanced Practice Registered Nurse may immediately and directly request outreach assistance for a client who meets any of the conditions listed directly below in Section B.3., or for similar circumstances (e.g., abnormal lab results, significant risk of non-

adherence to treatment regimen, etc.). Such circumstances must be clearly documented in the client's chart and indicate that the assistance of an Outreach Worker was requested (i.e., the medical practitioner writes a prescription for the needed outreach and documents such in the client's medical record).

3. Examples of clients considered lost to care or at risk of being lost to care, which require a valid consent for outreach and three (3) documented attempts by the referring agency to reach the client, include:

- Missing two (2) consecutive medical appointments;
- Having no contact with a Medical Case Manager for more than three months;
- Checking out of residential substance abuse treatment;
- Not "reporting to" residential substance abuse treatment;
- Missing the first medical care appointment after hospital discharge and/or referral to care;
- Missing picking up prescription medications or prescription referrals from a pharmacy or a Medical Case Manager;
- Missing an appointment with the jail linkage or prison re-entry coordinator; and/or
- Missing a medical or social service appointment that the jail linkage or prison re-entry coordinator has scheduled.

IMPORTANT NOTE: Clients lost to care or at risk of being lost to care may be contacted after one or two unsuccessful attempts at communication ONLY IF extenuating circumstances as outlined above are clearly documented in the individual client chart and are recorded in the Ryan White Program In Network Referral or OON Referral from the Jail Linkage or Prison Re-entry programs.

Outreach providers must work with and establish formal linkages with Ryan White Program medical providers and Medical Case Management sites in order to receive outreach referrals from these providers who will identify clients who are lost to care or at risk of being lost to care. Outreach Workers will then try to locate these clients and assist them in returning to ongoing medical care and treatment.

C. One Time Referrals

~~If in the course of outreach activities, Outreach Workers encounter a high risk person with no documentation of HIV+ status, a referral should be made to an HIV testing site and/or appropriate prevention program in order to determine the client's HIV status. This one-time referral may be counted and entered into the Provide® Enterprise Miami data management system in the Outreach Registration screen. This is a **secondary** outreach function that will be monitored by OMB and should not supersede the primary goals of connecting newly diagnosed (newly identified)~~

Commented [SM3]: Outreach workers are not entering clients in provide for clients without preliminary HIV+ status. The recommendation is to remove C. "One Time Referrals"

~~clients to care, as well as locating and reconnecting to the service system those clients who have been lost to care or who are at risk of becoming lost to care. These secondary Outreach Services must be planned and delivered in coordination with local HIV prevention/education programs, including counseling and testing programs, in order to avoid duplication of effort~~.

D. Allowable Outreach Activities

1. Ryan White Part A/MAI-funded Outreach Workers may provide services to clients in the following situations to link or retain clients in HIV care: 1) for their agency's own clients; 2) upon receipt of a Ryan White Program In Network Referral for a particular client, for whom the referring agency has a valid informed outreach-specific consent signed by the client and filed in the client's chart; 3) upon receipt of a signed, completed Consent/Referral for Linkage to Care from state-licensed Counseling and Testing sites; 4) a prescription from a Physician, Physician Assistant, or Advanced Practice Registered Nurse; or 4) by a letter or OON Referral from a jail linkage or prison re-entry coordinator as indicated in Section B above.

2. Outreach Workers may engage in the following activities, if the activity is properly documented and filed in the client's chart at the referring agency and at the receiving agency where applicable:

- Obtain from the client all required consents for the Outreach Worker to access client-related information in the Ryan White Program's Provide® Enterprise Miami data management system;
- Conduct brief intakes for new clients referred from a state-licensed Counseling and Testing Site, jail linkage or prison re-entry coordinator and enter data into the Provide® Enterprise Miami data management system outreach registration screen;
- Upon receipt of a proper referral, review data in the Provide® Enterprise Miami data management system for existing clients who are lost to care or are at risk of falling out of care;
- Complete assessments and document new clients' barriers to accessing care and lost-to-care clients' reasons for falling out of care;
- Contact the service provider of the client's choice to coordinate appointments and obtain required documentation for services;
- Accompany newly diagnosed, lost to care, or otherwise unconnected program-eligible people with HIV (clients) to the initial physician appointment and/or Medical Case Management appointment for the purpose of reconnecting them to care or enrolling them in service;
- Accompany clients, as necessary, for the purpose of assisting them to obtain necessary documents for entry into the service system;
- Contact clients who have a history or are at risk of falling out of care

