Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

COMMITTEE: Quality Management Committee
MEETING AGENDA
Date/Time: Monday, April 15, 2013 at 12:30 p.m.
Location: Governmental Center Annex, A335
Claudette Grant, **Chair**

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*

2. **APPROVALS:** 1/7/13, 3/18/13 and 4/15/13 Agendas and 10/15/12, 1/7/13 and 3/18/13 Meeting Minutes

3. **STANDARD COMMITTEE ITEMS**
   a. New Business
   b. Request for Information/Directives
   c. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
   d. Next Meeting Date: May 20, 2013

4. **UNFINISHED BUSINESS**

5. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Action Items*
Update on Outcome and Indicator Revisions (HANDOUT A)	**ACTION ITEM:** Discuss status of revisions to the pending Oral Health Care Outcome and Indicator.
Review Service Delivery Models	**ACTION ITEM:** Review and discuss recommended changes to QI Network Service Delivery Models.
Annual QM Committee Work Plan (HANDOUT B)	**ACTION ITEM:** Review revised annual work plan and discuss FY 13-14 activities.
Review 3-Year QM Work Plan	**ACTION ITEM:** Update on revisions to 3-year work plan.
Review Policies and Procedures	**ACTION ITEM:** Update on revisions to policies and procedures.

6. **GRANTEE REPORTS**

7. **PUBLIC COMMENT**

8. **AGENDA ITEMS/TASKS FOR NEXT MEETING**

Agenda Items/Tasks for next Meeting (Work Plan Item/Goal#)	*Responsible Party for Completing Task*	*Information requested (i.e. data, research, etc.)action to be taken, presentation, discussion, brainstorm etc.*
Item #1		
Item #2		
Item #3		

9. ANNOUNCEMENTS

10. ADJOURNMENT

Broward Regional Health Planning Council, Inc.
200 Oakwood Lane, Suite 100
Hollywood, Florida 33020
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Quality Management Committee
Meeting Agenda
March 18, 2013 at 12:30 P.M
Claudette Grant, Chair

1. **Call to Order**
2. **Welcome and Introductions**
3. **Moment of Silence**
4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
   B. Review Public Comment Requirements (Please Sign-in)
   C. Excused Absences
   D. Approval of 1/7/13 and 3/18/13 Agendas
   E. Approval of 10/15/12 and 1/07/13 Meeting Minutes
5. **Update on Outcome and Indicator Revisions**

ACTION ITEM: Discuss status of revisions to the pending Oral Health Care Outcome and Indicator.

6. **Review NQC Retention Rates Report and QI Network Update** (HANDOUT A-1, A-2)

ACTION ITEM: Review annual summary of measures and discuss QI Network activities.

7. **Review Service Delivery Models**

ACTION ITEM: Review and discuss changes to QI Network Service Delivery Models.

8. **Accomplishments and Challenges** (HANDOUT B)

ACTION ITEM: Review annual accomplishments and challenges.

9. **Annual QM Committee Work Plan** (HANDOUT C)

ACTION ITEM: Review annual work plan and discuss changes for FY13-14.

10. **Unfinished Business**
11. **New Business**
12. **Grantee Reports**
    A. Part A Grantee Report
13. **Resources and Announcements**
14. **Public Comment**
15. **Reminder:** Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
16. **Request for Information/Directives**

IMPORTANT NOTICE:

Please be aware this meeting and all information stated thereof is a matter of public record under FL's Government in the Sunshine Law (Florida Chapter 119.01). Acknowledgement of HIV status is not required, and if disclosed becomes a part of the public record

Broward Regional Health Planning Council, Inc.
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17. Agenda Items for Next Meeting

18. Next Meeting Date: April 15, 2013

19. Adjournment

Celebrating 30 Years of Excellence
BRHPC
HEALTH & HUMAN SERVICE INNOVATIONS
Broward Regional Health Planning Council • www.BRHPC.org

Broward Regional Health Planning Council, Inc.
200 Oakwood Lane, Suite 100
Hollywood, Florida 33020
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HIVPC
Broward County HIV Health Services Planning Council

Quality Management Committee
Meeting Agenda
January 7, 2013 at 12:30 P.M
Claudette Grant, Chair

1. **Call to Order**
2. **Welcome and Introductions**
3. **Moment of Silence**
4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
   B. Review Public Comment Requirements (Please Sign-in)
   C. Excused Absences
   D. Approval of Today's Agenda
   E. Approval of 10/15/12 Meeting Minutes
5. **Update on Outcome and Indicator Revisions**
   A. Summary Report to the HIVPC

ACTION ITEM: Discuss status of revisions to the pending Oral Health Care Outcome and Indicator and review the HIVPC response to the QMC-approved revisions forwarded for approval.

6. **Review of NQC Retention Rates Report and QI Network Update**

ACTION ITEM: Review annual summary of measures and discuss QI Network activities.

7. **Review Joint Planning Report**

ACTION ITEM: Review Community Viral Load data plan and discuss process of collaboration with other HIVPC Committees.

8. **Development of Annual QM Committee Work Plan**

ACTION ITEM: Review annual work plan and discuss development of FY13-14 plan.

9. **Unfinished Business**
   A. FAQ's for New Committee Members

ACTION ITEM: Review proposed orientation for new committee members.

10. **New Business**
11. **Grantee Reports**
    A. Part A Grantee Report
12. **Resources and Announcements**

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13. Public Comment

14. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

15. Request for Information/Directives

16. Agenda Items for Next Meeting

17. Next Meeting Date: TBD

18. Adjournment

Quality Management Committee
Monday, March 18, 2013 at 12:30 P.M.
Minutes

Attendance					
#	**Members**	**Present**	**Absent**	**Guests**	**Grantee Staff**
1	Grant, C., Chair	X		Jamie Finkelstein	Degraffenreidt, S.
2	Katz, H.B.	X		Ettinger, R.	Strong, K.
3	Martin, M.		X	Majcher, B.	
4	Mitchell, T.		X		**CQM Support Staff**
5	Quintana-Jefferson, M.	X			Eshel, A.
7	Schweizer, M.		X		Solomon, R.
Quorum = 4		**3**	**3**		

1. **Call to Order**
   The Chair called the meeting to order at 12:44PM without quorum.

2. **Welcome and Introductions**
   The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law. It was noted that a statement was added to the agenda on the Sunshine Law. Meeting reporting requirements, which include the recording of minutes, was also made known to attendees. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

3. **Moment of Silence**
   A moment of silence was observed.

4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
      The Chair reviewed Meeting Ground Rules and Statement of Sunshine.

   B. Review Public Comment Requirements (Please Sign-in)
      There was no Public Comment.

   C. Excused Absences
      There were no excused absences.

   D. Approval of 1/7/13 and 3/18/13 Agendas
      The agendas were not approved due to lack of quorum.

   E. Approval of 10/15/12 and 1/7/13 Meeting Minutes
      The minutes were not approved due to lack of quorum.

5. **Update on Outcomes and Indicators Revisions**
   The Committee was informed that all Broward County outcome and indicator revisions have been approved except for Oral Healthcare outcome and indicator #2 as the revision is still pending. Oral Healthcare QI Network to have a conference call with Florida/Caribbean AIDS Education and Training Center (FC/AETC) for recommendations. Quality Management Committee (QMC) to approve outcome and indictor #2 once the Network reaches consensus.

6. **Review of NQC Retention Rates Report and QI Network Update**
   The Committee heard an annual summary of the National Quality Center's (NQC) In+Care Campaign retention rates. The Broward County EMA showed an improvement in all measures: Gap Measure (30%-20%), Medical Visit Frequency (49%-52%), Patients Newly Enrolled (35%-53%) and Viral Load Suppression (66%-70%). The EMA will continue to report to NQC through Fiscal Year 2013-2014 as the campaign has been extended. A comparison of the annual rates for all Part A campaign participants to the Broward County EMA's rates showed Broward County at 20% compared to 13% in the Gap Measure, 52% compared to 69% in Medical Visit Frequency, 53% compared to 61% in Patients Newly Enrolled and 70% compared to 73% in Viral Load Suppression. Lastly, a comparison of the Broward County EMA rates to the average, top 10% and top 25% of the Part A participants was projected.

   The Committee reviewed a quarterly QI Network Update detailing the activities of all Networks during December 2012- February 2013. (*Copy on file*).

7. **Review Service Delivery Models**
   The Networks' revised and approved Service Delivery Models (SDM) were presented for Committee approval; the Committee tabled approval of the SDM's for the April meeting due to lack of quorum. The Committee agreed to review the SDMs in preparation for the April meeting.

8. **Accomplishments and Challenges**
   The Committee discussed the Accomplishments and Challenges for FY 2012-2013. (*Copy on file*). The Committee was informed that, while the final Client Survey report is pending, summary reports may be requested as needed.

   The Committee discussed the upcoming Medical QI Network Quality Improvement Project (QIP) on cervical cancer screening. Staff reviewed what has already been done to improve cervical cancer screening rates. The Committee was informed of the new structural changes to the Medical QI Network meetings; the first part dedicated to clinical issues and the other to programmatic issues. The Committee was also informed of the Medical Case Management (MCM) QIP based on analysis of the In+Care Campaign's Gap Measure.

9. **Annual QM Committee Work Plan**
   The annual QM Committee work plan was presented to the Committee for approval; the Committee tabled approval of the annual work plan for April's meeting due to lack of quorum. The Committee agreed to review the annual QM Committee work plan in preparation for the April meeting.

10. **Unfinished Business**
    There was no unfinished business.

11. **New Business**
    There is no new business.

12. **Grantee Reports**
    A. **Part A Grantee Report**
       There were no announcements.

13. Resources and Announcements
There were no resources or announcements.

14. Public Comment
None.

15. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

16. Request for Information/Directives
There were no requests for information or directives.

17. Agenda Items for Next Meeting

- **A.** Standing Agenda Items
- **B.** Approve 10/15/12, 1/7/13 and 3/18/13 meeting minutes and 1/7/13, 3/18/13, and 4/15/13 meeting Agendas
- **C.** Review of Annual QM Committee Work Plan
- **D.** Review of SDM Revisions
- **E.** Review Policies and Procedures
- **F.** Review 3-Year QM Work Plan

18. Next Meeting Date: Monday, April 15, 2013

19. Adjournment
The meeting was adjourned at 1:25PM.

Quality Management Committee
Monday, January 07, 2013 at 12:30 P.M.
Minutes

Attendance					
#	**Members**	**Present**	**Absent**	**Guests**	**Grantee Staff**
1	Grant, C., Chair	X		Jamie Finkelstein*	Degraffenreidt, S.
2	Katz, H.B.	X			Strong, K.
3	Martin, M.		X		
4	Mitchell, T.		E		**CQM Support Staff**
5	Quintana-Jefferson, M.	X			Eshel, A.
6	Rajner, M.		X		Solomon, R.
7	Schweizer, M.	X			

*Attended via phone

1. **Call to Order**
   The Chair called the meeting to order at 12:41PM without quorum.

2. **Welcome and Introductions**
   The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law. It was noted that a statement was added to the agenda on the Sunshine Law. Meeting reporting requirements, which include the recording of minutes, was also made known to attendees. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

3. **Moment of Silence**
   A moment of silence was observed.

4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
      The Chair reviewed Meeting Ground Rules and Statement of Sunshine.

   B. Review Public Comment Requirements (Please Sign-in)
      There was no Public Comment.

   C. Excused Absences
      There was one excused absence.

   D. Approval of Today's Agenda
      The agenda was not approved due to lack of quorum.

   E. Approval of 10/15/12 Meeting Minutes
      The minutes were not approved due to lack of quorum

5. Update on Outcomes and Indicators Revisions

A. The Committee reviewed a summary of HIVPC comments made during the review and approval of the Broward Client-Level Outcomes and Indicators. The Quality Improvement (QI) Networks will review the HIVPC comments and consider further revisions at a later date. It was noted that the Oral Health Care outcomes and indicators were not presented to the HIVPC as the Network has not finalized revisions to outcome and indicator #2. It was noted that the Service Delivery Models (SDM) for all service categories are currently being reviewed; all revised outcomes and indicators will be incorporated into the SDM's.

