MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, February 28, 2025
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 24, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Oral Health Care Items: Service Descriptions	All
	• Minimum Primary Medical Care Standards	All
IX.	New Business	
	• Source of Income Disclosures	All
X.	Announcements and Open Discussion	All
	• Get on Board Training, March 5, 2025	
XI.	Next Meeting**: March 28, 2025** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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Meeting Housekeeping Medical Care Subcommittee

Updated February 20, 2025

Behavioral Science Research

MIAMI-DADE HIV/AIDS PARTNERSHIP

BEHAVIORAL SCIENCE RESEARCH

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.

General Housekeeping

- You must sign in to be counted as present.
- Place cell phones on mute or vibrate - *If you must take a call, please excuse yourself from the meeting.*
- Eligible committee members should see staff for a voucher at the end of the meeting.

About the Partnership

- The Miami-Dade HIV/AIDS Partnership is the official Ryan White Program Planning Council for Miami-Dade County.
- Partnership Members are appointed by the Mayor of Miami-Dade County based on recommendations by the Community Coalition.
- The Medical Care Subcommittee is a subcommittee under the Care and Treatment Committee which is one of six Standing Committees of the Partnership.
- All Partnership and Standing Committee members are volunteers and commit to abiding by the Partnership's Bylaws, including regular meeting attendance and completion of required training and paperwork.
- See staff after the meeting for additional details.

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 experiencing homelessness, 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

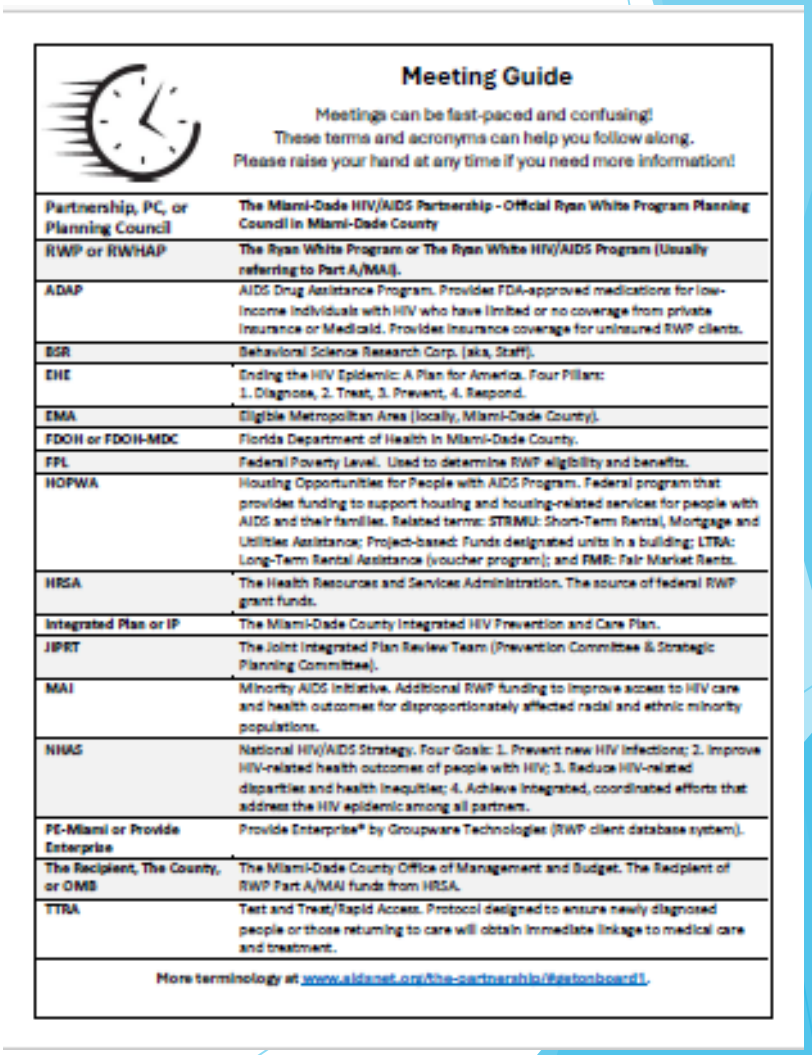
Everyone has a role to play!

- ❑ All attendees may address the board as time allows and at the discretion of the Chair.
- ❑ Please *share your expertise* on the current Agenda topics and motions. Remember to . . .
  - Raise your hand to be recognized by the Chair or added to the queue during discussions.
  - Avoid repeating points previously addressed.

Meeting Terminology

Meetings can be fast-paced and confusing!

- ❑ Terms and acronyms you might hear at today's meeting are on the back of your Agenda.
- ❑ Please raise your hand at any time if you need more information!



Meeting Guide

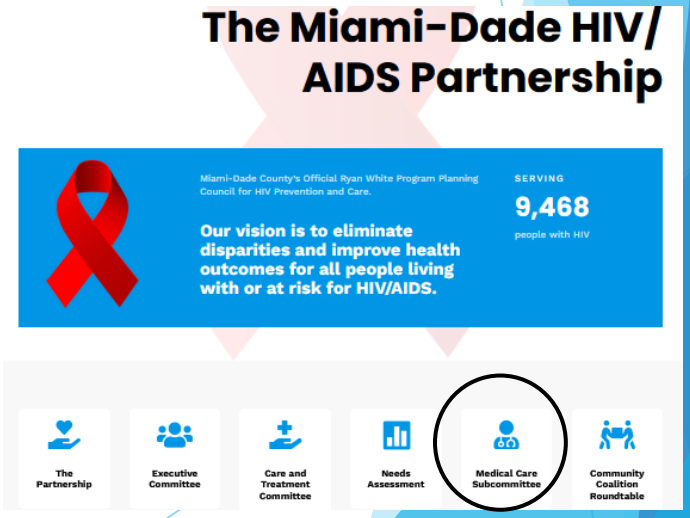
Meetings can be fast-paced and confusing!
These terms and acronyms can help you follow along.
Please raise your hand at any time if you need more information!

Partnership, PC, or Planning Council	The Miami-Dade HIV/AIDS Partnership - Official Ryan White Program Planning Council in Miami-Dade County
RWP or RWHAP	The Ryan White Program or The Ryan White HIV/AIDS Program (Usually referring to Part A/MAI).
ADAP	AIDS Drug Assistance Program. Provides FDA-approved medications for low-income individuals with HIV who have limited or no coverage from private insurance or Medicaid. Provides insurance coverage for uninsured RWP clients.
BSR	Behavioral Science Research Corp. (aka, Staff).
EHE	Ending the HIV Epidemic: A Plan for America. Four Pillars: 1. Diagnose, 2. Treat, 3. Prevent, 4. Respond.
EMA	Eligible Metropolitan Area (locally, Miami-Dade County).
FDOH or FDOH-MDC	Florida Department of Health in Miami-Dade County.
FPL	Federal Poverty Level. Used to determine RWP eligibility and benefits.
HOPWA	Housing Opportunities for People with AIDS Program. Federal program that provides funding to support housing and housing-related services for people with AIDS and their families. Related terms: STRMU: Short-Term Rental, Mortgage and Utilities Assistance; Project-based: Funds designated units in a building; LTRA: Long-Term Rental Assistance (voucher program); and FMR: Fair Market Rents.
HRSA	The Health Resources and Services Administration. The source of federal RWP grant funds.
Integrated Plan or IP	The Miami-Dade County Integrated HIV Prevention and Care Plan.
JPRT	The Joint Integrated Plan Review Team (Prevention Committee & Strategic Planning Committee).
MAI	Minority AIDS Initiative. Additional RWP funding to improve access to HIV care and health outcomes for disproportionately affected racial and ethnic minority populations.
NHAS	National HIV/AIDS Strategy. Four Goals: 1. Prevent new HIV infections; 2. Improve HIV-related health outcomes of people with HIV; 3. Reduce HIV-related disparities and health inequities; 4. Achieve integrated, coordinated efforts that address the HIV epidemic among all partners.
PE-Miami or Provide Enterprise	Provide Enterprise® by Groupware Technologies (RWP client database system).
The Recipient, The County, or OMB	The Miami-Dade County Office of Management and Budget. The Recipient of RWP Part A/MAI funds from HRSA.
TTRA	Test and Treat/Rapid Access. Protocol designed to ensure newly diagnosed people or those returning to care will obtain immediate linkage to medical care and treatment.

