

**Fiscal Year (FY) 2011 Ryan White Program
Service Delivery Guidelines (SDG)
Summary of Updates**

The following is a snapshot of changes made to the Service Delivery Guidelines from FY 2010 to FY 2011; see the actual Guidelines for details:

Section I: Service Definitions

1) General Requirements

- a) Clarification on the intent of the Property Information search, requiring it to be completed at initial intake and at each 6-month re-assessment for all Ryan White Program clients. This is to support review of client's sources of income and must be documented in client chart.
- b) Clarification of Referral process.
- c) Update to Minority AIDS Initiative (MAI) definition and requirements.
- d) Update references to the new FY 2011 Federal Poverty Level (FPL) Guidelines throughout the FY 2011 SDG.

2) Outpatient Medical Care

- a) Update to requirement for posting and providing walk-in slots for access to outpatient medical staff by clients with urgent or emergent health issues.
- b) Update to Fee Schedule references.
- c) Clarification of limitations to some specialty care services: psychiatry, podiatry, acupuncture, and chiropractic services.
 - i) Reference to "psychiatry" was clarified as "clinical psychiatry".
 - ii) Podiatry services may only be provided in relation to a client's HIV diagnosis.
 - iii) Chiropractic services are for pain management in relation to a client's HIV diagnosis.
 - iv) Acupuncture services, per Federal guidelines, are not covered under this service category, as Ryan White Program funds may only be used to support limited acupuncture services for HIV+ clients as part of substance abuse treatment services.

3) Prescription Drugs

- a) Notation added that vaccines were removed from the Ryan White Program Prescription Drug Formulary, and may be available under outpatient medical care services.
- b) Update to language under "Coordination of Care".
- c) Update to Fee Schedule references.
- d) Indication that prescriptions for vitamin supplements that appear on the most current Ryan White Program Prescription Drug Formulary – that are not temporarily suspended – may and should be written for a 90-day supply, and dispensed accordingly.

4) Medical Case Management

- a) Update to definition, incorporating the actual definition from HRSA, the Federal granting agency.
- b) Update to language regarding case closures.
- c) Restrictions on Peer Education and Support Network (PESN, peer) services.
- d) Inclusion of Comprehensive Health Assessment, and schedule for completion.

- e) Addition of new billing code to track services provided to Newly Identified Clients (NIC). (Development of written procedures is currently pending completion.)
- f) Included references to new billing codes developed or clarified during FY 2010: override (OVR) requests and adherence (ADH) counseling.

5) Oral Health Care

- a) Added requirement for posting and providing walk-in slots for access to dental staff by clients with urgent or emergent dental health issues.
- b) Updates to Fee Schedules.
- c) Update to the Current Dental Terminology (CDT) reference.

6) Mental Health Therapy/Counseling

- a) Inclusion of "Licensed Clinical Psychologist" as an acceptable provider of Level I services.

7) Substance Abuse Counseling – Residential

- a) Added a reference to the new reporting requirement for documenting client disposition in the Service Delivery Information System (SDIS) after leaving treatment; will be tied to billing. (NOTE: The discharge reasons will be changed to reflect reasons used by the Department of Children and Families.)

8) Health Insurance

- a) Minor change to AIDS Insurance Continuation Program description.

9) Outreach Services

- a) Added reference to the Program's collaboration with the Miami-Dade County Health Department regarding connecting newly diagnosed (identified) clients to care.
- b) Definition of connection to care was changed to reflect connections to medical care and medical case management services only, not all core services.
- c) Added note that the outreach service category will undergo significant changes during FY 2011. These changes will be necessary to address Federal requirements under the Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative.

10) Psychosocial Support Services

- a) Added clarification about who completes initial assessments and subsequent assignments to Level III and Level IV PSS services, which must be documented in the client chart.
- b) Minor change made to the educational requirement for Pastoral Care to remove the phrase "or a related field" from the allowable educational degree focus.
- c) Added statement that Pastoral Care services must be available to eligible clients regardless of their religious or denominational affiliation.

11) Substance Abuse Counseling – Outpatient, Food Bank, Home Delivered Meals, Transportation Vouchers, Legal Assistance, and Transportation Services (Vans)

- a) No major changes.

Section II – Cost & Eligibility Summary

- 1) Updates made to reflect changes in the Fee Schedules and service definitions as indicated above, where applicable.

Section III – Standards

- 1) System-wide Standards of Care
 - a) Added requirement for posting and providing walk-in slots for access to medical and dental staff by clients with urgent or emergent medical or dental health issues.
 - b) Removed reference to Home Health Care, which is a service category that is not funded in FY 2011.
- 2) Medical Case Management Standards of Service
 - a) Update and clarification made to the requirement for Medical Case Management Supervisor and Medical Case Manager training hours.
 - b) Revised wording for Advance Directives.
- 3) HAB HIV Performance Measures
 - a) The printouts of the actual Performance Measures included in the FY 2010 SDG have been replaced by a 1-page list of the measures and a corresponding internet web link for locating the measures on-line, or requesting a hard copy from the Office of Grants Coordination.
- 4) Additional Guidelines
 - a) Updated references to clinical guidelines and other generally accepted treatment guidelines.
- 5) Culturally and Linguistically Appropriate Services (CLAS), Primary Medical Care, & Oral Health Care Standards
 - a) No changes.

Section IV – Licensing

- 1) Updated educational, supervisory, and staffing requirements for psychosocial support services.
- 2) Added reference to “Licensed Clinical Psychologist” under Mental Health Therapy/Counseling.

Section V – Letters of Medical Necessity (LOMN), Prior Authorization (PA), etc.

- 1) Updated to only include current LOMNs and PAs.
 - b) Discontinued Letter of Nutritional Supplementation in Children.
 - c) Updated Neupogen and Procrit letters to remove reference to Mercy Hospital SIS program.

Section VI – Client Eligibility

- 1) Revised contract shell excerpt related to acceptable documentation to support client financial eligibility.
 - a) Clarification of Property Information search for all Ryan White Part A/MAI Program clients at initial intake and at 6-month re-assessments.
- 2) Updated FY 2011 FPL table.
- 3) Included reference to corrective action or repayment by contracted service providers if the Ryan White Program Certified Referral or General Out of Network (OON) referral plus supporting documents are not found in client charts.

Ryan White Program Service Delivery Guidelines Fiscal Year 2011-2012 (Year 21)



*Miami-Dade County
Office of Grants Coordination*

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RYAN WHITE PROGRAM SERVICE DELIVERY GUIDELINES
FY 2011-2012 (YEAR 21)

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**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2011-2012
(Year 21)**

**Section I –
Service Definitions**



*Miami-Dade County
Office of Grants Coordination*

I. GENERAL REQUIREMENTS – All Service Categories

[IMPORTANT NOTE: Except for residential substance abuse treatment services, all Ryan White Program Part A and Minority AIDS Initiative-funded services are restricted to outpatient services only.]

A. Service Delivery Standards: All providers will adhere to the *Ryan White Program System-wide Standards of Care* and other applicable standards and guidelines that are relevant to individual service categories (i.e., *Ryan White Program Case Management Standards of Service*, Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, HAB HIV Core Clinical Performance Measures for Adults/Adolescent Clients, etc.), as may be amended. Please refer to Section III of this book for details.

B. Client Eligibility Criteria: Providers must document that clients who receive Ryan White Program-funded services have a Ryan White Program Certified Referral or have documentation on file that the client:

- Is HIV positive or has AIDS
- Has a documented gross household income that does not exceed 400% of the 2011 Federal Poverty Level (FPL) for core services (see below for definition);
 - Income level caps for support services vary and can be found in the individual service definitions located in this book.
 - Although the Ryan White Program has no cash asset qualifications, providers are required to check for Property Information on the property tax page of the Miami-Dade County Tax Collector website (www.miamidade.gov/proptax/) to ensure that all Ryan White Program-eligible clients are screened at initial intake and at each 6-month re-assessment to ensure that they do not have additional income from rental property. Clients who have more than one property listed in their name must have their gross household income adjusted accordingly. Documentation to support the completion of this search (showing additional properties or no properties) must be filed in the client's chart.
- Is a current, permanent resident of Miami-Dade County;
- Is documented as having been properly screened for Medicaid, Medically Needy, Medicaid Project AIDS Care (PAC) Waiver, Medicare, other public sector funding, and private insurance, as appropriate. While clients qualify for and can access Medicaid, Medicaid PAC Waiver, Medicare, other public funding, or private insurance for services, they will not be eligible for Ryan White Program-funded services, except for those services, tests, and/or procedures, etc., related to the client's HIV disease that are not covered by other funding sources.

- The Ryan White Program is the payer of last resort; with the exception of client's who have Veteran's Administration benefits, are otherwise eligible for Ryan White Program services, and choose to access the Ryan White Program first.

PLEASE NOTE: Some service categories (i.e., home-delivered meals, legal assistance, transportation services, etc.) may have more restrictive client eligibility criteria. Carefully review each service category description for additional information.

Additionally, Ryan White Program clients must be re-assessed for income and Miami-Dade County residency eligibility every six (6) months as mandated in the *Ryan White Program Case Management Standards of Service*, unless otherwise specified.

CLIENT ELIGIBILITY DOCUMENTATION, INCLUDING SPECIFIC DOCUMENTATION REQUIRED FOR THE SERVICE CATEGORY (E.G., PHYSICIAN'S CERTIFICATION OF HOMEBOUND STATUS, LETTER OF MEDICAL NECESSITY, ETC.), MUST BE MAINTAINED IN EACH ORGANIZATION'S CLIENT CHARTS AND IS SUBJECT TO AUDIT BY THE OFFICE OF GRANTS COORDINATION (OGC). FAILURE TO MAINTAIN CLIENT ELIGIBILITY DOCUMENTATION MAY RESULT IN FORFEITURE OF REIMBURSEMENT FOR SERVICES RENDERED.

- C. Core Services:** These services, as defined in the Ryan White HIV/AIDS Treatment Extension Act of 2009, include outpatient medical care; prescription drugs; oral health care; health insurance premium and cost-sharing assistance for low-income individuals; medical nutrition therapy; mental health services, substance abuse outpatient care; and medical case management, including treatment adherence services. Ryan White Program clients may access any of these services without restriction as long as Ryan White Program eligibility has been determined either via a Ryan White Program Certified Referral or an Out-of-Network (OON) referral, also known as the "General Certified Referral for Ryan White Program Services," that is generated by a non-Ryan White Program case manager. An OON referral must be accompanied by appropriate Ryan White Program supporting documentation of client eligibility for services and this documentation must be kept in the client chart at the Ryan White Program referral site.

D. Support Services: These services, as defined in the Ryan White HIV/AIDS Treatment Extension Act of 2009, include outreach; medical transportation; legal services; food and meal programs; psychosocial support; and residential substance abuse treatment/counseling. Except in certain outreach scenarios (see revised Outreach Services definition), clients may only receive these support services if they have a Ryan White Program Certified Referral or an OON referral. The Health Resources Services Administration (our federal funder) expects that clients receiving a support service are documented as being engaged in on-going medical care and treatment. Referrals must specify an end date that is detailed in each of the corresponding, specific service category definitions (e.g., food and meal programs – referral expires after 3 months; residential substance abuse treatment/counseling – after 4 months; and legal services – after 1 year). OON referrals are good for up to six months, regardless of the service; then a re-certification is required.

E. Performance Improvement and Outcome Measures: All providers will develop internal performance improvement programs and collaborate with the Miami-Dade County Ryan White Program Quality Management Program contracted to Behavioral Science Research Corporation (BSR). Providers will be evaluated against the outcome measures contained in Miami-Dade County Professional Service Agreements (contracts), the Health Resources and Services Administration's HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3; HAB Performance Measures for Medical Case Management, Oral Health Care, Systems-Level, and Pediatrics; Ryan White Program Minimum Primary Medical Care Standards for Chart Review; Ryan White Program Oral Health Care Standards; and/or the Performance Improvement Plan (PIP) and its addenda; where applicable. They will be responsible for collecting and reporting on specific data to measure performance and outcomes, as detailed in the documents listed above.

Outpatient medical care, prescription drug, medical case management, oral health care, substance abuse counseling, outreach, and mental health therapy/counseling providers must participate in external quality assurance reviews, utilizing individual standardized tools as developed by the Ryan White Program, the Performance Improvement Advisory Team (PIAT), and the Miami-Dade HIV/AIDS Partnership (Partnership). As individual standardized tools are developed by the Ryan White Program, the PIAT, and the Partnership for Ryan White Program-funded support services, providers will be required to utilize such tools and participate in related external quality assurance reviews.

F. Reporting: Providers must report monthly activity according to the recorded number of client visits, dates of services, type of procedures (if applicable), units of service provided, and unduplicated number of clients served. See individual service category definitions for additional reporting requirements, where applicable.

II. MINORITY AIDS INITIATIVE (MAI) REQUIREMENTS (as may be amended) – The following requirements will apply to the following services if funded with MAI resources: outpatient medical care, prescription drugs, medical case management, residential substance abuse treatment/counseling, and outreach services.

Funding available under the MAI for outpatient medical care (primary and specialty care), prescription drugs, medical case management, residential substance abuse treatment/counseling, and outreach services are identical to general Part A-funded services, except that MAI-funded services provide culturally sensitive services that target minority communities exclusively.

MAI funds are designated to reduce the HIV-related health disparities and improve the health outcomes for HIV+ minority populations such as Black/African Americans (including but not limited to Haitians), Hispanics, Native Americans, etc. The overarching goal of the MAI is to improve health outcomes by preventing transmission or slowing disease progression for disproportionately impacted communities by:

- Getting persons living with HIV disease into care at an earlier stage in their illness,
- Assuring access to treatments that are consistent with established standards of care, and
- Helping individuals and families to remain in care.

Providers qualify as “Minority Community Based Organizations” by being a non-governmental agency serving a clientele that is composed of 85% or more of racial/ethnic minority populations.

In addition, per Federal requirements, organizations funded to provide MAI services must meet the following criteria:

- 1) Are located in or near to the targeted community they are intending to serve;
- 2) Have a documented history of providing services to the targeted community(ies);
- 3) Have documented linkages to the targeted populations, so that they can help close the gap in access to service for highly impacted minority communities; and
- 4) Provide services in a manner that is culturally and linguistically appropriate.

- 5) Understand the importance of cross-cultural and language appropriate communications and general health literacy issues (including cultural competency, limited English proficiency, and health literacy) in an integrated approach to develop the skills and abilities needed by HRSA-funded providers and staff to effectively deliver the best quality health care to the diverse populations they serve.

Providers must clearly specify the target population(s) to be served [i.e., Black/African American (including but not limited to Haitians), Hispanic, Native Americans, etc.]. If more than one racial/ethnic group is targeted, the percentage that each group will represent of the total number of clients to be served must be identified.

III. REFERRAL REQUIREMENTS – All Ryan White Program-funded providers may accept Ryan White Program Certified Referrals for service if the referral is current, signed and dated (by hand or electronically) and includes the title of the referring medical case manager, and indicates the referral’s end date, which may be different depending on the service category. The Ryan White Program Certified Referral verifies that all client eligibility documentation (HIV status, financial income level verification, and current permanent Miami-Dade County residency) and all required consents (Notice of Privacy Practices, SDIS Consent to Release and Exchange Information, and the Composite Consent) have been gathered by the referring Ryan White Program-funded medical case manager and can be found in the client chart at the referring agency’s location. Ryan White Program Certified Referral forms must also be kept on file in the client’s chart at each site where a referral has been received. Failure of the referring agency to maintain appropriate eligibility documentation in the client chart, or of the receiving agency to maintain the actual Ryan White Program Certified Referral in the client chart, is subject to corrective action and fiscal repayment to the County.

A General or Out-of-Network (OON) referral may be generated by a non-Part A or non-MAI-funded case manager [Medicaid Project AIDS Care (PAC) Waiver, etc.]. However, all supporting eligibility documentation and consent forms required by Miami-Dade County must accompany the referral and be kept in the client chart at the referral site. For these referrals, a brief intake must be entered into the Service Delivery Information System (SDIS) in order that the Part A or MAI-funded organization may generate reimbursement requests (billing) for services rendered. For the agency receiving an OON referral, failure to maintain the actual OON referral and its allowable supporting documentation and consent forms on file in the client’s chart is also subject to corrective action and fiscal repayment to the County. Under no circumstances can an agency receiving an OON referral require that the client be assigned a Part A or MAI-funded medical case manager.

OUTPATIENT MEDICAL CARE (General HIV/AIDS Population & MAI)
(Year 21 Service Priority #1)

- A. This service includes **Primary Medical Care** and **Outpatient Specialty Care** required for the treatment of individuals living with HIV or AIDS. It focuses on timely/early medical intervention and continuous health care and disease treatment and management over time. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service (PHS) guidelines. Such care must include access to antiretroviral (ARV) and other drug therapies, including prophylaxis and treatment of opportunistic infections (OI) and combination antiretroviral therapies.

[IMPORTANT NOTE: Services are restricted to outpatient services only.]

I. Primary Medical Care

1. **Primary Medical Care Definition and Functions:** Primary medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, advanced registered nurse practitioner, or other health care professional who is certified in their jurisdiction to prescribe ARV therapy in an outpatient setting. Outpatient settings include clinics, medical offices, and mobile vans where clients in general do not stay overnight. **Emergency room services are not considered outpatient settings, and are not covered. Inpatient services are also not covered.** Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, continuing care and management of chronic conditions, and referral to and provision of specialty care, as necessary.

If a phenotype lab test is needed, a *Ryan White Program Letter of Medical Necessity, completed by a physician, for Antiretroviral Phenotype Resistance Assays for Experienced Patients* is required. Note: the Virtual Phenotype test does not require a Letter of Medical Necessity.

Additionally, if the client is eligible for ADAP, the Trofile Assay (for Maraviroc resistance) and the Abacavir HLA-B*5701 hypersensitivity test will not be reimbursed by the Ryan White Program. Medical providers and/or medical case managers must verify and document on the Ryan White Program Letter of Medical Necessity that the client has been thoroughly screened for ADAP eligibility and been denied ADAP enrollment before they access Ryan White Program funding for any of these services. Utilization of these tests will be monitored quarterly.

2. **Client Education:** Providers of primary medical care services are expected to provide the following basic education as part of client care:
 - Treatment options, with benefits and risks, including information about state of the art combination drug therapies and reasons for treatment;
 - Self-care and monitoring of health status;
 - HIV/AIDS transmission and prevention methods; and
 - Significance of CD4 counts, viral load and related disease aspects, adherence and resistance concepts.

3. **Adherence Education:** Providers of primary medical care services are responsible for assisting clients with adherence in the following ways:
 - Adherence with medication regimens in order to reduce the risk of developing and spreading a resistant virus and to maintain health;
 - Taking medications as prescribed and following recommendations made by physicians, nutritionists, and pharmacists;
 - Client involvement in the development and monitoring of treatment and adherence plans; and
 - Ensuring immediate follow-up with clients who miss their prescription refills, physician appointments, and/or who experience difficulties with adherence.

4. **Coordination of care:** Providers of primary medical care services are responsible for ensuring continuity and coordination of care. They must:
 - Maintain contact as appropriate with other caregivers (medical case manager, nutritionist, specialty care physician, pharmacist, counselor, etc.) and with the client in order to monitor health care and treatment adherence;
 - Ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives; and
 - Identify a single point of contact for medical case managers and other agencies that have a client's signed consent and other required information.

5. Additional primary medical care services may include:

- Respiratory therapy needed as a result of HIV infection; and
- Consumable medical supplies and durable medical equipment (DME) for the administration of medications that are not available through prescription drug services and that have been prescribed or ordered by the client's primary care physician. Providers must submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Providers may request approval of a supplemental list for items that have a HCPC code, but do not have a corresponding Medicare or Medicaid rate.

II. Outpatient Specialty Care

- 1. Outpatient Specialty Care Definition and Functions:** This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for HIV+ clients who are referred by a primary care provider through a Ryan White Program Certified Referral, OON referral, or prescription referral. Specialty medical care includes outpatient rehabilitation, dermatology, oncology, optometry, ophthalmology, obstetrics and gynecology, urology, chiropractic, podiatry, pediatrics, rheumatology, physical therapy, occupational therapy, speech therapy, respiratory therapy, clinical psychiatry, nutritional assessments or counseling, and other specialties as related to the client's HIV diagnosis or co-morbidities. Chiropractic services under the Ryan White Program are limited to pain management services in relation to a client's HIV diagnosis. NOTE: Per Federal guidelines, acupuncture services are not covered under this service category, as Ryan White Program funds may only be used to support limited acupuncture services for HIV+ clients as part of substance abuse treatment services.

Note: primary medical care provided to persons with HIV disease is not considered specialty care.

- 2. Client Education:** Providers of specialty care services will be expected to provide the following basic education as part of client care:
- Basic education to clients on various treatment options offered by the specialist;
 - Taking medications pertaining to specialty care treatment as well as adhering to treatment recommendations made by the primary care physician; and

- Educating clients about HIV/AIDS and its relationship to the specialty care service being provided.
3. **Coordination of Care:** The specialist must communicate, as appropriate, with the primary care physician and client for results, follow-up, and/or to re-evaluate the client in order to coordinate treatment.
4. **Additional specialty care may include:**
- Consumable medical supplies and durable medical equipment (DME) for the administration of medications that are not available through prescription drug services and that have been prescribed or ordered by the client's specialist. Providers must also submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Providers may request approval of a supplemental list for items that have a HCPCS code, but do not have a corresponding Medicare or Medicaid rate.

B. Program Operation Requirements (for both Primary and Specialty Care):

- Providers must offer, post, and maintain walk-in hours to ensure maximum accessibility to outpatient medical care, to ensure that medical services are available to clients for urgent/emergent issues;
- Providers must demonstrate a history and ability to serve Medicaid eligible clients; and
- Providers must ensure that medical care professionals have a minimum of three (3) years of experience treating HIV clients or have served a high volume of HIV+ clients in the past year.

Additionally, for outpatient specialty care only:

- A referral from the client's primary care physician is required for all specialty care services.

C. Additional Service Delivery Standards: Providers of these services will also adhere to the following guidelines and standards (please refer to Section III of this book for details)

- Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses (as amended and current)

- HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3
- Minimum Primary Medical Care Standards for Chart Review

D. Rules for Reimbursement: Providers will be reimbursed for outpatient primary medical care and specialty care services as follows:

- Reimbursements for medical procedures and follow-up contacts to ensure client's adherence to prescribed treatment plans will be no higher than the rates found in the "2011 Florida Medicare Part B Physician Fee Schedule (Participating, Locality 04), text file dated January 4, 2011."
- Reimbursements for medical procedures performed at Ambulatory Surgical Centers (ASC) will be no higher than the rates found in the "2011 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates, revised January 7, 2011; for Core Based Statistical Area 33124 (Miami, FL)." (Applies only to organizations with on-site or affiliated Ambulatory Surgical Centers).
- Reimbursements for medical procedures performed at Outpatient Hospital centers will be no higher than the rates found in the approved "Medicare Addendum B Outpatient Prospective Payment System (OPPS) by HCPCS Code for CY 2011, dated January 2011." (Applies only to organizations with on-site or affiliated outpatient hospital centers).
- Evaluation and management visits and psychiatric visits will be reimbursed at rates no higher than the Medicare "allowable" rates times a multiplier of up to 1.5.
- Reimbursements for lab tests and related procedures will be based on rates no higher than those found in the "2011 Medicare Clinical Diagnostic Laboratory Fee Schedule, for Florida (FL), revised January 2011." If the client is eligible for ADAP, that program should be accessed for genotype and phenotype testing. A Letter of Medical Necessity is required for Ryan White Program reimbursement for phenotype tests (not including virtual phenotype tests), as well as for the Trofile Co-Receptor Tropism Assay.
- Reimbursements for injectables will be based on rates no higher than those found in the "2011 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, dated December 29, 2010 (payment limit column)."

- Reimbursement for consumable medical supplies will be based on rates no higher than those found in the “Medicare Durable Medical Equipment and Supplies Revised 2011 Fee Schedule, for Florida (FL), dated January 2011.” In the absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates no higher than those found in the most current Florida Medicaid’s Durable Medical Equipment for All Medicaid Recipients, as of September 1, 2010.
- No multiplier will be applied to reimbursement rates for laboratory tests and related procedures, for non-evaluation and management procedures, for injectables, supplemental procedures, or for consumable medical supplies.

Additional rules for reimbursement:

- Medical procedures and consumable medical supplies excluded from the Medicare (or Medicaid, for consumable supplies) Fee Schedules may be provided on a supplementary schedule. A flat rate along with a detailed description of the procedure and a cost justification for each supplemental procedure must be included in the provider’s submission request for review and approval by the County.

- E. Additional Rules for Reporting:** Provider monthly reports for consumable medical supplies must include the number of clients served, medical supply distributions per client, and dollar amounts spent per client.
- F. Additional Rule for Reimbursement:** Requests for reimbursement of primary and/or specialty medical care services that are not submitted to the County within four (4) calendar months from the date of service may be denied.

PRESCRIPTION DRUGS (General HIV/AIDS Population & MAI)
(Year 21 Service Priority #2)

- A. This service includes the provision of medications and related supplies prescribed or ordered by a physician or other licensed medical practitioner to prolong life, improve health, or prevent deterioration of health for HIV+ persons who are ineligible for Medicaid, Medicare Part D, ADAP, or other public sector funding, or have private insurance with limited or no prescription drug coverage.

[IMPORTANT NOTE: Services are restricted to outpatient services only. Inpatient and emergency room prescription drug services are not covered. Vaccines provided during a medical office visit are no longer found in the Ryan White Program Prescription Drug Formulary, but may be available under outpatient medical care services.]

1. Medications Provided: This service pays for injectable and non-injectable **Prescription Drugs**, pediatric formulations, and non-prescription nutritional supplements, appetite stimulants, and/or related supplies for the administration of medications. Medications are provided in accordance with the most recent release of the Ryan White Program Prescription Drug Formulary and also include assistance for the acquisition of non-Medicaid, Medicare Part D, or ADAP reimbursable drugs, as well as the purchase of consumable medical supplies that are required to administer prescribed medications. The Ryan White Program Prescription Drug Formulary is subject to change due to guidance from HRSA, the federal granting agency, and/or the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

2. Client Education and Adherence:

- Providers are expected to educate clients on the importance of adhering to their medication regimen with the objectives of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client.
- Providers are expected to offer basic education to clients on various treatment options, including information about state of the art combination drug therapies.
- Clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by physicians, nutritionists, and pharmacists regarding medication management.