6. Review of NQC Retention Rates Report and QI Network Update

The Committee heard an annual summary of the National Quality Center's (NQC) In+Care Campaign retention rates. The Broward County EMA showed an improvement in all measures: Gap Measure (30%-22%), Medical Visit Frequency (49%-51%), Patients Newly Enrolled (35%-50%) and Viral Load Suppression (62%-70%). The EMA will continue to report to NQC through Fiscal Year 13-14 as the campaign has been extended. It was noted that the first year was spent cleaning up the data and reviewing trends. The next steps are to put more Quality Improvement Projects (QIP) into place. A comparison of the annual rates for all Part A campaign participants to the Broward County EMA's rates showed Broward County at 23% compared to 14% in the Gap Measure, 51% compared to 64% in Medical Visit Frequency, 50% compared to 61% in Patients Newly Enrolled and 70% compared to 72% in Viral Load Suppression. Lastly, a comparison of the Broward County EMA rates to the average, top 10% and top 25% of the Part A participants was projected.

The Committee reviewed a quarterly QI Network Update detailing the activities of all Networks during October-December, 2012. (Copy on file).

7. Review Joint Planning Report

The Joint Planning Summary to the HIVPC was discussed with the Committee to highlight discussion taking place in other HIVPC Committees regarding Viral Load Suppression and collection of Community Viral Load data. It was noted that the QM Committee should expect a greater degree of collaboration with other committees in the upcoming year.

8. Development of Annual QM Committee Work Plan

The Grantee and CQM Support Staff are working on updating the Service Delivery Models (SDM) for all networks. Revisions will be brought to the Networks and, upon Network approval, to the QM Committee.

9. Unfinished Business

The Committee was asked to review the *FAQ's for New Committee Members*, a document created as a QM resource for new members. It was noted that the document includes previous comments made by the Committee. The Committee will provide additional comments and finalize the document at the next meeting.

10. New Business

There is no new business.

11. Grantee Reports

A. Part A Grantee Report

There were no announcements.

12. Resources and Announcements
There were no resources or announcements.

13. Public Comment
None.

14. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

15. Request for Information/Directives
There were no requests for information or directives.

16. Agenda Items for Next Meeting

- **A.** Approve 10/15/12 meeting minutes and 1/7/13 Agenda
- **B.** Update on Oral Health Care Outcomes and Indicators Revision
- **C.** NQC Retention Rates Report
- **D.** Review Changes to the Service Delivery Models
- **E.** Finalize *FAQ's for New Committee Members*
- **F.** Review Revised Annual QM Work Plan

17. Next Meeting Date: Monday, February 18, 2013

18. Adjournment
The meeting was adjourned at 1:28PM.

Quality Management Committee
Monday, October 15, 2012 at 12:30 P.M.
Minutes

Attendance					
#	**Members**	**Present**	**Absent**	**Guests**	**Grantee Staff**
	Gammell, B. ,HIVPC Vice Chair	X		Bonnie Majcher	Degraffenreidt, S.
1	Grant, C., Vice Chair	X		Jamie Finkelstein*	Strong, K.
2	Johnson, K.		X	Brenda Colon	Jones, L.
3	Katz, H.B.	X		Rita Volpitta	
4	Martin, M.	X			**CQM Staff**
5	Mitchell, T.	X			Eshel, A.
6	Quintana-Jefferson, M.	X			Desa, G.
7	Rajner, M.		X		Crawford, T.
8	Schweizer, M.	X			Rosiere, M.
Quorum = 5		**6**	**2**		

*Attended via phone

1. **Call to Order**
   The meeting was chaired by the HIV Planning Council Vice-Chair with the assistance of the QM Committee Vice-Chair. The Chair called the meeting to order at 12:36 P.M.

2. **Welcome and Introductions**
   The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law. It was noted that a statement was added to the agenda on the Sunshine Law. Meeting reporting requirements, which include the recording of minutes, was also made known to attendees. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

3. **Moment of Silence**
   A moment of silence was observed.

4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
      The Chair reviewed Meeting Ground Rules and Statement of Sunshine.

   B. Review Public Comment Requirements (Please Sign-in)
      There was no Public Comment.

   C. Excused Absences
      There were no requests for excused absences.

   D. Approval of Today's Agenda
      The agenda was approved via consensus.

   E. Approval of 09/24/12 Meeting Minutes
      The minutes were approved via consensus.

5. **Review Revisions to Outcomes and Indicators-Update**

A. Outreach

The Committee reviewed the Outreach Outcomes and Indicators. Attendees voiced concern of whether having an appointment occur within two weeks of a client establishing eligibility was realistic. Members also voiced concern of whether targeting 25% of lost to care clients was too low, but it was concluded that there was no previous tracking so that was a good starting point.

The following is the revised Outreach outcome and indicators presented to the committee for approval:

Outreach	
Outcomes	**Revised Indicators**
Facilitate client access to outpatient/ambulatory medical care and/or medical case management.	1.1 80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit ~~to~~ occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).
	1.2 25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or medical case management visit ~~to~~ occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).

After discussion, the Committee decided to accept Outreach indicators 1.1 and 1.2 as presented.

Motion 1	"To approve Outreach Indicator 1.1 as presented."
First	Claudette Grant
Second	H. Bradley Katz
Action	Passed Unanimously

Motion 2	"To approve Outreach Indicator 1.2 as presented."
First	Claudette Grant
Second	H. Bradley Katz
Action	4 approved, 1 opposition

B. Oral Health Care

Outcomes and Indicators for Oral Health will be discussed at the next Network meeting; an update will be provided at the next Committee meeting.

6. **Update on 2012-2015 Comprehensive Plan Implications for QM Committee Work Plan**

The Committee was presented with the 2012-2015 Comprehensive Plan. The purpose was to review the comprehensive plan in order to incorporate the National HIV/AIDS Strategy (NHAS) goals into the 2013-2015 work plans. It was noted that Chapter 4 of the comprehensive plan discusses monitoring and evaluation activities in detail and should be reviewed by members.

While reviewing the NHAS goals, the Committee expressed concern that there were some things that the QM committee could not capture and control. The Committee emphasized the need to acknowledge what pieces are missing as well as collaborate with other agencies.

There was also a recommendation made that the Committee review data on a regular basis (every three months) in order to monitor success towards achieving the NHAS goals.

7. **Review Annual QM Work Plan**

It was announced that the Annual QM Work Plan is included in the committee's agenda packet and is for informational purposes only.

8. Unfinished Business
None.

9. New Business
None reported.

10. Grantee Reports

A. Part A Grantee Report

The following announcements were made:

i. The National Quality Center (NQC) has extended the In+Care campaign to 2013, and the EMA will continue its participation.

ii. CQM Grantee and support staff will be traveling to a Central Florida Regional QI Group meeting facilitated by NQC on Thursday, October 25, 2012 to present on the EMA's participation in the campaign regarding programming, collection, and analysis.

11. Resources and Announcements

A. Review 2012 Client Survey Tool
The committee was presented with the draft survey and was instructed to review and direct questions, comments, or suggestions to staff by Tuesday, October 16, 2012 in order for additions to be incorporated and presented at the Executive Committee meeting on Thursday, October 18, 2012.

B. MCM Resource Fair
The MCM Resource Fair will be held on October 24, 2012 at Central Broward Regional Park. The session times are 11:00 a.m. to 1:00 p.m. or 1:00 p.m. to 3:00 p.m. This fair is mandatory for all medical case managers, HOPWA case managers and peers.

12. Public Comment
None.

13. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

14. Request for Information/Directives
There were no requests for information or directives.

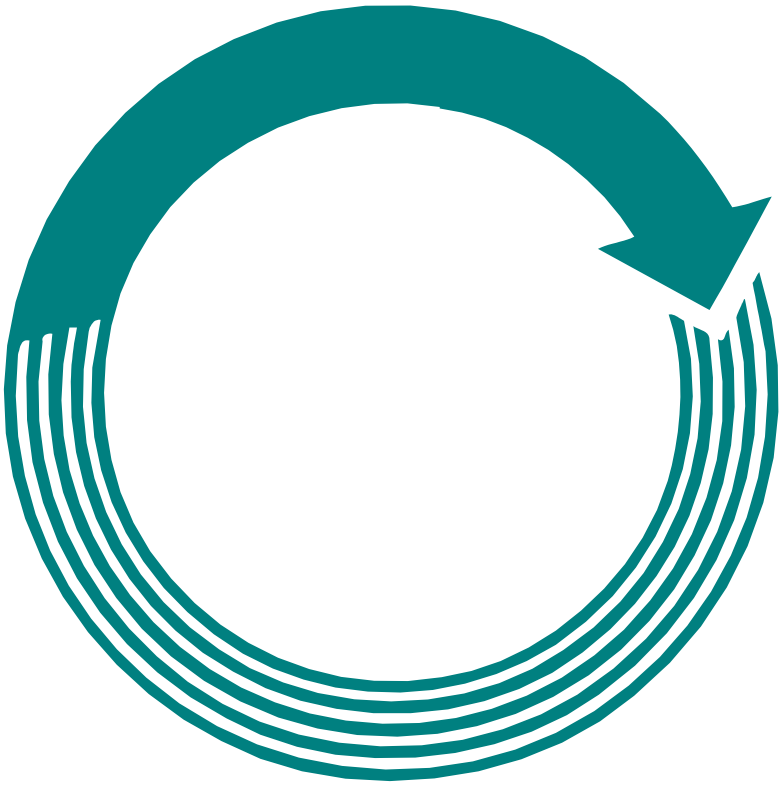
15. Identify Agenda Items for Next Meeting

A. Review Annual QM Work Plan
B. Review NQC Retention Rates Report
C. Review Revisions to Outcomes and Indicators-Oral Health
D. Quarterly QI Network Update

16. Next Meeting Date: Monday, **December 17, 2012** at 12:30 p.m.
The cancellation of the November QM Meeting was proposed; a Coordination meeting will be held instead.

17. Adjournment
The meeting was adjourned at 2:34 P.M.

Ryan White Part A Quality Management



Medical Case Management Service Delivery Model

Broward Regional Health Planning Council, Inc.

The creation of this public document is fully funded by a federal Ryan White CARE Act Part A received by Broward County and sub-granted to Broward Regional Health Planning Council, Inc.

Ryan White Part A Quality Management

Medical Case Management
Service Delivery Model

Definition:

~~A range of client-centered services that link clients with health care, psychosocial, and other services.~~ A range of client-centered services that link clients with health care, psychosocial, and other services including benefits/ entitlement, counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. 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 client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. In addition, Peer Education Counseling is coupled with Medical Case Management to offer clients individual therapeutic support services by an individual who may be the same age, gender, and HIV status as the client. This person will have had experienced and resolved the same type of problems as the client. The peer counselor will assist the client with the implementation of the case plan goals and objectives, which may include a recommended therapeutic regimen, medication adherence, compliance with medical procedures and self-care. The Peer Education Counselor will also conduct medical case management services including face-to-face, phone contact, home visits, medical eligibility screenings, educating new client regarding HIV and accompanying client(s) to initial appointments for medical care and other support services.

OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

Client Outcomes	Outcome Indicators	Inputs	Strategies	Data Source (Only one required for each strategy.)
~~1. Improved ability to independently navigate and access needed services.~~	~~1.1 100% of new clients receive information regarding available services and corresponding eligibility criteria.~~	~~Funding~~ ~~Clients~~ ~~Staff~~ ~~Facilities~~ ~~Supplies~~	~~1.1.1. Explain RW eligibility by service~~ ~~1.1.2. Obtain client signature~~	~~1.1.1.1. Progress Notes~~ ~~1.1.2.1. Clients Rights, Responsibilities and Acknowledgement form~~
	~~1.2. 80% of clients achieve initial Plan Of Care (POC) goals by designated target dates.~~		~~1.2.1. Assess client needs~~ ~~1.2.2. Create POC with client input~~ ~~1.2.3. Provide necessary support and referrals~~ ~~1.2.4. Follow up by designated target dates~~ ~~1.2.5. Revise target dates to POC as needed~~	~~1.2.1.1. Needs Assessment~~ ~~1.2.2.1. Signed Action Plan by CM and client~~ ~~1.2.3.1. Action Plan~~ ~~1.2.3.2. Referrals and Progress Notes~~ ~~1.2.4.1. Action Plan~~ ~~1.2.5.1. Action Plan~~

Client Outcomes	Outcome Indicators	Inputs	Strategies	Data Source (Only one required for each strategy.)
1-Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care *NOTE: Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	**1.1-80% of clients achieve POC goals related to Outpatient/ Ambulatory Medical Care services by designated target dates** **1.2- 80% of clients are retained in Outpatient/ Ambulatory Medical Care**	Funding Clients Staff Facilities Supplies	**1.1** **1.1.1. Collaborate with client to assess client medical needs.** **1.1.2. Develop POC goals that reflect client's medical needs.** **1.1.3. Develop obtainable target dates.** **1.2** **1.2.1 Assist client in making medical appointments as needed.** **1.2.2 Follow-up to ensure client attended medical appointments.** **1.2.3 Educate clients on the importance of attending medical appointments.**	1.1.1.1. Progress Notes 1.1.1.2. Action Plan 1.1.2.1. Progress Notes 1.1.2.2. Action Plan 1.1.3.1. Progress Notes 1.1.3.2. Action Plan 1.2.1.1.Needs Assessment 1.2.1.2.Client appointment record 1.2.1.3. Action Plan 1.2.2.1.Client appointment record 1.2.2.2. Action Plan 1.2.3.1. Progress Notes 1.2.3.2. Action Plan

STANDARDS FOR SERVICE DELIVERY

Standard	Indicator	Data Source
1. Each client receives an assessment.	1.1. 100% of client records will have a completed Needs Assessment.	1.1.1. Needs Assessment 1.1.2. Designated HIV MIS System
2. Each client will be assessed to determine if he/she currently receives primary medical care.	2.1. 100% of client records will have documented client's primary medical care status in the Needs Assessment.	2.1.1. Needs Assessment 2.1.2. Designated HIV MIS System
3. Each client's viral load and CD4 will be collected.	3.1. 100% of client viral loads and CD4 will be requested at least semi-annually with the intent of collecting data.	3.1.1. Client Chart 3.1.2. Lab Report 3.1.3 Designated HIV MIS System
4. Each client's viral load and CD4 will be tracked to observe trends.	4.1. 100% of the collected client viral loads and CD4 will be recorded at least semi-annually.	4.1.1. Client Chart 4.1.2. Lab Report 4.1.3 Designated HIV MIS System
5. Each client will be assessed for barriers to access care, treatment adherence, adherence to medications, and culturally specific needs.	5.1. 100% of client Needs Assessment will have documented the barriers to access primary medical care, adherence to treatment, adherence to medications and culturally specific needs as agreed with client.	5.1.1. Action Plan 5.1.2. Needs Assessment 5.1.3. Designated HIV MIS System

6. An individual Action Plan will be developed in agreement with the client.	6.1. 100% of Action Plan will have client and/or caregiver's signature.	6.1.1. Action Plan 6.1.2. Designated HIV MIS System
7. The Action Plan will be based on identified needs and will address client's cultural needs.	7.1. 100% of Action Plan will address client needs identified in Needs Assessment.	7.1.1. Action Plan 7.1.2. Designated HIV MIS System
8. Each client will be assisted to develop time frames for the resolution of barriers to care identified in the Needs Assessment.	8.1. 100% of Action Plan documented the interventions to resolve the barriers to care. 8.2. 100% of Action Plan documented achieves dates. 8.3. 100% of Client Progress Notes document assistance.	8.1.1. Action Plan 8.1.2. Client Progress Notes 8.1.3. Designated HIV MIS System
9. Each client will be assisted to establish expected outcomes based on the Action Plan.	9.1. 100% of Action Plan document expected outcomes. 9.2. 100% of Progress Notes document assistance.	9.1.1. Target dates in Action Plan 9.2.1 Progress Notes

Standard	Indicator	Data Source
10. Each client will be assisted to remain in primary medical care and adhere to treatment.	10.1. 100% of Client Progress Notes document attempted assistance. 10.2. 100% of Client Action Plans outline barriers to retention to medical care.	10.1.1. Action Plan 10.1.2. Client Progress Notes 10.1.3. Designated HIV MIS System
11. Each client receiving medical case management for at least 6 months during the measurement year will have two or more medical visits.	11.1. 95% of clients receiving medical case management for at least 6 months during the measurement year will have two or more medical visits.	11.1.1. Client Progress Notes 11.1.2. Documented Provider Visit 11.1.3. Designated HIV MIS System
12. Each client receiving medical case management for at least 6 months will have their medical case management Action Plan updated two or more times in the measurement year.	12.1. 95 % of clients receiving medical case management for at least 6 months will have their medical case management Action Plan updated two or more times in the measurement year.	12.1.1. Client Progress Notes 12.1.2. Action Plan 12.1.3. Designated HIV MIS System
13. Each client will be assessed for prescribed HAART therapy when CD4 count is below 500.	13.1. 100% of clients are assessed for HAART prescription.	13.1.1. Needs Assessment 13.1.2. Client Progress Notes 13.1.3. Designated HIV MIS System
14. Each client will be assessed for other medication use.	14.1. 100% of clients are assessed for medications adherence.	14.1.1. Needs Assessment 14.1.2. Client Progress Notes 14.1.3. Designated HIV MIS System

15. Conduct multi-disciplinary case staffing for appropriate clients, defined as clients identified with a decrease in CD4, increase in viral load and/or missed appointments.	15.1. 100% of clients identified with a decrease in CD4 , increase in viral load and/or missed appointments will be assessed for a multi-disciplinary case staffing.	15.1.1. Action Plan 15.1.2. Client Chart
16. Upon a face-to-face discharge medical case managers will review community resources with client.	16.1. 100% of clients' files will document a review of community resources to access upon discharge.	16.1.1 Progress Notes
17. Upon termination of active medical case management services, a client case is closed and contains a closure summary documenting the case disposition and an exit interview with Medical Case Manager & Medical Case Management Supervisor.	17.1. 100% of closed cases include documentation stating the reason for closure and a closure summary. 17.2. 100% of case closure summaries are signed off by a Medical Case Management Supervisor. 17.3. 100% of Exit Interviews document client discharge	17.1.1. Case closure summary 17.1.2. Progress Notes 17.1.3. Action Plan 17.2.1. Case closure summary 17.2.2. Progress Notes 17.2.3. Action Plan 17.3.1. Case closure summary
18. Progress notes and all program and service related documentation must be entered in Designated HIV MIS System within 3 business days of client contact.	18.1. 100% of progress notes will be written within 3 business days of client contact.	18.1.1. Progress Notes 18.1.2. Designated HIV MIS System
19. Each client will receive a return call within 1 business day of client's voice message requesting a return call.	19.1. 80% of clients will receive a return call within 1 business day of client's voice message requesting a return call.	19.1.1. Telephone Log 19.1.2. Progress Log

PROTOCOLS

The Medical Case Management and Peer Counseling Protocol identifies the specific ways to implement the Medical Case Management and Peer Counseling Standards and processes inherent to medical case management and peer counseling services. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, HAB HIV Medical Case Management Performance Measures, etc.).

Eligibility Verification
The medical case manger shall verify client's eligibility is established by reviewing the certification in the designated HIV MIS System. MCM (or other authorized individual such as Peer Educator), shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System. MCM (or designee) will review client's eligibility for all funding streams and services for which client may qualify. MCM's will follow-up with referrals as appropriate. The purpose of the assessment is to ensure 1) client's access to all services client may be eligible for and 2) the status of Ryan White as payer of last resort.

Needs Assessment
The medical case manager shall assess client needs by completing all sections of the Needs Assessment document and/or designated HIV MIS System. The medical case manager shall complete the Needs Assessment within three (3) sessions from the time of initial visit.

Additionally, client's progression of HIV will be indicated under *HIV Disease Progression* in the Needs Assessment in designated HIV MIS System.

Action Plan

Individualized Plan of Care (POC)
The medical case manager in conjunction with the client shall complete an individualized Action Plan that incorporates the specific needs of the client. Action Plan includes the needs that can be met in the time frame agreed with the client. The medical case manager completes the Action Plan the same day the Needs Assessment is completed.

Time frames
The medical case manager shall assist the client to set client driven, realistic time frames to resolve the barriers for access to primary medical care identified in the Needs Assessment. Time frames shall be documented in the *Target Date* field in the Action Plan.

Addressing Cultural Needs
The medical case manager shall ensure client cultural needs are addressed in Action Plan by including those agreed with the client in the Action Plan.

Addressing Client Needs
The medical case manager shall use the Needs Assessment data in the development of the Action Plan. The medical case manager, in conjunction with the client, shall prioritize the client needs to be addressed in the Action Plan.

Resolutions to Barriers
The medical case manager shall assist the client in determining appropriate strategies to resolve barriers to access primary medical care. The resolutions shall be client driven. The strategies shall

be documented in the column *Interventions*.

Goals

As a member of the clinical care team, the medical case manager shall assist the client to define both medical and social service goals for the needs identified in the Action Plan. The expected results/benefits shall be documented in the Action Plan. The medical case manager shall document the specific assistance provided to the client in the Progress Notes.

In making sure that the client meets their objectives and defined case plan goals in their action plans the peer counselor will document efforts to assist the client by documenting with a progress note in the client record.

Client Participation

The medical case manager shall ensure client participation in the development of the Action Plan. The client's signature on the Action Plan shall evidence the client participation in agreements stated in the Action Plan.

Once barriers are addressed and goals are achieved, case management is no longer needed and client should be discharged from services.

Referral Process

Purpose

To standardize the process used to provide clients with information, and referrals when appropriate, within the Ryan White system of care and to other third party providers.

Procedure

Referring medical case manager shall assess client needs by completing a Needs Assessment. The analysis of the Needs Assessment shall assist the medical case manager in determining the referrals needed.

An Action Plan shall be developed by the referring medical case manager based on the identified needs. Referrals shall be documented in the Action Plan and the Progress Notes.

Referring medical case manager or peer counselor shall provide client with information of available services. This shall be documented in Progress Notes.

Referring medical case manager or peer counselor shall follow-up and document the results of the referral in the Progress Notes.

Status of Referral

Referring medical case manager , peer and provider that receives the referral shall communicate to update each other on the status of the referral.

No Show

Referring medical case manager or peer counselor shall contact "no show" clients to assess potential barriers and/or conditions leading to "no show".

Referring medical case manager or peer counselor and client shall determine future steps to resolve the situations that triggered the "no show".

Referring medical case manager or peer counselor shall establish coordination with the agency that received the initial referral to re-activate it after client consents.

Medical case manager or peer counselor shall document all client follow-up (phone calls, mail, face-to-face and/or electronic communication) on Progress Notes as soon as information is collected.

Medical case manager or peer counselor shall access outreach services if client remains unreachable after 6 months of not showing for outpatient/ambulatory medical care or medical case management appointments.

Access to Primary Medical Care
The medical case manager or peer counselor shall assist the client to get primary medical care, if he/she is not in care, using information provided in the Needs Assessment. The medical case manager or peer counselor shall discuss with the client the reasons for accessing primary medical care and with client participation determine how the medical case manager can help him/her access primary medical care. The medical case manager or peer counselor shall discuss with the client what needs to happen so he/she can start primary medical care. The medical case manager or peer counselor shall coordinate a primary medical care appointment for consenting client within 2 weeks of client contact with medical case manager.