More terminology at www.aidsnet.org/the-partnership/#gotoboard1.

Resources

- Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- 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 https://aidsnet.org/the-partnership/#mcsc1 or by scanning the QR code on your agenda.



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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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Medical Care Subcommittee Meeting
Behavioral Science Research
2121 Ponce de Leon Boulevard, Suite 240
Coral Gables, FL 33134

January 24, 2024 Minutes

#	Members	Present	Absent
1	Baez, Ivet	X	
2	Dougherty, James	X	
3	Friedman, Lawrence	X	
4	Goubeaux, Robert		X
5	Miller, Juliet	X	
6	Romero, Javier	X	
7	Serrano-Irizarry, Yendi	X	
8	Ysea, Cristhian A.	X	
Quorum: 4			

Guests
Dr. Katrina Ciraldo
Ana M. Nieto
Vanesa Rojas
Carla Valle-Schwenk
Kiesha Zephirin
Staff
Robert Ladner
Marlen Meizoso

All documents referenced in these minutes were accessible to both members and the general public prior to and during the meeting, at https://aidsnet.org/the-partnership#mcsc1.

I. Call to Order

James Dougherty

James Dougherty, Subcommittee Chair, called the meeting to order at 9:36 a.m. He introduced himself, provided an overview of the work for the meeting, and welcomed everyone.

II. Introductions

All

Mr. Dougherty requested members, guests, and staff to introduce themselves.

III. Meeting Housekeeping

James Dougherty

Mr. Dougherty reviewed the meeting housekeeping presentation indicating people first language, meeting protocols, and the location of Subcommittee meeting items online.

IV. Floor Open to the Public

Cristhian Ysea

Cristhian Ysea, Vice Chair, read the following:

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

before you talk about your concerns. BSR has a dedicated phone line and email for statements to be read into the record. No statements were received."

There were no comments, so the floor was closed.

V. Review/Approve Agenda *All*

The Subcommittee reviewed the agenda. The presentation on methadone was requested to be the first item under "Standing Business" since the speaker on the topic had to leave no later than 10:30 a.m. Members made a motion to accept the agenda with the revision.

Motion to accept the agenda with the revision requested.
Moved: Ivet Baez **Seconded: Cristhian Ysea** **Motion: Passed**

VI. Review/Approve Minutes of November 22, 2024 *All*

Members reviewed the minutes of November 22, 2024. On page three of four, instead of "unit (?)" the item should be "cap". The Subcommittee made a motion to accept the minutes with the change discussed.

Motion to accept the minutes of November 22, 2024, with the change as discussed.
Moved: Cristhian Ysea **Seconded: Ivet Baez** **Motion: Passed**

VII. Reports

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

Carla Valle-Schwenk reviewed the Ryan White Program (RWP) expenditures and clients served to date. As of the November report (printed 12/30/24), the RWP has served 8,772 unduplicated clients. All contracts have been executed. Amendments to contracts are in progress. Ryan White HIV/AIDS Program Services Report (RSR) instructions have been shared, and the portal will open February 3. A partial RWP Part A reward has been received, the remainder is pending. Affordable Care Act (ACA) enrollments currently total 2,881 enrollees.

- **AIDS Drug Assistance Program (ADAP)** *Dr. Javier Romero*

Mrs. Meizoso reviewed the December 2024 ADAP report as of January 6, 2025, including enrollments, expenditures, prescriptions, premium payments, and highlighted program updates. Dr. Javier Romero added that open enrollment for 2025 has ended. Additional details will be shared for the next report and will reflect an increase in clients.

- **Vacancy Report** *Marlen Meizoso*

Mrs. Meizoso referenced the January vacancy report indicating several vacancies on the Subcommittee and on the Partnership. If anyone knows of any additional individuals interested in membership, they may contact staff, invite them to attend a meeting, or invite them to the next New Member Orientation.

VIII. Standing Business

- **Methadone Access and the Ryan White Program**

The Subcommittee continued their discussion on this issue from last month. Dr. Katrina Ciraldo, who works at the Comprehensive Psychiatric Center (CPC), provided information on the low access to methadone. CPC is one of two clinics licensed to provide the treatment. The low usage may be a lack of knowledge by providers and clients. Currently, the program has a contract with Thriving Minds with limited enrollment. There are 250 people on methadone at the clinic and of those about five are people with HIV. The center has a capacity of 1,700 clients per their DCF license. Ther are two locations, one in Palmetto Bay and the other in Miami Gardens. The average cash cost per person is $396 per month, and requires eight to twelve urine tests per client per year. Once a client is on the medication, they are likely on the medication for life. The center is trying to work with insurance plans to cover the service.

This medication cannot be added to the RWP Prescription Drug Formulary because the medication can only be provided at licensed locations. The CPC would have to subcontract with a current provider or apply for services when the new RFP is released.

- **Oral Health Care Items: Service Descriptions and Standards**

Staff forwarded the Oral Health Care Service Description and Oral Health Care Standards to the former members of the Oral Health Care Workgroup for feedback, and no requests for edits were made to either document. The only related comment was not to reinstate the service cap per client, which may limit clients accessing services. The draft reviewed contained some updates on language to align with other service definitions. The Subcommittee requested staff provide some data on how many clients went over the $6,500 limit to estimate potential impact. The Subcommittee will determine any additional edits to the oral health care service definition at the next meeting.

The Subcommittee reviewed the Oral Health Care Standards and request changing "dentist (DDS)" and "DDS" with licensed dental provider, on page five.

Motion to approve the Oral Health Care Standards with edits to licensed medical provider on page five.
Moved: Cristhian Ysea **Seconded: Yendi Serrano-Irizarry** **Motion: Passed**

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

Staff provided the Subcommittee with redlined and clean versions of the Minimum Primary Medical Care Standards which were updated to IDSA recommendations. Because of the number of changes in the document, members were advised to review the two documents and if they wish to make any additional changes these can be brought to the next meeting.

- **Service Descriptions: Substance Abuse** *All*

The edits to the 2025 Substance Abuse service descriptions included justification along with updates to dates, rankings, and corrections to scrivener's errors. The Subcommittee decided to approve the draft as presented.