(i.e. substance abuse history, homelessness, mental illness) during the 30 and 60 day follow-up period with the end of increasing retention in care;

- Conduct home visits to meet with a client for the purpose of connecting them to care;

  - **IMPORTANT NOTES**:

    - If a Part A/MAI-funded outreach service provider has an established agency policy not to send staff to conduct home visits, and it is determined that a home visit is necessary for successful linkage, the client's case **must** be transitioned to a Part A/MAI-funded outreach provider that is able to conduct home visits;

    - In cases of transfer due to the home visits, the new outreach provider agency replaces the previous outreach provider agency;

- Maintain tracking and contact logs for new to care and lost to care clients;
- As a safety precaution, Ryan White Program Outreach Workers who must locate clients in high-risk areas or very rough neighborhoods may go out in two-person teams. In this scenario, both Outreach Workers should document the activity in the client chart or outreach log, making note that they went to a high-risk area, with one of the Outreach Workers clearly stating that they went along as a safety back-up and should use the OSFT safety back-up code to record the service. Both Outreach Workers may reflect the time they spent on the encounter and have their agency or respective agencies report for the time and be reimbursed accordingly. However, in the Provide® Enterprise Miami data management system the encounter should only be counted/recorded (i.e., OFFE, OTEL, ORFL, etc.) by the main Outreach Worker/agency that received the referral;

  - **IMPORTANT NOTE:** If a Peer Educator is the safety back-up, the Peer Educator must use the corresponding safety encounter code, PSFT, under the PESN billing category.

- Provide education on available care and treatment options and services for people with HIV who receive outreach services via a Ryan White Program In Network Referral, Jail linkage referral, Department of Corrections Certification or a Referral Consent Linkage to Care form with the goal of directly empowering and enabling the client to access existing HIV/AIDS service programs, including Counseling & Testing sites;

- Provide out-stationed linkage and coordination to care services at key points of entry, including but not limited to counseling and testing facilities and other facilities with a high percentage of people with HIV as identified by the counseling and testing facility and verified by the Ryan White Part A/MAI Program;
- Coordinate and participate in planned outreach/testing events such as "Take Control Miami" in cooperation with the FDOH-MDC;
- Conduct 30- and 60-day follow-ups from the date of initial appointment with a medical provider or Medical Case Manager to ensure the client (regardless of whether the client is receiving services through the Ryan White Program) remains connected to care.

E. Inappropriate Outreach Activities

Funds awarded under Part A and MAI of the Ryan White HIV/AIDS Treatment Extension Act of 2009 may not be used for outreach programs that exclusively promote HIV education and prevention programs, condom distribution, and/or case finding that have as their main purpose broad-based or general HIV prevention education. Additionally, broad-scope awareness activities about HIV services that target the general public (i.e., poster campaigns for display on public transit, TV or radio public service announcements, health fairs directed at the general public, etc.) will not be funded.

Ryan White Part A/MAI Program funds may not be used to pay for HIV counseling or testing under this service category. Ryan White Part A/MAI Outreach Services must be planned and delivered in coordination with local HIV prevention programs to avoid duplication of effort.

Outreach Workers may <u>not</u> conduct random searches in the Provide® Enterprise Miami data management system for clients who are not enrolled at the Outreach Workers' assigned agency, or for clients for whom they do not have a Ryan White Program In Network Referral. Searches conducted in the Provide® Enterprise Miami data management system to identify clients lost to care must be initiated by the Medical Case Manager or medical or pharmacy staff of the referring agency.

Ryan White Program-funded outreach activities are not to be used for general recruitment of clients to the Outreach Worker's agency.

F. Documentation of Outreach Activity

All Outreach Workers must maintain documentation which includes the following:

- Name of Outreach Worker;