3. Coordination of Care:

- Providers must maintain appropriate contact with other caregivers (i.e., the client's medical case manager, physician, nutritionist, counselor, etc.) and with the client in order to monitor that the client adheres to their medication regimen; and ensures that the client receives coordinated, interdisciplinary support for adherence, and assistance in overcoming barriers to meeting treatment objectives.
- Providers will be expected to immediately inform medical case managers when clients are not adhering to their medication regimen (i.e., the client misses prescription refills, misses physician visits, or is having other difficulties with treatment adherence).
- Providers are expected to ensure immediate follow-up with clients who miss their prescription refills, physician visits, and/or who experience difficulties with treatment adherence.

B. Program Operation Requirements:

- Providers are encouraged to provide county-wide delivery. However, **Ryan White Program funds** may not be used to pay for the delivery of medications or consumable medical supplies unless one of the following conditions is met by the client, is documented by the client's physician, and said documentation is maintained in the client's chart:
 - (1) The client is permanently disabled (condition is documented once);
 - (2) The client has been examined by a physician and found to be suffering from an illness that significantly limits his/her capacity to travel [condition is valid for the period indicated by the physician or for sixty (60) days from the date of certification].

Note: Medical case managers requesting home delivery must have documentation on file that meets one of the conditions listed above.

- Providers must specify provisions for home delivery of medications and related supplies and equipment for eligible Ryan White Program clients who require this service.
- Provision of this service may not be limited to an agency's own clients unless 340B covered entity status requires this restriction. **However, if the provider is a 340B covered entity and the client is enrolled in the state ADAP Program, that client is eligible for 340B pricing for prescriptions not covered by the ADAP formulary regardless of whether or not the client is the agency's own client.**

- The service provider must be linked to an existing medical case management system through agreements with multiple medical case management providers. Providers are contractually required to enter into formal referral agreements that detail responsibilities of both parties and penalties for not complying with the referral agreement.

A Ryan White Program Certified Referral Form for Prescription Drug Services must be completed by a medical case manager (or a General Out-of-Network Referral from a non-Part A or non-MAI case manager) and must be attached to the original prescription presented by the client or a designee. The Certified Referral Form must include a client ID number traceable to the case management agency initiating the referral and a client CIS number assigned by the Ryan White Program Service Delivery Information System, if applicable. The referring case management agency is responsible for collecting and reporting all required client eligibility documentation, release of information, consent for services, and demographic information. The Ryan White Program's referring medical case management agency maintains this information on-site. The non-Part A or non-MAI referring case management agency must include this documentation with the OON referral form. Prescription referrals require the full name of the client's prescribing physician or practitioner and/or the primary care physician.

C. Rules for Reimbursement: Dependent on the type of pharmacy provider, please adhere to the following reimbursement structures.

- Where applicable, providers will be reimbursed for prescription drugs based on the Public Health Services (PHS) 340B price of the prescription provided to the Ryan White client, plus a flat rate dispensing fee. Total costs should include the cost of home delivery, as allowable, and other direct costs associated with the provision of this service. Providers must stipulate the flat rate that will be added to the PHS price. (For example, if the PHS price of a prescription for Ritonivir is \$50.00, and your proposed flat rate is \$5.00 then the straight rate is equal to \$55.00.) An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form.
- Where applicable, providers will be reimbursed for prescription drugs based on the Average Wholesale Price (AWP) of the prescription provided to the Ryan White client, minus a per-prescription discount rate. Total costs should include the cost of home delivery, as allowable. Providers must stipulate the discount rate that they will be subtracting from the AWP, which may not be less than 10%. Please note that providers may utilize a discount rate higher than 10% (i.e., AWP - 14%). (For example, if the AWP of a prescription for Ritonivir is \$100.00, and your proposed discount rate is 10%, then the straight rate is equal to \$90.00.) An

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

- Providers will be reimbursed for consumable medical supplies related to the administration of medications based on rates not to exceed the rates found in the “Medicare Durable Medical Equipment and Supplies Revised 2011 Fee Schedule, for Florida (FL), dated January 2011.” In the absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates no higher than those found in the most current Florida Medicaid’s Durable Medical Equipment for All Medicaid Recipients, as of September 1, 2010. No multiplier will be applied to Medicare or Medicaid rates for consumable medical supplies. Providers must also submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Consumable medical supplies excluded from Medicare and Medicaid may be submitted to the County for approval of a supplementary flat rate fee schedule only.

D. Additional Rules for Reporting: Providers must report monthly activity in terms of the individual drugs dispensed (utilizing federally assigned drug codes to be provided by the County), the number of prescriptions filled for each drug, the number of pills or units dispensed, the amount of Ryan White Program funds spent dispensing each drug, and the unduplicated number of clients that received each drug limited to those medications listed in the most recent release of the Ryan White Program Prescription Drug Formulary.

Provider monthly reports for consumable medical supplies must include the number of clients served, medical supply distributions with HCPCS codes as appropriate per client, and dollar amounts per client.

E. Ryan White Program Prescription Drug Formulary: Ryan White funds may only be used to purchase or provide vitamins, nutritional supplements, appetite stimulants, and/or other prescription medications to HIV/AIDS clients as follows:

- Prescribed medications that are included in the most recent release of the Ryan White Program Prescription Drug Formulary. This formulary is subject to periodic revision; and
- Medications, nutritional supplements, appetite stimulants, or vitamins that have been prescribed for the client by his/her physician. NOTE: Prescriptions for nutritional supplements and vitamins should be written for a 90-day supply.

F. Letters of Medical Necessity: The following medications and test require a completed Ryan White Letter of Medical Necessity or Prior Authorization Form (See Section V of this Service Delivery Guidelines book, as may be amended):

Medications:

- **Aptivus** (Tipranavir)
- **Fuzeon** (Enfuvirtide)
- **Neupogen** (Filgrastim)
- **Nutritional Supplements** (for Adults)
- **Procrit** (Epoetin Alpha)
- **Roxicodone** (Oxycodone) **and Percocet** (Oxycodone/APAP)
- **Selzentry** (Maraviroc)
- **Sporanox** (Itraconazole)

Test:

- **Trofile Co-Receptor Tropism Assay** [required to prescribe Selzentry (Maraviroc)]

Please Note: Medical Case Managers must work with clients to diligently and in a timely manner explore all payer options and evaluate the client's best option to ensure that prescription medications are covered by the appropriate program. For Medicare Part D recipients, any client whose gross household income falls below 135% of the 2011 Federal Poverty Level (FPL) must be enrolled in the Low Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 136% and 150% of the FPL must be enrolled in the ADAP Wrap Around Pilot Project (AWAPP). For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who fall into the "donut hole," must be referred to the ADAP Program.

MEDICAL CASE MANAGEMENT (General HIV/AIDS Population & MAI)
(Year 21 Service Priority #3)

The Ryan White Program Medical Case Management service category has two (2) distinct components: **Medical Case Management and the Peer Education and Support Network (PESN)**. *Providers are required to offer both components of this service category.*

The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) defines medical case management as a range of client-centered services that link clients with health care, psychosocial, and other services. Coordination and follow-up of medical treatments are components of medical case management. Services ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of clients' and key family members' needs and personal support systems. Medical case management includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes all types of case management, including face-to-face meetings, telephone contact, and any other forms of communication.

The purpose and goals of medical case management are: 1) to maintain the client in on-going medical care and treatment; 2) to coordinate services across funding streams; 3) to reduce service duplication across providers; 4) to assist the client with accessing needed services; 5) to use available funds and services in the most efficient and effective manner; 6) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 7) to empower clients to remain as independent as possible; 8) to improve service and client health outcomes; and 9) to control costs while ensuring that client needs are properly addressed.

MEDICAL CASE MANAGEMENT COMPONENTS

- I. Medical Case Management:** Medical case managers must be knowledgeable about the diversity of programs and be able to develop service plans from various funding streams. They are responsible for helping clients access needed services, not just Ryan White Program-funded services.

Locally, medical case managers are responsible for performing the following functions: 1) conducting a full assessment of the client's medical, financial, social, and other needs (initial intake); 2) developing care plans including coordination and follow-up of medical treatment; 3) managing and coordinating services (referrals, assisting with initial appointments, and coordinating services identified in the care plan, etc.); 4) monitoring client adherence to the care plan

and medication regimens, as well as ensuring that service providers involved in the client's care are rendering services as requested; 5) evaluating services provided to the client by all funding sources to determine consistency with the established care plan; 6) re-assessing and revising the care plan every six months at a minimum for active clients, or more often as needed; 7) conducting secondary prevention; and 8) closing client cases when warranted and documenting the reason for case closure (including, but not limited to, case closures for clients that have not been seen in over 6 months). The Service Delivery Information System (SDIS) will automatically close a client's case after twelve (12) months of no Ryan White Part A or Minority AIDS Initiative (MAI) funded service and no progress notes. Medical case managers should run a "Last Known Contact Report" in the SDIS monthly to identify any clients who have not been seen in six (6) months, and follow-up as appropriate to locate the client and bring them back into care.

- II. Peer Education and Support Network (PESN):** At the option of the client, the medical case management agency will assign an HIV+ "Peer" (i.e., PESN, Case Aide, Peer Educator, Peer Navigator) to provide "peer support," including client orientation and education about health and social service delivery systems. The HIV+ Peer may assist with initial client intake, paperwork and applications for financial and medical eligibility, educating new clients on the process of accessing core and support services, as well as accompanying clients to initial appointments for medical care and other services. The HIV+ Peer may also make phone calls or send mail (where authorized) to clients for the purpose of reminding them of medical appointments, in order to improve the client's attendance and reduce no-shows. Peers are restricted from completing Ryan White Program Certified Referrals, Plans of Care, and Comprehensive Health Assessments, as these are functions of a medical case manager.

The Peer will have basic knowledge of HIV/AIDS services and receive necessary training on HIV funding streams.

As incentives for productivity, providers are encouraged to provide the Peer with educational opportunities, as well as a standard living wage and medical benefits.

If the client decides not to access the PESN services, then the medical case manager will also be responsible for providing the following services: 1) presentation of information regarding the HIV service delivery system across funding streams, and 2) assistance to clients in preparing applications for other benefit programs.

The following requirements apply to both Medical Case Management and PESN services (including Minority AIDS Initiative services) as indicated:

- A. Program Operation Requirements:** Providers must ensure that medical case management services include, at a minimum, the following: peer support, assessment, follow-up, direction of clients through the entire system of health and support services, and facilitation and coordination of services from one service provider to another. Providers of medical case management services are expected to educate clients on the importance of complying with their medication regimen.

Medical case managers must maintain frequent contact with other providers (the client's physician, nutritionist, pharmacist, counselor, HOPWA housing specialist, etc.) and with the client in order to assure the client adheres to medication regimens and ensure that the client receives coordinated, interdisciplinary support for adherence, attendance at medical care appointments, picking up prescriptions and re-fills, and assistance in overcoming barriers to meeting treatment objectives.

Medical case management providers are expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and to ensure that immediate follow-up is available for clients who miss their prescription refills, physician visits, and/or who experience difficulties with adherence. Medical case management providers must ensure that the client is knowledgeable about HIV/AIDS; understands CD4 count, viral load, adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors or barriers affecting treatment adherence; and understands his/her treatment regimen to the best of the client's ability.

1. Medical Case Manager Qualifications:

Providers of this service will adhere to the educational and training requirements of staff as detailed in the *Ryan White Program System-wide Standards of Care* and the *Ryan White Program Case Management Standards of Service* (see Section III of this book).

2. Provider Requirements:

- a) Contractual.* Providers will be expected to report to Miami-Dade County the following:
- An explanation of the training, including cultural sensitivity issues, that will be offered to case management staff, including "peers."
 - An explanation of how a client's adherence to treatment will be monitored and how adherence problems will be identified and resolved.

- An explanation of how the provider will serve clients who speak English, Spanish, and Creole or who have limited language proficiency. **Medical case management providers must budget for the following expenses or otherwise accommodate client needs for: American Sign Language interpreter, foreign language interpreter, Braille, and other materials to accommodate clients with disabilities, limited English language proficiency, and/or low literacy levels.**
 - A description of linkage agreements in place with other HIV/AIDS service providers.
- b) **Required Forms.** Medical case management staff will utilize Ryan White Program standardized forms, as approved by the Miami-Dade HIV/AIDS Partnership and the County, for all medical case management functions.
- c) **Referrals.** All referrals made by Part A or MAI-funded medical case managers to Ryan White Program services must be made utilizing the Ryan White Program Certified Referral process, which is available through the Service Delivery Information System (SDIS). Referrals cannot be made for services not documented in the client's Plan of Care. However, in the case of emergency, a Plan of Care may be amended within two (2) business days to allow for the referral. Referrals for non-Part A or non-MAI services made by Part A/MAI medical case managers will use the general certified referral form in the Service Delivery Information System (SDIS). Referrals made to Part A/MAI services by non-Part A or non-MAI funded case managers will use the Out-of-Network (OON) general certified referral form available from the County's Office of Grants Coordination – Ryan White Program. The OON referral must be accompanied by appropriate supporting documentation and signed consents.
- d) **Caseload.** Medical case managers should have a caseload of no more than 70 active clients. Clients limited to only "situational needs" should not be included in the "active" caseload count.
- e) **Peer schedules.** Providers are reminded that some "peer" workers may be eligible for disability income and/or other supplemental income. Consequently, a part-time work schedule should be well-planned to meet the needs and benefits of the peer employee.

f) ***Comprehensive Health Assessments.*** Medical case managers are expected to complete a Comprehensive Health Assessment annually for each client. However, brief updates should be conducted at 6-month intervals in conjunction with the client's re-certification process.

B. Additional Service Delivery Standards: Providers of this service will adhere to the *Ryan White Program Case Management Standards of Service*. (Please refer to Section III of this book for details.)

C. Rules for Reimbursement: The units of service used for medical case management and PESN reimbursements are as follows.

1. *Medical Case Management Services:*

- *Face-to-Face encounter (FFE):* quarter-hour units (15 minutes), at rates not to exceed \$14.00 per unit, defined as any time the medical case manager has direct contact with the client in person. In consultations with a child and one or more adults, encounters are billed for one family member only who must be HIV+ and eligible for Ryan White Program-funded services.
- *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed \$14.00 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone (TEL) contacts with the client and/or his/her representatives; development of a Plan of Care or progress note documentation (DOC); travel time (with documentation in the client chart of the reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan, collateral (COL) contacts with other providers or representatives on behalf of the client, referral activities (setting up appointments, arranging transportation, etc.), or treatment planning or consultation meetings held on behalf of a client; encounters with or on behalf of the client for the purpose of enrolling or re-certifying the client in the AIDS Drug Assistance Program (ADAP); adherence counseling (ADH); and for time spent attending authorized Ryan White Program trainings (TRN), such as monthly case management and case management supervisor trainings, Service Delivery Information System trainings, and quarterly Ryan White Program Provider Forums. (NOTE: The TRN code may not be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code cannot be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, or other employer-required training.) Travel time is not

included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

NOTE: Prior to completing a formal Ryan White Program Intake and Assessment for newly identified HIV+ clients, a total of up to three (3) visits with either a medical case manager or a peer educator/counselor within a 30-day period may be billed to the Ryan White Program. These visits are to be used for providing supportive counseling and support in preparation for linkage to care (i.e., connection to a medical provider), as well as for assisting the client in gathering documentation to confirm program eligibility in order to link these clients to outpatient primary medical care or medical case management services. The new billing code "NIC" should be used to record such services to newly identified HIV+ clients.

- *Case Manager Supervisor encounters: (may only be billed by documented Case Manager Supervisors)* quarter-hour units (15 minutes), at rates not to exceed \$14.00 per unit, defined as services associated with chart review (REV) processes to ensure that case management staff are in compliance with the *Ryan White Program Case Management Standards of Service* or quarter hour units (15 minutes) consulting with case management staff (CON) on client, supervisory, or quality management issues. Case Manager Supervisors may also use the TRN code, using the guidelines specified above; and the "OVR" code to record appropriate and authorized electronic override activities.

2. *Peer Education and Support Network (PESN) Services:*

- *Face-to-Face encounter (FFE):* quarter-hour units (15 minutes), at rates not to exceed \$7.50 per unit, defined as any time the "Peer" has direct contact with the client in person.
- *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed \$7.50 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone contacts (TEL) with the client and/or his/her representatives; progress note documentation (DOC), travel time (with documentation in the client chart of the reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan; or collateral contacts (COL) with other providers or representatives on behalf of the client. Peer Educators may also use the ADAP and TRN codes where applicable, using the guidelines specified above.

3. Providers are required to document in the client's chart each unit of service performed (including the type of encounter and length of time spent) as face-to-face encounters or on behalf of a client. Units of service must be documented and reported separately for PESN and medical case management services.
 4. Client eligibility screening for voucherable services is billable as a unit of service depending on the amount of time spent with the client. Costs related to the distribution of voucher services should be covered under the dispensing charge allowed for handling of vouchers under the voucherable service category (i.e., transportation EASY Tickets).
- D. Additional Rules for Reporting:** Providers of PESN and medical case management services must report, separately, their monthly activities according to quarter-hour (15 minutes) "Face-to-Face" encounters and quarter-hour (15 minutes) "Other" encounters. In addition, providers must report the number of unduplicated clients served.

**SUBSTANCE ABUSE COUNSELING -
RESIDENTIAL AND OUTPATIENT TREATMENT**
(General HIV/AIDS Population & MAI for Residential Treatment)
(Year 21 Service Priorities #4 and #7)

Two types of **Substance Abuse Treatment/Counseling** programs are included under this service category, **Residential and Outpatient**. Services must be provided to HIV+ clients in state-licensed treatment facilities, and should be limited to the pre-treatment program of recovery readiness and relapse, as well as harm reduction, conflict resolution, anger management, relapse prevention, family group and intensive counseling to reduce depression, anxiety and other substance abuse related disorders, drug-free treatment and treatment for alcohol and other drug addictions.

Both **Residential and Outpatient Substance Abuse Treatment/Counseling** programs shall comply with the following requirements:

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

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

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

Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. Providers are encouraged to offer program services to families without separating the family unit. If the client is participating in a residential treatment program, the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in residential treatment with the client during the treatment process. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.A. of this service definition on the following page for details). *Note: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

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

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

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

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

Residential and outpatient substance abuse providers must coordinate billing so that outpatient counseling services provided as a result of a referral by a residential facility are only reimbursed once as part of the outpatient facility's billing.

I. Substance Abuse Counseling – Residential Treatment (Priority #4)

This program offers substance abuse treatment, including alcohol addiction and/or addiction to legal and illegal drugs, and counseling to HIV+ clients in state-licensed treatment facilities. Residential substance abuse treatment provides room and board, substance abuse treatment, including specific HIV counseling, in a secure, drug-free, state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Ryan White Program funds may not be used for hospital inpatient detoxification. All clients must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance dependence.

Residential treatment programs shall comply with the following requirements:

B. Rules for Reimbursement: The unit of service for reimbursement of substance abuse counseling - residential treatment is a *client-day* of care up to a maximum amount of \$125.00 per day. (NOTE: Use of the maximum per day rate requires prior approval from the Miami-Dade County Office of Grants Coordination – Ryan White Program.) **Under no circumstance may clients be enrolled in any Ryan White Program-funded residential substance abuse treatment program for longer than 120 days within a twelve-month period. Twelve months begins on the first day of a client’s residential treatment. NO EXCEPTIONS. The length of stay for existing clients will be closely monitored by the County’s Office of Grants Coordination – Ryan White Program.**

C. Additional Rules for Reporting: Monthly activity reporting for residential substance abuse treatment is per *client-day* of care and number of unduplicated clients served. Providers will indicate in the SDIS the client’s disposition after residential substance abuse treatment services has ended (e.g., treatment completed, client referred to outpatient substance abuse counseling, client withdrew from treatment, etc.).

- D. Linkage/Referrals:** Providers of residential substance abuse treatment must document the client's progress through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the client, his/her medical case manager, and the primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving medical case management services; if not, the provider must seek enrollment of the client in a medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. **A client's Ryan White Program-funded medical case manager will receive an automated "pop-up" notification through the Service Delivery Information System upon the client's discontinuance or release from, completion of, and/or relapse in residential substance abuse treatment.** *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.
- E. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation including all required consent forms and Notice of Privacy Practices) is required for this service. Clients receiving Ryan White Program Part A or MAI-funded residential substance abuse counseling/treatment must be documented as having a gross household income below 300% of the 2011 Federal Poverty Level (FPL).

II. Substance Abuse Counseling - Outpatient Treatment (Priority #7)

This program provides regular, ongoing substance abuse monitoring and counseling on an individual and/or group basis in a state-licensed outpatient setting. Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The minimum amount of group participants is three (3) Ryan White clients per group and should be no higher than fifteen (15) persons per group. The ratio of support group participants to counselors should be no lower than 3:1 and no higher than 15:1. One unit is equal to one half-hour counseling session.

- **Substance Abuse Counseling (Level I) - Professional Substance Abuse Treatment.** This service includes *general and intensive* substance abuse therapy and counseling (individual, family, and group) provided by trained mental health or certified addiction professionals. Direct service providers must possess at least *postgraduate degrees* in the appropriate

counseling-related field, and preferably, be a *certified addiction professional (CAP)*.

- **Substance Abuse Counseling (Level II) - Counseling and Support Services.** This service includes supportive and crisis substance abuse counseling by trained and supervised counselors, peers, and facilitators. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Non-certified personnel providing this service will be supervised by professionals with appropriate Level I substance abuse counseling credentials.

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

- C. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed \$30.00 per unit for Level I individual counseling; \$34.00 per unit for Level I group counseling; \$27.00 per unit for Level II individual counseling; and \$30.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and/or family member(s) receiving the therapy, whereas, reimbursement for group sessions are calculated for the counselor that provided the group therapy. Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. The HIV+ client must be currently receiving such services; and preferably, but not necessarily, the family member may be served on the same day as the client.

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

- E. Linkage/Referrals:** Providers of outpatient substance abuse treatment must document the client's progress through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the client, his/her medical case manager, and primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving medical case management services; if not, the provider

must seek enrollment of the client in a medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.

INSURANCE SERVICES
(Year 21 Service Priority #5)

There are three types of assistance under this service category: **AIDS Insurance Continuation Program (AICP), Insurance Deductibles, and Prescription Drug Co-Payments.**

I. AIDS Insurance Continuation Program

This program provides assistance to clients who already have private health insurance but are not financially able to pay the premiums. This program does not provide new health insurance policies to eligible clients; it allows them to continue with their current insurance carrier. This program does not include coverage of disability or life insurance payments. The maximum amount of assistance a client may receive each month is \$750.00 (seven hundred fifty dollars) towards their monthly insurance premium. The Ryan White Program will be able to assist the client in making back payments of premiums as long as the insurance policy has not been terminated. Assistance may also be provided to facilitate conversion of group coverage (i.e., COBRA) to an individual insurance policy.

The Ryan White Part A Program supplements the State of Florida's AICP when the primary funding sources (Part B and Florida General Revenue) exhaust their funds. Ryan White Part A Program support depends on the amount allocated to this service and the amount of funds available at the time of the request. This service description covers only those services paid for by Ryan White Part A funds.

- A. Program Operation Requirements:** Providers may not reimburse clients directly for their premium expense.

Providers are required to inform clients of their rights regarding insurance coverage and to ensure they use their private health insurance to obtain medical care, prescription drugs, and other treatment. Clients will not be eligible for Ryan White Part A-funded services if such services are available under their existing health insurance, private or public.

- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended per insurance premium plus a dispensing fee of \$15 per month per premium.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *expended per insurance premium per client.*

- D. Special Client Eligibility Criteria:** Clients receiving Part A assistance for this service must also: 1) have active health insurance under a group, individual, or COBRA policy; and 2) be willing to sign all required forms and provide all requested eligibility information. A complete financial assessment and disclosure are required.

II. Insurance Deductibles

- A. Program Operation Requirements:** The goal of this program is to maintain a client's private health insurance coverage, thereby minimizing the client's reliance on the Ryan White Part A Program for services. Under no circumstances shall payment be made directly to recipients of this service. The maximum amount of assistance a client may receive annually is \$2,500. A complete financial assessment and disclosure are required.
- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per deductible plus a dispensing fee*.
- C. Units of Service for Reporting:** Monthly activity reporting for this service must be in dollars expended *per deductible per client*. The service provider must also report the number of unduplicated clients served each month and the dollars spent per client.

III. Prescription Drug Co-Payments and Co-Insurance

- A. Program Operation Requirements:** This type of assistance is available to privately insured clients who are required to pay a co-payment for their medications. The pharmaceutical provider will bill the insurance carrier for a portion of the cost of the prescription plus the dispensing fee and Part A will cover the remaining portion of the cost for clients who meet Ryan White Part A Program eligibility criteria. Assistance for both co-insurance and co-payments is restricted to those medications on the currently approved Ryan White Program Prescription Drug Formulary. A complete financial assessment and disclosure are required. A Physician's prescription is also required.
- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per co-payment plus a flat fee dispensing rate*.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per co-payment per client*.

Please Note: Medical case managers and insurance enrollment specialists must work with clients to diligently and in a timely manner explore all insurance options and evaluate the client's best option to ensure that deductibles and co-payments are reasonable. For Medicare Part D recipients, any client whose gross household income falls below 135% of the 2011 Federal Poverty Level (FPL) must be enrolled in the Low Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 136% and 150% of the FPL must be enrolled in the ADAP Wrap Around Pilot Project (AWAPP). For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who fall into the "donut hole," must be referred to the ADAP Program.

ORAL HEALTH CARE
(Year 21 Service Priority #6)

This service includes routine **Oral Health Care** examinations and prophylaxis, X-rays, fillings, prosthetics, treatment of gum disease, oral surgery, and instruction on maintaining oral health.

- A. Program Operation Requirements:** Provision of oral health care services for any one client is limited to an annual cap of \$3,000 per the Ryan White Part A Fiscal Year (March 1, 2011 through February 29, 2012). Very limited exceptions to the annual cap may be approved by the County, with consultation from the Miami-Dade HIV/AIDS Partnership's Oral Health Care Subcommittee as needed, on a case-by-case basis for the provision of preventative oral health care services only.