Motion to accept the Substance Abuse Outpatient Care and Substance Abuse Service (Residential) Service Description as presented.
Moved: Juliet Miller **Seconded: Ivet Baez** **Motion: Passed**

- **2025 Meeting Workplan Update**

Staff provided the Subcommittee with a 2025 meeting workplan with the updates requested at the last meeting. Any changes from today's meeting will be added to the workplan and brought back for the March meeting.

IX. New Business

- **2025 Officer Elections** *All*

At the last meeting, the current officers were nominated for an additional term. With no other members interested in placing their names on the ballot at the meeting, the Subcommittee made a motion to reelect the current officers.

Motion to reelect the current officers, James Dougherty, Chair, and Cristhian Ysea, Vice Chair, for another year.
Moved: Dr. Lawrence Friedman **Seconded: Dr. Javier Romero** **Motion: Passed**

- **Annual Conflict of Interest Disclosures**

Subcommittee members were reminded to complete the annual Conflict of Interest Form in their meeting packets and return them to staff. Completion of the forms is a requirement based on the formulary policy and procedures. The annual Source of Income Statement that members need to complete should be available at the next meeting.

X. Announcements and Open Discussion *All*

Mrs. Meizoso announced the next Get on Board training will be on Grantees on the Planning Council, on February 5, 2025.

No open discussion items were shared.

XI. Next Meeting *Cristhian Ysea*

The next Subcommittee meeting is scheduled for Friday, February 28, 2025, at 9:30 a.m. at BSR.

XII. Adjournment *James Dougherty*

Mr. Dougherty thanked everyone for participating in today's meeting and called for a motion to adjourn.

Motion to adjourn.
Moved: Dr. Lawrence Friedman **Seconded: Juliet Miller** **Motion: Passed**

The meeting adjourned at 10:53 a.m.

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RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **January 2025**

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)	1	32	1	5
Health Insurance Premium and Cost Sharing Assistance	25	4,547	23	1,760
Medical Case Management	8,008	97,519	3,733	8,755
Mental Health Services	30	592	17	111
Oral Health Care	579	9,817	432	2,800
Outpatient Ambulatory Health Services	2,600	29,113	1,394	4,407
Substance Abuse Outpatient Care	2	28	2	8
Support Services				
Food Bank/Home Delivered Meals	1,730	12,816	322	874
Medical Transportation	312	6,506	234	967
Other Professional Services	25	373	4	75
Outreach Services	39	424	29	253
Substance Abuse Services (residential)	624	6,159	30	84
TOTALS:	13,975	167,926		

Total unduplicated clients (month): 4,511

Total unduplicated clients (YTD): 9,199

See Service Unit Definitions on page 4

REPORT COMPILED ON: 02/26/2025

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **January 2025**

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)	1	32	1	5
Health Insurance Premium and Cost Sharing Assistance	25	4,547	23	1,760
Medical Case Management	6,773	84,814	3,321	8,456
Mental Health Services	20	552	9	88
Oral Health Care	579	9,817	432	2,800
Outpatient Ambulatory Health Services	2,495	26,323	1,343	4,229
Substance Abuse Outpatient Care	2	28	2	8
Support Services				
Food Bank/Home Delivered Meals	1,730	12,816	322	874
Medical Transportation	277	6,300	201	926
Other Professional Services	25	373	4	75
Outreach Services	36	392	26	229
Substance Abuse Services (residential)	624	6,159	30	84
TOTALS:	12,587	152,153		

Total unduplicated clients (month): 4,187

Total unduplicated clients (YTD): 9,074

REPORT COMPILED ON: 02/26/2025

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **January 2025**

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	1,235	12,705	596	1,110
Mental Health Services	10	40	8	23
Outpatient Ambulatory Health Services	105	2,790	65	664
Support Services				
Medical Transportation	35	206	33	48
Outreach Services	3	32	3	24
TOTALS:	1,388	15,773		

Total unduplicated clients (month): 630

Total unduplicated clients (YTD): 1,480

REPORT COMPILED ON: 02/26/2025

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 MCM encounter
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

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

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR34

FORMULA AND SUPPLEMENTAL FUNDING

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

This report includes YTD paid reimbursements for FY 2024 Part A service months up to January 2025, as of 2/26/2025. This report reflects reimbursement requests that were due by 2/20/2025, and have been paid thus far. Pending Part A reimbursement requests that have been received and are in the review process currently total $5,196,422.35. All contracts for Part A services have been executed. Three Part A amendments are pending execution by 2/28/2025.

Project #: BURW3403	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount Formula	16,389,150.00	FORMULA	
Grant Award Amount FY22 Formula	2,353.00	PY_FORMULA	
Grant Award Amount Supplemental	6,799,165.00	SUPPLEMENTAL	FY 2024 Award
Grant Award Amount FY22 Supplemental	1,620,086.00	PY_SUPPLEMENTAL	$24,810,754
Carryover Award of FY'23 Formula Funds	795,210.00	CARRYOVER	
Total Award	**$ 25,605,964.00**		

CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations
8	AIDS Pharmaceutical Assistance	7,679.00	
6	Health Insurance Services	328,454.00	
1	Medical Case Management	6,063,727.00	
3	Mental Health Therapy/Counseling	69,501.00	
4	Oral Health Care	4,082,857.00	
2	Outpatient/Ambulatory Health Svcs	8,020,778.00	
9	Substance Abuse - Outpatient	9,441.00	
	CORE Services Totals:	18,582,437.00	

	Support Services	Allocations	Carryover Allocations	
12	Emergency Financial Assistance	0.00		
5	Food Bank	972,532.00	795,210.00	1,767,742
13	Medical Transportation	253,654.00		
15	Other Professional Services	40,274.00		
14	Outreach Services	149,032.00		
7	Substance Abuse - Residential	1,731,750.00		
	SUPPORT Services Totals:	3,147,242.00	795,210.00	
	FY 2024 Award (not including C/O)	21,729,679.00		

DIRECT SERVICES TOTAL:		**$**	**22,524,889.00**
Total Core Allocation	18,582,437.00		
Target at least 80% core service allocation	17,383,743.20		
Current Difference (Short) / Over	**$ 1,198,693.80**		
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,477,019.00**		
Quality Management	**$ 604,056.00**	3,081,075.00	
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (Formula & Supp)	$ -		
Unobligated Funds (Carry Over)	$ -	$ -	25,605,964.00

Core medical % against Total Direct Service Allocation (Not including C/O):
Cannot be under 75% — **85.52%** — **Within Limit**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **2.43%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **9.98%** — **Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures
5606970000	AIDS Pharmaceutical Assistance	1,490.50	
5606920000	Health Insurance Services	240,904.99	
5606870000	Medical Case Management	3,768,074.75	
5606860000	Mental Health Therapy/Counseling	45,370.00	
5606900000	Oral Health Care	2,699,914.00	
5606610000	Outpatient/Ambulatory Health Svcs	5,142,547.57	
5606910000	Substance Abuse - Outpatient	1,320.00	
	CORE Services Totals:	11,899,621.81	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	599,157.20	795,210.00	1,394,367.20
5606460000	Medical Transportation	88,933.63		
5606890000	Other Professional Services	33,606.00		
5606950000	Outreach Services	96,296.35		
5606930000	Substance Abuse - Residential	1,481,500.00		
	SUPPORT Services Totals:	2,299,493.18	795,210.00	
	FY 2024 Award (not including C/O)	14,199,114.99		

TOTAL EXPENDITURES DIRECT SVCS & % :		**$**	**14,994,324.99**	**66.57%**
	Formula Expenditure %	**81.39%**		
5606710000	**Recipient Administration**	**1,635,731.52**		
5606880000	**Quality Management**	**500,000.00**		2,135,731.52
	Grant Unexpended Balance	**FY 2023 Award**	**Carryover**	
		8,475,907.49	-	8,475,907.49
	Total Grant Expenditures & %		**$**	**17,130,056.51**	**66.90%**

Core medical % against Total Direct Service Expenditures (Not including C/O):
Cannot be under 75% — **83.81%** — **Within Limit**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **2.02%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **6.59%** — **Within Limit**

Printed On: 2/26/2025

MAI

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

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR34

MINORITY AIDS INITIATIVE (MAI) FUNDING

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

This report includes YTD paid reimbursements for FY 2024 MAI service months up to January 2025, as of 2/26/2025. This report reflects reimbursement requests that were due by 2/20/2025, and have been paid thus far. Pending Part A reimbursement requests that have been received and are in the review process currently total $260,183.00. All contracts and amendments for MAI services have been executed.