- Name, signature, and consent of client;
- Client's date of birth;
- Client's gender;
- Client's race and ethnicity;
- Client's address or follow-up information;
- Date of diagnosis and site of diagnosis;
- Date of the encounter;
- Type of encounter (i.e., telephone, face-to-face, collateral, travel, referral, or coordination of care);
- Description of the encounter with a client and/or work done on behalf of the client;
- Time spent on the encounter in minutes;
- Total units documented;
- For newly diagnosed clients, a Referral/Consent for Linkage to Care;
- For clients lost to care, a Ryan White Program signed outreach consent to be contacted (found at the top of the County's Notice of Privacy Practices form);
- Site where client was identified (i.e., last known contact information, a specific geographic region, and/or key point of entry into the system of care in Miami-Dade County);
- One-time referral to a testing site for a high-risk client without documentation of HIV status;
- Document "initial contact" and all "follow-up" contacts;
- Maintain call logs and tracking logs for new-to-care and lost-to-care clients;
- If lost to care or identified as at risk of being lost to care, a copy of the initiating agency's referral to outreach;
- An individualized assessment of the client's barriers to care or reasons for falling out of care;
- Documentation that explanation of service system and choice of provider agency were provided;
- A copy of a Provide® Enterprise Miami In Network referral or documented attempt to make a referral by the Outreach Worker to a Medical Case Management agency and/or medical provider of the client's choice;
- Documentation of 30- and 60-day (calendar days) follow-up on referrals to ensure that the client is enrolled in medical care and treatment;
- Final disposition of the client must be documented in the Provide® Enterprise Miami data management system, the client's chart or service log indicating whether or not the client was connected to care (i.e., referral was made; client was taken to a medical provider or Medical Case Manager) or if the case was closed with a statement as to why it was closed; and

- Contact with the referring agency to communicate the client's final disposition.

II. Outreach Worker Incentives, Program Operation Requirements, and Staff Training Requirements

As incentives for productivity, providers are encouraged to provide Outreach Workers with educational training opportunities. The Ryan White Program also has educational and training requirements for Outreach Workers to improve productivity.

A. Program Operation Requirements:

1. **Staff Training.** Outreach Workers must possess at least a High School diploma or GED. All staff providing Outreach Services must complete the FDOH's "HIV/AIDS 101 – Know Your HIV Status" video training [this training is available on-line at https://knowyourhivstatus.com/hiv-resources/]. Outreach Workers must attend periodic training provided by the Ryan White Program's Clinical Quality Management and Training Program provided by BSR. In addition, effective June 1, 2018, any new hire Outreach Worker or Outreach Supervisor under the Ryan White Part A or MAI Programs must complete all 13 of the Southeast AIDS Education and Training Center's (SE-AETC) web-based Medical Case Management Curriculum and Cultural Competency Curriculum modules as required and as may be amended by the local Ryan White Part A Program **prior to** being approved for Provide® Enterprise Miami User Access. These curricula modules are indicated on the local Ryan White Program's AETC Training Module Checklist and the modules can be accessed at the following website: https://www.seaetc.com/modules/. Time spent completing the SE-AETC training modules **cannot** be charged to the local Ryan White Part A/MAI Programs.

   Outreach providers must ensure that Outreach Workers are knowledgeable about resources and providers of medical care, substance abuse treatment, Medical Case Management, and other core medical and support services. At a minimum, the outreach provider should have reference material on hand which provides information on services offered, intake requirements, hours of operation, and contact personnel information. Outreach Workers must also have on hand Ryan White Program consent forms available for signature by clients lost to care or at risk of being lost to care.

2. **Hours.** Outreach Services must be offered during non-traditional business hours, 10 hours at a minimum per week, per agency. Traditional business hours are defined as 9:00 a.m. to 5:00 p.m., Monday through Friday. Each Ryan White Program-funded outreach provider must have written procedures in place to address on-call coverage to reach an Outreach Worker after traditional business hours. The written procedures should include steps for contacting an on-call medical provider and/or Medical Case Manager, where immediate intervention is necessary.

3. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target subpopulations (i.e., substance abusers, illiterate persons, hard of hearing, sex workers, etc.). It is desirable that Outreach Workers reflect the community in which they are working and/or are targeting.

4. **Documentation of Units of Service.** Providers are required to document in the client's chart each unit (15-minute encounter) of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact, collateral encounter on behalf of the client, coordination of care, travel, or referral activity on behalf of a client. Use the appropriate code from the following table to record outreach services (listed in alphabetical order by code):