Clients referred for oral health care by a Ryan White Part A or MAI medical case manager require a Ryan White Program Certified Referral Form, as approved by the Miami-Dade HIV/AIDS Partnership and the County. If the client is referred by a non-Part A or non-MAI provider ("Out of Network" provider), a OON general certified 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 supporting documentation, are also able to access Ryan White Part A oral health care services, upon completion of a brief intake in the SDIS by the oral health care provider agency and the client's signed consent for service.

Providers must offer, post, and maintain walk-in hours to ensure maximum accessibility to oral health care services, to ensure that dental services are available to clients for urgent/emergent issues.

- B. Additional Service Delivery Standards:** Providers of this service will adhere to the *Ryan White Program System-wide Standards*. (Please refer to Section III of this book for details.) Providers will be required to demonstrate that they will adhere to generally accepted clinical guidelines for oral health care treatment of HIV and AIDS-specific illnesses.
- 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 Ryan White Program Oral Health Care Formulary, using the 2011-12 American Dental Association Current Dental Terminology (CDT 2011-2012), codes for dental procedures, at rates that represent a constant multiple of the most current State of Florida Medicaid Dental General and Oral/Maxillofacial Fee Schedules, dated January 1, 2011. The

constant multiple may not exceed 3.0 times this Medicaid Dental Services rate. Providers must stipulate the multiplier they will be applying to the Medicaid Dental Services reimbursement rates during the program year. An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form. Provider negotiated Medicaid rates will not be accepted.

Necessary tests or procedures that have a CDT 2011-12 procedure code and are excluded from Medicaid must be submitted to the County for approval of a supplementary fee schedule. A flat rate for each procedure and a detailed description of the procedure and a cost justification must be included in the request for approval.

- D. Children's Eligibility Criteria:** Providers must document that HIV+ children who receive Part A-funded oral health care services are permanent residents of Miami-Dade County and have been properly screened for Medicaid and other public sector funding (i.e., the Medically Needy Program), as appropriate. While children qualify for and can access Medicaid or other public sector funding for oral health care services, they will not be eligible for Ryan White Part A-funded oral health care services, except those tests or procedures excluded by Medicaid.
- E. Ryan White Program Oral Health Care Formulary:** Ryan White Part A funds may only be used to provide oral health care services that are included in the most recent release of the Ryan White Program Oral Health Care Formulary. The Formulary is subject to periodic revision.

MENTAL HEALTH THERAPY/COUNSELING

(Year 21 Service Priority #8)

This service offers non-judgmental psychological treatment and counseling services including individual, group, and crisis intervention counseling provided by licensed mental health counseling professionals. **Mental Health Therapy/Counseling** services may be delivered in individual or group settings. **Please note that Ryan White Program funds may not be used for bereavement support for uninfected family members or friends.**

Mental health therapy/counseling services reimbursed under Part A of the Ryan White Program are limited to conditions stemming from and treated within the context of the client's HIV or AIDS diagnosis. This service is not intended to be general psychosocial practice, but is intended to address HIV-related issues and strengthen coping skills to increase adherence and access to on-going medical care and treatment.

PLEASE NOTE: All initial assessments and subsequent assignments to Level III and Level IV psychosocial support services will be done by a licensed Level I or Level II mental health professional.

- **Mental Health Therapy/Counseling (Level I)** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *postgraduate degrees* in psychology or counseling (PhD, EdD, Psy.D) and must be *licensed by the State of Florida* as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.
- **Mental Health Therapy/Counseling (Level II)** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *Master's degrees* in psychology, psychotherapy or counseling (MS, MA, MSW, or M.Ed.), and must be *licensed by the State of Florida* as a LCSW, LMHC or LMFT to provide such services.

Mental Health Therapy/Counseling Components:

Counseling services (**Level I**) provided to clients by licensed professionals will include psychosocial assessment and evaluation, testing, diagnosis, treatment planning with written goals, crisis counseling, periodic re-assessments, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction

strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

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

Group Counseling (Levels I and II) – refers to a group of individuals [minimum of three (3) Ryan White clients, maximum of fifteen (15) total clients] with similar problems meeting under the expert guidance of a trained mental health professional. Members of the group will be selected by the mental health professional in order to maximize the interaction, learning, and benefits derived from a group dynamic. Group counseling provides therapy in a social context, reduces the feeling of isolation many clients experience, provides an opportunity for clients to share methods of problem-solving, and allows the therapist an opportunity to observe how an individual interacts with others.

- A. Program Operation Requirements:** Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV+ family members (as defined by the client) only if the HIV+ client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of support group participants to counselors may not be lower than 3:1 and may not be higher than 15:1. One visit is equal to one half-hour counseling session.
- B. Additional Service Delivery Standards:** Level I and Level II providers must adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV/AIDS-related illnesses. (Please refer to Section III of this book for details.)
- C. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half-hour counseling session not to exceed \$32.50 per unit for Level I individual counseling; \$35.00 per unit for Level I group counseling; \$32.50 per unit for Level II individual counseling; and \$35.00 per unit for Level II group counseling. Reimbursement for individual counseling units are calculated

for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for the counselor that provided the group therapy (i.e., number of group counseling units per counselor).

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

OUTREACH SERVICES
(General HIV/AIDS Population & MAI)
(Year 21 Service Priority #9)

(NOTE: THIS SERVICE DEFINITION IS SUBJECT TO FURTHER REVISIONS DURING FY 2011-2012, IN ORDER TO ADDRESS THE FEDERALLY REQUIRED EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA) INITIATIVE AND ON-GOING COLLABORATION WITH THE MIAMI-DADE COUNTY HEALTH DEPARTMENT.)

I. Definition and Purposes of Outreach Services

Ryan White Program outreach services target HIV positive (HIV+) clients in need of assistance accessing HIV care and treatment who are:

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

Ryan White Program outreach services are directed to those known to be HIV+ and consist of activities to a) assist HIV+ clients who are lost to care with re-entry into the care and treatment system; b) assist HIV+ clients determined to be at risk of being lost to care with their retention and access to on-going medical care and treatment; and, c) to engage and enroll newly diagnosed clients into the system of care.

Once an HIV+ lost-to-care or at risk of being lost-to-care client is located or an HIV+ client newly diagnosed and/or never in care is located, an SDIS referral must be made to a medical case manager or medical provider of the client's choice. The outreach worker may assist the client in obtaining necessary documentation to receive services and must accompany the person to a point of entry into the system of care. Outreach workers must follow-up on each referral to ensure that the client is enrolled in medical care and treatment.

Referrals to Ryan White Program Part A or MAI-funded outreach services may only be initiated if there is a valid outreach-specific consent signed by the client and filed in the client's chart.

A. Newly Diagnosed HIV+ or HIV+ Never in Care

1. Linkage agreements form the basis of collaborative relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the eight (8) key points of entry to the system of care listed below for the purpose of receiving referrals for HIV+ clients identified at key points of entry.

- STD clinics
- HIV counseling and testing sites
- hospitals/emergency room departments
- substance abuse treatment providers
- mental health clinics
- adult and juvenile detention centers
- jail and/or correctional facilities, including, but not limited to, re-entry programs
- homeless shelters

Linkage agreements must include outreach worker's contact information, work schedule availability, geographic areas of the County covered, and a description of the outreach services offered. Clients referred from a key point of entry will be assisted to obtain necessary documentation for enrollment in the service system, will receive an SDIS referral to the primary medical care or medical case management service provider of their choice, be accompanied to the initial appointment and be followed-up to ensure that they are connected to care.

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

1. Outreach workers must work with service providers, including medical case managers, to locate people lost to medical care or medical case management and bring them back to care. The medical case manager, or pharmacy staff, after repeated attempts to contact the client by phone and mail without success, may refer the case through a SDIS certified referral to an outreach worker. A Physician may immediately and directly request outreach assistance for a client who meets any of the conditions indicated directly below in Section A. 2. or similar circumstances (e.g., abnormal lab results, etc.). Such circumstances must be clearly documented in the client's chart and indicating that the assistance of an outreach worker was requested (i.e., the physician writes a prescription for the needed outreach service and documents such in the client's chart). Jail linkage and prison re-entry coordinators may refer a client to an outreach worker if they have a signed document with permission for a Ryan White Program Part A or MAI outreach worker to contact them; such documents must be included with the OON referral and the supporting documentation being sent to the outreach provider. There must be clear documentation in the client chart

at the referring agency of at least three (3) repeated attempts by the medical case manager, pharmacy staff, or jail linkage/prison re-entry coordinator to contact the client and the reason why the case is being referred to an outreach worker. A Ryan White Program Certified Referral with last known contact information on the client indicating the reason for the outreach referral must be provided to the outreach worker and be maintained in both agencies' client charts.

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

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

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

C. One Time Referrals

If in the course of outreach activities, outreach workers encounter a high-risk person with no documentation of HIV+ status, a referral should be made to an HIV testing site and/or appropriate prevention program in order to determine the client's HIV status. This one time referral may be counted and entered into the SDIS in the Outreach Registration screen. This is a **secondary** outreach function that will be monitored by OGC and should not supersede the primary goals of connecting newly diagnosed (newly identified) clients to care, as well as locating and reconnecting to the service system those clients who have been lost to care or who are at risk of becoming lost to care. These secondary outreach services must be planned and delivered in coordination with local HIV prevention/education programs, including counseling and testing programs, in order to avoid duplication of effort.

D. Outreach Activities

1. Outreach workers may engage in the following activities, if documented and filed in the client's chart at the referring agency and at the receiving agency where applicable: 1) for their agency's own clients; 2) upon receipt of a Ryan White Program Certified Referral for a particular client, for whom the referring agency has a valid informed outreach-specific consent signed by the client and filed in the client's chart; 3) upon receipt of a signed, completed Consent/Referral for Linkage to Care from the Miami-Dade County Health Department; 4) a prescription from a physician; or 4) by a letter or referral from a jail linkage or prison re-entry coordinator as indicated in Section A.1. above:

- obtain from the client all required consents for the outreach worker to access client-related information in the Ryan White Program's Service Delivery Information System (SDIS);
- conduct brief intakes for new clients and enter data into the SDIS outreach registration screen;
- upon receipt of a proper referral, review data in the SDIS for existing clients who are lost to care or are at risk of falling out of care;
- assess and document the client's barriers to accessing care; contact the service provider of the client's choice to coordinate appointments and obtain required documentation for services;
- accompany newly diagnosed, lost to care, or otherwise unconnected HIV+ clients to the initial physician appointment, medical case management appointment, and/or intake at a residential substance abuse facility of the client's choice for the purpose of reconnecting them to care or enrolling them in service;
- accompany clients, as necessary, for the purpose of assisting them to obtain necessary documents for entry into the service system;
- make home visits to meet with a client for the purpose of connecting them to care;
- as a safety issue, Ryan White Program outreach workers who must locate clients in high-risk areas or very rough neighborhoods may go out in two-person teams. In this scenario, both outreach workers should document the activity in the client chart or outreach log, making note that they went to a high risk area, with one of the outreach workers clearly stating that they went along as a safety back-up. Both outreach workers may reflect the time they spent on the encounter and have their agency or respective agencies bill for the time and be reimbursed accordingly. However, in the Service Delivery

Information System (SDIS) the encounter should only be counted/recorded by the main outreach worker/agency that received the referral;

- provide education on available care and treatment options and services available to HIV+ individuals with the goal of directly empowering and enabling the client to access existing HIV/AIDS service programs, including Counseling & Testing sites;
- provide out-stationed linkage and coordination to care services at key points of entry, including but not limited to counseling and testing facilities and other facilities with a high percentage of HIV+ clients as identified by the counseling and testing facility and verified by the Ryan White Part A Program;
- coordinate and participate in planned outreach/testing events in cooperation with the Miami-Dade County Health Department.

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

Outreach Workers may not conduct random searches in the SDIS for clients who are not enrolled at the Outreach Workers' assigned agency, or for clients for whom they do not have a Ryan White Certified Referral. Searches conducted in the SDIS to identify clients lost to care must be initiated by the medical case manager or medical staff of the referring agency.

Ryan White Program outreach activities are not to be used for the recruitment of clients to the outreach worker's agency.

3. **Documentation of Outreach Activity.** All outreach workers must maintain documentation which includes the following:

- name of outreach worker;
- name, signature, and consent of client;
- client's date of birth;
- client's gender;
- client's race and ethnicity;
- client's address or follow-up information;
- date of diagnosis and site of diagnosis;

- the date of the encounter;
- type of encounter (i.e., telephone, face-to-face, collateral, travel, referral, or coordination of care);
- description of the encounter with a client and/or work done on behalf of the client;
- time spent on the encounter in minutes;
- total units documented;
- site where client was identified (i.e., last known contact information, a specific geographic region, and/or key point of entry into the system of care in Miami-Dade County);
- one time referral to a testing site for a high-risk client without documentation of HIV status;
- document “initial contact” and all “follow-up” contacts
- if lost to care or identified as at risk of being lost to care, a copy of the initiating agencies’ referral to outreach;
- an individualized assessment of the client’s barriers to care;
- documentation that explanation of service system and choice of provider agency were provided;
- a copy of an SDIS referral or documented attempt to make a referral by the outreach worker to a medical case management agency or medical provider of the client’s choice;
- documentation of follow-up on referrals to ensure that the client is enrolled in medical care and treatment;
- final disposition of the client must be documented in SDIS, the client’s chart or service log indicating whether or not the client was connected to care (i.e., referral was made; client was taken to a medical provider or medical case manager) or if the case was closed with a statement as to why it was closed.

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

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

A. Program Operation Requirements:

1. **Staff Training.** Outreach workers must possess a High School diploma or GED. All staff providing outreach services must be certified through the State of Florida’s Department of Health HIV/AIDS 104 course. Outreach workers must also receive training related to Limited English Proficiency (LEP). Outreach workers must attend periodic training provided by the Ryan White

Program's Quality Management and Training Program provided by Behavioral Science Research (BSR).

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

2. **Hours.** Outreach services must be offered during non-traditional business hours up to 10 hours at a minimum per week, per agency. Traditional business hours are defined as 9:00 A.M. to 5:00 P.M., Monday through Friday.
3. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target sub-populations (i.e., substance abusers, illiterate persons, hard of hearing, sex workers, etc.). It is desirable that outreach workers reflect the community in which they are working and/or are targeting.
4. **Documentation of Units of Service.** Providers are required to document in the client's chart each unit (15-minute encounter) of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact, collateral encounter on behalf of the client, coordination of care, travel, or referral activity on behalf of a client.

Outreach workers may also record and bill for time spent attending authorized Ryan White Program trainings (TRN), such as monthly case management and case management supervisor trainings, outreach worker trainings, Service Delivery Information System trainings, and quarterly Ryan White Program Provider Forums. (NOTE: The TRN code may not be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code cannot be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, or other employer-required training.) Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

5. **Connection to Care.** Providers are expected to demonstrate through documentation on file at the provider agency that at least twenty-five (25) percent of people contacted and billed for are actually returned to primary medical care and/or medical case management services or that a case was closed, and at least three (3) percent of the people contacted and billed for are new to primary medical care and/or medical case management services, on a quarterly basis. Connections to care will also be monitored by the County on a quarterly basis through the Service Delivery Information System (SDIS) and/or analysis of outreach data conducted by Behavioral Science Research Corporation, as a Quality Management Program activity.

B. Rules for Reimbursement: Providers will be reimbursed on the basis of a line-item budget for Part A and MAI-funded outreach services. Ryan White Program outreach services will be paid on the basis of full-time equivalent (FTE) employees providing direct services as outlined in this service definition, as well as on the basis of other direct and administrative costs. Reimbursement of salaries will be based on the approved budget and productivity as recorded by hours spent doing outreach activities, people contacted, their risk factors, and the number of people connected to care. All administrative and/or indirect expenses allocated to this service category (other than those associated with the delivery of outreach services to clients) are capped at 10% of the total budget.

C. Additional Rules for Reporting: Monthly activity reporting for this service will be on the basis of an outreach contact.

Reimbursement requests will be continuously evaluated on the basis of productivity in particular, people contacted and connected to primary medical care or medical case management services. A sufficient level of outreach services must be provided and a corresponding bill generated through the SDIS on a monthly basis in order for reimbursement to be approved by the County. The County maintains the right to assess the sufficiency of the services provided before reimbursement for services is made.

PSYCHOSOCIAL SUPPORT SERVICES
(Year 21 Service Priority #10)

This service offers non-judgmental psychosocial support/pastoral care treatment and counseling services including individual, group, and crisis intervention counseling provided by non-licensed psychosocial support counseling providers, peers, and pastoral care counselors. **Psychosocial Support Services** may be delivered in individual or group settings. **Please note that Ryan White Part A Programs funds for this service may not be used for bereavement support for uninfected family members or friends.**

Psychosocial support services reimbursed under the Ryan White Part A Program are limited to conditions stemming from and treated within the context of the client's HIV/AIDS diagnosis. This service is not intended to be general psychosocial practice, but is intended to address HIV-related issues and strengthen coping skills to increase adherence and access to on-going medical care and treatment.

PLEASE NOTE: All initial assessments and subsequent assignments to Level III and Level IV psychosocial support services will be done by a licensed Level I or Level II mental health professional. If counseling is provided by a non-licensed professional and/or peer counselor, oversight and supervision must be conducted by a licensed professional or a professional exempt from licensing under F.S. 491.014. The supervisor will approve and sign progress notes, mini-evaluations, and referrals.

Reimbursement will be differentiated according to the level of intensity of the service and the training of the direct service practitioner, as follows:

- **Psychosocial Support Services/Counseling (Level III)** - This service includes *general* psychosocial support counseling (individual, family, and group) provided by a *Bachelor's degree* level or *unlicensed Master's degree level provider* (MSW or MS only) provider in the appropriate counseling-related field.
- **Pastoral Care and Support Services** – Pastoral Care and Support Services is equivalent to Level III psychosocial support counseling with respect to the qualifications of counseling staff. Pastoral care counselors must: (1) hold a Master's degree in theology, philosophy, social work, or psychology from an accredited institution; and (2) have completed at least four units (1,600 hours or one full year) in clinical pastoral education (CPE) in an institution accredited by one of the following professional associations: the Association of Clinical Pastoral Education, National Association of Catholic Chaplains, National Association of Jewish Chaplains, American

Institute of Islamic Studies, or Canadian Association of Pastoral Education.

- **Psychosocial Support Services/Counseling (Level IV)** – This service includes supportive counseling by trained and supervised HIV-infected or affected peers. Activities include forming or strengthening support groups and other areas appropriate for individual and group socio-emotional support related to conditions and situations stemming from a client's HIV status.

Psychosocial Support Services/Counseling Components:

Level III – Provides supervised psychosocial support/counseling designed to improve the client's psychosocial health and promote feelings of well-being. Services will include crisis counseling, periodic re-assessments, and re-evaluations of plans and goals documenting progress. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to mental health and medical treatments, depression, and safer sex will be addressed. Psychosocial support counselors are encouraged to practice and introduce motivational interviewing and harm reduction strategies with their clients, if deemed clinically appropriate. Counseling at this level may include relationship difficulties, client-centered advocacy, stress management and coping skills, personal and social adjustments as they relate to HIV/AIDS, and the provision of needed information and education to clients to enhance their quality of life. Services at this level are provided for clients experiencing mild to moderate mental or emotional health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Pastoral Care and Support Services – This service assists HIV+ persons, members of their immediate family and of their household, in the clarification/identification of their own resources/tasks/priorities and in the development and/or enhancement of their resources through individual or family/household pastoral care sessions. Pastoral Care Counselors will work with clients to clarify the spiritual and pragmatic options that order and validate the client's individual life experiences, strengthen their belief systems, purpose, and values as related to their HIV status. Pastoral care counseling is an intervention at a point of need in a client's life that strives to progressively move the client along a continuum of self-acceptance and responsibility. Pastoral care counseling must be available to all individuals eligible to receive Ryan White Program services, regardless of the client's religious or denominational affiliation.

Level IV – This service provides supervised peer support and advice through coaching, information sharing, listening, and role modeling in groups and limited individual settings. Its primary goal is the promotion of an independent living philosophy wherein the client becomes his or her own self-advocate. Individual support counseling will be provided only within the guidelines and goals of a treatment plan developed by a professional mental health counselor with assistance and consultation with the peer

support worker. The peer support counselor will provide timely feedback and information to the professional mental health counselor in order to monitor client progress. Support counseling will address adherence to mental health and medical treatments. Support counselors will not make referrals themselves, but will consult and make known to his or her supervisor information/changes in the client's condition that may require a referral. Appropriate referrals will then be made by the supervisor.

Group Counseling (Levels III and Pastoral Care) - a group of individuals (minimum of three (3) Ryan White clients, maximum of fifteen (15) total clients) with similar problems meeting under the expert guidance of a trained psychosocial support or pastoral support professional. Members of the group will be selected by the psychosocial support or pastoral support professional in order to maximize the interaction, learning, and benefits derived from a group dynamic. Group counseling provides therapy in a social context, reduces the feeling of isolation many clients experience, provides an opportunity for clients to share methods of problem solving, and allows the counselor an opportunity to observe how an individual interacts with others.

Support (Group) Counseling (Level IV) – a group of individuals [minimum of three (3) Ryan White clients, maximum of fifteen (15) total clients] with similar problems meeting with a supervised peer. These groups provide emotional support and validation through discussion of shared problems and feelings. Such support may take the form of ego-empowerment, encouragement, positive affirmation or more objective methods, as in helping to plan specific courses of action, giving advice on how to solve an immediate problem, etc. Services at this level are provided for clients experiencing mild functional or emotional problems and are generally not provided on a long term basis.

- A. Program Operation Requirements:** Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV family members (as defined by the client) only if the HIV+ client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of support group participants to counselors should be no lower than 3:1 and no higher than 15:1. One visit is equal to one half-hour counseling session.

- B. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed \$25.00 per unit for Level III and Pastoral Care individual counseling; \$27.00 per unit for Level III and Pastoral Care group counseling; \$15.00 per unit for Level IV individual counseling; and \$20.00 per unit for Level IV group support counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for the counselor that provided the group therapy (i.e., number of group counseling units per counselor).

- C. Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a one-half-hour counseling session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level III, Level IV, and pastoral care counseling services.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for a client to receive a Level III, Level IV, or pastoral care psychosocial support service and must be updated every six (6) months. Additionally, a medical referral from a licensed Level I or Level II mental health professional (indicating that the client is suitable for Level III or Level IV psychosocial support counseling) is also required. Documentation of the medical referral must be indicated in the Ryan White Program Certified Referral, or must accompany the OON Referral. Clients receiving Ryan White Program Part A-funded psychosocial support services must be documented as having a gross household income below 300% of the 2011 Federal Poverty Level (FPL).

FOOD SERVICES
(Year 21 Service Priorities #11 and #14)

Food services include **Food Bank** and **Home-Delivered Meals**. Providers must offer nutritional counseling to all food service clients through qualified staff supervised by a licensed dietitian or nutritionist. Clients may not be enrolled in more than one Ryan White Part A-funded food service program simultaneously, except if the client needs to access food bank services only for the purpose of obtaining personal hygiene products while enrolled in the home-delivered meals program.

I. Food Bank (Priority #11)

This program is a central distribution center providing groceries, including personal hygiene products when available, for indigent HIV+ clients. The food is distributed in cartons or bags of assorted products to eligible Ryan White Program clients.

A. Program Operation Requirements:

Standard Provisions

Food bank services may be provided only on an **emergency basis**. An emergency is defined as an extreme change of circumstance: loss of income (i.e., job loss or departure of person providing support), loss of housing, or release from institutional care (substance abuse treatment facility, hospital, jail, or prison) within the last two weeks. Duration of food bank service provision is to be **temporary**. Other emergencies, as defined by the client's medical case manager, must be documented in the client's chart as they arise. A severe change to the client's medical condition, as defined below under the provision for additional occurrences, may also be considered an emergency.

Medical case managers must conduct initial and on-going assessment of each client to determine if the client is eligible for food-related services under any other public and/or private funding source, including food stamps or other charity care food banks.

The provision of this service will be limited to twelve (12) occurrences within the Ryan White Part A Fiscal Year (March 1, 2011 through February 29, 2012). One (1) occurrence is defined as all food bank services provided within one (1) calendar week. For example, a client could receive food bank services once a week every week for three (3) months, or one week per month for 12 months, in the Fiscal Year or any variation thereof, with the limit of 12 occurrences in a Fiscal Year.

Groceries, including personal hygiene products when available, can be picked up on a weekly or monthly basis. If groceries will be picked up on a **weekly** basis, the client will be limited to groceries valued at \$50.00 per week at each pick-up. A client accessing food bank services on a weekly basis may not pick up groceries sooner than seven (7) days from the prior pick-up day.

If the client chooses to pick up his/her groceries on a **monthly** basis, the client will be limited to \$50.00 per week multiplied by the number of times the original day of pick-up occurs in the month. A client accessing food bank services on a monthly basis may not pick up groceries in a new month prior to the same pick-up day from the previous month.

Providers must make every effort to obtain matching funds, donations, or any supplemental assistance for the program and these efforts should be documented. Providers must also be familiar with and capable of referring clients to other community, faith-based, and/or neighborhood food bank sites when the client is not in an emergency situation and/or has reached their food bank allowance limit.

Providers must demonstrate their capacity to provide ethnic foods and foods suited to special client dietary needs.

Additional Occurrences

A **severe** change to the person's medical condition (i.e., new HIV-related diagnosis/symptom, wasting syndrome, protein imbalance, recent chemotherapy, etc.) may warrant additional occurrences of food bank services. However, additional occurrences require certification in the form of a completed **Ryan White Program Nutritional Assessment Letter for Food Bank Services**. This Letter of Nutritional Assessment must be completed by an independent physician or registered dietitian not associated with the Part A-funded food bank provider. The client must be reassessed for the "warranting" medical condition every three (3) months. The physician or registered dietitian must specify the frequency and number of additional food bank visits (occurrences) that should be allowed for the client (maximum of twelve).

Provision for Families

In addition to the maximum amount defined above for groceries available per month to eligible clients, each additional adult who is HIV+ and lives in the same household is eligible to receive \$50.00 per week in groceries subject to the same service guidelines. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is HIV+) is also eligible to receive \$20.00 per week in groceries, subject to

the same service guidelines above. The client must provide documentation to prove the dependent's age and place of residence.