PROJECT #: BURW3403	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI	2,600,572.00	MAI
Carryover Award of FY'23 MAI Funds	1,474,770.00	MAI_CARRYOVER
Total Award	**$ 4,075,342.00**	

CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations		Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures	
	AIDS Pharmaceutical Assistance				5606970000	AIDS Pharmaceutical Assistance			
	Health Insurance Services				5606920000	Health Insurance Services			
1	Medical Case Management	350,102.00	661,318.00	1,011,420.00	5606870000	Medical Case Management	347,707.30	342,549.80	690,257.10
3	Mental Health Therapy/Counseling	18,960.00			5606860000	Mental Health Therapy/Counseling	1,592.50		
	Oral Health Care				5606900000	Oral Health Care			
2	Outpatient/Ambulatory Health Svcs	1,024,748.00	712,385.00	1,737,133.00	5606610000	Outpatient/Ambulatory Health Svcs	363,727.84	305,435.02	669,162.86
6	Substance Abuse - Outpatient	8,058.00			5606910000	Substance Abuse - Outpatient	0.00		
	CORE Services Totals:	1,401,868.00	1,373,703.00			CORE Services Totals:	713,027.64	647,984.82	
	Support Services	**Allocations**	**Carryover Allocations**		**Account**	**Support Services**	**Expenditures**	**Carryover Expenditures**	
5	Emergency Financial Assistance	0.00			5606940000	Emergency Financial Assistance	0.00		
	Food Bank				5606980000	Food Bank			
13	Medical Transportation	7,628.00	8,300.00	15,928.00	5606460000	Medical Transportation	6,881.69	421.91	7,303.60
	Other Professional Services				5606890000	Other Professional Services			
7	Outreach Services	39,816.00			5606950000	Outreach Services	16,590.00		
	Substance Abuse - Residential				5606930000	Substance Abuse - Residential			
	SUPPORT Services Totals:	47,444.00	8,300.00			SUPPORT Services Totals:	23,471.69	421.91	
	FY 2024 Award (not inlcuding C/O)	1,449,312.00				FY 2024 Award (not inlcuding C/O)	736,499.33		
	FY 2024 Carryover Award		1,382,003.00						
	DIRECT SERVICES TOTAL:		**$ 2,831,315.00**			**TOTAL EXPENDITURES DIRECT SVCS & %:**		**$ 1,384,906.06**	**48.91%**
	Total Core Allocation	1,401,868.00							
	Target at least 80% core service allocation	1,166,089.60							
	Current Difference (Short) / Over	**$ 235,778.40**							
	Recipient Admin. (OMB-GC)	**$ 260,057.00**			5606710000	**Recipient Administration**	**82,425.03**		
	Quality Management	**$ 100,000.00**	360,057.00	$ 3,191,372.00	5606880000	**Quality Management**	**83,333.30**		165,758.33
	(+) Unobligated Funds / (-) Over Obligated:					**Grant Unexpended Balance**	**FY 2024 Award**	**Carryover**	
	Unobligated Funds (MAI)	**$ 791,203.00**					**1,698,314.34**	**826,785.18**	2,525,099.52
	Unobligated Funds (Carry Over)	**$ 92,767.00**	883,970.00	4,075,342.00		**Total Grant Expenditures & % (Including C/O):**		**$ 1,550,664.39**	**38.05%**

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**96.73%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.85%**	**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%	**96.76%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.20%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**3.17%**	**Within Limit**

Printed On: 2/26/2025

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, February 28, 2025
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 24, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Oral Health Care Items: Service Descriptions	All
	• Minimum Primary Medical Care Standards	All
IX.	New Business	
	• Source of Income Disclosures	All
X.	Announcements and Open Discussion	All
	• Get on Board Training, March 5, 2025	
XI.	Next Meeting**: March 28, 2025** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Vision: To be the **Healthiest State** in the Nation

Ron DeSantis
Governor

Joseph A. Ladapo, M.D., Ph.D.
State Surgeon General

FEBRUARY 3, 2025

ADAP MIAMI-DADE / SUMMARY REPORT ^ – JANUARY 2025

UTILIZATION & EXPENDITURES

MONTH	1ST ENROLLMENTS	RE-ENROLLMENTS	CLIENTS^^	CHD PHARMACY $	RXS	PATIENTS	RX/PT	PAYMENTS	#PREMIUMS	~$ / PREMIUM
APR-24	93	763	7,182	$1,299,197.75	1,574	759	2.1	$4,760,132.82	2,869	$1,659.16
MAY-24	99	660	7,358	$1,348,852.85	2,632	781	3.4	$4,661,276.34	2,804	$1,662.37
JUN-24	75	305	7,365	$1,224,156.67	2,319	672	3.5	$4,735,158.01	2,855	$1,658.55
JUL-24	86	268	7,414	$1,281,998.16	2,551	762	3.3	$4,743,763.59	2,867	$1,654.61
AUG-24	72	199	7,495	$1,297,441.51	2,592	744	3.5	$4,715,538.90	2,854	$1,652.26
SEP-24	47	211	7,373	$1,328.957.85	2,666	760	3.5	$4,696,503.85	2,856	$1,644.43
OCT-24	70	384	7,414	$1,268,167.89	2,617	713	3.7	$4,678,577.74	2,838	$1,648.55
NOV-24	66	527	7,593	$1,089,868.82	2,184	635	3.4	$4,605,650.34	2,797	$1,646.64
DEC-24	61	835	7,688	$1,435,602.25	2,900	786	3.7	$4,569,896.77	2,778	$1,645.03
JAN-25	99	781	7,659	$1,327,091.08	2,637	749	3.5	$5,203,613.10	2,975	$1,749.11
FEB-25										
MAR-25										
FY24/25	770	4,933	7,659	$12,901,334.78	24,565	7,361	3.3	$47,370,111.46	28,493	$1,662.52

PROGRAM UPDATE

*02/03/25: BENEFIT LEVEL ^	*7,659*	DIRECT DISPENSE 55 % *4182* - PREMIUM PLUS 45 % *3477 [ACA-MP, EMPLOYER SPONSORED INSURANCE, COBRA, M. PART-D] – [92 % W FLAGLER & 8 % WP]*
*02/03/25: CABENUVA ®	*202*	DIRECT DISPENSE 65 % *130* - PREMIUM PLUS 35 % *72*
*02/03/25: MEDICARE ELIGIBLE ^	*18*	UNDER REVIEW THIS MONTH. – *62* CLIENTS WITHIN *7-MONTH WINDOW AROUND 65TH BIRTHDAY THIS MONTH.*
*02/03/25: MEDICARE	*228*	OPEN ENROLLMENT. ENDED DECEMBER 7TH. CHANGES TO MEDICARE PLANS.
*02/03/25: ACA-MP ^	*2,907*	OPEN ENROLLMENT. APPROVED PLANS FOR 2025 *[62; 5 PLANS AVAILABLE TO 2024 CLIENTS]*. ENDED JANUARY 15TH.