The medical case manager or peer counselor shall detail the assistance provided in the Progress Notes including any coordination conducted to get the client in primary medical care.

Retention in Primary Medical Care
The medical case manager or peer counselor shall assist client to remain in primary medical care. The medical case manager or peer counselor shall assess possible barriers to continue in primary medical care and assist in their removal.

The medical case manager or peer counselor shall detail the assistance provided in the Progress Notes. The medical case manager or peer counselor shall document any coordination conducted to assist client to remain in primary medical care.

Adherence to Treatment
The medical case manager or peer counselor shall assist the client to adhere to treatment using information provided in the discussion of retention in primary medical care documented in the Progress Notes. The medical case manager or peer counselor shall discuss with the client the reasons for not adhering to medical treatment and with the client participation determine how the medical case manager can help to have him/her to adhere. The medical case manager or peer counselor shall discuss with the client strategies to improve adherence treatment. The medical case manager or peer counselor shall detail the assistance provided in the Progress Notes. The medical case manager or peer counselor shall document any coordination conducted to assist client to adhere to treatment.

Medical Case Management and Peer Counselor Monitoring
The medical case manager and peer counselor will collect, plot, analyze and monitor and review with client his/her CD4 and viral loads at a minimum biannually. Each client will be assessed to determine whether multidisciplinary case staffing is warranted upon receipt and analysis of lab results. The peer

counselor will provide clients with services such as face-to-face, phone contact, home visits, and medial eligibility screenings.

Follow-up
Schedule of Client Follow-up

The medical case manager or peer counselor shall provide follow-up based on the client Action Plan. The medical case manager and peer counselor shall follow-up the progress of the Action Plan and adherence to treatment and medications. The medical case manager and peer counselor shall document the follow-up in the Progress Notes, including phone calls, mail, face-to-face and/or electronic communication. Checking lab reports (trending viral loads and CD-4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. The medical case manager and the peer counselor shall take every possible interaction with the client as a window of opportunity to assess and/or reinforce access, retention and adherence to treatment.

Documentation
The medical case manager and the peer counselor shall document within three business days any coordination and/or intervention with the client and/or on behalf of the client. The Progress Notes make up the major source of documentation.

Reassessment
The medical case manager shall conduct: a) continuous client monitoring to assess the efficacy of the Action Plan and b) Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary ~~a reassessment of each active client as indicated by the Action Plan and at a minimum once annually.~~ The medical case manager shall document the reassessment in the Progress Notes. The medical case manager shall revise and update the Action Plan at reassessment.

If the client chooses to receive services from a different provider, the medical case manager shall ask if the client desires to have the record transferred once he/she has selected another provider. The medical case manager shall document the reasons for client's refusal of services. If the client does not express a reason, the medical case manager shall document this.

Continuous Quality Improvement
Medical case management shall conduct chart reviews at least quarterly to ensure appropriate documentation of all services, including referrals, follow-up and reassessment.

Responsibilities of Medical Case Managers
Ryan White Part A medical case managers shall provide services to clients as indicated below:

Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
Complete Needs Assessment
Complete POC
Monitor service delivery and client adherence to POC
Follow-up POC
Re-assess Needs Assessment and POC
Promote medical adherence, including medication
Facilitate access to primary medical care, medications, home health care, specialty care
Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)

Coordinate medical referrals
Monitor referral status
Coordinate medical care needs
Ensure all non-Ryan White Part A medical clients' verified Viral Loads, CD4 counts are available and entered into designated HIV MIS system
Refer to disease management programs non-adherent clients
Identify, refer, follow-up social support service needs identified in the POC
Coordinate client care with all appropriate parties
Document all interventions
Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)

Responsibilities of Peer Counselors
Ryan White Part A peer counselors shall provide services to clients as indicated below:

Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
Monitor service delivery and client adherence to POC
Follow-up POC
Promote medical adherence, including medication
Facilitate access to primary medical care, medications, home health care, specialty care
Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
Coordinate medical referrals
Monitor referral status
Coordinate medical care needs
Refer to disease management programs non-adherent clients
Identify, refer, follow-up social support service needs identified in the POC
Coordinate client care with all appropriate parties
Document all interventions
Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)
Assist Medical Case Manager in care coordination

Payer of last resort
An applicant may not be eligible for services from Ryan White Part A Program if the applicant is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White may be utilized for HIV related services only when no other source of payment exists.

An applicant cannot be receiving services or be eligible to participate in local, state, or federal programs where the same type service is provided or available. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state, or federal programs, or pending determination of eligibility from other local, state or federal programs. Ryan White Part A services is the payer of last resort. All community resources should be explored with clients prior to obtaining and receiving Ryan White Part A services.

Professional Requirements and Training

Peer Counselor

Education Requirements:
High School Diploma or Equivalent

Requirement: Must be a consumer of services and have at least one-year's experience in the HIV/AIDS service delivery system.

Other experience that would be helpful to assist consumers:
Knowledge of community resources and support groups
Knowledge of target population
Knowledge of HIV disease and treatment

Skills:
Written documentation
Adherence assessment and reinforcement
Time management

Additional requirement based on the type of setting and/or project:
Knowledge of substance abuse
Knowledge of women's health
Knowledge of medical issues

Training of the Medical Case Manager:
HIV Basic Training
Annual HIV Update

Additional requirement:
Mandatory Case Management Seminars and/or training sessions required by Grantee
Cultural and linguistic competence

Medical Case Manager
Education Requirements:
Earned Bachelor or graduate degree from an accredited institution with a major in either social work, nursing or social services field with a minimum of one year medical case management experience.

Other Requirements:
Knowledge of community resources
Knowledge of target population
Knowledge of HIV disease and treatment
Cultural and linguistic competence
Experience in care coordination

Skills:
Client assessment
Written documentation
Adherence assessment and reinforcement
Time management

Additional requirement based on the type of setting and/or project:

Knowledge of substance abuse
Knowledge of women's health
Knowledge of medical issues

Training of the Medical Case Manager:
HIV Basic Training
Annual HIV Update
Medical Case Manager must have a minimum of 8 hours of training annually on medically-related topics

Medical Case Management Supervisors

In addition to the case manager requirements:

Master's degree from an accredited institution in health/human services preferred or Bachelors with a minimum of 3 years case management experience
A minimum of one year supervisory experience in a health or social services setting
Knowledge of program goals, outcomes, indicators, protocols, quality improvement evaluation, staff training and development
Experience with chart review
Experience with assessment of staff performance

Training:
Updates on management issues and/or skills
Other appropriate to the position
Medical Case Manager must have a minimum of 8 hours of training annually on medically-related topics

MULTI-DISCIPLINARY CASE STAFFING FORM

Collaborative staffing required? Yes No

Provide client URN#

Date of staffing

State reason for staffing
(i.e.: client not adherent with medical appointments or medication regimens, client at risk to fall out of care (substance use relapse, mental health issue, etc.), client medical condition not improving (CD4 counts, viral loads, etc.), client dropped out of care (no labs in past 6 months), or any situation detrimental to client remaining in care or adhering to care and medications)

Client medical provider information:
Medical funding source: RW Part A, Medicaid, Medicare, other:
Physician name:
Physician agency:
Physician address:

Pharmacy provider agency:
Medications Medical funding source: RW Part A, ADAP, Med Co- Pay Medicaid, Medicare, other:

List other services client is receiving. Give provider name and source of funding.

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

Service Name:
Provider Name:
Funding Source:

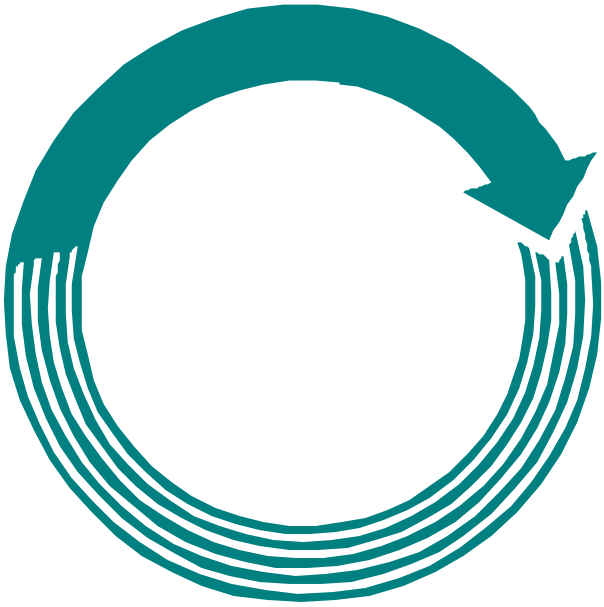
Service Name:
Provider Name:
Funding Source:

-List those in attendance at staffing.

-List issues discussed at staffing.

-Describe outcome or resolution of each issue discussed.

Ryan White Part A Quality Management



Ambulatory/Outpatient Medical Care Service Delivery Model

Fort Lauderdale/Broward County EMA

Ryan White Part A Quality Management

Ambulatory/Outpatient Medical Care
Service Delivery Model

Service Definition:

Outpatient/Ambulatory medical care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes 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, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Practitioner Definition:

Physicians, Nurse Practitioners, and Physician Assistants with current prescribing privileges in the state Florida.

Practitioner Continuing Education Recommendation:

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.

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OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

Client Outcome	Outcome Indicators	Inputs	Strategies	Data Source
1. Slow/prevent clients' HIV disease progression	1.1 80% of clients with CD4 ≤~~<~~ 500 are prescribed ~~HA~~ART 1.2 70% of clients on ~~HA~~ART for > 6 months will have a viral load <400	Funding Staff Clients Tests/Labs	1.1.1. Complete appropriate diagnostic testing 1.1.2 The clinician should refer to appropriate guidelines for treatment strategies 1.1.3. Monitor and follow-up	1.1.1.1 Clients Chart 1.1.2.1 PHS Guidelines, DHHS Guidelines, IAS Guidelines 1.1.3.1 Clients Chart

STANDARDS OF CARE

Note: Data source is client chart unless stated otherwise.

Documentation of HIV Infection

Standard	Indicator
1. Documentation of HIV infection[i] is in medical record.	1.1. 100% of client charts have documentation of HIV positive status. Diagnosed by a rapid HIV test or a conventional enzyme-linked immunosorbent assay (ELISA) and confirmed by Western blot or indirect immunofluorescence assay **OR** a detectable viral load.

Laboratory Testing

2. Basic laboratory tests shall be obtained.	2.1. 100% of client charts have basic screening labs done by second visit. 2.2. 100% of client charts have complete labs per protocol. 2.3. 100% of client charts screen for Hepatitis A, B, and C.
3. CD4 T-cell count[ii] laboratory tests shall be obtained before and after start of antiretroviral (ART) therapy.	3.1. 100% of clients have documentation of CD4 T-Cell count at entry into care and before ART initiation. 3.3~~3.2~~. 100% of clients have documentation of CD4 T-Cell count every 3-6 months for all patients not meeting criteria in 3.2.~~.~~ 3.2~~3.3~~ 100% of clients have documentation of CD4 T-Cell count at least every 6-12 months if client is documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for >2-3 years.
4. HIV RNA[ii] laboratory tests shall be obtained.	4.1. 100% of clients have documentation of HIV RNA at entry into care and before ART initiation. 4.2~~4.23.~~ 100% of clients have documentation of HIV RNA every 3-6 months. Interval MAY be extended to 6 months only if patient is documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for >2-3 years.
5. Resistance tests[ii] shall be obtained	5.1. 100% of naïve clients have documentation of genotype resistance tests at entry into care.~~new to care with HIV viral load ≥ 1000 have documentation of genotype resistance tests at entering into care~~. 5.2. 100% of clients have documentation of resistance tests at treatment failure with HIV viral load ≥ 1000 copies/mL. If drug resistance is suspected, client should be on failing regimen at time of test or within 4 weeks of regimen discontinuation. For client with suspected treatment failure due to issues of adherence, medication intolerance, or pharmacokinetic reasons, resistance testing is not warranted until these reasons are addressed.
6. HLA-B*5701[ii] laboratory test shall be obtained if considering start of abacavir.	6.1. 100% of clients have documentation of HLA-B*5701 if considering start of abacavir.
7. Tropism testing[ii] shall be obtained when considering use of CCR5 antagonist	7.1. 100% of clients have documentation of Tropism Testing if considering use of CCR5 antagonist.