- B. Rules for Reimbursement:** Providers will be reimbursed based on properly documented invoices reflecting the distribution of weekly bags of groceries, including personal hygiene products, plus a dispensing charge to be agreed upon between the provider and the Office of Grants Coordination. The cost of the weekly bag of groceries will not exceed \$50.00. Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing expenses, and other line items as listed on the approved budget.
- C. Additional Rules for Reporting:** Providers must report monthly activities according to client visits (i.e., weekly occurrences).
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation) is required for this service. Referrals expire on February 29th of this Fiscal Year. Each medical case management referral must document the number of eligible dependents (i.e., minors). For additional occurrences, the client must be reassessed for the “warranting” medical condition every three (3) months. Providers must document that HIV+ clients who receive Ryan White Part A-funded food bank services have a gross household income that does not exceed 250% of the 2011 Federal Poverty Level (FPL).

Clients receiving food bank services must be documented as having been properly screened for Food Stamps, Medicaid Project AIDS Care (PAC) Waiver, or other public sector funding as appropriate. Medical case managers must document a client's need for food services in the client's Plan of Care (POC), and indicate if the client is eligible to access food services under other available programs, with the understanding that the Ryan White Program-funded food bank services are provided on an emergency basis. If the client is eligible to receive food service benefits from another source, the medical case manager will assist the client in applying to such program(s). If the client already receives food stamp benefits at the time he/she applies for Ryan White Program-funded food bank services, the client must submit a copy of his/her Food Stamp program award/benefit letter as documentation that the award is \$25.00 or less per month in food stamp benefits. If the client applied for Food Stamp benefits and was denied, a copy of the denial letter must be filed in the client's chart and a copy should accompany the referral for food bank services.

While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Part A-funded food bank services. Similarly, while clients qualify for and can access other public funding for food services, they will not be eligible for Ryan White Part A-funded food bank services, unless the provider is able to document that the client has an emergency need, has applied for such benefits and eligibility determination is pending (a copy of benefit application must be kept in the client's chart).

In addition, referrals for food bank services must clearly state that the client is not currently receiving Part A-funded home delivered meals.

II. Home-Delivered Meals (Priority #14)

This service provides nutritionally balanced home-delivered meals for persons living with AIDS, or under certain circumstances persons who are HIV+, are indigent, disabled, and homebound, as defined by Medicaid Project AIDS Care (PAC) Waiver and as certified by a physician. PAC Waiver defines a homebound individual as one who is "confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals." In addition, clients accessing this service must be functionally impaired. A functional impairment means difficulty performing one or more activities of daily living (i.e., bathing, dressing, walking, eating), and are not capable of preparing meals. Additionally, it must be documented that no other person in the client's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation. **A physician's certification of a client's homebound status is required and must be updated every three (3) months. This certification must be kept on-site in the client chart at the home-delivered meal provider agency.**

- A. Program Operation Requirements:** This service includes the provision of both frozen and hot meals. Providers must demonstrate their capacity to provide ethnic foods and food suited to special client dietary needs. A meal must be defined according to current American Dietary Association (ADA) guidelines (minimum daily requirements).
- B. Rules for Reimbursement:** Providers will be reimbursed on the basis of a delivered meal that meets commonly accepted nutritional guidelines, at a rate not to exceed \$6.25 per meal (frozen or hot) with a maximum of three (3) meals per day per client. The projected cost per meal must include the cost of nutritional counseling.

- C. Additional Rules for Reporting:** Providers must report monthly activity on the basis of a delivered meal meeting the nutritional guidelines indicated above under program operations requirements.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service. Every three (3) months, client eligibility for this service must be re-certified by a medical case manager and the physician's certification of homebound status must be re-confirmed and updated. Providers must document that persons receiving Part A-funded home-delivered meal services: (1) are homebound as defined by Medicaid Project AIDS Care (PAC) Waiver and as certified by a physician. (PAC Waiver defines a homebound individual as one who is "confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals."); (2) clients accessing this service must be functionally impaired. A functional impairment means difficulty performing one or more activities of daily living (i.e., bathing, dressing, walking, eating), and are not capable of preparing meals. Additionally, it must be documented that no other person in the client's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation; (3) are current permanent residents of Miami-Dade County; (4) have AIDS (as defined by the CDC) or are HIV+ with a condition (certified by a physician) that makes home-delivered meals necessary; and (5) have a gross household income that does not exceed 300% of the 2011 Federal Poverty Level (FPL). While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Part A-funded home delivered meals.

PLEASE NOTE: A complete referral for this service includes either the Ryan White Program Certified Referral or an Out-of-Network Referral (including appropriate supporting documentation) AND the physician's certification of homebound status. No referral for home-delivered meals may be for longer than three (3) months duration and all supporting documentation must be kept in the client chart on-site at the home-delivered meal provider agency.

Clients receiving home-delivered meals must be documented as having been properly screened for other public sector funding as appropriate. While clients qualify for and can access Medicaid Project AIDS Care (PAC) Waiver, or other public or faith-based funding for home delivered meals, they will not be eligible for Ryan White Part A-funded home-delivered meals. In addition, referrals for home-delivered meals must

clearly state that the client is not currently receiving Part A-funded food bank services, except for personal hygiene products.

ALSO NOTE: Where the HIV positive status of the client and a medical condition renders the client homebound, physicians must indicate whether the condition is temporary or permanent, and if temporary, the period of time that home-delivered meal service is authorized. If no such time indication is provided, such certification will last for a maximum of thirty (30) days.

TRANSPORTATION VOUCHERS *(Year 21 Service Priority #12)*

This service provides specially-designated, discounted Miami-Dade Transit Agency (MDTA) Metro (transportation) EASY Tickets to eligible HIV+ clients attending medical and/or social service appointments. The client's qualified dependents and caregivers are also eligible to receive reduced rate tickets if attending medical and/or social service appointments along with the client. This includes monthly tickets.

Providers of EASY Tickets must demonstrate coordination with Miami-Dade transportation agencies and services, Medicaid Special Transportation, Miami-Dade Special Transportation Services (STS), and other existing transportation programs to avoid duplication of services. In addition, providers of transportation tickets are encouraged to apply annually to the Miami-Dade Transit Transportation Disadvantaged Program in order to obtain assistance for clients eligible under that program. As a reminder, the Ryan White Program is to be used as the payer of last resort.

- A. Program Operation Requirements:** EASY Tickets cost \$50.00 (fifty dollars) per month for unlimited trips during the calendar month. These specially-designated EASY Tickets will not be usable in other months and are not "re-loadable." The amount for EASY Tickets should be consistent throughout the duration of the contract period and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. For any given month, once an allotment of tickets has been exhausted, providers may not distribute additional tickets for that month.

Monthly transportation tickets must be distributed in a timely manner (no later than the 5th day of the month) in order to maximize ticket usage. Unused transportation tickets should be returned to the MDTA for credit. Agencies must follow MDTA's procedures for ticket returns.

Providers must inform clients that this type of assistance is **not** an entitlement. Therefore, the level of assistance provided to individual clients is based on relative need. Clients must also be informed that the availability of transportation tickets is contingent upon funding availability and, therefore, the continuance of this type of assistance is not guaranteed.

Providers must specify criteria, policies, and procedures utilized to determine transportation EASY Tickets allotments for clients that must take into account not only minimum requirements, but also consideration for those clients who demonstrate the greatest need for these services.

Documentation of multiple monthly medical and social service appointments must be submitted by the client to his/her medical case manager before the client can receive transportation assistance. If allowable appointments are appropriately documented in the client chart, the Ryan White Program will not restrict the number of months in which the client can receive transportation services during the Fiscal Year.

- B. Rules for Reimbursement:** Providers will be reimbursed based on properly documented service utilization reports from the Service Delivery Information System (SDIS), indicating the date of EASY Ticket distribution, client CIS number, and dollar amount including dispensing charge. Dispensing charges, not to exceed 15%, will be reimbursed after services have been provided, client utilization and disbursement information is submitted to the County, and vendor payment has been documented. This service is subject to audit by the Office of Grants Coordination. EASY Ticket orders, invoices, and payments, as well as monthly distribution logs signed by the client, will be reviewed.
- C. Additional Rules for Reporting:** Providers must report monthly activity according to the dollar amount of the tickets issued, the number of tickets, and the unduplicated number of clients served.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated every six (6) months. Clients receiving Ryan White Program Part A-funded transportation assistance must be documented as having a gross household income below 150% of the 2011 Federal Poverty Level (FPL). Clients receiving transportation EASY Tickets must be documented as having been properly screened for other public sector funding as appropriate every six (6) months. Qualified dependents and caregivers are eligible to receive transportation tickets as long as they are not eligible to receive and cannot access this service under another funding source [i.e., Miami-Dade County Golden Pass Program, Special Transportation Services (STS), Medicaid, etc.]. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Part A-funded transportation EASY Tickets.

LEGAL ASSISTANCE
(Year 21 Service Priority #13)

This service provides **Legal Assistance** to individuals living with HIV or AIDS who would not otherwise have access to these services with the goal of maintaining clients in health care. Services include assistance with access to benefits and health care-related services.

A. Program Operation Requirements: Funds may be used to support and complement pro bono activities. All legal assistance will be provided under the supervision of an attorney licensed by the Florida Bar Association. Only civil cases are covered under this Agreement. Therefore, the service provider will assist eligible Ryan White Program clients with civil legal HIV-related issues which will benefit the overall health of the client and/or the Ryan White care delivery system in the following areas:

- Collections/Finance – issues related to unfair or illegal actions by collection agencies related to health care debt (e.g., bankruptcy due to health care debt).
- Employment Discrimination Services – issues related to discrimination while at work, unfair terminations, unfair promotion policies, or hostile work environment as related to HIV diagnosis or status.
- Health Care Related Services – issues related to ensuring that the client is treated in a fair manner, and issues relating to breach of confidentiality by divulging HIV status or other confidential medical/income information without client consent.
- Health Insurance Services – issues related to seeking, maintaining, and purchasing of private health insurance. Issues may also relate to refusal of coverage based upon “pre-existing conditions.”
- Government Benefit Services – issues related to obtaining or retaining public benefits which the client has been denied and is eligible to receive, including but not limited to Social Security Disability and Supplemental Income Services benefits, Unemployment Compensation, as well as welfare appeals, and similar public/government services.
- Rights of the Recently Incarcerated Services – issues related to a client’s right to access and receive medical treatment upon release from a correctional institution.

Providers should demonstrate experience in providing similar services and the ability to meet the multi-lingual needs of the HIV/AIDS community.

- B. Rules for Reimbursement:** The unit of reimbursement for this service is *one hour* of legal consultation and/or advocacy provided by an attorney or paralegal at a rate not to exceed \$90.00 per hour.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of *one hour of legal consultation and/or advocacy* provided by an attorney or paralegal.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated annually. Providers must also document that HIV+ clients receiving Ryan White Program Part A-funded legal assistance are permanent residents of Miami-Dade County and have a gross household income that does not exceed 200% of the 2011 Federal Poverty Level (FPL).

TRANSPORTATION SERVICES (VANS)
(Year 21 Service Priority #15)

This program provides free transportation to and from HIV medical and support service programs, Miami-Dade HIV/AIDS Partnership functions, and/or home for HIV+ clients and their qualified dependents and/or caregivers in cars or vans operated directly by service providers. **Funding for this service is restricted to providers located in the area of South Miami-Dade County (designated as South of SW 88th Street, Kendall Drive).**

Providers of **Transportation Services (Agency-Based Transportation/Vans)** must demonstrate coordination with Miami-Dade transportation agencies and services, Medicaid Special Transportation and Special Transportation Services (STS) and other existing transportation programs to avoid duplication of services.

- A. Program Operation Requirements:** These services are provided in combination with core services (outpatient medical care, oral health care, pharmaceuticals, mental health therapy/counseling, substance abuse treatment/counseling, and/or medical case management services) to clients enrolled in HIV service programs.
- B. Rules for Reimbursement:** The unit of service for reimbursement for this service will be a one-way trip at a rate not to exceed \$13.00 per one-way trip (i.e., each way).
- C. Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of one-way trips.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated every six (6) months. Providers must document that eligible HIV+ clients who receive Ryan White Program Part A-funded agency-based transportation services also: (1) have a gross household income that does not exceed 150% of the 2011 Federal Poverty Level (FPL); and (2) have been documented as having been properly screened for other public sector funding as appropriate. Qualified dependents and/or caregivers are eligible to receive free agency-based transportation if riding along with the client. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Program Part A funding for this service.

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2011-2012
(Year 21)**

**Section II –
Cost and Eligibility Summary**



*Miami-Dade County
Office of Grants Coordination*

RYAN WHITE PROGRAM
FY 2011-2012 (YEAR 21)
COST AND ELIGIBILITY SUMMARY



Miami-Dade County
Office of Grants Coordination

Effective March 1, 2011

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2011-2012 (YR 21) <u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outpatient Medical Care [including Minority AIDS Initiative (MAI)]	Client Medical Visit and Unduplicated # of Clients Served	<p>Multiplier applied to reimbursable procedure rate listed in the Year 2011 Florida Medicare Part B Physician Fee Schedule (Participating, Locality 04), file dated January 4, 2011, for Evaluation and Management (E&M) codes for outpatient medical care and psychiatric visits only. Inpatient and emergency room services are not covered.</p> <p>Medical Procedures performed at Ambulatory Surgical Centers (ASCs) will be reimbursed at rates found in the 2011 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates, revised January 7, 2011.</p>	<p>Maximum Multiplier Rate of 1.50 Applied to Medicare Reimbursable Rates for Evaluation and Management codes for outpatient medical care and psychiatric visits only.</p> <p>No multiplier will be applied to the Medicare ASC Reimbursement Rates</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2011-2012 (YR 21)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
<p>Outpatient Medical Care (including MAI)</p> <p>(cont'd)</p>	(see previous page)	<p>Medical Procedures performed at Outpatient Hospital centers will be reimbursed at rates found in the approved Medicare Addendum B Outpatient Prospective Payment System (OPPS) by HCPCS Code for CY 2011 Fee Schedule, dated January 2011.</p> <p>All other non-E&M procedures will be reimbursed at the 2011 Medicare rate as referenced above. No multiplier will be applied to non-E&M procedures.</p> <p>Laboratory procedures will be reimbursed at rates included in the 2011 Medicare Clinical Diagnostic Laboratory Fee Schedule, for Florida (FL), revised January 2011.</p>	<p>No multiplier will be applied to the Medicare OPPS Reimbursement Rates</p> <p>All other non-E&M procedures will be reimbursed at the 2011 Medicare rate as referenced above. No multiplier will be applied to non-E&M procedures.</p> <p>Flat rate only for labs and injectables. No multiplier may be applied.</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2011-2012 (YR 21)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
<p>Outpatient Medical Care (including MAI)</p> <p>(cont'd)</p> <p>Consumable Medical Supplies</p>	<p>Number of Clients Served, Consumable Medical Supply Distributions per Client (for Administering Prescribed Medications Only), and Dollar Amount Spent per Client</p>	<p>Injectables will be reimbursed at rates included in the 2011 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, dated December 29, 2010.</p> <p>Allowable flat rate listed in the Medicare Durable Medical Equipment and Supplies Revised 2011 Fee Schedule, for Florida (FL), dated January 2011.</p> <p>If no Medicare Rate is available for DME and supplies, providers will be reimbursed at the Medicaid DME for All Medicaid Recipients fee schedule rates, dated September 1, 2010. In such case, providers must submit a request to the County for a Supplemental Reimbursement Rate</p>	<p>No multiplier may be applied to laboratory or injectable fees.</p> <p>Flat rate only. No multiplier may be applied.</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2011-2012 (YR 21)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Prescription Drugs (including MAI for all components)	Individual Drugs Dispensed, # of Filled Prescriptions, \$ Spent per Drug, and Unduplicated # of Clients Served	PHS of Injectable/ Non-Injectable Medication Plus Flat Rate Dispensing Fee AND AWP of Injectable/ Non-Injectable Medication Minus Discount Rate	PHS Price Plus Flat Rate Dispensing Fee AND AWP Minus Applied Discount Rate of No Less Than 10%	400%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity or Prior Authorization Form, if Applicable	Yes
Prescription Drugs: Consumable Medical Supplies (for Administering Prescribed Medications only)	Number of Clients Served, Consumable Medical Supply Distributions per Client (for Administering Prescribed Medications Only), and Dollar Amount Spent per Client	Allowable flat rate listed in the Medicare Durable Medical Equipment and Supplies Revised 2011 Fee Schedule, for Florida (FL), dated January 2011. If no Medicare Rate is available for DME and supplies, providers will be reimbursed at the Medicaid DME for All Medicaid Recipients fee schedule rates, dated September 1, 2010. In such case, providers must submit a request to the County for a Supplemental Reimbursement Rate	Flat rate only. No multiplier may be applied.	400%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity, if Applicable	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Medical Case Management (including MAI)	Type of 15 Minute Client Encounter (Face-to-Face or Other) and Unduplicated # of Clients Served OR Type of 15 Minute Activity Performed by a Case Management Supervisor (chart review, consultation, etc.)	Cost of 15 Minute Encounter	\$14.00 / Encounter	400%	I, II, III	Yes
Medical Case Management: Peer Education and Support Network (PESN) (including MAI)	Type of 15 Minute Encounter (Face-to-Face or Other) and Unduplicated # of Clients Served	Cost of 15 Minute Encounter	\$7.50 / Encounter	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Substance Abuse Counseling – Residential – Residential (including MAI)	# of Days of Residential Substance Abuse Treatment per Client and Unduplicated # of Clients Served	Cost of One Day of Residential Counseling Treatment Per Client	\$125.00 per client day [up to a maximum of 120 days within a 12-month period; 12-months begins on the 1 st day of client’s residential treatment regardless of Part A / MAI provider] [includes the cost of family member(s) participating in the substance abuse counseling session provided during day of treatment]	300%	I, II, III	Yes A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services (AIDS Insurance Continuation Program)	Dollars per Insurance Premium, Unduplicated # of Clients Served, and Dollars Expended per Client	Dollars Expended per Insurance Premium Per Client Plus a Dispensing Fee of \$15 per month	Reimbursement will be based on documentation of dollars expended per insurance premium plus a dispensing fee. Maximum amount of assistance a client may receive on a monthly basis is \$750.	400%	I, II, III	Yes Client must have insurance under a group, individual or COBRA policy. Client must be willing to sign all required forms and to provide eligibility information. A complete financial assessment and disclosure are required.

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Insurance Services (Insurance Deductibles)	Dollars per Deductible, Unduplicated # of Clients Served, and Dollars Expended per Client	Dollars Expended per Client per Deductible Plus a Dispensing Fee	Reimbursement will be based on documentation of dollars expended per deductible plus a dispensing fee. Maximum amount of assistance a client may receive on an annual basis is \$2,500.	400%	I, II, III	Yes A complete financial assessment and disclosure are required.
Insurance Services (Prescription Drugs Co-payments & Co-insurance)	Dollars per Co-payment, Unduplicated # of Clients Served, and Dollars per Client	Dollars Expended per Co-payment Plus a Dispensing Fee	Reimbursement will be based on documentation of dollars expended per co-payment plus a dispensing fee. Assistance is restricted to those medications listed on the current approved Ryan White Program Prescription Drug Formulary	400%	I, II, III Physician's Prescription	Yes A complete financial assessment and disclosure are required.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Oral Health Care	Client Office Visit, Oral Health Care Procedure Provided, and Unduplicated # of Clients Served	Multiplier applied to procedure rate listed in the State of Florida Medicaid Dental Services Fee Schedule, most current as of March 1, 2011; reimbursement rates based on the American Dental Association's Current Dental Terminology CDT 2011-2012, codes for dental procedures	<p>Maximum Multiplier Rate of 3.0</p> <p>Maximum Annual Limit (Fiscal Year) for Oral Health Care Services: \$3,000 per client</p> <p>Very limited exceptions to the annual cap may be approved by the County, with consultation from the Miami-Dade HIV/AIDS Partnership's Oral Health Care Subcommittee as needed, on a case-by-case basis for the provision of preventative oral health care services only.</p>	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Substance Abuse Counseling – Outpatient (Level I) Individual and Group	½ Hour Counseling Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client & Family Member</p> <p>Group: ½ Hour Counseling Session per Counselor</p>	<p>Individual: \$30.00 per unit</p> <p>Group: \$34.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)</p>	400%	I, II, III	Yes
Substance Abuse Counseling – Outpatient (Level II) Individual and Group	½ Hour Counseling Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client and/or Family Member, as appropriate</p> <p>Group: ½ Hour Counseling Session per Counselor</p>	<p>Individual: \$27.00 per unit</p> <p>Group: \$30.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)</p>	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Mental Health Therapy/ Counseling (Level I) Individual and Group (PhD, EdD, or PsyD; and licensed by the State of Florida as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT)	½ Hour Counseling Session and Unduplicated # of Clients Served	Individual: ½ Hour Counseling Session per Client Group: ½ Hour Counseling Session per Counselor	Individual: \$32.50 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service) Group: \$35.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)	400%	I, II, III	Yes
Mental Health Therapy/ Counseling (Level II) Individual and Group (MS, MA, MSW, or MEd; and licensed by the State of Florida as a LCSW, LMHC, or LMFT)	½ Hour Counseling Session and Unduplicated # of Clients Served	Individual: ½ Hour Counseling Session per Client Group: ½ Hour Counseling Session per Counselor	Individual: \$32.50 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service) Group: \$35.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outreach Services (including MAI)	Type of 15 Minute Outreach Encounter [Face-to-Face or Other (i.e., Telephone Contact, Referral Activity, etc.)] and Unduplicated # of Clients Served At least 25% of the people contacted through Part A / MAI outreach services and billed for must be returned into medical care and/or other core services, and at least 3% of those clients contacted by outreach workers will be new to care, on a quarterly basis	Line Item Budget Reimbursement will be based on a line item budget (for actual expenses incurred per month by the outreach service provider).	Outreach services will be paid based on full-time employees (FTEs) providing direct services as outlined in the corresponding service definition, as well as on the basis of other direct and administrative costs. Reimbursement will be based on the approved budget and productivity as recorded by hours spent conducting outreach activities, people contacted, their risk factors; and the # of people actually brought and/or returned into medical care and/or other core services on a quarterly basis. All indirect expenses (other than those associated with the delivery of outreach services) are capped at 10%.	N/A	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Psychosocial Support Services (Level III) Individual and Group (Bachelor's degree or Unlicensed MSW or MS in appropriate counseling-related field)	½ Hour Counseling Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client</p> <p>Group: ½ Hour Counseling Session per Counselor</p>	<p>Individual: \$25.00 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)</p> <p>Group: \$27.00 per unit (min. of 3 Ryan White clients to max. of 15 total clients)</p>	300%	I, II, III	Yes A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.
Psychosocial Support Services (Pastoral Care) Individual and Group (Master's degree in theology, philosophy, social work, or psychology from an accredited institution)	½ Hour Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client</p> <p>Group: ½ Hour Counseling Session per Counselor</p>	<p>Individual: \$25.00 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)</p> <p>Group: \$27.00 per unit (min. of 3 Ryan White clients to max. of 15 total clients)</p>	300%	I, II, III	Yes A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Psychosocial Support Services (Level IV) Individual and Group (Trained and Supervised Peers)	½ Hour Counseling Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client</p> <p>Group: ½ Hour Session per Counselor</p>	<p>Individual: \$15.00 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)</p> <p>Group: \$20.00 per unit (min. of 3 Ryan White clients to max. of 15 total clients)</p>	300%	I, II, III	Yes A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Food Bank	Food Bank Occurrence	<p>Dollars per Food Bank Occurrence (weekly bag of groceries, including personal hygiene products), Plus a Dispensing Fee</p> <p>Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing, and other line items listed on the approved budget.</p>	<p>Food Bank Services may be accessed on an emergency basis ONLY.</p> <p>The provision of this service will be limited to twelve (12) occurrences in a Ryan White Program Part A fiscal year. One (1) occurrence is defined as all food bank services provided within one (1) calendar week.</p> <p>General Provision: Groceries, including personal hygiene products when available, can be picked up on a weekly or monthly basis.</p> <p>Weekly client limit = \$50.00 per week at each pickup.</p> <p>Monthly client limit = \$50.00 per week multiplied by the number of times the original day of pick-up occurs in the month.</p>	250%	<p>I, II, III Client eligibility for this service must be certified by the Medical Case Manager</p> <p>Medical Case Management Referral and has applied for Food Stamps, as appropriate.</p>	<p>Yes</p> <p>A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.</p>

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Food Bank (continued)	Additional Food Bank Occurrence	Dollars per Food Bank Occurrence (weekly bag of groceries, including personal hygiene products), Plus a Dispensing Fee	<p>Additional Occurrences: A severe change to the person’s medical condition (i.e., new HIV related diagnosis/ symptom, wasting syndrome, protein imbalance, recent chemotherapy, etc.) may also warrant additional occurrences of food bank services.</p> <p>Provision for Families: Each additional adult who is HIV+ and lives in the same household is eligible to receive an additional \$50 per week in groceries, subject to the same general provisions above. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is HIV+) is also eligible to receive \$20 per week, subject to the same general provisions above.</p>	250%	<p>The client must be reassessed for the “warranting” medical condition every three (3) months.</p> <p>Additional occurrences require a Ryan White Program Nutritional Assessment Letter for Food Bank Services to be completed by an independent physician or registered dietician not associated with the Part A food bank provider.</p> <p>For Families: The client must provide documentation to prove the dependent’s age and place of residence.</p>	<p>Yes</p> <p>A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.</p>

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Transportation Vouchers (Discounted EASY Ticket)	Dollars per Voucher, # of Vouchers, and Unduplicated # of Clients Served	Dollars per Voucher Plus a Dispensing Fee Not to Exceed 15%	Cost of Vouchers Plus Dispensing Fee Not to Exceed 15%	150%	I, II, III Medical Case Management Referral Case Manager re-certification required every 6 months.	Yes Clients must be screened for eligibility of Miami-Dade County Golden Pass Program, Special Transportation Services (STS), Miami-Dade Transit Transportation Disadvantaged Program, Medicaid, etc. A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Legal Assistance	Hour of legal consultation and/or advocacy provided by an attorney or paralegal	Cost of one hour of legal consultation and/or advocacy provided by an attorney or paralegal	\$90.00 per Hour	200%	I, II, III	Yes A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Home Delivered Meals	# of Home Delivered Meals	Cost per Meal	\$6.25 / Meal (Frozen or Hot) (rate must include cost of nutritional counseling)	300%	<p align="center">III</p> <p align="center">Physician's Certification of Client's Homebound** and Impaired Status</p> <p align="center">[**as defined by Florida Medicaid Project AIDS Care Waiver (PAC Waiver)]</p> <p align="center">Case Management Re-certification for a "warranting" medical condition is required every three (3) months.</p> <p align="center">A copy of the Physician's Certification must remain in the client's chart on-site at the home delivered meals provider facility.</p>	<p align="center">Yes</p> <p align="center">A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.</p>

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2011 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Transportation Services (Vans)	One-Way Trip	Cost of One-Way Trip	\$13.00 per One-Way Trip	150%	I, II, III	Yes A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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Ryan White Program Service Delivery Guidelines Fiscal Year 2011-2012 (Year 21)

Section III –

- **Ryan White Program System-wide Standards of Care**
- **Ryan White Program Case Management Standards of Service**
- **National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care**
- **HAB HIV Performance Measures (web links to the following measures):**
 - **Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3**
 - **Medical Case Management**
 - **Oral Health Services**
 - **Systems-Level**
 - **Pediatrics**
- **Ryan White Program Minimum Primary Medical Care Standards for Chart Review**
- **Ryan White Program Oral Health Care Standards**
- **Treatment Guidelines & Additional Service Delivery Standards**



***Miami-Dade County
Office of Grants Coordination***

MIAMI-DADE COUNTY RYAN WHITE PROGRAM



SYSTEM-WIDE STANDARDS OF CARE

(Revised March 1, 2011)

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**MIAMI-DADE COUNTY
RYAN WHITE PROGRAM
SYSTEM-WIDE STANDARDS OF CARE**

The following sets of standards are an essential component of the Ryan White Program's quality management program and form the basis for on-going monitoring and evaluation of Ryan White Program-funded service providers by the Miami-Dade County Office of Grants Coordination and/or its authorized representatives. With the exception of staff qualifications (Standard #2), it is not expected that *newly* contracted organizations be in full compliance with the System-Wide Standards of Care at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. However, all providers are expected to maintain full compliance at all times with documentation of client eligibility (*Standard #3*).