DATE: 02/03/25. - SOURCE: PROVIDE ENTERPRISE & PHARMACY SYSTEMS. - ^ ALL DATA SUBJECT TO REVIEW & EDITING. ^^ OPEN + ACTIVE PTS. – NOTE: EXPENDITURES NOT INCLUDED: UNINSURED CLIENTS FROM WP & PBM PHARMACIES.

DIRECT DISPENSE ACCESS

CURRENT ONGOING CHD PHARMACY **SERVICES**		
1	FDOH CHD PHARMACY @ FLAGLER STREET	ON SITE – 90 DAYS
2	FDOH CHD PHARMACY @ FLAGLER STREET	MAIL SERVICE
3	FDOH ADAP PROGRAM @ WEST PERRINE	CVS SPECIALTY MAIL ORDER

ADDITIONAL PHARMACIES – **PRIME THERAPEUTICS** PBM MIAMI-DADE – 11/01/24		
AIDS HEALTHCARE FOUNDATION	COMMUNITY HEALTH OF SF - CHI	WALGREENS
BORINQUEN HEALTHCARE CTR	CVS SPECIALTY MAIL ORDER	FRESCO Y MÁS
MIAMI BEACH COMMUNITY HC	NAVARRO SPECIALTY PHARMACY	PHARMCO RX

NEW: CARE RESOURCE PHARMACY, LARKIN HOSPITAL COMMUNITY PHARMACY

PHARMACY SELECTION IS THE CLIENT'S CHOICE. STAFF MEMBERS FROM ADAP MIAMI ASSIST CLIENTS WITH THEIR PHARMACY SELECTION PROCESS.

CONTACT: WWW.ADAPMIAMI.COM / ADAP.FLDOHMDC@FLHEALTH.GOV

Florida Department of Health in Miami-Dade County
ADAP Program & FLDOHMDC CHD Pharmacy
2515 W Flagler Street, Suite 102. Miami, Florida 33135 - Phone: 305-643-7400

Accredited Health Department
Public Health Accreditation Board

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, February 28, 2025
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
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VIII.	Standing Business	
	• Oral Health Care Items: Service Descriptions	All
	• Minimum Primary Medical Care Standards	All
IX.	New Business	
	• Source of Income Disclosures	All
X.	Announcements and Open Discussion	All
	• Get on Board Training, March 5, 2025	
XI.	Next Meeting**: March 28, 2025** at **BSR**	Cristhian Ysea
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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

February 3, 2025

The Miami-Dade HIV/AIDS Partnership

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

Opportunities for Ryan White Program Clients

5 *seats are available to Ryan White Program Clients who are not affiliated or employed by a Ryan White Program Part A funded service provider.*

Opportunities for General Membership

7 *seats are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the relevant knowledge, skills and expertise in these membership categories:*

Hospital or Health Care Planning Agency Representative
Mental Health Provider Representative
Housing, Homeless or Social Service Provider
Other Federal HIV Program Grantee Representative (Part F)
Other Federal HIV Program Grantee Representative (SAMHSA)
Non-Ryan White Program Miami-Dade County Representative
Part D Grantee Representative

Are you a Member?

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

Do You Qualify for Membership?

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

Are you a resident of Miami-Dade County?

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

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

Get Started Today!
Scan the QR Code or contact
mdcpartnership@behavioralscience.com.

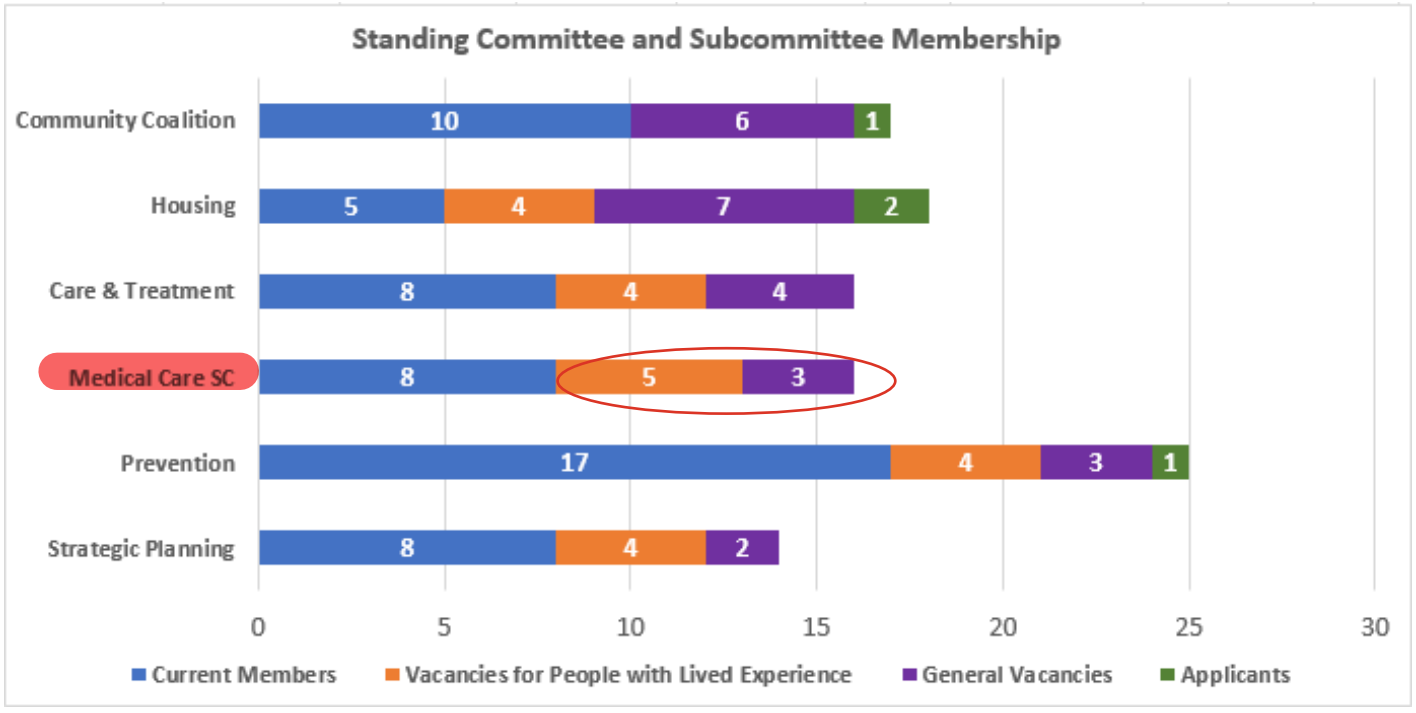
when you say Yes! good things happen.