Laboratory Testing (continued)

8. Basic chemistry [Serum Na, K, HCO3, Cl, BUN, creatinine, glucose (preferably fasting)][ii] , Liver function tests (ALT, AST, T. bili, & D. bili)[ii] , CBC with differential[ii] shall be obtained.	8.1. 100% of clients have documentation of basic chemistry at entry into care. 8.2. 100% of clients have documentation of basic chemistry follow-up at least every 3-6 months. 8.3. 100% of clients have documentation of basic chemistry before ART initiation or modification. 8.~~3~~4. 100% of clients have documentation of basic chemistry 2-8 weeks post ~~-~~ART initiation or modification.
9. Fasting lipid profile[ii] shall be obtained.	9.1. 100% of clients have documentation of fasting lipid profile at entry into care ~~or within 6 months of first visit~~. 9.2. 100% of clients have documentation of fasting lipid profile annually (if normal at last measurement) or every six months (if abnormal or borderline at last measurement).
10. Urinalysis[ii] shall be obtained.	10.1. 100% of clients have documentation of urinalysis at entry into care. 10.2. 100% of clients have documentation of urinalysis at least every 12 months.
11. Hepatitis A screening[v] shall be obtained.	11.1. 100% of clients have documentation of Hepatitis A Screening - Hepatitis A total antibody (HAVAb) or IgG (not IgM).
12. Hepatitis B screening[iv] shall be obtained	12.1. 100% of clients have documentation of Hepatitis B Screening - Hepatitis B core antibody (HBcAb) total or IgG (not IgM), Hepatitis B surface antibody (HBsAb), and Hepatitis B surface antigen (HBsAg). 12.2. 100% of clients with documentation of positive HBsAg, have further Hepatitis B testing; HBeAg, HBeAb and Viral Load by DNA PCR.
13. Hepatitis C screening[iv] shall be obtained.	13.1. ~~95~~100% of clients have documentation of Hepatitis C Screening - Hepatitis C antibody (HCVAb). 13.2. 100% of clients with documentation of positive HCVAb, have Hepatitis C (HCV) Viral Load, HCV genotype, and a treatment plan in the record.
14. Syphilis, N. gonorrhea (GC), and C. trachomatis (Chlamydia) screening shall be obtained[vi].	14.1. 100% of clients have documentation of Syphilis screening at baseline and annually thereafter~~.~~, 14.2. ~~90~~100% of female clients who report sexual activity since their last screening have documentation of N. gonorrhea (GC) and C. trachomatis (Chlamydia) screening annually.

Immunizations/Treatments

15. Clients are offered immunizations.	15.1. 100% of client's are offered pneumococcal vaccine[vii] and a follow up booster 5 years later. 15.2. 100% of clients are offered influenza immunization[viii]. 15.3. 100% of non immune clients are offered Hepatitis A and B vaccine[vii].
16. Anti-Retroviral therapy shall be prescribed.	16.1. 100% of clients have documentation of consideration and discussion of ART therapy at the times of CD4 T-Cell count and HIV RNA monitoring.

17. Treatment for opportunistic infections and prophylaxis for opportunistic infections shall be provided.[x]	17.1. 100% of clients have documentation of treatment, when indicated, for opportunistic infections. 17.2. 100% of clients have documentation of prophylaxis for opportunistic infections, when indicated, and prophylaxis is discontinued, when indicated.

Additional Assessments

18. Consenting female clients are given PAP test[xi xii], at least annually.	18.1. ~~90~~100% of charts of female clients show a PAP test and pelvic exam offered annually . 18.2 90% of charts of female clients for which a PAP test and pelvic exam were appropriate are successfully completed 18.3~~18.2~~. 100% of charts of female clients with abnormal PAP tests or with lesions present show referral to a gynecologist and the outcome will be documented.

Additional Assessments (continued)

19. Client is tested for Tuberculosis[ix] annually.	19.1. 75% of client charts document TB reading within 48-72 hours. 19.2. 75% of charts of clients who do not have test read within 48-72 hours have it repeated and read within 48-72 hours with completion within 1 month. Suggestion – If patient did not return for PPD read, for to IGRA directly. 19.3. 100% of charts of clients with a positive PPD reading are assessed for history of TB. Suggestion - 100% of patients should have history of TB assessed at entry into care with reassessment of risk annually 19.4. 100% of client charts show client with a positive PPD reading is referred for chest x-ray and prophylactic treatment. Interferon gamma releasing assays (IGRAs) may be considered in place of PPD.
20. Mammogram[vi] (females) shall be provided.	20.1. 100% of female clients, starting at age 40, have documentation of offering mammogram annually. 20.2. 100% of female clients with documentation of abnormal mammogram have documented plan of care in record.
21. Colon and Rectal Cancer Screening[ix] shall be provided.	21.1. 100% of clients have documentation of colorectal cancer screening by being offered a colonoscopy starting at age 50. If unable to perform or if patient refuses, a fecal occult blood test (FOBT)[xiii] 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. High risk groups should have screening earlier or more frequently based on USPSTF~~S~~ guidelines. 21.2. 100% of clients with documentation of abnormal screening have documented plan of care in record. ~~21.3. 100% of clients have digital rectal exam offered annually.~~

Care Assessments

22. Clients are educated about medication adherence.	22.1. 90% of clients with HIV infection, as part of their primary care, will be assessed and counseled for adherence ~~two or more times annually.~~ at every visit.
23. Clients with HIV infection attend 2 or more medical visits annually.	23.1. 90% of clients with HIV infection attend 2 or more medical visits annually. 23.2. 100% of clients not adherent to 23.1 have documentation of attempts to re-establish in care.
24. Clients with CD4 T-cell counts below 200 are prescribed PCP prophylaxis. Add - need to include Toxoplasma gondii CD4 < 100 if patient is toxoplasma positive	24.1. 95% of clients with CD4 T-cell counts below 200 are prescribed PCP prophylaxis

25. Pregnant women are prescribed antiretroviral therapy.	25.1. 100% of pregnant women are prescribed antiretroviral therapy
26. Cytomegalovirus (CMV) screening for patients with CD4 T-cell count < 50mm^3.	26.1. 100% of clients with CD4 T-cell count < 50mm^3 , have documentation of referral to ophthalmology.
27. Nutritional health education shall be assessed.	27.1. 100% of clients have documentation of annual nutritional assessment.
28. Oral health education/care shall be provided.	28.1. 75% of clients have documentation of annual oral health assessment referral to a dentist.
29. Mental health assessment/care shall be provided.	29.1. 100% of clients have documentation of annual mental health assessment/care. 29.2. 100% of clients with documentation of depression have documented plan of care in record.
30. Drugs/Alcohol/ assessment/education shall be performed.	30.1. 100% of clients have documentation of drug/alcohol education/assessment at least annually.
31. Tobacco (including smokeless tobacco) assessment/education shall be performed.	31.1. 100% of clients who have used tobacco products within one year have documentation of tobacco (including smokeless tobacco) education/assessment at least annually.
32. Sexual health education, to include birth control method, discussion of condom use, and risk identification, shall be provided.	32.1. 100% of clients have documentation of sexual health education, to include birth control method, discussion of condom use, and risk identification, once a year.
33. Transgender[xv] health care.	33.1. 100% of transgender clients will have documentation of birth sex and self-reported gender identity. 33.2. 100% of transgender clients will receive routine health care within this document's standards appropriate for their birth sex as anatomically permitted. 33.3. 100% of transgender clients are assessed for additional medical and mental health needs in addition to those inherent in birth sex and including those incurred from additional anatomical changes.

Charting/Documentation

34. Current Medication List is in medical record.	34.1. 100% of client charts have a current Medication List in client chart. (Data Source: Medication List)
35. Clients sign a written informed consent for vaccinations.	35.1. 100% of client charts show consent for each vaccine. 35.2. 100% of charts for children, show consent signed by a parent or guardian.
36. Client chart shall contain problem list.	36.1. 100% of client charts contain a problem list.
37. Client chart shall contain allergy list.	37.1. 100% of client charts contain an allergy list.
38. Client chart shall contain immunization list.	38.1. 100% of client charts contain an immunization list.

References

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[viii] http://www.faetc.org/PDF/Newsletter/Newsletter-Volume10-2009/HIVCareLink-Vol10-Issue-5-April-15.pdf

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[xii] http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/womenHiv.htm Accessed July 22, 2009.

[xiii] http://my.clevelandclinic.org/services/fecal_occult_blood_test/hic_fecal_occult_blood_test.aspx. Accessed July 22, 2009.

[xiv] Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents: Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2009;58(No. RR-4):20

xv Definition by representatives of TLCA forum, January 2001.

PROTOCOLS

The Ambulatory/Outpatient Medical Care Protocol identifies the specific ways to implement medical care standards and processes inherent to this service category. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, HAB HIV Core Clinical Performance Measures for Adults Clients, etc.). The delivery of ambulatory/outpatient medical care shall be conducted by culturally competent service providers.

Provider staff shall have a client grievance process that shall be discussed with client during intake. Provider staff shall explain that if a client is dissatisfied after completing the agency grievance process, the client has a right to present a grievance to the Broward County HIV Health Services Planning Council.

Accessing Outpatient/Ambulatory Medical Care
The medical staff will contact the Centralized Eligibility Intake Worker to determine the new client's eligibility. Once eligibility is determined and approved, the Centralized Eligibility Intake Worker will refer the new client to access outpatient/ambulatory medical care at one of the Ryan White Part A outpatient/ambulatory medical care providers.

NOTE: Please be mindful that clients have the right to choose their medical provider. Clients should be advised as to their choices of providers. Be sure to inform clients of providers that have the shortest wait time for an appointment so that they can make an informed decision.

Retention & Adherence to Medical Care
If medical staff is **unable** to reach a client who has missed an appointment or when a client has missed 2 appointments in a row, the medical provider will contact the medical case management provider first (if client receives this service).

- If the client is not receiving medical case management services, the medical provider will refer the client to outreach providers by telephone call, fax, or through the PE system.
- If the client is receiving medical case management services and the client's medical case management provider cannot bring the client back to care, medical case managers will refer the client to outreach providers by telephone call, fax, or through the PE system.
- Within 2 weeks, outreach providers will fax the final progress notes as follow-up on the case to the medical provider.

Basic Laboratory Tests
Complete laboratory tests include:

Complete blood count
Chemistries
RPR, hepatitis profile:

Hepatitis A Screening - At initial screening, Hepatitis A total antibody (HAVAb) or IgG (not IgM). Unless Hepatitis B or Hepatitis C infected, may consider administering immunization when CD4 cell count greater than 200 cells/mm^3.

Hepatitis B Screening - 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

Hepatitis C Screening - 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)

Toxoplasma antibody
Lymphocyte profile
Viral load
Resistance testing as appropriate

Medications
Medications will be documented in all clients' charts with start and end dates.

CD4 and Viral Load Monitoring
Practitioner shall do CD4 and Viral Load monitoring following PHS guidelines.

Tuberculosis Documentation
Practitioner shall test clients for tuberculosis. Practitioner shall treat based on most updated PHS guidelines.

PAP Test for Women
Practitioner shall give a PAP test a minimum of once annually.
Practitioner shall test for gonorrhea and chlamydia at time of PAP test.

Immunizations
Practitioner must offer immunizations per PHS guidelines to all clients.