SYSTEM-WIDE STANDARDS OF CARE

No Barriers to Service

Standard #1

Client access to services, system wide, shall be facilitated and barriers to service eliminated.

Guidelines	Indicator	Data Source
<p>(1.1 – 1.5) Providers shall eliminate barriers to service caused by: (A) hours of operation, (B) language and culture, and/or (C) lagtime. <i>Exemptions: (A) All services not specified (B) None (C) 1.5 None; (C) 1.6 Prescription Drugs, Medical Case Management, MAI Medical Case Management</i></p>	<p>A: Hours of Service: 1.1 Medical care, pharmaceuticals, and medical case management shall provide a minimum of 40 hours access to services per week including 4 hours outside of regular business hours (9:00 am – 5:00 pm, Monday-Friday). Outpatient medical care and oral health care providers will offer, post, and maintain daily walk-in slots to accommodate clients with urgent/emergent health issues.</p> <p>1.2 24-hour on-call access to pharmaceutical services, emergency medical and oral health care, and crisis counseling</p> <p>B: Language: 1.3 Agencies must offer and provide language assistance services, including bilingual staff and interpreter services (including Spanish and Haitian Creole) at no cost to each client with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.</p> <p>1.4 Agencies must provide to clients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.</p>	<ul style="list-style-type: none"> ➤ Scope of Service Description ➤ Posted hours of service ➤ Scope of Service Description ➤ Posted hours of service ➤ Record Review ➤ Personnel Files ➤ Observation ➤ Written Policies and Procedures ➤ Invoices (reviewed during on-site visit) ➤ Observation ➤ Personnel Files ➤ Record Review

Staff Qualifications/Training

Standard #2

Agencies shall ensure that all staff has sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population: agencies must provide initial orientation and training for new staff and ensure all staff participate in ongoing HIV/AIDS trainings, thereby promoting provision of high quality, up-to-date services.

Guidelines	Indicator	Data Source
<p>(2.1 – 2.2) Supervisory staff and core service staff shall meet the qualifications of education and experience required by the Miami-Dade County Office of Grants Coordination and the Miami-Dade HIV/AIDS Partnership. Agencies should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. <i>Exemptions: 2.1 None; 2.2 Home Delivered Meals, Food Bank, Transportation Vouchers, Prescription Drugs, Medical Case Management (Refer to Case Management Standards for education/experience requirements).</i></p>	<p>2.1 Core service supervisors are licensed and/or have a bachelor’s degree in social sciences, counseling or nursing; have management experience; or have equivalent HIV/AIDS or related experience</p> <p>2.2 Core service staff have an associate degree (AA) in social sciences, counseling or nursing. HIV/AIDS or related experience, including living with HIV, may be substituted on a year-for-year basis. Exempt personnel must be supervised by staff that meets minimum supervisory qualifications (2.1)</p>	<p>➤ Personnel Files</p> <ul style="list-style-type: none"> • Copies of degrees/licenses • Documentation of work experience (letters of recommendation, work references, etc) <p>➤ Personnel Files</p> <ul style="list-style-type: none"> • Copies of degrees/licenses • Documentation of work experience, HIV/AIDS experience (letters of recommendation, work references, training certificates, etc.) • Personnel Records
<p>(2.3) Initial orientation and training shall be given to new staff. <i>Exemptions: None</i></p>	<p>2.3 Documentation of initial orientation and training including Ryan White Program services, standards and requirements</p>	<p>➤ Personnel Files</p> <ul style="list-style-type: none"> • Signed, dated orientation schedule or Orientation Attendance Log • Signed, dated Ryan White Program standards or form acknowledging training/receipt of same
<p>(2.4) Staff members will have a clear understanding of their job definition and responsibilities. <i>Exemptions: None</i></p>	<p>2.4 Written job description including responsibilities</p>	<ul style="list-style-type: none"> • Signed, dated job description

Guidelines	Indicator	Data Source
<p>(2.5 – 2.6) Policies and procedures for service provision shall be in written form and made available to all staff. <i>Exemptions: None</i></p> <p>(2.7) Training in OSHA and universal precautions appropriate to job duties is provided and staff adheres to these principles.</p> <p>Agencies should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery <i>Exemptions: None</i></p>	<p>2.5 Written Policies and Procedures (P & P's)</p> <p>2.6 Documentation that staff have read and are familiar with P & P's</p> <p>2.7 Documentation of training</p>	<ul style="list-style-type: none"> ➤ Administrative Policies and Procedures ➤ Personnel Records <ul style="list-style-type: none"> • Signed, dated agency policies and procedures • Signed, dated letter documenting P&P review, understanding ➤ Signed, dated training acknowledgement, attendance logs with dates and subject matter of training, agency training logs ➤ Signed, dated Ryan White Program standards or form acknowledging receipt/training on same
<p>(2.8) Core service staff is knowledgeable about Ryan White Program standards and service requirements. <i>Exemptions: None</i></p>	<p>2.8 Annual update on Ryan White Program standards and service requirements</p>	<ul style="list-style-type: none"> ➤ Personnel Records <ul style="list-style-type: none"> • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training
<p>(2.9) Staff shall remain updated on HIV/AIDS information. <i>Exemptions: None</i></p>	<p>2.9 At least once annually: core service staff shall attend an HIV/AIDS seminar/training appropriate to their level of service delivery</p>	<ul style="list-style-type: none"> ➤ Agency training record
<p>(2.10) Personnel working with children are to be screened in accordance with state or local laws. <i>Exemptions: None</i></p>	<p>2.10 Clearance letters for abuse and criminal screening</p>	<ul style="list-style-type: none"> ➤ Personnel files

Documentation Standards

Standard #3

Standardized forms and consistent up-to-date protocols will be utilized across the system to ensure uniform quality of care.

Guidelines	Indicator	Data Source
<p>(3.1 – 3.12) Documentation for intake and service provision shall include, at a minimum, standard forms and required client data. The treatment or care plan shall be unique for each client, culturally sensitive, non-judgmental, personalized and with an appropriate standard of care and with respect to a person's right to privacy.</p>	<p>Record contains: 3.1 Financial assessment and proof of HIV OR a Ryan White Program Certified Referral 3.2 Eligibility screening for third party payers 3.3 Consent for enrollment/treatment OR a Ryan White Program Certified Referral 3.4 Consent to Release and Exchange Information (SDIS) OR a Ryan White Program Certified Referral 3.5 Intake history (Client demographics and personal contact information) 3.6 Documentation that client confidentiality is explained 3.7 Documentation that grievance procedure is explained 3.8 Documentation that choice of providers is explained 3.9 Service provision history 3.10 Treatment/Service Plan documenting reason(s) for treatment, process and progress, outcomes of treatment 3.11 Treatment/Service Plan update at least once per year <i>Note: Medical Case Managers are required to update Program Certified Referrals (Recertification) every 6 months dependent on service category</i> 3.12 SDIS Notice of Privacy Practices</p>	<p>➤ Record Review</p> <ul style="list-style-type: none"> • All required forms are complete, initialed, dated, signed as appropriate • Copies of required eligibility documents are present, current (within 6 months), and legible • Documentation of eligibility screening for third party payers is present • Cases are closed as appropriate

Guidelines	Indicator	Data Source
<p>(3.13 – 3.17) Referrals: Providers must maintain adequate documentation on referral activities. <i>Exemptions: None</i></p>	<p>3.13 Inbound referrals for all Ryan White Program Certified Referrals, shall record origin of referral and service requested</p> <p>3.14 Outbound referrals for all Ryan White Program Certified Referrals shall record the referral destination and service requested, must have an end date, and will note the type of service referred to (e.g., medical, nutrition)</p> <p>3.15 All inbound referrals filed in client record</p> <p>3.16 Service referrals not initiated by a medical case manager shall be documented in a progress note or treatment plan</p> <p>3.17 Out of network referrals require a completed general referral form with supporting documents as relevant (e.g., proof of HIV, proof of residency, proof of income); original referral shall be kept in client's chart and a copy will be given to the service provider by the client and/or by the referring out of network case manager</p>	<ul style="list-style-type: none"> ➤ SDIS Referral Report ➤ Record Review
<p>(3.18 – 3.20) Providers must avail themselves of all other available resources to provide needed services to HIV/AIDS clients including the Ryan White service network, key points of service entry, city, state and private organizations. <i>Exemptions: None</i></p>	<p>3.18 Linkage agreements</p> <p>3.19 Service resources</p> <p>3.20 Inbound, Outbound Referrals</p>	<ul style="list-style-type: none"> ➤ Administrative Records ➤ Lists of Service Resources ➤ SDIS Referral Report

Quality Assurance/Performance Improvement

Standard #4

Ongoing quality assurance activities with regular feedback to core service staff promote performance improvement and quality care.

Guidelines	Indicator	Data Source
<p>(4.1 – 4.4) Supervisory record reviews are conducted regularly, with feedback to core service staff resulting in improved performance. <i>Exemptions: None</i></p>	<p>4.1 Record reviews will be conducted and submitted to Behavioral Science Research on a quarterly basis</p> <p>4.2 No less than 20 records or 10% of Ryan White Part A or MAI population (whichever is less)</p> <p>4.3 Evidence of feedback between supervisor and employee</p> <p>4.4 Documentation review ensures Ryan White eligibility standards are met and that case notes are appropriate, timely, and legible</p>	<ul style="list-style-type: none"> ➤ Supervisor’s Records <ul style="list-style-type: none"> • Documentation of reviews with identifying client information • Documentation of employee feedback ➤ Record Review ➤ Review submission ➤ Personnel file
<p>(4.5) Medical Services: Quality assurance or patient care review meetings will identify problems to be resolved through action. <i>Exemptions: None</i></p>	<p>4.5 Documentation of quarterly patient care reviews or quality assurance meetings recording attendance, date, subject matter, steps taken to resolve identified problems with time frames for resolution.</p>	<ul style="list-style-type: none"> ➤ Meeting minutes ➤ Attendance logs
<p>(4.6) Non-Medical Services: Quality improvement issues will be addressed through staff meetings. <i>Exemptions: None</i></p>	<p>4.6 Documentation of quarterly quality improvement meetings recording attendance, date, subject matter, steps taken to resolve identified problems with times frames for resolution.</p>	<ul style="list-style-type: none"> ➤ Meeting minutes ➤ Attendance logs

Guidelines	Indicator	Data Source
<p>(4.7 – 4.8) Annual client satisfaction survey conducted and results utilized as appropriate to improve service delivery. <i>Exemptions: None</i></p> <p>(4.9 - 4.12) Agencies should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction assessments, and outcome-based evaluations.</p>	<p>4.7 Client satisfaction survey to include: Rating of services, perception of treatment by staff, satisfaction with services provided, fair access to services provided.</p> <p>4.8 Written plans and objectives incorporate results as appropriate from client satisfaction surveys.</p> <p>4.9 Updated and clearly displayed mission statement to include a commitment to the delivery of culturally and linguistically competent services</p> <p>4.10 Agency information and educational material available in English, Spanish and Creole translated from the appropriate cultural perspective</p> <p>4.11 Appropriate number of bilingual staff (or a current directory of interpreters) able to provide services in the predominant language(s) of the agency's clients</p> <p>4.12 Percentage of clients served in their preferred language</p>	<ul style="list-style-type: none"> ➤ Review of client satisfaction survey ➤ Client Satisfaction Survey ➤ Administrative records ➤ Record Review ➤ Personnel file ➤ Quality Management Plan ➤ Client satisfaction survey addresses delivery of services in a culturally and linguistically appropriate manner ➤ Written policies and procedures ➤ Observation

Confidentiality

Standard #5

Every agency shall provide staff with initial and ongoing training regarding client confidentiality to ensure client information is protected in accordance with state and federal laws.

Guidelines	Indicator	Data Source
<p>(5.1 – 5.2) Every agency shall have a written Policy and Procedure (P & P) addressing confidentiality. <i>Exemptions: None</i></p> <p>(5.3) Services shall be provided in a confidential setting. <i>Exemptions: None</i></p> <p>(5.4) All hard copy materials and records shall be securely maintained.</p> <p>(5.5) All clients shall be informed regarding their rights to confidentiality. <i>Exemptions: None</i></p> <p>(5.6) No release of client information without a signed, dated client release. <i>Exemptions: None</i></p>	<p>5.1 Written P & P addressing HIV confidentiality and agency procedures, including policies and procedures that limit access to passwords, electronic files, medical records, faxes, release of client information</p> <p>5.2 P & P is signed and dated annually by staff</p> <p>5.3 Areas in which client contact occurs allow exchange of confidential information in a private manner.</p> <p>5.4 Records, hard copy materials maintained under double lock in files and in areas secure from public access.</p> <p>5.5 Documentation signed and dated by client acknowledging client has been fully informed of his/her right to confidentiality.</p> <p>5.6 Signed, dated Release of Information* specific to HIV, TB, STD, substance abuse and mental health OR note reflecting client’s unwillingness to sign a Release.</p> <p><i>* This release shall be renewed annually.</i></p>	<ul style="list-style-type: none"> ➤ Administrative P & P’s ➤ Personnel files <ul style="list-style-type: none"> • Signed, dated copy of P & P for all staff ➤ Observation ➤ Observation ➤ Record review ➤ Record Review

Program Operating Requirements (POR)

POR #1	Indicator	Data Source
(POR 1.1 – 1.3) Agencies must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area. <i>Exemptions: None</i>	The following shall be posted in an area to which clients have free access: POR 1.1 Hours of operation POR 1.2 Grievance procedures POR 1.3 Client’s Bill of Rights and Responsibilities	➤ Observation

POR #2	Indicator	Data Source
(POR 2.1) Computer and backup systems are kept current. <i>Exemptions: None</i>	POR 2.1 Computer and backup systems are updated at least weekly	➤ Record Review ➤ SDIS

POR #3	Indicator	Data Source
(POR 3.1– 3.4) Client participation and education in the treatment process shall be maximized. <i>Exemptions: None</i>	Documentation shall reflect: POR 3.1 Client and family (as defined by client) participation in care decisions POR 3.2 Development of client’s understanding of treatment options POR 3.3 Client empowerment POR 3.4 Monitoring of client adherence to prescribed plans of treatment and care including medication regimens	➤ Record Review • Progress Notes • Treatment/Care Plans
(POR 3.5) Client education and knowledge lead to improved compliance, health status. <i>Exemptions: None</i>	POR 3.5 Documentation of client education and/or resources provided, as appropriate	

POR: Facility/Operation Requirements

POR #4	Indicator	Data Source
(POR 4.1 – 4.7) All provider sites are safe and secure. <i>Exemptions: None</i>	POR 4.1 Site is clean and well-maintained, inside and out	➤ Observation
	POR 4.2 Clients have untroubled access coming and going	
	POR 4.3 Security personnel are available as needed	➤ Personnel Records
	POR 4.4 Written policy to refuse service to clients who are being verbally abusive, threatening physical abuse or possessing illegal substances or weapons on provider property	➤ Administrative Policies and Procedures
	POR 4.5 Facility complies with applicable Occupational Safety and Health Administrative (OSHA) requirements	➤ Observation
	POR 4.6 Facility complies with the American's with Disability Act's programmatic and accessibility requirements	➤ Observation
	POR 4.7 Facility complies with the Domestic Violence Leave requirements	

POR #5	Indicator	Data Source
(POR 5.1) Client access to care will be facilitated during regular hours and after hours. <i>Exemptions: As noted in Standard 1.1</i>	POR 5.1 Written P & P addresses contacts (including appointments) during regular hours and walk-ins, emergency and after hours care.	➤ Administrative Policies and Procedures <i>(Refer to Standard #1.1)</i>

POR #6	Indicator	Data Source
<p>(POR 6.1 – 6.2) Agencies shall provide an explanation of the agency's grievance procedures and confirm clients' understanding of such. Conflict and grievance resolution processes shall be culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients. <i>Exemptions: None</i></p>	<p>POR 6.1 Written P & P's addressing formal and informal grievance procedures for clients</p> <p>POR 6.2 Documentation that client has had grievance procedures, formal and informal explained and/or given to him/her and understands same.</p>	<ul style="list-style-type: none"> ➤ Administrative Policies and Procedures ➤ Record Review

POR #7	Indicator	Data Source
<p>(POR 7.1 – 7.2) Agency policies are known to staff and supervisors. <i>Exemptions: None</i></p>	<p>POR 7.1 Written P & P's addressing agency procedures including a formal grievance procedure for staff.</p> <p>POR 7.2 Documented acknowledgement that staff are familiar with written P & P's, including grievance procedures.</p>	<ul style="list-style-type: none"> ➤ Administrative Policies and Procedures ➤ Personnel Records

POR: Accreditation Standards

POR #8	Indicator	Data Source
(POR 8.1) Agency complies with appropriate professional licensing in accordance with professional training and responsibilities of caregivers, the agency's functions, or both, through national associations and/or the Florida Department of Health. <i>Exemptions: None</i>	POR 8.1 Current licenses, accreditations are posted and on file	<ul style="list-style-type: none"> ➤ Administrative Records ➤ Observation
(POR 8.2) Staff are licensed as specified in the Ryan White Program Service Descriptions. <i>Exemptions: None</i>	POR 8.2 Copies of current licenses are on file	<ul style="list-style-type: none"> ➤ Personnel Records

POR: Client Acknowledgement of Services Received

POR #9	Indicator	Data Source
(POR 9.1) Client acknowledgement of service(s) received and cost shall be maintained.	POR 9.1 Client shall acknowledge by signature and date, specified services and cost of services received at each visit. Required information includes client name, date of service, definition of unit, service provided, and number of units.	<ul style="list-style-type: none"> ➤ Record Review <ul style="list-style-type: none"> • Signed, dated logs with name and services received noted OR ➤ Billing Review <ul style="list-style-type: none"> • Signed, dated encounters or superbills with name and services received noted OR • Receipt given to client with a copy in the chart <i>(Refer to POR #1.4)</i>

POR: Service Delivery Information System (SDIS)

POR # 10	Indicator	Data Source
(POR 10.1 – 10.2) Timely entry into the SDIS of new client information, updated client information and of services provided. <i>Exemptions: None</i>	POR 10.1 New client information shall be entered at intake POR 10.2 Updated client information and service information shall be entered in accordance with time specifications as detailed in the current Ryan White Program contract	<ul style="list-style-type: none"> ➤ Record Review ➤ SDIS

POR #11	Indicator	Data Source
(POR 11.1) A record (client chart) shall be maintained for each individual client	POR 11.1 An individual record (chart) shall be maintained for each client that records the services provided by the Ryan White Program.	<ul style="list-style-type: none"> ➤ Record Review

MIAMI-DADE COUNTY RYAN WHITE PROGRAM



MEDICAL CASE MANAGEMENT STANDARDS OF SERVICE

(Revised March 1, 2011)

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**MIAMI-DADE COUNTY
RYAN WHITE PROGRAM
MEDICAL CASE MANAGEMENT STANDARDS OF SERVICE**

In addition to the System-wide Standards of Care applicable to all Part A and Minority AIDS Initiative (MAI)-funded providers, the following program specific standards apply to **medical case management providers only**. These standards are an essential component of the Ryan White quality management program and form the basis on-going monitoring and evaluation of Part A and MAI-funded medical case management providers by the Miami-Dade County Office of Grants Coordination.

With the exception of staff qualifications (*Standard #1*), it is not expected that contracted organizations be in full compliance with the Medical Case Management Standards of Service at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. However, all providers are expected to maintain full compliance at all times with the standards for documentation of client eligibility (*Standards #4 & #7*).

Medical case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring, and evaluating available options and services. Medical case management addresses situational needs and promotes continuity of care for the client. Medical case management is predicated upon client empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services. Medical case management addresses the needs of both individual and family entities, including both adults and children.

The purpose and goals of medical case management are: 1) to maintain the client in on-going medical care and treatment; 2) to coordinate services across funding streams; 3) to reduce service duplication across providers; 4) to assist the client with accessing needed services; 5) to use available funds and services in the most efficient and effective manner; 6) to increase the client's adherence to the care plan (i.e., including coordination and follow-up of medical treatment and the medication regimen) through counseling; 7) to empower clients to remain as independent as possible; 8) to improve service and client health outcomes; and 9) to control costs while ensuring that client needs are properly addressed.

Staff Qualifications

Standard #1

All medical case management supervisors, medical case managers and peer counselors shall have sufficient education, knowledge, skills, and experience to competently serve the HIV/AIDS client population.

Guidelines	Indicators	Data Source
<p>(1.1 – 1.9) All medical case management supervisors, medical case managers and peer counselors must meet the qualifications of education and experience required by the Miami-Dade County Office of Grants Coordination.</p>	<p>Medical Case Management Supervisors: 1.1 Master’s degree OR Bachelor’s degree with 5 years work experience in HIV/AIDS 1.2 HIV/AIDS and supervisory experience preferred 1.3 Completion of a proficiency test based on required system-wide training within 12 months of hire</p> <p>Medical Case Managers:*</p> <p>1.4 Bachelor’s degree in a social science area OR, Bachelor’s of Science in Nursing (BSN) degree with 6 months of case management experience OR, Bachelor’s degree not in a social science with 1 year of case management experience 1.5 Knowledge of HIV/AIDS disease and the Miami-Dade HIV/AIDS service delivery system preferred 1.6 Completion of a proficiency test based on required system-wide training within 12 mos. of hire. <i>*An individual in a case management position prior to the effective date of these standards (August 12, 2002) may substitute applicable experience on a year-to-year basis for the required education.</i></p> <p>Peer Counselors 1.7 High school degree 1.8 One year’s experience in HIV/AIDS services 1.9 Training on funding streams for HIV/AIDS services and eligibility criteria for these services</p>	<ul style="list-style-type: none"> ➤ Personnel files <ul style="list-style-type: none"> • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Proof of knowledge on HIV/AIDS services, eligibility for these services and funding streams • Training Certificate • Copy of degree • Documentation of HIV/AIDS service system experience (letters of reference, documented telephone interview) • Proof of training on HIV/AIDS services , eligibility for these services and funding streams

Training

Standard #2

To ensure the highest level of medical case management service, medical case management supervisors, medical case managers and peer counselors, through initial and ongoing monthly trainings, shall be continuously updated on changes in HIV/AIDS health care, the community-wide service system (services and limitations), community resources, local, state, and federal programs in the area.

Guidelines	Indicators	Data Source
<p>(2.1 – 2.4) Medical case management supervisors, medical case managers, and peer counselors shall comply with all training requirements mandated and approved by the Miami-Dade County Office of Grants Coordination.</p> <p>(2.5) Medical case managers and peer counselors shall maintain all updated materials and lists of resources provided at trainings.</p>	<p>Medical case management supervisors, medical case managers and peer counselors shall complete:</p> <p>2.1 HIV/AIDS 104¹ within 1 month of hire</p> <p>2.2 Medical case management supervisors: 32 hours annually of quarterly Ryan White Program Medical Case Manager Supervisor Training, of which up to 8 hours may be substituted by another Ryan White Program-approved supervisory management-related training</p> <p>2.3 Medical case managers and peer counselors: 20 hours annually of monthly system-wide case management related training (i.e., monthly Ryan White Program Medical Case Manager Training)</p> <p>2.4 In addition to the training hours in 2.3, medical case managers and peer counselors in the Ryan White Program System less than 2 yrs: 20 hours of basic case management training¹</p> <p>2.5 Provider/service listings, updated Ryan White Program Case Management Handbook, other training materials as appropriate</p>	<p>➤ Personnel files</p> <ul style="list-style-type: none"> • 104 Certificate dated within 1 month of hire • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training. • Agency training record • Case management system- wide attendance logs • Training Certificate • Training agendas • On-site inspection/observation

¹HIV/AIDS 104 and basic case management training are not part of the 20-hour system-wide training requirement (item 2.3).

No Barriers to Service

Standard #3

Client access to medical case management and peer counseling services shall be facilitated in a timely and orderly manner.