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Collateral Contacts	**OCOL**	Use this code to record all activities related to **coordination of care** for clients, including communication with other care providers, such as telephone contacts or other electronic methods of communication (e.g., email or fax). This code also includes other coordination of care activities that are conducted for or on behalf of the client, such as **referral activities** that are not face-to-face with the client and obtaining completed documents for the client from another (outside) care provider. This code should NOT be used for internal agency activities that are unrelated to the coordination of care for clients with outside providers. Examples of inappropriate use of this code include pulling a chart to copy documents for a client's personal use or filing for chart maintenance.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Consultation	**OCON**	Only Outreach Supervisors may use this OCON code. This code shall be used to record activities associated with consulting with outreach staff on Ryan White Program-related client, supervisory, or quality management issues.
Documentation	**ODOC**	Use this code to record activities related to documenting any encounter in the Provide® Enterprise Miami data management system, such as the client's care plan, progress note, face-to-face encounter, telephone contact, etc. This service code also includes time spent filing or organizing the client chart or pulling the chart to make copies that are unrelated to coordination of care for the client. **IMPORTANT NOTE**: See subsection II.D. below regarding "Applicability to Local Ryan White Program Requirements" for staff supervising Ryan White Program-funded Outreach Workers.
Face to Face Encounter	**OFFE**	This encounter is defined as any time the Outreach Worker or Outreach Supervisor has direct contact with the client in person. The OFFE encounter includes activities that are conducted face-to-face with the client where no other encounter code is appropriate. OFFE may also include referral activities if done face-to-face with the client.
Chart Review Activity	**OREV**	Only Outreach Supervisors may use this OREV code. This code should be used to record activities associated with chart review processes to ensure that outreach staff is in compliance with this service definition, and with the Ryan White Program System-wide Standards of Care. As of May 1, 2018, there is no longer a required number of hours of OREV code use. **IMPORTANT NOTE**: See subsection II.D. below regarding "Applicability to Local Ryan White Program Requirements" for staff supervising Ryan White Program-funded Outreach Workers.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Referral Activity	**ORFL**	Use this code to record outreach referral activities that do not fit in any other outreach encounter/ activity in this list.
Safety Back-up	**OSFT**	Ryan White Part A/MAI Program-funded Outreach Workers who as a safety precaution accompany a Ryan White Program Outreach Worker when locating clients in high-risk areas or very rough neighborhoods, as indicated in Section I.D.1 above, should use the OSFT safety back-up code to record the service. In this scenario, if applicable, both Outreach Workers should document the activity in the client chart or outreach log, making note that they went to a high- risk area, with one of the Outreach Workers clearly stating that they went along as a safety back-up. Both Outreach Workers may reflect the time they spent on the encounter and have their agency or respective agencies bill for the time and be reimbursed accordingly. However, in the Provide® Enterprise Miami data management system the other outreach billing code (i.e., OFFE, OTEL, ORFL, etc.) should only be counted or recorded by the main Outreach Worker/agency that received the referral.
Outreach Telephone Encounter	**OTEL**	Use this code to record telephone contacts.
Outreach Contact Travel Time	**OTVL**	Use this code to document travel time with or on behalf of the client that is specific to care coordination, linkage to care, retention or retention in care activities. In such cases, documentation in the client chart must include reason for travel in relation to care coordination, linkage to care, or retention in care.
Take Control Miami events	**TCM**	Use this code to record outreach activities conducted at authorized "Take Control Miami" events.

Commented [SM4]: Not sure if these are still occurring

Commented [SM5R4]: I confirmed with Sandra Estevez and the Take Control Events are still occurring.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Training	**TRN**	Use this code to record and bill for time spent attending authorized Ryan White Program trainings (TRN), such as Outreach Worker trainings, County-approved Provide® Enterprise Miami data management system trainings, and ~~quarterly~~ Ryan White Program Subrecipient (Service Provider) Forums. The TRN code may **not** be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code **cannot** be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, on-site BSR technical assistance visits; appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, AETC training modules, or other employer-required training. Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

Commented [SM6]: Outreach workers are not on the list to have access to the TRN encounter code.

5. **Connection to Care.** Providers are expected to document the client's connection(s) to care in the Provide® Enterprise Miami data management system as evidenced by documentation on file at the outreach provider agency that at least fifty percent (50%) of people contacted and billed for are actually returned to primary medical care and/or Medical Case Management services or that a case was closed, and at least fifty percent (50%) of the people contacted and billed for are new to primary medical care and/or Medical Case Management services, on a quarterly basis. Connections to care will also be monitored by the County on a quarterly basis through the Provide® Enterprise Miami data management system and/or analysis of outreach data conducted by BSR, as a Clinical Quality Management Program activity.