Opportunistic Infection Prophylaxis
Assessment of Opportunistic Infections shall be completed and prophylaxis shall be given per most updated USPHS/IDSA Guidelines.

Combination Antiretroviral Therapy
If less than 500 CD4 count and not on combination drug therapy, document reason in the chart.

Pregnancy
Under state law all pregnant women should be recommended to receive HIV counseling and testing early during their pregnancy. Subsequently, all women with HIV infection should be offered an antiretroviral treatment regimen in accordance with USPHS, Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Prenatal HIV-1 Transmission in the United States.

Specialist Referrals
Practitioner shall refer client to appropriate specialist based on the client clinical status. Examples of referrals are:
Female client charts show gynecology referral of patient with a cervical lesion or identifies atypical squamous cells (ASCUS and ASC-H), low-grade squamous intraepithelial lesion (LSIL, CIN1), high-grade squamous intraepithelial lesion (HSIL, CIN2-3, carcinoma-in-situ) and invasive carcinoma level PAP.
Ophthalmology for patient with CD4 count less than 50/ul or with ocular manifestations.
Psychological/psychiatric for patient presenting with mental health needs.

Practitioner may make appropriate Medical Nutritional Therapy (MNT) referral out when client reports any of the following and agrees to a MNT referral:
1. Physical changes/weight concerns
2. Oral/GI Symptoms
3. Barriers to nutrition, living environment, functional status
4. Changes in diagnosis requiring nutrition intervention

Adherence
Practitioner shall assess and document adherence to medication.

Co-morbidities
Practitioner shall assess and document co-morbidities, minimally:
Hepatitis B, C
STDs
Substance abuse
Severe mental illness

Transgender Care
Transgender individuals are defined as individuals whose gender identity, expression, or behavior is not traditionally associated with their birth sex.

Professional Standards
Practitioner must have current prescribing privileges within the State of Florida.

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 provider, a 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

Appendix A – Quick Guideline for Laboratory Testing

(Current as of 10/11/09)

The following is a minimal guideline based upon the current DHHS Guidelines
Additional labs should be ordered as clinically needed and appropriate

Baseline labs
CD4 T-cell count
HIV RNA
Resistance testing
Basic chemistry - Serum Na, K, HCO3, Cl, BUN, creatinine,
glucose (preferably fasting)
ALT, AST, T. bili, D. bili
CBC w/ differential
Fasting Lipid Profile (12 hours fasting)
Fasting Glucose (12 hours fasting)
Urinalysis
Hepatitis A total antibody (HAVAb) or IgG (not IgM)
Hepatitis B core antibody (HBcAb) total or IgG (not IgM)
Hepatitis B surface antibody (HBsAb)
Hepatitis B surface antigen (HBsAg)
Hepatitis C antibody (HCVAb)
Syphilis (RPR)
N. gonorrhea (GC)
C. trachomatis (Chlamydia)

3-6 month labs, before ART
CD4 T-cell count
HIV RNA
CBC w/ differential

6-12 month labs, before ART
Basic chemistry - Serum Na, K, HCO3, Cl, BUN, creatinine,
glucose (preferably fasting)
ALT, AST, T. bili, D. bili
Fasting Lipid Profile (12 hours fasting)
Fasting Glucose (12 hours fasting)

3-6 month labs, post ART
CD4 T-cell count
HIV RNA
Fasting Lipid Profile (12 hours fasting)
Fasting Glucose (12 hours fasting)
Urinalysis

12 months
Prostate-specific antigen (PSA) Screening (males)
Syphilis (RPR)
N. gonorrhea (GC)
C. trachomatis (Chlamydia)
Urinalysis

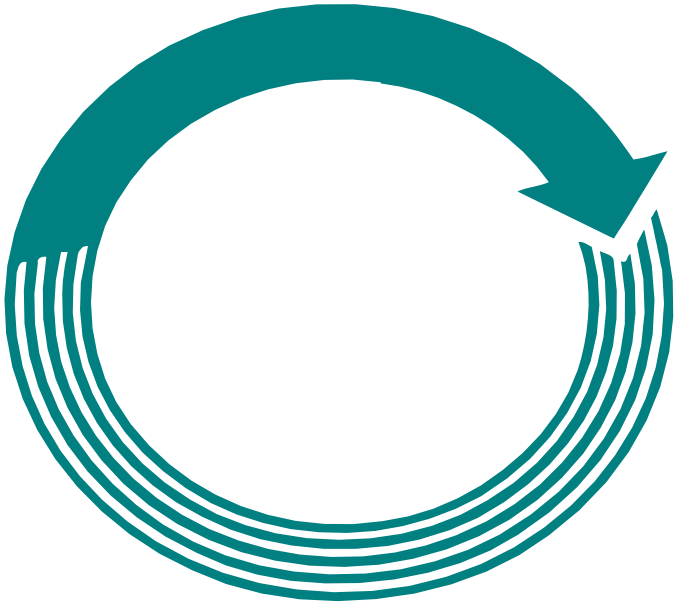
ART initiation or switch
CD4 T-cell count
HIV RNA
Resistance testing
Basic chemistry - Serum Na, K, HCO3, Cl, BUN, creatinine,
glucose (preferably fasting)
ALT, AST, T. bili, D. bili
CBC w/ differential
Fasting Glucose (12 hours fasting)
Urinalysis

2-8 weeks post-ART initiation
HIV RNA
Basic chemistry - Serum Na, K, HCO3, Cl, BUN, creatinine,
glucose (preferably fasting)
ALT, AST, T. bili, D. bili
CBC w/ differential
Fasting Lipid Profile (12 hours fasting)

Treatment Failure
CD4 T-cell count
HIV RNA
Resistance testing

Special Circumstance
HLA-B*5701 - If considering start of abacavir and document in record carrying data forward to most current volume
Tropism testing – If considering use of CCR5 antagonist
(HIV viral load must be ≥ 1000) or if clinically indicated.
If performed, record carried forward to most current volume
Pregnancy test (females) – if starting an efavirenz containing regime

Ryan White Part A Quality Management



Mental Health Services Service Delivery Model

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Ryan White Part A
February 2013

Ryan White Part A Quality Management

Mental Health Services
Service Delivery Model

The Service Delivery Model serves as a minimum set of standards that every provider should follow.

Definition:

Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. Mental health professionals or authorized within the State of Florida are referred to as licensed practitioners in this document.

OUTCOMES, OUTCOME INDICATORS, INPUTS, STRATEGIES, DATA SOURCES

Client Outcome	Outcome Indicators	Inputs	Strategies	Data Source
1-Improvement in client's symptoms associated with primary mental health diagnosis.	1.1-85% of clients achieve Plan of Care goals by designated target date.	Staff Funding Clients Clinical Scales Facilities Supplies	~~1.1.1 Initial intake completed~~ 1.1.2 Complete Biopsychosocial Evaluation 1.1.3 Administer appropriate Clinical Scale as needed 1.1.4 Develop Treatment Plan 1.1.5 Treatment Plan Review 1.1.6 Re-administer Clinical Scale at Time of Treatment Plan Review (Quarterly) 1.1.7 Discharge	~~1.1.1.1 Intake Form~~ 1.1.2.1 Biopsychosocial Evaluation 1.1.3.1 Clinical Scale 1.1.4.1 Agency Treatment Plan 1.1.5.1 Agency Treatment Plan Review Form ~~1.1.6.1 Clinical Scale~~ 1.1.7.1 Transfer/Discharge Summary

Client Outcome	Outcome Indicators	Inputs	Strategies	Data Source
2-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care. *NOTE: Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	2.1-85% of clients are retained in Outpatient/Ambulatory Medical Care.	Staff Funding Clients Facilities Supplies	2.1.1. Determine if client is currently enrolled in Outpatient/Ambulatory Medical care 2.1.2. Assess for barriers to care 2.1.3. Address any identified barriers in treatment plan 2.1.4. If indicated, complete referral to Outpatient/Ambulatory Medical care 2.1.5Documentation of medical appointment kept on file	2.1.1.1. Biopsychosocial Evaluation 2.1.2.1. Biopsychosocial Evaluation 2.1.3.1. Treatment Plan ~~2.1.4.1. MIS service request~~ ~~2.1.4.2. Paper certified referral~~ 2.1.4.3. Progress ~~Notes~~ Log 2.1.5.1. Lab documentation ~~2.1.5.2. Doctor Letter~~ 2.1.5.3. ~~Medical slip (appointment reminder note)~~ PE appointment record 2.1.5.4 Documented phone conversation with medical clinic

STANDARDS FOR SERVICE DELIVERY

Standard	Indicator	Data Source
1. Client agrees to assessment and treatment.	1.1. 100% of clients have signed Consent and Acknowledgment Form	1.1.1 Consent Acknowledgment Form.
2. Client is oriented to Ryan White Mental Health Services.	2.1. 100% of clients will be informed of expected participation in and development of individualized treatment plan.	2.1.1. Consent Acknowledgment Form
	2.2. 100% of clients will be informed as to availability of various treatment modalities (internal and external to the individual provider).	2.2.1. Combined Consent and Acknowledgment Form
	2.3. 100% of clients will be informed of availability of psychiatric evaluation as part of individualized treatment plan.	~~2.3.1. Combined Consent and Acknowledgment Form~~
	2.4. 100% of clients will be informed of availability of access to psychotropic medications as part of their individualized treatment plan.	~~2.4.1. Combined Consent and Acknowledgment Form~~

Standard	Indicator	Data Source
3. Client is orientated to other Ryan White services.	3.1. 100% of client charts show orientation was provided.	3.1.1. Combined Consent and Acknowledgment Form
	3.2. 100% of client charts have a copy of Client Rights and Responsibilities in the Combined Consent and Acknowledgment Form, signed by the client.	~~3.2.1. Combined Consent and Acknowledgment Form~~
	3.3. 100% of client charts show discussion of client confidentiality.	~~3.3.1. Combined Consent and Acknowledgment Form~~
	3.4. 100% of client charts show discussion of grievance process.	3.4.1. Agency grievance process 3.4.2. Combined Consent and Acknowledgment Form
	3.5 100% of clients are provided education, orientation to programs and services.	3.5.1 Client signature in chart.
4. Client Biopsychosocial needs are assessed.	4.1. 100% of client charts have completed Biopsychosocial needs assessment by the third counseling session.	4.1.1. Agency Biopsychosocial assessment
5. A Biopsychosocial Evaluation and treatment plan are completed prior to treatment (treatment is defined as an intervention).	5.1 100% of clients will have a Biopsychosocial Evaluation and treatment plan completed prior to treatment.	5.1.1 Biopsychosocial Evaluation 5.1.2 Treatment Plan
	5.2 100% of charts have Biopsychosocial Evaluation and treatment plan completed by a licensed practitioner or registered clinical intern and signed by a licensed practitioner prior to providing treatment or intervention to client.	5.2.1 Biopsychosocial Evaluation 5.2.2 Treatment Plan
6. Complete clinical scales where appropriate.	6.1 100% of Biopsychosocial Evaluation where depression, anxiety, schizophrenia, adjustment disorder with mood disorder or bipolar are suspected will have Mental Health/Substance Abuse QI Network approved clinical scale(s) administered.	6.1.1 CES-D, Hamilton Anxiety Scale, Goldberg Bi-Polar Spectrum, Global Assessment of Function (GAF), Brief Psychiatric Rating Scale (BPRS)