Guidelines	Indicators	Data Source
<p>(3.1 – 3.2) Initial intake and financial eligibility assessment initiated.</p>	<p>No later than 5 workdays from a request for service or receipt of referral:</p> <p>3.1 Appointment made for intake/financial eligibility assessment</p> <p>3.2 Medical case manager assigned</p>	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Intake/financial eligibility forms dated within 5 days of filed referral or date of service request AND • Intake progress note reflects: Date of referral or service request and date of intake/financial eligibility assessment • Record reflects name of assigned medical case manager and date of assignment
<p>(3.3) If client wishes to meet with a peer counselor, an appointment is facilitated.</p>	<p>3.3 Meeting will take place no later than 2 workdays from the date of request for service or receipt of referral.</p>	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Dated progress note reflects date of referral OR date of request for service AND service rendered or refused per progress note from peer counselor documenting appointment completed or appointment declined <i>(See Standards #4 and #5)</i>

Eligibility and Financial Assessment *

Standard #4

A comprehensive eligibility and financial assessment shall be completed taking into account all funding streams and services for which the client may qualify: the client’s education and orientation to the service delivery system and to client rights and responsibilities shall be initiated.

Guidelines	Indicators	Data Source
<p>(4.1 – 4.11) Eligibility and financial assessment shall ensure all required documents are present and filed in the eligibility section of the client chart. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws, choice of providers, explanation of grievance procedures, privacy in compliance with HIPAA regulations (4.11), and rights and responsibilities (4.2).</p>	<p>No later than 10 workdays from receipt of referral or date of request for service, the following shall be completed:</p> <ul style="list-style-type: none"> 4.1 Client Chart/Record Face Sheet 4.2 Composite Consent (includes Client Bill of Rights and Responsibilities) 4.3 Consent to Release and Exchange Information (SDIS) 4.4 Proof of HIV 4.5 Proof of Income 4.6 Financial Assessment 4.7 Current and valid proof of Miami-Dade County residency 4.8 Picture ID (for identification purposes only, may be expired) 4.9 Social Security (if client has SS Number) 4.10 Eligibility screening for third party payers 4.11 Miami-Dade County Notice of Privacy Practices 4.12 Outreach Consent 	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • All required forms are complete, initialed, dated, and signed as appropriate. (See Standard #5, 5.9- 5.11) • Copies of required eligibility documents are present and legible. • Documentation of eligibility screening for third party payers is present. (See Standard #11, 11.1 – 11.4)

* Eligibility and financial assessment need not be done by a case manager. This function may be performed by a trained eligibility clerk or a peer counselor with the appropriate training to conduct financial assessment and eligibility screening.

Initial Client Assessment and Plan of Care

Standard #5

The medical case manager shall develop a comprehensive and individualized Needs Assessment and Plan of Care (POC); orientation and education on the service delivery system shall continue; the client shall be assisted to access timely, appropriate services; medication adherence shall be reinforced and medical information necessary to appropriately serve the client shall be obtained; and the POC will include activities related to the coordination and follow-up of the client's medical treatment.

Guidelines	Indicators	Data Source
<p>(5.1 – 5.3) An initial comprehensive assessment and plan of care shall be completed for all case management clients to include:</p> <p>Adherence assessment with appropriate client referrals to existing adherence programs as part of the POC.</p> <p>Referrals to the University of Miami for pregnant women shall be made within 24 hours of initial contact with the case manager.</p>	<p>No later than 5 workdays from completion of the eligibility/financial assessment the medical case manager shall complete:</p> <p>5.1 Initial Comprehensive Assessment 5.2 Initial Plan of Care (POC) 5.3 Referrals</p>	<p>➤ Record review ➤ SDIS review</p> <ul style="list-style-type: none"> • Completed, dated, signed (medical case manager and client) comprehensive assessment • Completed, dated, signed (medical case manager and client) POC based on needs identified in the comprehensive assessment
<p>(5.4 – 5.7) All referrals shall be documented in the POC. <i>(Applies to the referring agency.)</i></p>	<p>Referrals documented in the POC will include:</p> <p>5.4 Date and purpose of referral 5.5 Frequency of the requested service, if applicable 5.6 Provider of the requested service (agency receiving the referral) 5.7 Documentation reflecting follow-up of referral(s)</p>	<ul style="list-style-type: none"> • SDIS Referral Report • POC • Progress notes <p><i>(See Standards# 6, 6.2 – 6.8; #11, 11.1 – 11.4)</i></p>
<p>(5.8) The client will be scheduled to meet with a peer counselor, unless the client refuses and the refusal is documented.</p>	<p>5.8 Progress note reflecting date of appointment with a peer counselor or documentation that an appointment was refused.</p>	<p>➤ Record review ➤ Progress notes ➤ SDIS review</p>

Guidelines	Indicators	Data Source
<p>(5.9 – 5.10) Medical case managers shall ensure all required medical data is complete, legible, dated, filed in the appropriate section of the client chart and entered into the SDIS.</p> <p>(5.11) Applications for eligibility under entitlement and benefit programs must be completed and filed with the appropriate entities.</p> <p>(5.12) A progress note shall document the needs assessment and POC.</p>	<p>Medical Certification of Diagnosis 5.9. The medical case manager shall obtain Medical Certification of Diagnosis within 90 days of completion of the initial POC. The form shall be filed in the client record and the information entered into SDIS within 48 hours of availability.</p> <p>Quarterly/Annual Lab Results 5.10 The case manager shall obtain initial (using Quarterly/Annual Lab Results Form) quarterly labs within 90 days of completion of the initial POC: the form shall be filed in the client record and the information entered into the SDIS within 48 hours of availability.</p> <p>5.11 Within 45 days of completion of eligibility and financial screening: dated, signed copies of applications, referral and progress note reflecting screening and submission of forms.</p> <p>5.12 Dated, signed progress note corresponding to completion date of POC</p>	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • POC • Progress notes <ul style="list-style-type: none"> ➤ Record review • POC • Progress notes

Referrals/Follow-Up

Standard #6

Medical case managers and peer educators shall follow-up to verify clients are receiving necessary services as documented in the Plan of Care and coordinate their efforts with other service providers to ensure service delivery is as seamless as possible to the client. The client's satisfaction with services received shall be assessed.

Guidelines	Indicators	Data Source
(6.1) The peer counselor shall follow-up, either face to face or by telephone, within 2 weeks of his/her initial meeting with a newly enrolled client.	6.1 Dated, signed progress note	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review
(6.2 – 6.4) Certified referrals between Ryan White Program providers shall be generated electronically through the SDIS using the Ryan White Program Certified Referral Form and recertified as appropriate for the service.	6.2 POC 6.3 SDIS 6.4 Progress notes	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review ➤ Record Review (See Standard #5, 5.4 – 5.7)
(6.5) Medication referrals shall note the name of the medication, dosage, strength and quantity.	6.5 POC	<ul style="list-style-type: none"> ➤ Record review • POC
(6.6 – 6.7) Referral follow up for medications and other services shall be done in a timely way to ensure coordination and benefit of service. All follow-up shall be documented in the progress notes.	Progress notes shall reflect: 6.6 Medication referrals followed-up no later than 5 workdays from the referral date 6.7 Referrals for other services followed-up no later than 30 days from the appointment date or service delivery date.	<ul style="list-style-type: none"> ➤ Record review • Progress notes ➤ Record review ➤ SDIS review • Progress notes
(6.8) All follow up on referrals shall assess the client's satisfaction with the service.	6.8 Client satisfaction, or lack thereof, documented in progress note.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • Progress notes

Updates to Client Record

Standard #7

Appropriate client contact shall be maintained as needed to monitor the client's personal/medical status. Coordination and follow-up of the client's medical treatment shall be conducted. The efficacy of the Plan of Care (POC) shall be assessed to ensure service needs, goals, objectives, and barriers as noted in the POC are addressed.

Guidelines	Indicators	Data Source
(7.1) An update (client contact) shall be documented no less than once every 3 months, or more often as client need may dictate per documentation.	7.1 Dated, signed progress note documenting client contact and adherence monitoring.	➤ Record review • Progress notes
(7.2 – 7.3) Client medical care and compliance shall be monitored to ensure optimal health results.	7.2 Quarterly/Annual Lab Results updated every quarter with CD4 and VL entered in SDIS within 7 business days of availability. 7.3 Annual medical data entered in SDIS prior to end of the calendar year.	• Quarterly/Annual Lab Results • SDIS
(7.4 – 7.9) Financial eligibility, client chart/record face sheet, needs assessments and plans of care shall be updated no less than once every 6 months, more often as client need may dictate per documentation. ¹ The Medical Certification of Diagnosis for non-AIDS clients shall be updated every 6 months.	Dated and signed as appropriate: 7.4 Client Chart/Record Face Sheet 7.5 Financial assessments 7.6 Needs Assessments and Plans of Care 7.7 Medical Certification of Diagnosis 7.8 Progress notes 7.9 Quarterly/Annual Lab Results	➤ Record review ➤ SDIS review • Updated forms • Progress notes reflecting update and noting Medical Certification of Diagnosis has been addressed
(7.10) The Composite Consent for Enrollment and the Consent to Release and Exchange Information in the SDIS shall be renewed annually. Client must sign and date both forms annually.	7.10 Dated, signed Composite Consent and Consent to Release and Exchange Information in the SDIS Forms	➤ Record review

¹ A six-month reassessment must include, at a minimum, updating the financial assessment, the needs assessment (Sections 1-5 and 12), Plan of Care and Medical Certification of Diagnosis, as needed. Individual client need may require updating additional sections of the needs assessment and Plan of Care. A complete assessment process is required once every 12 months.

Documentation Standards

Standard #8

To ensure consistency and quality of care across the medical case management service system, standardized forms shall be used and uniform standards of documentation shall be followed.

Guidelines	Indicators	Data Source
(8.1) Standardized forms shall be used.	8.1 Required SDIS forms are complete, dated and signed as necessary, and filed in the client record.	➤ Record review ➤ SDIS review • SDIS printouts
(8.2 – 8.4) Agencies shall have available in 3 languages: Composite Consent for Enrollment (includes the Client Bill of Rights and Responsibilities), Consent to Release and Exchange Information in the SDIS, and Miami-Dade County Notice of Privacy Practices	8.2 Signed, dated Composite Consents and Outreach Consent 8.3 Signed, dated Consents to Release and Exchange Information (SDIS) 8.4 Signed, dated Miami-Dade County Notice of Privacy Practices	➤ Record review
(8.5) All client contacts shall be documented in the progress notes no later than 2 business days after occurrence.	8.5 Dated, signed progress notes	➤ Record review ➤ SDIS
(8.6) All peer counseling and medical case management units of service billed to the Ryan White Program shall be documented in the client chart.	8.6 Dated, signed progress notes	➤ Record review • Progress notes • Reimbursement requests
(8.7) Documentation shall accurately record the time services began and ended and number and type of service units provided (15 minute encounters).	8.7 Dated, signed progress notes documenting time and units, (e.g. 11:30 AM to 11:58 AM, 2 units, FFE)	➤ Record review • Progress notes • Reimbursement requests

Guidelines	Indicators	Data Source
(8.8) All documentation shall be complete and legible, dated, signed and include the name and title of the individual making the entry.	8.8 All required forms and progress notes	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Progress notes • Forms

Quality Assurance / Performance Improvement

Standard #9

Ongoing, systematic record reviews shall be performed with feedback provided to case managers resulting in continuously improving quality of service and performance.

Guidelines	Indicators	Data Source
(9.1 – 9.4) Medical case management supervisors shall implement and document ongoing record reviews as part of quality assurance and performance improvement activity. Review tools will be dated and signed by the supervisor.	9.1 Record reviews conducted and submitted to Behavioral Science Research on a quarterly basis 9.2 No less than 20 records or 10% (whichever is less) of Ryan White Part A or MAI population reviewed 9.3 Review documents information is entered in a timely fashion, is complete, legible and appropriate 9.4 Dated, signed review tools including client identification information	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Review of client records • Review of supervisor’s reviews
(9.5 – 9.6) Quarterly client care review and/or quality improvement meetings shall be documented.	9.5 Meeting attendance logs 9.6 Meeting minutes reflect issues discussed, problems identified, actions for correction and a time frame for completion of same	<ul style="list-style-type: none"> ➤ Attendance logs ➤ Minutes

Standard #10

The medical case manager shall carry a reasonable case load that allows the medical case manager to effectively plan, provide, and evaluate tasks related to client and system interventions.

Guidelines	Indicator	Data Source
(10.1 – 10.3) Case loads shall be reviewed between the supervisor and medical case manager to determine and document caseload size.	10.1 Case review at least every 6 months 10.2 Active case load not to exceed 70 clients, not including situational clients 10.3 Active case load for medical case management supervisors not to exceed 35 clients	<ul style="list-style-type: none"> ➤ SDIS <ul style="list-style-type: none"> • Case load (print out of active case load per medical case manager) ➤ Administrative <ul style="list-style-type: none"> • Supervisory logs or records documenting case review • Case load lists (medical case managers and supervisors)

Service Delivery Information System (SDIS)

Standard #11

Service access for clients, data collection and reporting requirements shall be facilitated by requiring all pertinent client data be entered into the SDIS in a timely manner.

Refer to Standards #4, #5, #6, #7, #8, #9, #10, and #13.

Guidelines	Indicators	Data Source
(11.1) All Ryan White Program intake information shall be entered into the SDIS in a timely manner.	11.1 Ryan White Program Intake information entered into the SDIS at time of initial contact.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review
(11.2 – 11.4) Financial eligibility, needs assessment and POC information shall be completed and entered into SDIS.	11.2 Financial eligibility, needs assessments and POCs entered into the SDIS within 48 hours 11.3 Dated, signed eligibility, assessment and POC 11.4 SDIS print outs	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review

Advance Directives

Standard #12

The client shall be assisted in developing a legally binding advance directive that is on file in the event of personal incapacitation.

Guidelines	Indicators	Data Source
(12.1 – 12.2) No later than one year from the date of the initial POC completion, the medical case manager will ensure that the client has completed an advance directive and a copy of it is on file; or will document that the client refused said service.	12.1 Advance directive to address the client's care and treatment decisions in the event of incapacitation is indicated in the progress notes or POC 12.2 Progress note or POC reflects client declined to develop an advance directive.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> • Needs Assessment • Plan of Care • Progress Notes

Case Closure/Case Transfer

Standard #13

Client records shall be closed with a case closure form; clients who wish to transfer shall be enabled to do so in a timely manner.

Guidelines	Indicators	Data Source
(13.1) Client records shall be closed with a Case Closure or Case Transfer Form.	Client records shall include: 13.1 A Case Closure Form detailing the reasons for closure	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> • Progress notes • Case Closure Form • Case Transfer Form • Outgoing record log • Current (at time of request) Consent to Release Information
(13.2 – 13.5) Clients who wish to transfer shall be assisted to do so.	Copies of client records for transfers shall be mailed: 13.2 No later than 10 days from the date of the receipt of a written request from the client or the client's legal representative	<ul style="list-style-type: none"> ➤ Record Review

Guidelines	Indicators	Data Source
<p>(13.6) Closure information shall contain an address/phone number/emergency contact where the client may be reached or detail the reason why said information cannot be obtained.</p> <p>(13.7) Case closures and transfers shall be entered into the SDIS.</p>	<p>13.3 Prior to releasing information a current Consent to Release Information must be in the record</p> <p>13.4 A completed Transfer Form.</p> <p>13.5 Initial agency shall make necessary changes in SDIS within 2 business days of transfer</p> <p>13.6 Completed Case Closure or Case Transfer Form</p> <p>No later than 24 hours after completing a closure or transfer:</p> <p>13.7 Data in SDIS</p>	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • Closure or Transfer Form

Program Specific Operating Requirements (PS)

Standard #PS 1

Standard	Indicators	Data Source
<p>Medical case management providers must offer both medical case management and peer education and support network services.</p>	<p>PS1.1 Progress notes</p> <p>PS1.2 Reimbursement requests</p>	<ul style="list-style-type: none"> ➤ Personnel files ➤ Record review ➤ SDIS

Standard #PS 2

Standard	Indicators	Data Source
<p>Medical case management providers must have trilingual capabilities.</p>	<p>PS2.1 Progress notes</p> <p>PS2.2 Staff interviews</p>	<ul style="list-style-type: none"> ➤ Record review ➤ Personnel files ➤ Observation

Standard #PS 3

Standard	Indicators	Data Source
Medical case management agencies must document they have sought enrollment in the Medicaid PAC Waiver Program within 30 days of the contract execution date.	PS3.1 Copy of completed, dated application PS3.2 PAC Waiver number(s)	➤ Agency records

Standard #PS 4

Standard	Indicators	Data Source
Medical case management agencies shall ensure clients are aware of their rights and responsibilities.	PS4.1 Copy of the Client Rights and Responsibilities posted in a public area.	➤ Observation

Standard #PS 5

Standard	Indicators	Data Source
Medical case management providers shall ensure the provision of interpreters/assistance to the hearing, vision, and reading impaired.	PS5.1 Providers shall allocate funds in their budgets to ensure provision of interpreters/assistance to the hearing, vision, and reading impaired.	➤ Budget review ➤ Invoices

Standard #PS 6

Standard	Indicators	Data Source
Providers shall ensure continuity and coordination of care across services.	PS6.1 Providers shall maintain linkage agreements with other service providers throughout the community.	➤ Administrative Review ➤ Linkage Agreements

Please note: With respect to the Miami-Dade County Ryan White Program, the term “health care organizations” in the following document is defined as “health care organizations and other HIV-related organizations” that receive funds under the Ryan White Part A and/or Minority AIDS Initiative (MAI) Programs.

NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE

**U.S. Dept. of Health and Human Services
Office of Minority Health
March 2001**

Definitions and Terms:

CULTURE:

“The thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.”

CULTURAL AND LINGUISTIC COMPETENCE:

“Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors and needs presented by consumers and their communities.”

CLAS mandates are current Federal requirements for all recipients of Federal funds. All funded agencies will be monitored for compliance with the following CLAS mandates:

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

- Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

CLAS guidelines are activities recommended by the Office of Minority Health for adoption as mandates by Federal, State and national accrediting agencies:

- Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcome-based evaluations.
- Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
- Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

- Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

CLAS recommendations are suggested by the Office of Minority Health for voluntary adoption by health care organizations:

- Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

HAB HIV Performance Measures

The Health Resources and Services Administration, HIV/AIDS Bureau (HRSA/HAB) has developed several performance measures that can be used by all programs funded by the Ryan White HIV/AIDS Program that provide HIV care or other relevant services. The measures can be used either at the provider or system level. Striving to reach 100% achievement for each performance measure is a laudable goal, but is not required. HRSA/HAB recommends that grantees use national benchmarks and baseline data to set realistic goals for funded agencies. As a result, the Miami-Dade HIV/AIDS Partnership and the County's Ryan White Program have adopted several of these performance measures.

Complete documents of the following HIV Performance Measures from can be found at <http://hab.hrsa.gov/special/habmeasures.htm>:

- **HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3**
- **HAB HIV Performance Measures: Medical Case Management**
- **HAB HIV Performance Measures: Oral Health Services**
- **HAB HIV Performance Measures: Systems-Level**
- **HAB HIV Performance Measures: Pediatrics**

Copies of these documents can also be requested by contacting:

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Miami-Dade County Ryan White Program

Minimum Primary Medical Care Standards for Chart Review

Medical Care Subcommittee Miami-Dade HIV/AIDS Partnership

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

Requirements for Practitioners (Physicians, Nurse Practitioners, and Physician Assistants):

- Practitioner must be a Physician (MD or DO), Nurse Practitioner, or Physician Assistant with current and valid license to practice medicine within the State of Florida
- Practitioners must have a minimum of three years of experience treating HIV clients or have served a high volume (50) of HIV+ clients in the past year
- 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. When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
 - a. DHHS Clinical Guidelines
<http://www.aidsinfo.nih.gov/Guidelines/>
 - b. American Cancer Society Guidelines for the Early Detection of Cancer
http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp
 - c. European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV
<http://www.ncbi.nlm.nih.gov/pubmed/18257770>
 - d. Lipid Disorders subset of the AIDS Education and Training Centers
http://www.faetc.org/PDF/15th_Annual/Advanced_Track/Finals_for_Handouts/Managing_Multiple_Diseases/Orrick_Handout_MMD_dyslipidemia.pdf
 - e. CDC Recommended Adult Immunization Schedule
<http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>
 - f. Incorporating HIV Prevention into the Medical Care of Persons Living with HIV
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>
- Follow an action plan to address any areas for improvement that are identified during quality assurance reviews

Minimum Standards of Which Practitioners Will Be Measured

Assessments and Referrals

2. **Initial** – At initial visit
 - a. Comprehensive initial history
 - b. Physical examination, including review of systems
 - c. Vital signs, including weight
 - d. Gynecological exam including pap smear and pelvic for females
 - e. Rectal examination and stool guaiac testing
 - f. Sexual transmitted infection assessment
 - g. Age appropriate cancer screening
 - h. Adherence to medications
 - i. Risk reduction (including safer sex practices)
3. **Interim Monitoring and Problem-Oriented visits** - At every visit:
 - a. Vital signs, including weight
 - b. Physical examination related to specific problem, as appropriate
 - c. Interval changes in vital signs addressed, especially trend in weight over time
 - d. Adherence to medications
 - e. Risk reduction (including safer sex practices)
4. **Annual** – At each annual visit:
 - a. Update comprehensive initial history, as appropriate
 - b. Physical examination, including review of systems
 - c. Vital signs, including weight
 - d. Interval changes in vital signs addressed, especially trend in weight over time
 - e. Gynecological exam including pap smear and pelvic for females
 - f. Rectal examination and stool guaiac testing
 - g. Sexual transmitted infection assessment
 - h. Age appropriate cancer screening
 - i. Adherence to medications
 - j. Risk reduction (including safer sex practices)

Assessments to be included at Incremental Visits

5. **Gynecological Exam**^{i ii} (females), including Pap smear and pelvic - Starting at 3 years post sexual activity onset or at age 21, at initial evaluation, or upon entry to prenatal care, and another Pap smear 6 months later. If both smears are negative, annual screening is recommended thereafter in asymptomatic women. More frequent screenings recommended - every 6 months - for women with symptomatic HIV infection, prior abnormal Pap smears, or signs of HPV infection

6. **Mammogram**ⁱⁱⁱ (females) - Starting at age 40, screening recommended annually
7. **Colon and Rectal Cancer Screening**^v - Colorectal cancer screening recommended for individuals starting at age 50. For those with several first-degree relatives who had prostate cancer at an early age, this discussion should take place at age 40. If unable to perform or if patient refuses, a fecal occult blood test (FOBT)^{iv} should be performed every year. For FOBT used as a screening test, the take-home multiple sample method should be used. A FOBT done during a digital rectal exam in the practitioner's office is not adequate for screening
8. **Purified Protein Derivative (PPD)**^v - QuantiFERON TB Gold or Tuberculin Skin Test (TST), placed by the Mantoux method, should be performed as close to diagnosis of HIV infection and annually thereafter. If tested when CD4 < 200, repeat after CD4 increases to above 200. Annual PPD 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 PPD positive or has had active Tuberculosis documented with adequate treatment, annual chest X-ray should be performed. If chest X-ray cannot be afforded, cough screen questionnaire may be used as suggested by David Ashkin, MD
9. **Assess annually and document health education on:**
 - a. Nutritional assessment/care
 - b. Oral health care
 - c. Mental Health assessment/care
 - d. Exercise
 - e. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
 - f. Domestic violence
 - g. Birth control
 - h. Living will (completion or review)
10. **Additional Charting/Documentation:**
 - a. Problem list complete and up-to-date
 - b. Medications list complete with start and stop dates, dosages
 - c. Allergies list complete and up-to-date
 - d. Immunization list complete and up-to-date

Laboratory

11. **CD4 T-cell count**ⁱⁱ - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, treatment failure, or if clinically indicated. For patients documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for > 2-3 years, can extend interval monitoring to every 6 months

12. **HIV RNA**ⁱⁱ - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation, treatment failure, or if clinically indicated. For patients documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for > 2-3 years, can extend interval monitoring to every 6 months
13. **Resistance testing**ⁱⁱ - entry into care, ART initiation or switch, treatment failure, or if clinically indicated. For treatment-naïve patients, if resistance testing was performed at entry into care, repeat testing is optional post-ART initiation; for patients with viral suppression who are switching therapy for toxicity or convenience, resistance testing will not be possible and therefore, is not necessary. Genotype conducted at entry into care, prior to start of antiretroviral (ARV) therapy and when failing therapy (HIV viral load \geq 1,000)
14. **HLA-B*5701**ⁱⁱ - If considering start of abacavir and document in record carrying data forward to most current volume
15. **Tropism testing**ⁱⁱ – If considering use of CCR5 antagonist (HIV viral load must be \geq 1000) or if clinically indicated. If performed, record carried forward to most current volume
16. **Basic chemistry**ⁱⁱ - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated. Serum Na, K, HCO₃, Cl, BUN, creatinine, glucose (preferably fasting). It is suggested to monitor phosphorus while on tenofovir; determination of renal function should include estimation of creatinine clearance using Cockcroft & Gault equation^{vii} or estimation of glomerular filtration rate based on MDRD equation
17. **ALT, AST, T. bili, D. bili**ⁱⁱ - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated
18. **CBC w/ differential**ⁱⁱ - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation if a zidovudine-containing regimen, or if clinically indicated
19. **Fasting Lipid Profile**ⁱⁱ (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, consider 2-8 weeks post-ART initiation, every 6 months if abnormal or borderline at last measurement, every 12 months if normal at last measurement, or if clinically indicated
20. **Fasting Glucose**ⁱⁱ (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, every 3-6 months if abnormal or borderline at last measurement, every 6 months if normal at last measurement, or if clinically indicated

21. **Urinalysis**ⁱⁱ - entry into care, at time of ART initiation or change, every 6 months in patients with HIV-associated nephropathy, and every 12 months in patients on a tenofovir-containing regimen, or if clinically indicated^{viii}
22. **Pregnancy test**ⁱⁱ (females) – if starting an efavirenz-containing regimen or if clinically indicated
23. **Hepatitis A Screening**^{ix} - At initial screening, Hepatitis A total antibody (HAVAb) or IgG (not IgM). Unless Hepatitis C infected, may consider administering immunization when CD4 cell count greater than 200 cells/mm³
24. **Hepatitis B Screening**^{vi} - At initial screening, Hepatitis B core antibody (HBcAb) total or IgG (not IgM), Hepatitis B surface antibody (HBsAb), and Hepatitis B surface antigen (HBsAg). If HBsAg is positive, evaluate Hepatitis B Viral Load by DNA PCR, and obtain Hep Be Ag and Ab
25. **Hepatitis C Screening**^{vi} - At initial screening, Hepatitis C antibody (HCVAb). If HCVAb is positive evaluate Hepatitis C (HCV) Viral Load, genotype, and include treatment plan in record; If negative and active Injection Drug User or other HCV risk factor, repeat HCVAb in 12 months; If there is an unexplained chronic LFT elevation, Hepatitis C viral load should be evaluated (even if HCVAb is negative)
26. **Syphilis, N. gonorrhoeae (GC), C. trachomatis (Chlamydia)**^x - Screening should be performed at least annually for all sexually active patients, more frequently might be appropriate depending on individual risk behaviors, the local epidemiology of STDs, and whether incident STDs are detected by screening or by the presence of symptoms. For men who have sex with men (MSM) via Receptive anal intercourse - screen for rectal gonorrhea and Chlamydia. For men who have sex with men (MSM) via receptive oral intercourse - screen for pharyngeal gonorrhea (Chlamydia not recommended). For men who have sex with men (MSM) with multiple or anonymous partners, or have sex during , illicit drug use, or use methamphetamine, or have sex partners with these risk factors, screening is recommended at 3-6 month intervals.^{xi} Assume that all adult patients are sexually active unless noted in history or progress note that patient denies being sexually active
27. **Prostate-specific antigen (PSA) Screening**^{xiii} (males) - Offered annually, beginning at age 50, to men who have at least a 10-year life-expectancy. For African American men and those with a first-degree relative (father, brother, son) who had prostate cancer at an early age (< 65y/o), this discussion should take place at age 45. For those with several first degree relatives with prostate cancer at an early age, screening should begin at age 40. Information should be provided to all men about what is known and what is uncertain about the benefits, limitations, and harms of early detection and treatment of prostate cancer so that they can make an informed decision about testing.