Committees

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

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

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



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ORAL HEALTH CARE

(Year 3~~3~~5 Service Priority: #~~6~~4 for Part A

Oral Health Care is a core medical service. This service includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide dental care in the State of Florida, including general d~~D~~entists, dental specialists, and ~~D~~dental ~~H~~hygienists, as well as licensed d~~D~~ental a~~A~~ssistants. In accordance with Rule 64B5-9.011 of the Florida Administrative Code, d~~D~~ental ~~A~~assistants who are formally trained or have an appropriate certification (e.g., radiography) meet HRSA's definition of a licensed ~~D~~dental ~~A~~assistant.

This service may include diagnostic, preventive, and restorative services; endodontics, periodontics, and prosthodontics (removable and fixed); maxillofacial prosthetics; limited implant services (i.e., removal, repair, and placement [restricted for edentulous patients only] of implants); oral and maxillofacial surgery; and adjunctive general services as detailed and limited in the most current, local Ryan White Program Oral Health Care Formulary.

A. Program Operation Requirements: Provision of Oral Health Care services for any one client is limited to an annual cap of $6,500 per Ryan White Part A Fiscal Year (March 1, 202~~3~~5 through February 2~~9~~8, 202~~6~~4). Exceptions to the annual cap may be approved by the County under special circumstances (e.g. implant placement) and the provision of preventive Oral Health Care services with consultation from the Miami- Dade HIV/AIDS Partnership's Medical Care Subcommittee as needed.

When a referral from a d~~D~~entist to a dietitian is needed, the d~~D~~entist must coordinate with the client's l~~L~~icensed m~~M~~edical ~~P~~provider (MD, DO, APRN, PAs) to obtain the required referral to nutrition services (i.e., a referral to Ryan White Program outpatient specialty care services). This is necessary to ensure communication between the care team (e.g., l~~L~~icensed m~~M~~edical ~~P~~providers and d~~D~~entist). The client's m~~M~~edical c~~C~~ase m~~M~~anager should also be informed of the client's need for nutrition services.

Labs ~~maybe~~may be requested from ~~L~~licensed m~~M~~edical ~~P~~providers as clinically indicated by the dentist.

All referrals to Ryan White Part A Oral Health Care services should include the client's ~~Primary Care or HIV l~~Licensed m~~M~~edical p~~P~~rovider's contact information (name, address, phone and fax numbers, and email if available) and note any known allergies the client may have. This information can be included in the comments section of the referral.

Providers must offer, post, and maintain a daily walk-in slot for clients with

urgent/emergent dental issues. Clients who come into or contact the office with urgent/emergent dental issues (e.g., pain, broken tooth, situation requiring immediate treatment, or situation causing client high level of distress) will be triaged by appropriate dental staff; and those clients with substantial issues will be seen as soon as possible, but within 48 hours (i.e., two business days).

Teledentistry services may also be available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details.

B. Additional Service Delivery Standards: Providers of this service will adhere to the most current, local *Ryan White Program System-wide Standards and Ryan White Program Oral Health Care Standards*. (Please refer to Section III of this FY 20254 Service Delivery Manual for details.) Providers will be required to demonstrate that they adhere to generally accepted clinical guidelines for Oral Health Care treatment of HIV and AIDS-specific illnesses, upon request and through monitoring site visits or quality management record reviews.

C. Rules for Reimbursement: Providers will be reimbursed for all routine and emergency examination, diagnostic, prophylactic, restorative, surgical and ancillary Oral Health Care procedures, as approved by the Miami-Dade HIV/AIDS Partnership and included in the most current, local Ryan White Program Oral Health Care Formulary using the 20245 American Dental Association Current Dental Terminology (CDT 20254) codes for dental procedures. Reimbursement is in accordance with the rates indicated in the most current, local Ryan White Program Oral Health Care Formulary; flat fee, no multiplier.

Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details regarding the reimbursement of teledentistry services.

An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding budget narrative.

D. Children's Eligibility Criteria: Providers must document that children with HIV who receive Ryan White Part A Program-funded Oral Health Care services are permanent residents of Miami-Dade County and have been properly screened for other private or public sector funding [i.e., private insurance, Medicaid, Medicaid's expanded dental insurance for its members with Managed Medical Assistance (MMA) or Long-Term Care (LTC) coverage who have LIBERTY Dental, DentaQuest, or MCNA Dental benefits (as may be amended), the Medically Needy Program, Children's Health Insurance Program (CHIP), Florida KidCare, etc.)], as appropriate. While children qualify for and can access private insurance, Medicaid (all programs), or other public sector funding for Oral Health Care services, they will not be eligible for Ryan White Part A Program-funded Oral Health Care services, except those dental procedures excluded by the other funding sources.

E. Client Eligibility Criteria: Clients receiving Oral Health Care must be

documented as having been properly screened for other public sector funding as appropriate every 366 days. While clients qualify for and can access dental services through other public funding [including, but not limited to, Medicaid, Medicaid Managed Medical Assistance (MMA), or Medicaid Long-Term Care (LTC)], Medicare, or private health insurance, they will not be eligible for Ryan White Part A Program-funded Oral Health Care except for such program-allowable services that are not covered by the other sources or if their related benefits have been maxed out for the benefit period.

Clients referred for Oral Health Care by a Ryan White Part A or MAI Medical Case Manager should use the Ryan White Program In Network Referral process in the Provide® Enterprise Miami data management system. If the client is referred by a non-Part A or non-MAI provider ["Out of Network"(OON) provider] or self-refers because they do not have a Part A/MAI Medical Case Manager, an OON referral form must be submitted accompanied by the required medical, financial, and permanent Miami-Dade County residency documentation as well as all required consent forms and Notice of Privacy Practices. Clients coming without a referral, but with necessary documentation to support Ryan White Part A Program eligibility and v~~V~~iral ~~L~~load and CD4 lab test results within 366 days, are also able to access Ryan White Part A Oral Health Care services, upon completion of a brief intake in the Provide® Enterprise Miami data management system by the Oral Health Care provider agency and the client's signed consent for service

F. **Ryan White Program Oral Health Care Formulary:** Ryan White Part A Program funds may only be used to provide Oral Health Care services that are included in the most recent release of the most current, local Ryan White Program Oral Health Care Formulary. The Formulary is subject to periodic revision.

G. **Letters of Medical Necessity**: Dental Implants require a completed Ryan White Letter of Medical Necessity (LOMN) (See Section V of this FY 2025~~3~~4 Service Delivery Manual for copies of the Letter of Medical Necessity, as may be amended).

H. **Rules for Documentation:** Providers must maintain a dental chart or electronic record that is signed by the licensed dental provider ~~(e.g., Dentist, etc.)~~ and includes a treatment plan, dates of service, services provided, procedure codes billed, and any referrals made. Providers must also maintain professional certifications, licensure documents, and proof of training, where applicable, of the dental staff providing services to Ryan White Program clients. Providers must make these documents available to OMB staff or authorized persons upon request.