Standard	Indicator	Data Source
7. Client has a Treatment Plan based on the needs identified through Biopsychosocial Evaluation and/or clinical scale.	7.1 100% of client charts have a completed Treatment Plan. 7.2 100% of client needs identified on the needs assessment are addressed in the Treatment Plans.	7.1.1. Treatment Plans 7.2.1 Biopsychosocial Evaluation
8. Client participates in decision making related to treatment.	8.1 100% of client charts show documentation of client participation through their signature on Treatment Plan.	8.1.1. Treatment Plan 8.1.2. Progress ~~Notes~~ Log
9. Treatment Plans are reviewed by a licensed practitioner.	9.1 100% of Treatment Plans must be signed by a licensed practitioner prior to providing treatment or intervention to a client.	9.1.1 Treatment Plan
10. Client Treatment Plan is followed up quarterly.	10.1 100% of client charts show Treatment Plan reassessed quarterly. 10.2 100% of client charts show at least, quarterly follow-up of referrals given.	10.1.1. Treatment Plan 10.1.2. Progress ~~Notes~~ Log ~~10.2.1. Progress Notes~~
11. Re-assessment is ongoing and driven by client need.	11.1 100% of clients will be re-assessed annually, at a minimum.	11.1.1. Assessment 11.1.2 Treatment plan 11.1.3 Progress ~~notes~~ Log
12. Client receives intervention to access Outpatient/Ambulatory Medical care.	12.1. 100% of clients consenting to receive Outpatient/Ambulatory Medical care receive a referral to medical care. 12.2. 100% of clients consenting to receive Outpatient/Ambulatory Medical care receive a list of Ryan White Outpatient/Ambulatory Medical care Providers.	12.1.1. Progress ~~Notes~~ Log 12.1.2. Certification/ Referral/Re-certification Form 12.2.1. List of Ryan White Outpatient/Ambulatory Medical care Providers

Standard	Indicator	Data Source
13. Client in Outpatient/Ambulatory Medical care is assessed for retention in Outpatient/Ambulatory Medical care.	13.1 100% of clients are assessed for retention in care on a quarterly basis 13.2. 100% of client charts show assessment of barriers to remain in Outpatient/Ambulatory Medical care. 13.3. 100% of charts of clients disclosing barriers to retention in Outpatient/Ambulatory Medical care show referral to Medical Case Manager.	13.1.1 Treatment Plan 13.2.1. Progress ~~Notes~~ Log 13.3.1. Certification/ Referral/Re-certification Form
14. Client is assessed for adherence to prescribed HIV and/or psychotropic medications.	14.1. 100% client charts minimally show assessment of client adherence to prescribed HIV and/or psychotropic medications at treatment plan review.	14.1.1. Progress ~~Notes~~ Log
15. Client completes mental health treatment plan.	15.1. 65% of clients complete the Treatment Plan.	15.1.1. Treatment Plan 15.1.2. Progress ~~Notes~~ Log
16. Client will receive after care plan and instructions for planned discharges. (Planned discharge is a discharge agreed upon by client and registered clinical intern or licensed practitioner.	16.1 100% of clients receive after care plan and instructions. 16.2 100% of client charts show documentation of client participation through their signature on Discharge Summary.	16.1.1. Transfer/Discharge Summary and Instructions 16.2.1. Transfer/Discharge Summary

PROTOCOL

The Mental Health Protocol identifies the specific ways to implement the mental health standards and processes inherent to mental health treatment. Service delivery shall be conducted with cultural competency by culturally competent service providers. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, Florida Medicaid Behavioral Health Handbook, etc.).

~~**Outcome/Indicator Definitions**~~
~~*Indicator 1.1*~~
~~This indicator is applicable to new clients only for a maximum of one year. Scales are to be administered quarterly in conjunction with treatment plan updates.~~

~~*Indicator 2.2*~~
~~Discharge definition is a planned and/or anticipated termination of service by the client and registered clinical intern or licensed practitioner.~~

- ~~Enrolled in Outpatient/Ambulatory Medical Care is defined as a client who has attended a Medical clinical (doctor's visit or lab) appointment in the last 6 months or presents an appointment card or faxed confirmation from physicians office of future appointment.~~

Eligibility Verification
Agency staff ensures client eligibility for mental health treatment prior to client receiving the service. Verification of client eligibility is accomplished by examining the eligibility documentation. Mental Health and Substance Abuse treatment providers (or other authorized individuals), shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System. Mental Health and Substance Abuse treatment provider (or designee) will review client's eligibility for all funding streams and services for which client may qualify. Mental Health and Substance Abuse treatment providers will follow-up with referrals as appropriate. The purpose of the assessment is to ensure 1) client's access to all services client may be eligible for and 2) the status of Ryan White as payer of last resort.

Client Intake
The consenting client shall receive an appointment date to meet with a registered clinical intern or licensed practitioner within three (3) business days of the time the client is determined eligible to receive Ryan White Part A mental health services. Agency staff shall collect client data using the agency intake form at which time the client shall receive an orientation of the Ryan White service system. The Behavioral Health Services Combined Consent and Acknowledgment form consisting of the *General Consent for Evaluation, Referral and Treatment; Client Confidentiality; Consent for Urine Collection and Analysis (if applicable), Client Grievance Procedure, Client Rights, Client Responsibilities, Orientation and Freedom of Choice Provider List; and Consent for Research* shall be discussed and signed by the client and the registered clinical intern or licensed practitioner. A Consent to Release Information and Obtain Information shall be discussed with the client and signed by the client and the registered clinical intern or licensed practitioner.

Provider shall have a client grievance process that shall be discussed with client during intake. Provider shall explain that if a client is dissatisfied after completing the agency grievance process, the client has a right to present a grievance to the Broward County Ryan White Part A Program Office. Provider shall briefly explain the process for filing a grievance with the Ryan White Part A Program Office including posted grievance instructions.

Assessment of Client Needs
The registered clinical intern or licensed practitioner shall assess the client's Biosychosocial needs using the Biopsychosocial Evaluation form. The registered clinical intern or licensed practitioner shall complete the assessment within 3 sessions from intake. The Biosychosocial evaluation must be reviewed and signed by a licensed practitioner prior to providing treatment or intervention to client.

Treatment Plan

Individualized

The licensed or certified practitioner shall complete a Treatment Plan for each client based on the needs identified in the bio-psychosocial. A formal review of active treatment plans must be conducted at least once every six (6) months. The electronic treatment plan may be reviewed more often than once every six months when significant changes occur with patients. Treatment plans and quarterly updates shall be completed with client participation as evidence by client signature. Objectives shall be reviewed and updated with necessary modifications reflecting any

The treatment plan must contain all of the following components:

- The recipient's ICD-9-CM or DSM diagnosis code(s) consistent with assessment(s);
- Goals that are appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences and needs expressed by recipient(s);
- Measurable objectives and target dates;
- A list of the services to be provided (Treatment Plan Development, Treatment Plan Review, and Comprehensive Behavioral Health Assessment need not be listed);
- It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Signature of the recipient;
- Signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18);
- Signatures of the treatment team members who participated in development of the plan;
- A signed statement by the treating licensed practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs; and
- Transition or discontinuation of services.

***Note-See the following for exceptions to the requirement for signature of participant, parent, guardian, or legal custodian:**

If the recipient's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided.

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian. Documentation and justification of the exception must be provided in the recipient's medical record. The following are exceptions:

- As allowed by Chapter 397, F.S., recipients less than 18 years of age seeking substance abuse services from a licensed service provider.
- As stated in Chapter 394.4784 (1 & 2), F.S., recipients age 13 years or older, experiencing an emotional crisis to such a degree that he or she perceives the need for professional assistance. The recipient has the right to request, consent to, and receive mental health diagnostic and evaluation services, outpatient crisis intervention services, including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, or in a mental health facility licensed by the state. The purpose of such services is to determine the severity of the problem and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services will not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services will not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.
- Recipients in the custody of the Department of Juvenile Justice that have been court ordered into treatment; or require emergency treatment such that delay in providing treatment would endanger the

mental or physical well being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.

- For recipients in the care and custody of the Department of Children and Families (foster care or shelter status), the child's DCF or CBC caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases in which the Department of Children and Families is working toward reunification, the parent should be involved and should sign the treatment plan.

Medicaid Reimbursement
Medicaid reimburses one treatment plan development per provider per state fiscal year (July 1- June 30) Medicaid reimburses a maximum total of two per fiscal year. **Note: Reimbursement will be based upon the contract year (March 1 – Feb. 28) instead of state fiscal year.**

Medicaid reimburses a maximum of four treatment plan reviews, per recipient per state fiscal year (July 1 – June 30). **Note: Reimbursement will be based upon the contract year (March 1 – February 28) instead of state fiscal year**.

Group Therapy
Clients are to participate in group therapy only as a result of an individualized treatment plan intervention. Group Therapy documentation must include the topics, assessment of the recipient, level of participation, finding and plan.

Expected Outcomes
The registered clinical intern or licensed practitioner shall assist the client to define outcomes for the needs addressed in the Treatment Plan. The strategies to achieve the outcomes shall be documented. The registered clinical intern or licensed practitioner shall document the progress and specific assistance provided to the client in the Progress Notes. Notes must be entered into the PE system within 3 business days of interfacing with the recipient.

Client Participation
The registered clinical intern or licensed practitioner shall ensure client participation in the development of the Treatment Plan. The client signature on the Treatment Plan shall evidence the client participation in the agreements stated. Registered clinical intern and licensed practitioner shall sign the Treatment Plan.

Review/Follow-up
Quarterly updates shall be completed with client participation. Objectives shall be reviewed and updated with necessary modifications reflecting any new agreements. This update shall be documented in Progress Notes.

Referral and Coordination
The registered clinical intern or licensed practitioner shall refer clients to appropriate resources to assist in the resolution of other client needs. Referrals shall be followed up at least quarterly. Coordination of client care shall be documented in the Treatment Plan and Progress Notes.

Retention in Treatment
The registered clinical intern or licensed practitioner shall assess and record the potential barriers to retention in mental health treatment and shall strategize with the client to identify the necessary action steps to assist the client to remain in treatment. The registered clinical intern or licensed practitioner shall document all assistance given to the client in the Progress Notes.

Adherence to Treatment
The registered clinical intern or licensed practitioner shall assist the client to adhere to mental health treatment. The registered clinical intern or licensed practitioner shall discuss with the client the reasons for not adhering to treatment, and with client participation, determine how the registered clinical intern or licensed practitioner can

help him/her to adhere. The registered clinical intern or licensed practitioner shall discuss with the client what needs to happen so he/she can adhere to treatment.

The registered clinical intern or licensed practitioner shall detail the assistance provided in the Progress Notes. The registered clinical intern or licensed practitioner shall document any coordination conducted to assist the client to adhere to treatment.

Outpatient/Ambulatory Medical care Status
The registered clinical intern or licensed practitioner shall assess client's current participation in Outpatient/Ambulatory Medical care and shall document the status in the Progress Notes.

Access to Outpatient/Ambulatory Medical care
The registered clinical intern or licensed practitioner shall assess any client barriers to access Outpatient/Ambulatory Medical care, including cultural issues and offer a referral to the medical case manager to facilitate access. The registered clinical intern or licensed practitioner shall ensure that consenting clients are referred to get an appointment and coordination is secured to ensure continuity of services.

Assessment of Medications Adherence
The registered clinical intern or licensed practitioner shall re-assess psychotropic and HAART medications at least quarterly and document in Progress Notes.

Retention in Outpatient/Ambulatory Medical care
The registered clinical intern or licensed practitioner shall assist client to remain in Outpatient/Ambulatory Medical care. The registered clinical intern or licensed practitioner shall discuss with the client the reasons the client had to access care in the first place and assess if those are still valid. The registered clinical intern or licensed practitioner shall assess any client barriers to retention in Outpatient/Ambulatory Medical care, including cultural issues and refer to the medical case manager to facilitate retention.

The registered clinical intern or licensed practitioner shall detail the assistance provided in the Progress Notes. The registered clinical intern or licensed practitioner shall document any coordination conducted to assist client to remain in Outpatient/Ambulatory Medical care.

A client is considered out of medical care if they have not attended a medical appointment within the previous six months.