Immunizations/Treatments

28. **Influenza vaccination**^{xi} - Offer TIV annually and document in record
29. **Pneumococcal polysaccharide (PPSV) vaccination**^{xi} - Offer initial vaccination as close to HIV diagnosis as possible, and then 1 booster after 5-6 years. Document in record carrying data forward to most current volume
30. **Hepatitis A vaccination**^{xi} - Offer vaccination if not immune. Assess for response 30 days after vaccination by performing Hep A antibody IgG or Hep A Total antibody. Document in record carrying data forward to most current volume
31. **Hepatitis B vaccination**^{xi} - Offer vaccination if not immune. Double dose is recommended. Assess for response 30 days after vaccination by performing Hepatitis B surface antibody quantitative (Hep B SAb Quant). Document in record carrying data forward to most current volume
32. **Tetanus, diphtheria, pertussis (Td/Tdap)**^{xiii} - Substitute 1-time dose of Tdap, for adults age 19-64 who have not received a dose of Tdap previously, for Td booster; then boost with Td every 10 yrs. Document in record carrying data forward to most current volume
33. **ARV therapy is considered and discussed** - If offered, the risks and benefits are discussed
34. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** - specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis Carinii Pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines^{xiv}

ⁱ Routine pelvic examination and cervical cytology screening. ACOG Committee Opinion No. 431. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:1190–3.

ⁱⁱ <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/womenHiv.htm>
Accessed July 22, 2009.

ⁱⁱⁱ http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp. Accessed July 21, 2009.

^{iv} http://my.clevelandclinic.org/services/fecal_occult_blood_test/hic_fecal_occult_blood_test.aspx. Accessed July 22, 2009.

^v Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.

^{vi} Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. November 3, 2008; 1-139. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed July 21, 2009. Page 6, Table 3.

^{vii} <http://www.clinicalcalculator.com/english/nephrology/cockroft/cca.htm>. Accessed July 22, 2009.

^{viii} For patients with renal disease, consult “Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America” (Clin Infect Dis 2005; 40: 1559-85).

^{ix} <http://www.aidsetc.org/pdf/workgroups/pcare/pcwg-heptools.pdf>. Accessed July 21, 2009.

^x *Counseling for Patients with HIV Infection and Referral to Support Services*, page 18, *Sexually Transmitted Diseases Treatment Guidelines, 2006*, <http://www.cdc.gov/MMWR/PREVIEW/MMWRHTML/rr5511a1.htm>. Accessed July 21, 2009

^{xi} <http://www.faetc.org/PDF/Newsletter/Newsletter-Volume10-2009/HIVCareLink-Vol10-Issue-5-April-15.pdf>. Accessed July 22, 2009.

^{xii} http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp.

Accessed July 21, 2009.

^{xiii} <http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>. Accessed July 22, 2009.

^{xiv} Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.

Miami-Dade County Ryan White Program Oral Health Care Standards

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

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

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

	Standard	Measure
Standard 2.1	Ryan White Program client eligibility screening and demographics present.	Proof of HIV status, financial eligibility, permanent residency in Miami-Dade County OR Current (not > 6 mos.) Ryan White Program Certified Referral.

Miami-Dade County Ryan White Program

Oral Health Care Standards

		Demographics include at a minimum: address, phone number, emergency information, age, race/ethnicity and gender.
Standard 2.2	Ryan White Program required documents present, signed, and dated.	Signed and dated Consent to Release and Exchange Information in the SDIS OR current (not > 6 mos.) Ryan White Program Certified Referral; <u>documentation that SDIS Notice of Privacy Practices was provided.</u>
Standard 2.3	General Consent for Treatment	Signed general consent for treatment present

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

	Standard	Measure
Standard 3.1	Initial Comprehensive Medical History	There is an initial comprehensive medical history including medications and conditions affecting diagnosis and management of oral health care. The initial comprehensive medical history is signed and dated by the client and dentist.
Standard 3.2	Medical History is updated as appropriate.	Medical history is updated every 6 months or at the next appointment after six months.
Standard 3.3.	Medical conditions and allergies are noted.	Medical conditions and/or medications requiring an alert are flagged. Allergies or NKA are noted.
Standard 3.4	An oral health history is taken.	Oral health history is taken that includes problems with or reactions to anesthesia, specific or chief complaints (if any), problems with previous treatment (if any).

Miami-Dade County Ryan White Program

Oral Health Care Standards

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

	Standard	Measure
Standard 4.1	Treatment assessment and planning.	<p>Completed treatment plan is in the progress notes OR a treatment plan form is completed.*</p> <p><i>*If clients access oral health services for episodic care only, documentation in treatment notes will reflect clients were advised to return for examination and a treatment planning appointment. If client does not present for this appointment, documentation in client's chart of advice to return for planning may serve as treatment plan.</i></p>
Standard 4.2	Documentation reflects services provided.	<p>Documentation, at a minimum, includes:</p> <ul style="list-style-type: none"> Date of service Tooth number, if appropriate Service description Anesthetic used including strength and quantity Materials used, if any Prescriptions or medications dispensed, including name of drug, quantity and dosage Education provided Signature and title
Standard 4.3	<p>A comprehensive examination is provided*</p> <p>*Not applicable for episodic care, follow up, or problem-focused examinations.</p>	<p>Comprehensive Examination includes:</p> <ul style="list-style-type: none"> Cavity charting Complete periodontal exam or periodontal screening record

Miami-Dade County Ryan White Program

Oral Health Care Standards

	<p>OR</p> <p>A problem-focused oral examination is performed.</p>	<p>Documentation of restorations & prosthesis Full mouth radiographs Pre-existent conditions Disease presence Structural anomalies Oral hygiene Instruction Prescriptions or medications Dispensed including name of drug, quantity and dosage Education provided</p> <p>Problem-focused examination includes: Chief complaint is documented Problem-focused evaluation is performed Prescriptions or medication Dispensed include name of drug, quantity, and dosage Radiographs as necessary Specific oral treatment plan Education provided Return for further evaluation documented</p>
<p>Standard 4.4</p>	<p>Charting grids are completed as appropriate.</p>	<p>Charting of the examination findings/treatment is completed in the appropriate tooth grids.</p>
<p>Standard 4.5</p>	<p>Informed specific consents are present for each oral surgery procedure.</p>	<p>A signed, informed, specific consent is present for all oral surgery procedures that includes the risks, benefits, alternatives and consequences of not having the procedure.</p>
<p>Standard 4.6</p>	<p>Refusal of treatments/radiographs is documented.</p>	<p>Client refusal for treatment/radiograph is documented (form or in progress note) with DDS signature, client signature or initials and date; <u>signature and date of witness are present.</u></p>

Miami-Dade County Ryan White Program

Oral Health Care Standards

		Reason for DDS refusal to perform a requested treatment is documented; signature and date of witness are present.
Standard 4.7	<p>Periodontal maintenance is regularly performed.*</p> <p>*Not applicable for clients who are “No shows” AND “No show” is documented; not applicable for episodic care.</p>	Periodontal maintenance is performed according to the treatment plan or at the next appointment, if later than six months.

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

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

Miami-Dade County Ryan White Program Oral Health Care Standards

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

	Standard	Measure
Standard 6.1	<p>Education will be provided in preventive oral health practices¹ including hygiene, nutritional education² as related to oral health care and education, as appropriate, concerning tobacco use³.</p> <p>¹Not applicable for episodic care.</p> <p>²Not applicable for episodic care.</p> <p>³Not applicable if no indication of tobacco use; not applicable for episodic care.</p>	<p>Documentation of education in preventive oral health practices including hygiene is provided every six months or at next appointment if later than six months.</p> <p>Documentation of nutritional education as related to oral health.</p> <p>Documentation of education, as appropriate, concerning tobacco use.</p>

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

OUTPATIENT MEDICAL CARE (INCLUDING MINORITY AIDS INITIATIVE)

Guidelines: Providers will adhere to the following clinical guidelines for treatment of HIV/AIDS specific illnesses (which can be found at www.aidsinfo.nih.gov/guidelines/, unless otherwise noted):

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. January 10, 2011; pp 1-166. Available at: <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed 1/31/2011.
- Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. August 16, 2010; pp 1-219. Available at: <http://aidsinfo.nih.gov/ContentFiles/PediatricGuidelines.pdf>. Accessed 1/31/2011.
- Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. May 24, 2010; pp 1-117. Available at: <http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>. Accessed 1/31/2011.
- A Guide to Primary Care for People with HIV/AIDS, 2004 Edition, John G. Bartlett, M.D., et al, U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; and Pocket Guide to Adult HIV/AIDS Treatment, February 2006 edition. (Available at: www.hab.hrsa.gov/tools/primarycareguide/)
- A Guide to the Clinical Care of Women with HIV/AIDS, 2005 Edition, Jean Anderson, MD, U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. (Available at: www.hab.hrsa.gov/publications/womencare05/)
- Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the HIV Medicine Association of the Infectious Diseases Society of America, Morbidity and Mortality Weekly Report (MMWR), April 10, 2009, vol. 58, No. RR-4; including pediatric dosing update for Valcyte, dated September 15, 2010. (Available at: http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009.pdf)

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

OUTPATIENT MEDICAL CARE (INCLUDING MINORITY AIDS INITIATIVE) **(continued)**

- Guidelines for Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children, Recommendations from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the HIV Medicine Association of the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the American Academy of Pediatrics, Morbidity and Mortality Weekly Report (MMWR), September 4, 2009, vol. 58, No. RR-11.
(Available at: http://aidsinfo.nih.gov/contentfiles/Pediatric_OI.pdf)
- Clinical Manual for Management of the HIV-Infected Adult, AIDS Education and Training Centers (AETC) National Resource Center, 2006 Edition, updated July 2007.
(Available at: <http://aidsetc.org/>)
- Care and Treatment for Hepatitis C and HIV Co-infection, HIV/AIDS Bureau, April 2006;
Available at <http://hab.hrsa.gov/tools/coinfection/>.
- Clinical Guide on Supportive and Palliative Care for People with HIV/AIDS, Alexander, Carla, MD; et. al., 2003 Edition. (Available at: www.hab.hrsa.gov/tools/palliative/)
- In addition, providers will adhere to other generally accepted clinical practice guidelines.

Standards:

- Providers will inform clients as to generally accepted clinical guidelines for HIV+ pregnant women, treatment of AIDS specific illnesses, clients infected with tuberculosis, hepatitis, or sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.
- Providers will screen for TB and make necessary referrals for appropriate treatment. In addition, providers will follow Universal Precautions for TB as recommended by the CDC. Providers will also screen for hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

SUBSTANCE ABUSE TREATMENT/COUNSELING – RESIDENTIAL & OUTPATIENT (INCLUDING MINORITY AIDS INITIATIVE)

Guidelines: Providers will adhere to generally accepted clinical guidelines for substance abuse treatment of persons living with HIV/AIDS. The following are examples of such guidelines:

- Published by the American Society of Addiction Medicine (ASAM), these guidelines include principles for working with HIV-positive patients in addiction treatment settings including, but not limited to, HIV antibody testing, post-exposure prophylaxis (PEP) for HIV, integrating HIV-positive patients into addiction treatment programs and groups, neuropsychiatric components of HIV/AIDS, approaching the medical evaluation in the era of HIV/AIDS, and harm-reduction strategies in addiction medicine (*Guidelines for HIV Infection and AIDS in Addiction Treatment*, American Society of Addiction Medicine, Melvin Pohl, M.D., Chair, et al, Chevy Chase, MD, most current as of March 1, 2011; and the *Principles of Addiction Medicine*, Fourth Edition).
- Published by the ASAM, national guidelines were developed for the implementation of a patient placement system. The purpose of this clinical guide is to place the patient in a level of care that has the appropriate resources to treat the patient's condition [*ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R)*, American Society of Addiction Medicine, Washington, DC, Second Edition-Revised (April 2001)].
- Published by the ASAM, public policy statements (see www.asam.org/policycategory.cfm) related to the substance abuse treatment of clients living with HIV/AIDS, that include *Access to Sterile Syringes and Needles (formerly "Needle Exchange")*, *Hepatitis C (with Physician Supplement)*, *HIV/AIDS Education for Drug and Alcohol Treatment*, *HIV Testing of Patients in Addiction Treatment Facilities*, *Primary Medical Care for HIV Infected Patients in Addiction Treatment*, and *The Treatment of Patients With Alcoholism or Other Drug Dependencies*, and *Who Have or are at Risk for Acquired Immunodeficiency Syndrome (AIDS)*, 1994-2003.
- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

SUBSTANCE ABUSE TREATMENT/COUNSELING – OUTPATIENT & RESIDENTIAL (INCLUDING MINORITY AIDS INITIATIVE) (continued)

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida’s Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.
- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30, Substance Abuse Services, of the Florida Administrative Code by the State of Florida Department of Children and Families, as may be amended.

MENTAL HEALTH THERAPY/COUNSELING & PSYCHOSOCIAL SUPPORT SERVICES

Guidelines (Mental Health Therapy/Counseling Levels I and II; and Psychosocial Support Services Levels III and IV): Providers will adhere to generally accepted clinical guidelines for mental health therapy/counseling or psychosocial support counseling of persons living with HIV or AIDS. The following are examples of such guidelines:

- American Psychiatric Association (APA) Policies and Position Statements, and Resource Documents on AIDS and HIV Disease, including: *HIV Infection; HIV and Discrimination; Confidentiality, Disclosure, and Protection of Others; HIV Antibody Testing; Psychiatric Implications of HIV/HCV Coinfection; Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV; HIV Infection and Pregnant Women; HIV and Children; HIV and Adolescents; Needle Exchange Programs; Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments; HIV-Infected Psychiatrists; Occupational HIV Exposure: Protocols and Protections; HIV & Crystal Methamphetamine; HIV Infection and People Over 50;* as well as *Outpatient Psychiatric Services*, American Psychiatric Association, Arlington, VA, 2003 through 2008, as may be amended.
- *Practice Guideline for the Treatment of Patients with HIV/AIDS*, American Psychiatric Association, Arlington, VA, November 2000; including *Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS*, Marshall Forstein, M.D., et al, American Psychiatric Association, April 2006, as may be amended.

RYAN WHITE PROGRAM TREATMENT GUIDELINES & ADDITIONAL SERVICE DELIVERY STANDARDS

MENTAL HEALTH THERAPY/COUNSELING & PSYCHOSOCIAL SUPPORT SERVICES **(continued)**

Guidelines (Pastoral Care): Providers will adhere to generally accepted clinical guidelines for pastoral care counseling of persons with HIV/AIDS. References for these guidelines include those issued by:

- *Association for Clinical Pastoral Education*
- *American Institute of Islamic Studies and Culture*
- *Canadian Association for Pastoral Practice and Education*
- *National Association of Catholic Chaplains*
- *National Association of Jewish Chaplains*

HOME DELIVERED MEALS

Guidelines:

- Providers will adhere to generally accepted nutritional standards for provision of meals to persons living with HIV or AIDS. One accepted clinical practice guideline is provided by The American Dietetic Association, *Manual of Clinical Dietetics*, that includes recommended allowances and a sample menu and daily meal plan for a high-protein, high calorie diet, commonly used for HIV infected individuals who are protein and energy malnourished (*Manual of Clinical Dietetics*, 6th Edition, co-published by The American Dietetic Association and the Dietitians of Canada, © October 2000, including the supplement of June 2001 and the errata update of September 2002).

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2011-2012
(Year 21)**

**Section IV –
Licensing & Accreditation
Requirements**



*Miami-Dade County
Office of Grants Coordination*

RYAN WHITE PROGRAM LICENSING AND ACCREDITATION REQUIREMENTS

GENERAL LICENSING REQUIREMENT FOR ALL RYAN WHITE PROGRAM-FUNDED SERVICES

Provider possesses appropriate occupational licensing from Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach, etc.).

ADDITIONAL LICENSING/ACCREDITATION REQUIREMENTS (Listed by specific service category, in order of priority):

Outpatient Medical Care (Primary & Specialty Care) [including Minority AIDS Initiative (MAI):

Provider may be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Individual caregivers are licensed by the Florida Department of Business and Professional Regulation within the appropriate professional board (i.e., Physicians, Nurse Practitioners, Registered Nurses, etc.). All physicians possess a Controlled Substance Registration License (DEA Certification) for dispensing controlled substances. Individuals providing nutritional counseling are Registered Dietitians (RD). A Registered Dietitian Eligible (RDE) may provide nutritional counseling under the supervision of a Registered Dietitian.

Prescription Drugs (including MAI)

Provider's Part A or MAI-funded pharmacists are registered pharmacists with the Florida Department of Business and Professional Regulation. In addition, Provider's pharmacists possess a Controlled Substance Registration License (DEA Certification).

Substance Abuse Counseling – Residential Treatment (including MAI)

Provider's residential treatment sites are licensed by the Florida Department of Health as a Residential Substance Abuse Treatment facility. If food is prepared on site, the facility will have a food service license from the Miami-Dade County Health Department. All caregivers providing direct counseling services possess *postgraduate degrees* in the appropriate counseling-related field, and, preferably, are a *certified addiction professional (CAP)*.

Oral Health Care

Provider's Part A-funded dentists are licensed to practice dentistry by the Florida Department of Business and Professional Regulation and possess a Controlled Substance Registration License (DEA Certification) for dispensing controlled substances.

RYAN WHITE PROGRAM LICENSING AND ACCREDITATION REQUIREMENTS

ADDITIONAL LICENSING/ACCREDITATION REQUIREMENTS (continued):

Substance Abuse Counseling – Outpatient

Provider's outpatient treatment sites are licensed by the Florida Department of Health as an Outpatient Substance Abuse Treatment facility. All counselors providing Level I substance abuse counseling services possess *postgraduate degrees* in the appropriate counseling-related field, and, preferably, are a *certified addiction professional (CAP)*. Non-certified personnel providing Level I or Level II outpatient substance abuse counseling services are supervised by a professional with appropriate Level I credentials.

Mental Health Therapy/Counseling (Levels I and/or II)

Provider's counselors providing Level I services are mental health professionals that possess postgraduate degrees in psychology or counseling (PhD, EdD, Psy.D), and are licensed by the State of Florida Department of Business and Professional Regulation as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.

Provider's counselors providing Level II services possess Master's degrees in psychology, psychotherapy, or counseling (MS, MA, MSW, M.Ed.), and are licensed by the State of Florida Department of Business and Professional Regulation as a LCSW, LMHC, or LMFT to provide such services.

Psychosocial Support Services (Levels III and IV, and/or Pastoral Care)

All initial assessments and subsequent assignments to Level III and Level IV psychosocial support services will be done by a licensed Level I or Level II mental health professional. If counseling is provided by a non-licensed professional and/or peer counselor, oversight and supervision must be conducted by a licensed professional or a professional exempt from licensing under F.S. 491.014. The supervisor will approve and sign progress notes, mini-evaluations, and referrals.

Provider's Level III counselors hold a Bachelor's degree, or are unlicensed with a Master's degree in an appropriate counseling-related field.

Provider's Level IV staff consists of trained and supervised HIV-infected or affected peers to provide supportive counseling. Activities include forming or strengthening support groups and other areas appropriate for individual and group socio-emotional support related to conditions and situations stemming from a client's HIV status.

RYAN WHITE PROGRAM LICENSING AND ACCREDITATION REQUIREMENTS

ADDITIONAL LICENSING/ACCREDITATION REQUIREMENTS (continued):

Psychosocial Support Services (cont'd)

Provider's pastoral care counselors hold a Master's degree in theology, philosophy, social work, or psychology from an accredited institution. Provider's pastoral care counselors have completed at least four units (1,600 hours or one full year) in clinical pastoral education (CPE) in an institution accredited by one of the following professional associations: the Association of Clinical Pastoral Education, National Association of Catholic Chaplains, National Association of Jewish Chaplains, American Institute of Islamic Studies, or Canadian Association of Pastoral Education.

Legal Assistance

Provider's attorneys providing legal assistance to eligible Ryan White Program clients are licensed by the Florida Bar Association. Provider's attorneys practicing in federal court are licensed by the South Florida U.S. District Court for the Southern District. Only civil cases are allowed under the Ryan White Program.

Home Delivered Meals

Provider's meal preparation facility is licensed by the State of Florida Department of Business and Professional Regulation. Provider's van drivers possess a current, valid, and class-appropriate State of Florida driver's license.

Transportation Services (Vans)

Provider's van drivers possess a current, valid, and class-appropriate State of Florida driver's license.

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2011-2012
(Year 21)**

**Section V –
Letters of Nutritional Assessment,
Medical Necessity, and
Prior Authorization**



*Miami-Dade County
Office of Grants Coordination*

**RYAN WHITE PROGRAM NUTRITIONAL ASSESSMENT LETTER FOR
FOOD BANK SERVICES**
(THIS DOCUMENT IS TO BE COMPLETED BY AN INDEPENDENT PHYSICIAN
OR A REGISTERED DIETITIAN
NOT ASSOCIATED WITH THE PART A FOOD BANK PROVIDER.)

TO BE COMPLETED BY PHYSICIAN

Date: _____

As the **primary medical caretaker** for _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

- Weekly Monthly

Please specify maximum number of additional food bank visits (occurrences) recommended within a twelve-month period, which starts with the date of the client's first visit to the food bank (first occurrence):

- One visit Two visits Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

Physician Signature _____ Name _____

Print MEO# _____

OR

TO BE COMPLETED BY REGISTERED DIETITIAN

Date: _____

As a **registered dietitian** who has completed an assessment of _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

- Weekly Monthly

Please specify maximum number of additional food bank visits (occurrences) recommended within a twelve-month period, which starts with the date of the client's first visit to the food bank (first occurrence):

- One visit Two visits Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

RD Signature _____ Name _____

Print

RD License # _____

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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Rev. 3/1/09

**RYAN WHITE PROGRAM
LETTER OF MEDICAL NECESSITY FOR HOME DELIVERED MEALS
(PHYSICIAN CERTIFICATION)**

As the primary physician for _____, CIS # _____, it is my professional opinion that he/she qualifies for home delivered meals assistance because he/she meets the conditions required for this service (as indicated below).

I hereby certify that:

1. This patient has the following diagnosis (check one):

- AIDS
- HIV+ symptomatic, with the following condition that makes home delivered meals necessary:
(please specify condition and check one of the following: _____)
_____ Temporary condition (specify time period _____)
_____ Permanent condition

AND

2. This patient meets the following Project AIDS Care (PAC) Waiver condition for home delivered meals (check as appropriate):

- The patient is homebound*; functionally impaired**; and no other person in the patient's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation.
- A therapeutic diet is authorized for this patient that can only be implemented through home delivered meals.

AND

3. This patient requires _____ home delivered meals per day, from the date of my signature, for a period of (check one):

- (# of meals)
- 1 MONTH 2 MONTHS 3 MONTHS

Definitions - * *Homebound: The individual is confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals.*

** *Functionally impaired: The patient has difficulty performing one or more activities of daily living such as bathing, dressing, walking, getting to the toilet, or eating. The functionally impaired person may not be capable of preparing meals.*

Sincerely,

Physician's Signature

Date

Physician's Name (please print)

Physician's Florida Medical License Number

Agency/Clinic/Practice Name

(_____)_____
Physician's Telephone Number

Agency/Clinic/Practice Street Address

Agency/Clinic/Practice City, State, Zip

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Rev. 3/1/09

**RYAN WHITE PROGRAM
LETTER OF MEDICAL NECESSITY FOR
ANTIRETROVIRAL PHENOTYPE RESISTANCE ASSAYS FOR EXPERIENCED PATIENTS
COVERAGE IS LIMITED TO A MAXIMUM OF ONE PHENOTYPE IN ANY CONSECUTIVE 12-MONTH PERIOD.
*(NOT REQUIRED FOR VIRTUAL PHENOTYPE TESTS)***

Date: _____

As the primary medical caretaker for _____ it is my considered opinion that he/she requires HIV phenotypic resistance testing. The following criteria have been met:

1. The patient at any time in the past has failed two (2) or more antiretroviral (ARV) regimens;
2. Results of at least one, preferably more, prior genotype(s) must be available in the chart and Resistance to two or more drugs per class in at least two classes of ARVs is present on prior genotype(s);

AND ONE OF THE FOLLOWING (check-off the appropriate condition below):

___ Prior genotype(s) show(s) resistance to at least 2 PIs other than ritonavir and use of a PI is being considered;

OR

___ Lopinavir/ritonavir is being considered in a PI-experienced patient with four or more mutations associated with resistance to lopinavir/ritonavir on a prior genotype;

OR

___ Four or more mutations at codons associated with PI cross-resistance are present;

OR

___ M184V mutation is present in the presence of 3 or more NRTI-associated mutations (NAMs);

OR

___ K65R mutation is present, or other mutations associated with NRTI cross-resistance (69 insertion complex or 151 complex);

OR

___ Rescue ARV regimens guided by results of two or more prior genotypes have failed to suppress viral replication, whether mutations present or not, and the patient has been determined to be adherent on re-evaluation. (Requires a minimum of two prior genotypes.)