I. **Rules for Reporting:** Provider monthly reports (i.e., reimbursement requests) for Oral Health Care must include the number of clients served, billing code for the dental procedures provided, number of units of service provided, and the corresponding reimbursement rate for each service provided. Providers must also develop a method to track and report client wait time (e.g., the time it takes for a client be scheduled to see the appropriate dental provider after calling for an

appointment; and upon arrival for the appointment, the time the client spends waiting to see the dental provider) and to make such reports available to OMB staff or authorized persons upon request.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, February 28, 2025
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 24, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Oral Health Care Items: Service Descriptions	All
	• Minimum Primary Medical Care Standards	All
IX.	New Business	
	• Source of Income Disclosures	All
X.	Announcements and Open Discussion	All
	• Get on Board Training, March 5, 2025	
XI.	Next Meeting**: March 28, 2025** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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

Redline

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. All clients, regardless of viral load levels, must have viral load tests every 6 months per the DHHS/HRSA standards.*

I. Requirements

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

- 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/Associates):

- 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/Associates 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**
  ~~c.~~ https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html~~https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html~~

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  b. **Adult Immunization Schedule**
  https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

~~d.~~c. **American Association for the Study of Liver Diseases**
https://www.aasld.org/practice-guidelines

~~e.~~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

~~f.~~e. **American Medical Association Telehealth Quick Guide**
https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

~~g.~~f. **Department of Health and Human Services (DHHS) Clinical Guidelines**
https://clinicalinfo.hiv.gov/en/guidelines

~~h.~~g. **Hepatitis (HEP) Drug Interactions University of Liverpool**
https://www.hep-druginteractions.org/

~~i.~~h. **HIV Drug Interactions University of Liverpool**
https://hiv-druginteractions.org/

~~j.~~i. **HIV Prevention with Adults and Adolescents with HIV in the US**
https://www.cdc.gov/hiv/guidelines/recommendations/personswithhiv.html

j. **Health Resources and Service Administration (HRSA) HIV Care for People Aging with HIV**
https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/special-populations-hiv-and-older
~~k.~~
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.~~k. **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.~~l. **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/pdf/programresources/cdc-hiv-npep-guidelines.pdf
https://www.cdc.gov/hivnexus/hcp/resources/?CDC_AAref_Val=https://www.cdc.gov/hiv/clinicians/materials/prevention.html

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

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. **Hepatitis (HEP) Drug Interactions University of Liverpool**
https://www.hep-druginteractions.org/
h. **HIV Drug Interactions University of Liverpool**
https://hiv-druginteractions.org/
i. **HIV Prevention with Adults and Adolescents with HIV in the US**
https://www.cdc.gov/hiv/guidelines/recommendations/personswithhiv.html
j. **Health Resources and Service Administration (HRSA) HIV Care for People Aging with HIV**
https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/special-populations-hiv-and-older
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
k. **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/
l. **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/pdf/programresources/cdc-hiv-npep-guidelines.pdf
https://www.cdc.gov/hivnexus/hcp/resources/?CDC_AAref_Val=https://www.cdc.gov/hiv/clinicians/materials/prevention.html
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 a 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

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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 ART 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 ART 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~~problems, 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.

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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, obesity prevention (midlife women), sexually transmitted infections, urinary incontinence, and contraception. For those who are pregnant, lactation support and screenings for diabetes mellitus (including post-pregnancy), 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-based estimated 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 postmenopausal women and men 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]~~ [iii] – Colorectal cancer screening recommended for individuals between 45-75 years of age if average risk (including personal and family history). For ages 76-~~85~~85, ~~screening~~ individualized screening based on overall health and prior screening. Consider screening earlier if first-degree relatives are diagnosed with colon cancer prior to age 50. Screening tests include: stool based screening (gFOBT, FIT, FIT-DNA) every year, ~~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),~~

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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

~~(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~~ or colonoscopy every 10 years if normal, or more frequently if polyps are identified~~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** [ii][iv][i] (females) – In women and adolescents with HIV, initiation of cervical cancer screening (Pap) should ~~with cytology alone should begin within~~be conducted 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. For those age 21-29, Pap should be done at diagnosis of HIV, repeated yearly for 3 years, then if all normal, Pap every 3 years. For those less than 30 years, no HPV testing unless abnormalities are found on Pap test. For those over 30 years old, Pap at diagnosis of HIV, repeat yearly x 3 years, then if all normal, Pap every 3 years or Pap with HPV testing, if both negative then Pap with HPV every 3 years. Abnormal Pap and/or HPV follow-up similar to general population; in general, continue screening past 65 years. ~~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 screening 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.~~

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obtained. HbA1C is no longer recommended for diagnosis of diabetes in person with HIV on ART, see American Diabetes Association Guidelines.

8. **Gynecological Exam** [iii] (females) – In women and adolescents with HIV, initiation of cervical cancer screening (Pap) should be conducted within one year of onset of sexual activity, but no later than 21 years of age. For those age 21-29, Pap should be done at diagnosis of HIV, repeated yearly for 3 years, then if all normal, Pap every 3 years. For those less than 30 years, no HPV testing unless abnormalities are found on Pap test. For those over 30 years old, Pap at diagnosis of HIV, repeat yearly x 3 years, then if all normal, Pap every 3 years or Pap with HPV testing, if both negative then Pap with HPV every 3 years. Abnormal Pap and/or HPV follow-up similar to general population; in general, continue screening past 65 years.

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 a 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 ART 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 ART 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

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.

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12. **Lipid Profile** [i] – Entry into care;4-8 weeks after ART initiation or modification; consider 1-3 months after ART 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 50-80 ~~and in fairly good health~~, who are currently smoking or former smokers with a 20 or more pack-year smoking history. Additional information at: https://www.cancer.org/cancer/types/lung-cancer.html. ~~or more (e.g. 1 pack a day x 20 years or 2 packs a day x 10 years).~~

~~13.~~

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.

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14. **Mammogram (**females) [iii] – From ages 40-49, inform of the potential risks and benefits of screening and offer screening every 2 years. From ages 50-75, mammography performed at least every 2 years. Additional information at: https://www.cancer.org/cancer/types/breast-cancer.html.

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** [iii] (males) – For ages 55-69 digital rectal exam, should be considered primary evaluation before PSA screening. For those age 50-69, they discuss the risks and potential benefits of PSA screening. For those ages 70 and older, PSA screening is not recommended. The impact of HIV on prostate cancer risk is not yet known. African Americans and people with a relative with prostate cancer have a higher burden of prostate cancer. Clinicians should follow USPSTF or American Cancer Society guidelines and consider patient wishes. Additional information at: https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html.

17. **TB Testing** [iii] – Perform annually in persons at risk for tuberculosis, either with a tuberculin skin test or IGRA.

18. **Urinalysis** [i] – Entry into care; or if clinically indicate e.g., in patients with chronic kidney disease (CKD) or diabetes mellitus (DM). 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 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.

14. **Mammogram** (females)[ii] [vi][i] – From ages 40-49, inform of the potential risks and benefits of screening and offer Starting at age 40, screening every 2 years recommended annually. From ages 50-75, mammography performed at least every 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.. Additional information at: https://www.cancer.org/cancer/types/breast-cancer.html.

15.

16.15. **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) – For ages 55-69 digital rectal exam, should be considered primary evaluation before PSA screening. For those age 50-69, they discuss the risks and potential benefits of PSA screening. For those ages 70 and older, PSA screening is not recommended. The impact of HIV on prostate cancer risk is not yet known. African Americans and people with a relative with prostate cancer have a higher burden of prostate cancer. Clinicians should follow USPSTF or American Cancer Society guidelines and considertesting is an individualized decision to be made by clinician and patient wishes. Additional information at: https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html.
17. based on current guidelines.