B. Rules for Reimbursement: Providers will be reimbursed $1/12^{th}$ of the contract total, subject to penalties for non-performance (i.e., reduced payment based on not meeting the required percentage of connections to care), as detailed below. Under this service category, Payment Requests

(invoices) submitted (via mail, email or the Provide® Enterprise Miami data management system) without any recorded services will not be processed for payment without the County's prior approval. In months where this occurs, the County will automatically apply a 1/12th penalty for the month without services and will not take into consideration this month for purposes of the quarterly performance review.

Reimbursement will be performance-based. Initially, payment will be made in equal monthly installments of the contract award for this service, as may be amended through Reallocation/Sweeps awards or reductions. Subrecipients' performance under this service category will be reviewed quarterly to ensure effective service delivery; whereby at least 50% of the clients contacted through Outreach Services during the quarter must be connected for the first time (for new to care clients) or re-connected (for lost to care clients) to Outpatient/Ambulatory Health Services and/or Medical Case Management services. Failure to reach this 50% quarterly performance goal will result in penalties (i.e., payment reductions), as follows:

% of Unduplicated Outreach Clients who were Connected / Re-connected to Care During the Quarter Reviewed	**% of Quarterly Reimbursement Totals Subrecipient is Authorized to Retain (i.e., no penalty applied) ***
50% or more	100%
45 – 49%	90%
40 – 44%	80%
35 – 39%	70%
30 – 34%	60%
25 – 29%	50%
20 – 24%	30%
0 – 19%	0%

IMPORTANT NOTES:

1) Adjustments (e.g., reductions, disallowances, etc.) will be made to reimbursements in monthly invoices following the quarter reviewed. Any adjustment will be made to one or more monthly reimbursement invoices in the subsequent months of the same grant fiscal year until the full amount of the penalty is recouped. For example, if only 36% of the outreach clients contacted/served in Quarter 1 – March to May – were connected to medical care and/or medical case management, the subrecipient would keep (retain) 70% of the amount reimbursed during that period and the amount of the penalty (i.e., 30% of amount reimbursed during the quarter) would be deducted from invoices between June and February until the full amount of the penalty is recouped.

2) Special circumstances (e.g., new hires, complexity of care for subpopulation served, COVID-19 restrictions, etc.) may be considered at the County's sole discretion for adjustments to any penalty reductions indicated in the table directly above.

3) Each Outreach Worker must be an approved user/provider in the local Ryan White Part A Program's MIS system (e.g., Provide® Enterprise Miami data management system) BEFORE their first service date. Approvals will no longer be made retroactively for this service category.

4) Reallocations/Sweeps actions will also be prospective, not retroactive.

5) If an Outreach Services budget includes a staff vacancy and that vacancy is not filled by the end of the next quarter reviewed, a proportionate amount will be deducted from the total award to reduce the amount allocated to the vacant position.

6) Sweeps requests for additional funds cannot be used to cover prior penalties.

7) These new percentage rates (see table directly above) will be closely monitored by the Recipient (i.e., Miami-Dade County) for effectiveness and may be subject to change.

C. Additional Rules for Reporting: Monthly activity reporting for this service will be on the basis of an outreach contact in comparison with the amount of time and effort billed to the program for each Outreach Worker.

Reimbursement requests will be continuously evaluated on the basis of productivity; in particular, people contacted and connected to primary medical care or Medical Case Management services. A sufficient level of Outreach Services must be provided and a corresponding bill generated through the Provide® Enterprise Miami data management system on a monthly basis in order for reimbursement to be approved by the County. The County maintains the right to assess the sufficiency of the services provided before reimbursement for services is made.

Outreach staff must follow all applicable requirements of this service category in the Provide® Enterprise Miami data management system which include the following: managing an Outreach Episode of Care; ensuring that an In Network or OON referral is opened for a client;

updating all client appointments evidencing connections to care; creating progress notes which fully document the client encounter; opening the Client Service Profile Record under the correct funding source; ensuring only eligible clients are served.

It is required that all staff working on Outreach Services review and become familiar with the Provide® Enterprise Miami user guides (manuals) titled "Outreach Services Program" and "Referrals: In Network Service and Out of Network" as part of their new outreach staff orientation and prior to providing outreach services. This practice will guide staff as they navigate and follow the requirements of this service category in the Provide® Enterprise Miami data management system with the goal of limiting unbillable services, which can affect the amount of reimbursement approved by the County if the service(s) entered cannot count towards the performance standards detailed above.