I understand HIV phenotypic resistance testing for experienced patients may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is fully adherent with his/her current ART regimen;
3. The patient's plasma HIV RNA (viral load) at the time of testing must be at least 1000 co/ml within the past month (attach copy to letter of medical necessity);
4. The patient must be on antiretroviral medications at the time of testing.

Sincerely,

_____, M.D.

Print Physician's name

Florida Medical License # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany Prescription for Tipranavir (Aptivus®)

Date: _____

As the prescribing healthcare provider for _____, I consider it to be medically necessary to add Tipranavir (Aptivus®) to this patient's antiretroviral regimen.

In addition, I hereby certify that the following criteria have been met:

1. The patient has failed treatment with Lopinavir/ritonavir (Kaletra®) and all three classes of antiretrovirals;

-AND-

2. I have fully discussed all issues and consequences related to non-adherence with the patient.

Sincerely,

_____, M.D.

Print Physician's name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/09

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany Prescription for
Enfuvirtide (Fuzeon®)

Date: _____

As the primary medical provider for _____, I consider it to be medically necessary to add Enfuvirtide (Fuzeon®) to this patient's antiretroviral regimen.

This patient has been on Enfuvirtide (Fuzeon®) through another funding source but this funding source is no longer available. This condition necessitates Ryan White Program coverage for continuity of care.

In addition, the patient meets one (1) of the following (check-off the appropriate criteria below):

The patient is eligible for the AIDS Drug Assistance Program (ADAP) and there is a completed application pending approval. A new prescription is allowed for a maximum of **60 days** and no refill authorizations are accepted.

-OR-

The patient is not eligible for ADAP and must be covered under the Ryan White Program pending another payment source. A new prescription is allowed for a maximum of **90 days** and no refill authorizations are accepted.

_____, M.D.

Print M.D.'s name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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Rev. 3/1/09

RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in ADULTS

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. (Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C

SIGNATURE

(Physician, Nurse Practitioner or Physician Assistant)

PRINT NAME

(Physician, Nurse Practitioner or Physician Assistant)

Florida Medical License #

PRINT NAME

(Registered Dietitian/Nutritionist)

SIGNATURE

(Registered Dietitian/Nutritionist)

Dietitian/Nutritionist Florida License #

Nutrition Products Available Through the Ryan White Program

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. (Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)

Please document patient's: Height: _____ Weight: _____ Lbs Kgs IBW/UBW: _____ Lbs Kgs

NOTE: 1 Serving = 2 Scoops

- Progain Powder - ___ No. of **SERVINGS per DAY** Vanilla Chocolate
(HIGH calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/dietitian as indicated above)
- IgG Pure - ___ No. of **SERVINGS per DAY** (Only natural flavor available)
(LOW calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above)

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.

Patient's 10 digit MEDICAID Number: _____

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**RYAN WHITE PROGRAM
CRITERIA FOR DISPENSING NUTRITIONAL SUPPLEMENTS**

The following are potential situations where commercial nutritional supplements could be considered medically indicated.

Patient must meet at least two (2) criteria listed below.

(Consultation with a Registered Dietitian/Nutritionist for nutritional assessment and a Letter of Medical Necessity are required.)

Please check all that apply:

- Current body weight < 10% IBW/UBW
- Weight loss of:
 - 5% of the initial/baseline weight over the past month -OR-
 - 7.5% over the past 3 months -OR-
 - 10% weight loss within the last 6 months
- Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
- Body Mass Index (BMI) < 20
- Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
- Diarrhea/malabsorption with > 3 large, liquid stools/day
- Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
- Serum albumin < 3.5 g/dl
- Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
- Inadequate living conditions or inability to buy/prepare meals
- Inability to understand and or follow nutritional recommendations

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

- Nutritional supplements **recommended** Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

- Nutritional supplements **continued** Nutritional supplements **discontinued**

III. ADDT'L FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

- Nutritional supplements **continued** Nutritional supplements **discontinued**

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Rev. 3/1/09

RYAN WHITE PROGRAM
Letter of Medical Necessity
for Roxicodone (Oxycodone) and Percocet (Oxycodone/APAP)

Date: _____

As the primary care physician treating _____ and in accordance with F.A.C. 64B8-9.013¹ it is my considered opinion that (check one of the following)

Roxicodone (Oxycodone)

Percocet (Oxycodone/APAP) 5/325 *generic only*

is medically necessary for this patient.

The patient's diagnosis related to the reason for prescribing this medication is _____.
The above medication will be prescribed for _____ (length of time) at a strength of _____ with a frequency of _____ (e.g. bid).

- I have documented that other pain medications have been used and have failed or were not tolerated.
- I have discussed the issue of dependency with the patient.

I attest the above conditions have been met and are fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida Medical License # (MEO#)

Patient's 10 Digit Medicaid # (if applicable)

Patient's CIS # (ID number assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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Rev. 3/1/09

¹ Florida Administrative Code 64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Pain. Specific Authority Florida Statute 458.309 and 458.331.

64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Pain.

(1) Pain management principles.

(a) The Board of Medicine recognizes that principles of quality medical practice dictate that the people of the State of Florida have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

(b) Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agencies for prescribing, dispensing, or administering controlled substances including opioid analgesics, for a legitimate medical purpose and that is supported by appropriate documentation establishing a valid medical need and treatment plan. Accordingly, these standards have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

(c) The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain including intractable pain should be based on current knowledge and research and includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

(d) The Board of Medicine is obligated under the laws of the State of Florida to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

(e) The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

(f) Each case of prescribing for pain will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these standards, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.

(g) The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. The following standards are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

(2) Definitions.

(a) Acute Pain. For the purpose of this rule, "acute pain" is defined as the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

(b) Addiction. For the purpose of this rule, "addiction" is defined as a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

(c) Analgesic Tolerance. For the purpose of this rule, “analgesic tolerance” is defined as the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

(d) Chronic Pain. For the purpose of this rule, “chronic pain” is defined as a pain state which is persistent.

(e) Pain. For the purpose of this rule, “pain” is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

(f) Physical Dependence. For the purpose of this rule, “physical dependence” on a controlled substance is defined as a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

(g) Pseudoaddiction. For the purpose of this rule, “pseudoaddiction” is defined as a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

(h) Substance Abuse. For the purpose of this rule, “substance abuse” is defined as the use of any substances for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

(i) Tolerance. For the purpose of this rule, “tolerance” is defined as a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

(3) Standards. The Board has adopted the following standards for the use of controlled substances for pain control:

(a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

(b) Treatment Plan. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

(c) Informed Consent and Agreement for Treatment. The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient’s surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician should employ the use of a written agreement between physician and patient outlining patient responsibilities, including, but not limited to:

1. Urine/serum medication levels screening when requested;
2. Number and frequency of all prescription refills; and
3. Reasons for which drug therapy may be discontinued (i.e., violation of agreement).

(d) Periodic Review. At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician’s evaluation of the patient’s progress. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

(e) Consultation. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.

(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:

1. The medical history and physical examination, including history of drug abuse or dependence, as appropriate;
2. Diagnostic, therapeutic, and laboratory results;
3. Evaluations and consultations;

4. Treatment objectives;
5. Discussion of risks and benefits;
6. Treatments;
7. Medications (including date, type, dosage, and quantity prescribed);
8. Instructions and agreements; and
9. Periodic reviews. Records must remain current and be maintained in an accessible manner and readily available for review.

Records must remain current and be maintained in an accessible manner and readily available for review.

(g) Compliance with Controlled Substances Laws and Regulations. To prescribe, dispense, or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual: An Informational Outline of the Controlled Substances Act of 1970, published by the U.S. Drug Enforcement Agency, for specific rules governing controlled substances as well as applicable state regulations.

Specific Authority 458.309(1), 458.331(1)(v) FS. Law Implemented 458.326, 458.331(1)(g), (l), (v) FS. History--New 12-21-99, Amended 11-10-02, 10-19-03.

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany a Prescription for
Maraviroc (Selzentry ®)

Date: _____

As the primary care physician treating _____, I consider it medically necessary to add Maraviroc (Selzentry) to this patient's antiretroviral regimen which will contain the following two other active agents: _____ and _____.

I certify that the following criteria have been met:

1. The patient has been screened for ADAP and has been found ineligible and must be covered under the Ryan White Program pending another payment source;
2. I have fully discussed all issues and consequences related to non-adherence with the patient;
3. There is evidence of ARV resistance, intolerance and/or lack of patient acceptability to reasonable alternatives resulting in inability to fully suppress HIV utilizing other regimens;
4. The patient has had a Trofile Co-Receptor Tropism Assay showing CCR5 mono-tropism (copy attached); and
5. I have reviewed the patient background and antiretroviral regimen and the Maraviroc dosage is appropriate.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/2009

RYAN WHITE PROGRAM
Letter of Medical Necessity for Sporanox (Itraconazole)

Date: _____

As the primary care physician treating _____, I consider it medically necessary to prescribe Sporanox (Itraconazole). The medication will be utilized to treat **ONLY** one of the following two conditions (please check one box):

	Histoplasmosis
	Aspergillosis

The diagnosis above is fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program
Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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Rev. 3/1/09

RYAN WHITE PROGRAM
Letter of Medical Necessity for the Trofile Co-Receptor Tropism Assay required to prescribe Maraviroc (Selzentry ®)

Date: _____

As the primary care physician treating _____, I intend to add Maraviroc (Selzentry) to this patient's antiretroviral regimen which will contain the following two other active agents: _____ and _____.

I certify that the following criteria have been met:

1. The patient has been screened for ADAP and has been found ineligible and must be covered under Ryan White Part A pending another payment source;
2. There is evidence of ARV resistance, intolerance and/or lack of patient acceptability to reasonable alternatives resulting in inability to fully suppress HIV utilizing alternative regimens;

I understand the Trofile Co-Receptor Tropism Assay may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is satisfactorily adherent with his/her current ART regimen;
3. The patient's plasma HIV RNA (viral load) at the time of testing is at least 1,000 co/ml within the past month (attach copy of viral load to letter of medical necessity); and
4. Patient does not have a history of dual/mixed tropism.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

**RYAN WHITE PROGRAM
Prior Authorization Form for Neupogen® (Filgrastim)**

Recipient's Full Name: _____ Date of Birth: _____ / _____ / _____
 Prescriber Full Name: _____ Prescriber License #: (ME,OS,RN) _____
 Prescriber Telephone #: _____ Prescriber Fax #: _____
 Drug Strength: _____

Please check below the diagnosis or indication for this product:

- Severe neutropenia in AIDS patients on antiretroviral therapy
- Severe Chronic Neutropenia: congenital cyclic idiopathic
- Cancer patients with HIV/AIDS receiving myelosuppressive chemotherapy

Select one of the following:

New Therapy **OR** Continuation of Therapy

Lab Test Date: _____ Absolute Neutrophil Count: _____ cells/mm³

What is the date range of therapy? Begin Date: _____ End Date: _____

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

<u>Ryan White Program-funded Pharmacy</u>	<u>Phone Number</u>	<u>Fax Number</u>
AIDS Healthcare Foundation (NW 170 th St.)	(305) 758-1984	(305) 758-8714
AIDS Healthcare Foundation (Biscayne Blvd.)	(305) 764-3780	(305) 764-3784
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
Community Health of South Florida (Doris Ison)	(305) 253-5100	(305) 254-7795
Community Health of South Florida (MLKJCC)	(305) 248-4334	(305) 246-1016
Miami Beach Community Health Ctr (Alton Rd.)	(305) 538-8835, Ext. 1128	(305) 795-2156
Miami Beach Community Health Ct. (Bev. Press)	(305) 538-8835, Ext. 2242, 265, and 266	(305) 867-4312
PHT/South Florida AIDS Network	(305) 585-5890	(305) 585-0088

FOR RYAN WHITE PROGRAM USE ONLY			
Date: _____	Notified: _____		
Approved: _____	Start Date: _____	Expiration Date: _____	
Denied: _____	Reason: _____		

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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Rev. 3/1/11

RYAN WHITE PROGRAM
Prior Authorization Form for Procrit® or Epogen® (both Epoetin Alpha)

Recipient's Full Name: _____ Date of Birth: _____ / _____ / _____
 Prescriber Full Name: _____ Prescriber License #: (ME,OS,RN) _____
 Prescriber Telephone #: _____ Prescriber Fax #: _____
 Drug Strength: _____

Please check below the diagnosis or indication for this product:

- Anemia associated with HIV
- Anemia associated with renal failure if patient is not on dialysis
- Anemia associated with chemotherapy
- Other _____

Select one of the following:

New Therapy **OR** Continuation of Therapy

Does the patient have active gastrointestinal bleeding? YES **OR** NO

Lab Test Date: _____ Hematocrit: _____ % Hemoglobin: _____ g/dl

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

<u>Ryan White Program-funded Pharmacy</u>	<u>Phone Number</u>	<u>Fax Number</u>
AIDS Healthcare Foundation (NW 170 th St.)	(305) 758-1984	(305) 758-8714
AIDS Healthcare Foundation (Biscayne Blvd.)	(305) 764-3780	(305) 764-3784
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
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FOR RYAN WHITE PROGRAM USE ONLY			
Date: _____	Notified: _____		
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Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2011-2012
(Year 21)**

**Section VI –
Client Eligibility Requirements**



*Miami-Dade County
Office of Grants Coordination*

**Ryan White Program
Client Eligibility Documentation**

(NOTE: The following client eligibility requirements are effective March 1, 2011.)

**Excerpt from the FY 2011-2012 Professional Services Agreement for
Ryan White Part A and MAI-funded Services, as may be amended**
(YR 21 Continuation Contract Shells)

Article VII
Reporting, Record-keeping, and Evaluation Studies

- 7.1 The SERVICE PROVIDER shall keep adequate, legible records of clients served and the services provided to those clients as required by the COUNTY and by the U.S. Department of Health and Human Services. Furthermore, the SERVICE PROVIDER shall maintain, and shall require that its subcontractors and suppliers maintain, complete and accurate records to substantiate compliance with the requirements set forth herewith in the Scope of Services (Exhibit A). The SERVICE PROVIDER and its subcontractors and suppliers, shall retain such records, and all other documents relevant to the services furnished under this Agreement for a period of five (5) years from the expiration date of this Agreement and any extension thereof, unless State of Florida laws or the COUNTY'S record retention schedule require a lengthier retention period.
- A. At a minimum, the following records shall be kept:
- (1) Documentation of the client having HIV or AIDS. Said documentation shall include a copy of one (1) or more of the following: lab test results (Western Blot, ELISA with Western Blot, detectable viral load or culture; a positive HIV viral culture or test result); or a certified referral form. A PAC Waiver Notification of Level of Care (Form 603) will also be accepted as proof of a minority client's HIV+ status. See Exhibit A, Section 1, of this Agreement for more details, as incorporated herein by reference.
 - (2) Documentation of the client's economic status that establishes their gross household income. Said documentation shall include but not be limited to a copy of one (1) or more of the following: the client's paycheck stubs for the most current two (2) pay periods; Supplemental Security Income (SSI) checks or benefit/award letters; Social Security Disability Insurance (SSDI) benefit/award letters; Social Security Administration (SSA) benefit/award letter; Temporary Assistance for Needy Families (TANF) checks or benefit/award letters; HOPWA/Section 8 Rental Assistance Statement; other letters of Notification of Benefits (i.e., Medicaid, Medicare, Food Stamps, private disability, retirement/pension, Worker's Compensation, etc.); other public assistance checks; current W2 Forms; current and signed Tax Return Forms; Third Party Query Procedure (TPQY) screenings for verifying SSA/SSI benefit information; notarized letter from Head of Household (HOH) detailing the client's relationship to the HOH, the level of financial assistance provided to the client, and indication that there is no co-mingling of income or assets; (for undocumented clients only) a letter from the employer indicating the level of pay provided to the client; a certified referral form; or in extreme and rare cases, a notarized self-declaration letter from the client indicating their income (which must be approved by a Ryan White Program Case Management Supervisor or the Office of Grants

Coordination). See Exhibit A, Section 1, of this Agreement for more details, as incorporated herein by reference.

In addition, providers are required to check for Property Information on the property tax page of the Miami-Dade County Tax Collector website (www.miamidade.gov/proptax/) to ensure that all Ryan White Program-eligible clients are screened at initial intake and at each 6-month re-assessment to ensure that they do not have additional income from rental property. Clients who have more than one property listed in their name must have their gross household income adjusted accordingly. Documentation to support the completion of this search (showing additional properties or no properties) must be filed in the client's chart.

- (3) Documentation of the client's permanent physical residency in Miami-Dade County. Such documentation shall include, but not be limited to, a copy of one (1) of the following forms of documentation showing the client's physical living address in Miami-Dade County: the client's current and valid, government-issued State of Florida driver's license or State of Florida Identification Card; rental lease, mortgage documents or rent receipts in the name of the client; notarized Head of Household (HOH) letter only if the client physically resides with the person completing the HOH letter; property search of Miami-Dade County Tax Collector website (www.miamidade.gov/proptax/) if the residence is listed in the client's name; Declaration of Domicile (Form 578; also known as the Declaration of Residence) as issued by the Miami-Dade County Courthouse; utility bills in the client's name; Department of Corrections Certification; or a certified referral form. See Exhibit A, Section 1, of this Agreement for more details, as incorporated herein by reference.
- (4) Service eligibility determination must be made and documented based on the most current Ryan White Program Service Delivery Guidelines and the corresponding Ryan White Program Cost and Eligibility Summary Chart.
- (5) Service provider receiving a Ryan White Program Certified Referral or OON Referral must maintain a copy of the referral in the client's chart.
 - (i) Failure of the referring agency to maintain appropriate eligibility documentation in the client chart, or of the receiving agency to maintain the actual Ryan White Program Certified Referral in the client chart, is subject to corrective action and fiscal repayment to the County.
 - (ii) For the service provider receiving an OON referral, failure to maintain the actual OON referral and its allowable supporting documentation and consent forms on file in the client's chart is also subject to corrective action and fiscal repayment to the County.
- (6) A cost allocation plan along with supporting documentation for any shared costs included in the SERVICE PROVIDER'S approved contract budget(s) for the provision of HIV-related services under the Ryan White Part A and/or MAI Programs, where applicable.

Out of Network Referral for Ryan White Part A/MAI Services

Referral Start Date: _____

Referral Stop Date*: _____

*Maximum referral length is generally 6 months; refer to Ryan White Program Service Descriptions for any time limits on the particular service for which you are referring.

NOTE: Only case managers from outside the Ryan White Part A/MAI Medical Case Management System may use this form.

REFERRAL FROM:

Case Manager Name: _____

Agency Name: _____

Phone: ____ - ____ - _____

Fax: ____ - ____ - _____

REFERRAL TO:

Service Provider (Agency Name): _____

Service Referred For: _____

Phone: ____ - ____ - _____

Fax: ____ - ____ - _____

Special Instructions _____

CLIENT INFORMATION:

Name: _____ Insurance ID# _____

PAC# _____ Street Address _____

City _____ Zip _____ Phone: ____ - ____ - _____

DOB ____ / ____ / ____ Social Security # _____

Emergency Contact Name _____ Phone: ____ - ____ - _____

Primary Care Physician _____ Phone: ____ - ____ - _____

INSURANCE INFORMATION:

Ryan White Part B _____ C _____ D _____ SFAN (General Revenue) _____

OR Medicaid _____ PAC Waiver _____ Medicare _____ Private Insurance _____

Other (specify) _____

I attest that all documentation provided with this referral is complete, accurate and true.

Client Signature _____

Date ____ / ____ / ____

Required Documentation: The Out of Network (OON) referral must be accompanied by proof of HIV positive status, financial eligibility and permanent Miami-Dade County residency. Please see the back of this form for a list of acceptable eligibility documents and check the type of proof provided with this referral.

Referring Agency Representative's Signature _____

Note to Ryan White Part A/MAI Providers: Prior to rendering Ryan White Part A/MAI services a current, signed and dated SDIS Authorization for the Release and Exchange of Information, Composite Consent and a Miami-Dade Notice of Privacy Practices must be signed by the client and agency representative and maintained in the client's chart.

Revised April 2010

Out of Network Referral for Ryan White Part A/MAI Services

Please check the eligibility documentation provided for this referral and attach to the OON referral form.

Acceptable eligibility documentation includes but is not limited to:

Medical Eligibility (HIV+ status):

HIV Western Blot _____
ELISA with Western Blot _____
Detectable viral load or culture _____
Positive HIV viral culture or test result _____
PAC Waiver Level of Care Determination (Form 603) _____

Financial Eligibility [Income not to exceed 400% of the Federal Poverty Level (FPL) (Core Services – see below)*:

Paycheck stubs for the most current 2 pay periods _____
SSI, SSDA, SSA, TANF checks or award letter _____
HOPWA/Section 8 Rental Assistance Statement _____
Food Stamp Award Letter _____
VA Benefits Statement/Award Letter _____
Current W2 Form _____
Tax Return Forms _____
Other Letters of Notification of Benefits (e.g., Private Disability, Retirement/Pension, Worker's Compensation Statement) _____

Residency Eligibility (permanent Miami-Dade County residency/address):

Current Government Issued ID (e.g., State of Florida Identification Card or Driver's License) _____
Rental lease (in client's name) _____
Mortgage or rent receipts (in client's name) _____
Miami-Dade County utility bills (in client's name) _____
Declaration of Domicile letter _____
Department of Corrections Certification _____
Notarized Head of Household Letter **ONLY** when client resides at same address as Head of Household _____

***Core Services:** Health Insurance Services, Medical Case Management, Mental Health Counseling/Therapy, Oral Health Care, Outpatient Medical Care, Prescription Drugs, Nutritional Counseling, Outpatient Substance Abuse Counseling/Treatment
Support services: Food Bank, Home Delivered Meals, Legal Assistance, Outreach, Psychosocial Support Services, Residential Substance Abuse Treatment, Transportation Services (Vans), Transportation Vouchers

The financial requirements (% of FPL) vary depending on the support service for which a client is referred; for income eligibility for support services please call the providing agency. The most current Ryan White Program Service Delivery Guidelines are available at http://www.miamidade.gov/ryanwhite/service_definitions.asp .

2011 HHS FEDERAL POVERTY GUIDELINES
Annual Income Ranges (Gross Household Income)

(Effective March 1, 2011 for Ryan White Part A & MAI Services in Miami-Dade County, FL)

Family Size	A 100-135%	B 136-150%	C 151-200%	D 201-250%	E 251-300%	F 301-400%	G ≥401%
1	< or equal to \$10,890 - \$14,809	\$14,810 - \$16,443	\$16,444 - \$21,888	\$21,889 - \$27,333	\$27,334 - \$32,778	\$32,779 - \$43,668	\$43,669 +
2	< or equal to \$14,710 - \$20,005	\$20,006 - \$22,211	\$22,212 - \$29,566	\$29,567 - \$36,921	\$36,922 - \$44,276	\$44,277 - \$58,986	\$58,987 +
3	< or equal to \$18,530 - \$25,200	\$25,201 - \$27,979	\$27,980 - \$37,244	\$37,245 - \$46,509	\$46,510 - \$55,774	\$55,775 - \$74,304	\$74,305 +
4	< or equal to \$22,350 - \$30,395	\$30,396 - \$33,748	\$33,749 - \$44,923	\$44,924 - \$56,098	\$56,099 - \$67,273	\$67,274 - \$89,623	\$89,624 +
5	< or equal to \$26,170 - \$35,590	\$35,591 - \$39,516	\$39,517 - \$52,601	\$52,602 - \$65,686	\$65,687 - \$78,771	\$78,772 - \$104,941	\$104,942 +
6	< or equal to \$29,990 - \$40,785	\$40,786 - \$45,284	\$45,285 - \$60,279	\$60,280 - \$75,274	\$75,275 - \$90,269	\$90,270 - \$120,259	\$120,260 +
7	< or equal to \$33,810 - \$45,981	\$45,982 - \$51,052	\$51,053 - \$67,957	\$67,958 - \$84,862	\$84,863 - \$101,767	\$101,768 - \$135,577	\$135,578 +
8	< or equal to \$37,630 - \$51,176	\$51,177 - \$56,820	\$56,821 - \$75,635	\$75,636 - \$94,450	\$94,451 - \$113,265	\$113,266 - \$150,895	\$150,896 +
9	< or equal to \$41,450 - \$56,371	\$56,372 - \$62,589	\$62,590 - \$83,314	\$83,315 - \$104,039	\$104,040 - \$124,764	\$124,765 - \$166,214	\$166,215 +
10	< or equal to \$45,270 - \$61,566	\$61,567 - \$68,357	\$68,358 - \$90,992	\$90,993 - \$113,627	\$113,628 - \$136,262	\$136,263 - \$181,532	\$181,533 +
+1	\$3,820	\$5,730	\$7,640	\$9,550	\$11,460	\$15,280	\$15,318 +

SOURCE: Federal Register, Volume 76, Number 13, January 20, 2011, pp. 3637-3638.

IMPORTANT NOTES:

- 1) For families with more than ten (10) members, add for EACH additional family member the amount indicated in the "+1" row under the appropriate poverty level range.
- 2) The Miami-Dade County Ryan White Program Service Delivery Information System (SDIS) will be programmed according to these guidelines, effective March 1, 2011 through February 29, 2012.
- 3) Ryan White clients whose gross household income falls between 301% and 400% of the Federal Poverty Level (Column F above) may only receive Ryan White-funded outpatient medical care, prescription drugs, oral health care, medical case management, mental health services (not including psychosocial support services), outpatient substance abuse counseling, and health insurance services (drug co-payments, insurance deductibles, and AICP support).