18.17. **TB Testing** [iii] – Perform annually in persons at risk for tuberculosis, either with a tuberculin skin test or IGRA.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.

19.18. **Urinalysis** [i] – Entry into care; or if clinically indicate e.g., in patients with chronic kidney disease (CKD) or diabetes mellitus (DM). 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 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 months, if CD4 count is <300 cells/$mm^{3;}$ every 6 months during the first 2 years of ART, 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 ART-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 ART-naïve patient who do not immediately begin ART, repeat testing before initiating of ART is optional 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 ART-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 ART-naïve patients who do 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 <50 copies/mL. Thereafter, repeat testing every 3-6 months. For

HIV Specific

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patients on ART, viral load typically is measured every 3-6 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 year, monitoring can be extended to 6-month intervals but is necessary for stable patients; 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. **COVID-19 vaccination** [v] – Vaccinate per CDC guidance.

28. **Hepatitis A vaccination** [v] – 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.

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

30. **Human Papillomavirus (HPV) Vaccine** [v] – HPV vaccination as indicate by current guidelines.

31. **Influenza vaccination** [v] – Offer IIV3 or RIV3 annually.

32. **Meningococcal vaccination** [v] – Use 2-dose series Menveo or MenQuadfi at least 8 weeks apart and revaccinate every 5 years if risk remains. See vaccination guidelines**.**

33. **Mpox vaccination** [v] – Vaccinate per CDC guidance. Additional information at: https://www.cdc.gov/mpox/hcp/vaccine-considerations/index.html

viral load is suppressed to <50 copies/mL. Thereafter, repeat testing every 3-6 months. For patients on ART, viral load typically is measured every 3-6 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 year~~s~~, monitoring can be extended to 6-month intervals but is necessary for stable patients; if ART initiation is delayed, repeat testing is optional; or if treatment failure or if clinically indicated.

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Immunizations

Document in medical record carrying data forward to most current volume

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~~31.~~30. **Human Papillomavirus (HPV) Vaccine** [~~vix~~] – HPV vaccination as indicate by current guidelines.

~~32.~~31. **Influenza vaccination** [~~vix~~] – Offer IIV4~~3~~ or RIV4~~3~~ annually.

~~33.~~32. **Meningococcal vaccination** [~~vix~~] – Use 2-dose series ~~MenACWY (~~Menveo or MenQuadfi~~)~~ at least 8 weeks apart and revaccinate every 5 years if risk remains. See vaccination guidelines.

~~34.~~33. **Mpox vaccination** [v] – Vaccinate per CDC guidance. Additional information at:~~See https://www.cdc.gov/poxvirus/monkeypox/vaccines/vaccine-basics.html~~https://www.cdc.gov/mpox/hcp/vaccine-considerations/index.html

~~35.~~34. **Pneumococcal vaccination** [v] –Vaccinate per guidelines**.** For guidance on which pneumococcal vaccine should be used go to:
~~www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html.~~
https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html.

~~36.~~35. **Tetanus, diphtheria, pertussis (Td/Tdap)** ~~[ix]~~[v] – One dose Tdap, then Td or Tdap booster every 10 years.

~~37.~~36. **Varicella** ~~[vix]~~[vi] – Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3.

37. **Zoster vaccination** ~~[vix]~~[vi] — Use 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2-6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). See vaccination guidelines for detailed information and considerations~~:~~.
https://www.cdc.gov/shingles/hcp/vaccine-considerations/immunocompromised-adults.html.

~~38.~~

STI Screenings

~~**Anal Dysplasia Screening** [iii] – For all patients with HIV~~ should have digital anorectal exam performed at least annual if asymptomatic. ~~≥35 years old, see information at https://www.hivguidelines.org/guideline/hiv-anal-cancer/?mycollection=hpv-care~~

38. Anal pap: screen transgender women and men over 35 years of age who have sex with men, and all other people with HIV over 45 years of age, with anal Pap smears if there is access to, or ability to, refer for high-resolution anoscopy and treatment. Abnormal anal Pap should prompt referral for high-resolution anoscope. Additional information at:
HIV Clinical Guidelines Now Recommend High Resolution Anoscopy as Part of Anal Cancer Screening Program for People with HIV | National Institutes of Health

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. More frequent screening might be appropriate depending on individual risk behavior and the local epidemiology. ~~See~~ Additional information at https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

34. **Pneumococcal vaccination** [v] –Vaccinate per guidelines**.** For guidance on which pneumococcal vaccine should be used go to: https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html.

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STI Screenings

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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 13~~August 3~~, 202~~3~~4.

[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/whats-new. Accessed on December 16~~August 4~~, 2024~~3~~.

[iii] Primary Care Guidance for Persons With Human Immunodeficiency Virus: 202~~0~~4 Update by the HIV Medicine Association of the Infectious Diseases Society of America. https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciae479/7818967. ~~https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/.~~ Accessed November 13~~August 4~~, 202~~3~~4.

[iv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines. Accessed November 13, 2024~~August 3 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 August 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. https://pubmed.ncbi.nlm.nih.gov/27661659/. Accessed August 4, 2023.~~

~~[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 August 4, 2023.~~

~~[viii] American Cancer Society Recommendations for Prostate Cancer Early Detection. August 4, 2023.~~

[ix] Recommended Adult Immunization Schedule for Ages 19 years or older, United States, 202~~3~~4~~5~~. https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-schedule-vaccines.html~~https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html~~. Accessed ~~November 1~~December 16~~7~~, 202~~3~~4.

~~[x] American Cancer Society Recommendations for Lung Cancer. https://www.cancer.org/cancer/types/lung-cancer.html. Accessed August 4, 2023.~~

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 13, 2024.

[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/whats-new. Accessed on December 16, 2024.

[iii] Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2024 Update by the HIV Medicine Association of the Infectious Diseases Society of America. https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciae479/7818967. Accessed November 13, 2024.

[iv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines. Accessed November 13, 2024.

[v] Recommended Adult Immunization Schedule for Ages 19 years or older, United States, 2025. https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-schedule-vaccines.html. Accessed December 16, 2024.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, February 28, 2025
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 24, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Oral Health Care Items: Service Descriptions	All
	• Minimum Primary Medical Care Standards	All
IX.	New Business	
	• Source of Income Disclosures	All
X.	Announcements and Open Discussion	All
	• Get on Board Training, March 5, 2025	
XI.	Next Meeting**: March 28, 2025** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

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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	Last Name (or, Consultant or Consulting Firm name)	First Name	Middle Name/Initial
2024			
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		
Miami-Dade HIV/AIDS Partnership		
Alternate address (if home address is exempt)	Work telephone	Term began on/ended on
111 NW 1st Street, 22nd Floor, Miami, FL 33128	305-375-3546	

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 ETHICS DEPARTMENT:
☐ Hardcopy
☐ Electronic Copy

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

MIAMI-DADE HIV/AIDS PARTNERSHIP

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Get on Board

Member Enrichment Training

Station 15: The Ryan White Part A Program

Wednesday, March 5, 2025

12:00 p.m. - 1:00 p.m
via Microsoft Teams

Topics

- What is Ryan White Part A?
- What are local Part A services?
- How to use Part A reports in decision-making.
- Why understanding Part A is important to the work of Partnership and Committee members.

Register at
https://bit.ly/Mar0325GOB-PartA

MIAMI-DADE HIV/AIDS PARTNERSHIP

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