D. **Applicability to Local Ryan White Program Requirements:** If a staff person has a Ryan White Program outreach service caseload, even one client, they will be required to adhere to the local Ryan White Program Service Delivery Manual, System-wide Standards of Care, and Clinical Quality Management Program activities. This requirement is applicable whether or not the outreach staff person appears on the program's line item budget and regardless of the percentage of time and effort spent performing Ryan White Program outreach activities. Similarly, if provider's staff supervises any Ryan White Program outreach staff, whether or not they are on the budget for such, they also must follow the requirements in the local Ryan White Program Service Delivery Manual, System-wide Standards of Care, and Clinical Quality Management Program activities.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, March 2, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

AGENDA

I.	Call to Order	Dr. Diego Shmuels
II.	Meeting Housekeeping and Rules	Dr. Diego Shmuels
III.	Introductions	All
IV.	Floor Open to the Public	Dr. Diego Shmuels
V.	Review/Approve Agenda	All
VI.	Special Presentation: HIV Epidemiology In Miami-Dade County, 2021	Dr. Anthoni Llau
VII.	Review/Approve Minutes of January 12, 2023	All
VIII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Vacancies	Marlen Meizoso
	• Medical Care Subcommittee Report	Marlen Meizoso
	• Partnership Report to Committees (reference only)	Dr. Diego Shmuels
IX.	Standing Business	
	• 2023 Vice-chair Election	All
	• Service Description: Outreach	All
X.	New Business	
XI.	Announcements	All
XII.	Next Meeting: **April 6, 2023** at Main Library- **Auditorium**	Dr. Diego Shmuels
XIII.	Adjournment	Dr. Diego Shmuels

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

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MIAMI-DADE COUNTY

SOURCE OF INCOME STATEMENT

Section 2-11.1(i) of the County Ethics Code requires that certain employees, public officials, and consultants file a financial disclosure Statement on a yearly basis by July 1st of every year. For the last year of service, file SOI-F.

Disclosure for Tax Year Ending [redacted]	Last Name (or, Consultant or Consulting Firm name)	First Name	Middle Name/Initial
Mailing Address – Street Number, Street Name, or P.O. Box			
City, State, Zip			

If your home address is your mailing address, and your home address is exempt from public records pursuant to Fla. Stat. §119.07, read instructions on the following page **and check here.** ☐

Filing as an Employee (check one)

☐ County ☐ Public Health Trust ☐ Municipal: _____ (Municipality)

Department		
Position or Title		Employee ID Number
Work address	Work telephone	Employment began on/ended on

Filing as (check one)

☐ County Board ☐ Municipal Board: _____ (Municipality) ☐ Consultant for County or Municipal Agency

Board where serving or name of County or Municipal Agency Consultant is providing professional services to		
Alternate address (if home address is exempt)	Work telephone	Term began on/ended on

List below every source of income you received, along with the address and the principal activity of each source. Include your public salary. Place the sources of income in descending order, with the largest source first. Examples of sources of income include: compensation for services, income from business, gains from property dealings, interest, rents, dividends, pensions, IRA distributions, and social security payments. Also, include any source of income received by another person for your benefit. However, the income of your spouse or any business partner need not be disclosed. **If continued on a separate sheet, check here.** ☐

Name of Source of Income	Address	Description of the Principal Business Activity

I hereby swear (or affirm) that the information above is a true and correct statement.

_____
Signature of Person Disclosing

_____
Date signed

RECEIVED BY ELECTIONS DEPARTMENT:
☐ Hardcopy
☐ Electronic Copy

OFFICE USE ONLY Accepted: Y / N Deficiency:_____ Processed Date/Initials:_____ Scanned Date/Initials: _____

138_SP-14 COE 2018

Complete this section with your name and home address

Miami-Dade HIV/AIDS address and phone number will be populated in the document and term info will be entered

List all sources of income, not their dollar amount

Must be signed

Sample of Source of Income with Place of Employment info:

Name of Source of Income	Address	Description of the Principal Business Activity
Joe's Deli	1235 Collins Ave. Miami Beach, FL 33140	Salary

Sample of Source of Income with Social Security info:

person for your benefit. However, the income of your spouse or any business partner need not be disclosed. **If continued on a separate sheet, check here.** ☐

Name of Source of Income	Address	Description of the Principal Business Activity
Social Security	1801 Alton Road, Ste. 200 Miami Beach, FL 33140	Social Security Income

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