Discharge
Clients shall be discharged from mental health services based on the following criteria:

- Successful completion of the treatment program
- Registered clinical intern or licensed practitioner determines client is no longer adherent to treatment plan
- Transfer client to another registered clinical intern or licensed practitioner
- Disruptive or hostile behavior
- Client expires
- Client declines services
- Client relocates
- Client is referred to another provider
- Client leaves before completing treatment

Registered clinical intern or licensed practitioner shall complete a Transfer/Discharge Summary form to document client discharge or transfer to another registered clinical intern or licensed practitioner.

Continuous Quality Improvement
Chart reviews shall be completed quarterly to ensure appropriate documentation of service, referrals, follow-up and to assess the progress of the Treatment Plan.

Professional Requirements

Education

Minimum of a Master degree in Mental Health Counseling, Marriage and Family Therapy, Social Work or Psychology

Credentials

- Active Florida license in any of the above
- Florida registered clinical intern
- ~~Graduate level student currently enrolled in an accredited university in Mental Health Counseling, Marriage and Family Therapy, Social Work or Psychology~~

Experience

Clinician

Registered clinical intern or licensed practitioner

AND

Minimum of one year serving clients with a chronic medical condition preferred

Supervisor

Licensed practitioner and State of Florida Qualified Supervisor

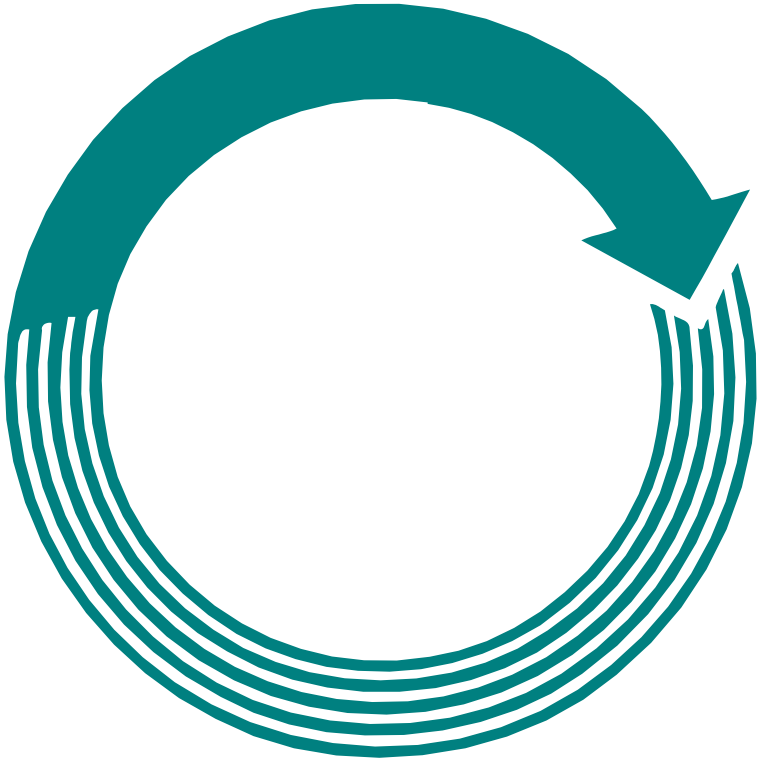
AND

Minimum of one year in a supervisory role in a mental health program

Minimum of one year serving clients with a chronic medical condition preferred

EXHIBITS

Ryan White Part A Quality Management



Substance Abuse Outpatient Care Services Service Delivery Model

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Ryan White Part A
February 2013

Ryan White Part A Quality Management

Substance Abuse Outpatient Care Services
Service Delivery Model

The Service Delivery Model serves as a minimum set of standards that every provider should follow.

Definition:

Substance abuse outpatient care services is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. Substance abuse treatment providers as defined in the State of Florida Mental Health Statutes are referred to as licensed or certified practitioners.

OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

Client Outcomes	Outcome Indicators	Inputs	Strategies	Data Source
1-Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	1.1-85% of clients achieve Plan of Care goals by designated target date.)	Funding Clients Staff	~~1.1.1 Initial Intake Completed~~ 1.1.2 Complete Biopsychosocial 1.1.3 Administer Appropriate Clinical Scale as needed 1.1.4 Develop Treatment Plan 1.1.5 Treatment Plan Review 1.1.6 Re-administer Clinical Scale at Time of Treatment Plan Review (Quarterly) 1.1.7 Discharge	~~1.1.1.1 Intake Form~~ 1.1.2.1 Biopsychosocial Evaluation 1.1.3.1 Clinical Scale 1.1.4.1 Agency Treatment Plan 1.1.5.1 Agency Treatment Plan Review Form ~~1.1.6.1 Clinical Scale~~ 1.1.7.1 Transfer/Discharge Summary

Client Outcomes	Outcome Indicators	Inputs	Strategies	Data Source
2-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care. *Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	2.1-85% of clients are retained in Outpatient/ Ambulatory Medical Care.		2.1.1. Determine if client is currently enrolled in primary medical care 2.1.2. Assess for barriers to care. 2.1.3. Address any identified barriers in treatment plan. 2.1.4. If indicated, complete referral to primary medical care. 2.1.5. Documentation of medical appointment kept on file.	2.1.1.1. Biopsychosocial Evaluation 2.1.2.1. Biopsychosocial Evaluation 2.1.3.1. Treatment Plan ~~2.1.4.1. MIS service request~~ ~~2.1.4.2. Paper certified referral~~ 2.1.4.3. Progress ~~notes~~ Log 2.1.5.1. Lab documentation ~~2.1.5.2. Doctor letter~~ 2.1.5.3. MIS CD4/viral load documentation 2.1.5.4. ~~Medical slip~~ PE appointment record 2.1.5.5. Documented phone conversation with medical clinic

STANDARDS FOR SERVICE DELIVERY

Standard	Indicator	Data Source
1. Client agrees to assessment and treatment.	1.1. 100% of clients have signed Consent to Treatment Form.	1.1.1 Consent Form.
2. Screen clients for level of care.	2.1 100% of clients receive an Intake Screening.	2.1.1. Initial Intake Packet.
3. Client is orientated to Ryan White service system.	3.1. 100% of client charts show orientation was provided	3.1.1. Combined Consent and Acknowledgment form (Exhibit 2)
	3.2. 100% of client charts have a copy of Client Rights and Responsibilities in the Combined Consent and Acknowledgment, signed by the client.	~~3.2.1. Combined Consent and Acknowledgment form~~
	3.3. 100% of client charts show discussion of client confidentiality.	~~3.3.1. Combined Consent and Acknowledgment form~~
	3.4. 100% of client charts show discussion of grievance process.	3.4.1. Agency grievance process 3.4.2. Combined Consent and Acknowledgment Form
	3.5 100% of clients are provided education, orientation to programs and services.	3.5.1 Client signature in chart.
4. Client Biopsychosocial needs are assessed.	4.1. 100% of client charts have completed Biopsychosocial needs assessment by the third counseling session.	4.1.1. Agency Biopsychosocial assessment

Standard	Indicator	Data Source
5. A Biopsychosocial and initial treatment plan are completed prior to treatment (treatment is defined as an intervention).	5.1 100% of clients will have a Biopsychosocial and initial treatment plan completed prior to treatment. 5.2 100% of charts have Biopsychosocial and initial treatment plan completed and signed by a licensed or certified practitioner prior to providing treatment or intervention to client.	5.1.1 Biopsychosocial Evaluation 5.1.2 Initial Treatment Plan 5.2.1 Biopsychosocial Evaluation 5.2.2 Initial Treatment Plan

Standard	Indicator	Data Source
6. Client has a Comprehensive Treatment Plan based on the needs identified through Biopsychosocial evaluation and/or clinical scale.	6.1. 100% of client charts have a completed Comprehensive Treatment Plan. 6.2. 100% of client needs identified on the needs assessment are addressed in the Comprehensive Treatment Plans.	6.1.1. Treatment Plans 6.2.1 Biopsychosocial Evaluation
7. Client participates in decision making related to treatment.	7.1. 100% of client charts show documentation of client participation through their signature on Comprehensive Treatment Plan.	7.1.1. Treatment Plan 7.1.2. Progress ~~Notes~~ Log
8. Comprehensive Treatment Plans are reviewed by a licensed or certified practitioner.	8.1 100% of Comprehensive Treatment Plans must be signed by a licensed or certified practitioner prior to providing treatment or intervention to a client.	8.1.1 Treatment Plan
9. Client Treatment Plan is followed up quarterly.	9.1. 100% of client charts show Treatment Plan reassessed quarterly. 9.2. 100% of client charts show at least, quarterly follow-up of referrals given.	9.1.1. Treatment Plan 9.1.2. Progress ~~Notes~~ Log ~~9.2.1. Progress Notes~~
10. Client receives intervention to access primary medical care.	10.1. 100% of clients consenting to receive primary medical care, receive a referral to medical care. 10.2. 100% of clients consenting to receive primary medical care, receive a list of Ryan White Primary Medical Care Providers (Exhibit 11).	10.1.1. Progress Notes 10.1.2. Certification/ Referral/Re-certification Form 10.2.1. List of Ryan White Primary Medical Care Providers

Standard	Indicator	Data Source
11. Client in primary medical care is assessed for retention in primary medical care.	11.1 100% of clients are assessed for retention in care on a quarterly basis 11.2. 100% of client charts show assessment of barriers to remain in primary medical care. 11.3. 100% of charts of clients disclosing barriers to retention in primary medical care show referral to case manager.	11.1.1 Treatment Plan 11.2.1. Progress ~~Notes~~ Log 11.3.1. Certification/ Referral/Re-certification Form
12. Client is assessed for adherence to prescribed HIV and/or psychotropic medications.	12.1.100% client charts minimally show assessment of client adherence to prescribed HIV and/or psychotropic medications at treatment plan review.	12.1.1. Progress ~~notes~~ Log 12.1.2. Tracking system
13. Client will receive after care plan and instructions for planned discharges. (Planned discharge is a discharge agreed upon by client and licensed or certified practitioner)	13.1 100% of clients receive after care plan and instructions. 13.2 100% of client charts show documentation of client participation through their signature on Discharge Summary.	13.1.1. Transfer/Discharge Summary and Instructions 13.2.1. Transfer/Discharge Summary

PROTOCOL

The Substance Abuse Protocol identifies the specific ways to implement the substance abuse standards and processes inherent to substance abuse treatment. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, Florida Medicaid Behavioral Health Handbook, etc.).

~~**Outcome/Indicator Definitions**~~
~~*Indicator 2.2*~~
~~Discharge definition is a planned and/or anticipated termination of service by the client and licensed or certified practitioner.~~

~~Enrolled in Outpatient/Ambulatory Medical Care is defined as a client who has attended a Medical clinical (doctor's visit or lab) appointment in the last 6 months or presents an appointment card or faxed confirmation from physicians office of future appointment.~~

Eligibility Verification
Agency staff ensures client eligibility for substance abuse treatment prior to client receiving the service. Verification of client eligibility is accomplished by examining the eligibility documentation.

Client Intake
The consenting client shall receive an appointment date to meet with a licensed or certified practitioner within three (3) working days of the time the client is determined eligible to receive Ryan White Part A substance abuse services. Agency staff shall collect client data using the agency intake form at which time the client shall receive an orientation of the Ryan White service system. The Behavioral Health Services Combined Consent and Acknowledgment form consisting of the *General Consent for Evaluation, Referral and Treatment; Client Confidentiality; Consent for Urine Collection and Analysis (if applicapable), Client Grievance Procedure, Client Rights, Client Responsibilities, Orientation and Freedom of Choice Provider List; and Consent for Research* shall be discussed and signed by the client and the licensed or certified practitioner. The Consent to Release Information and Obtain Information shall be discussed with the client and signed by the client and the clinician. The Rules of Conduct, and the Day Outpatient and Inpatient Rules of Conduct shall be discussed with client and both client and licensed or certified practitioner will sign the document. Client shall receive a copy of the signed documents.

Provider shall have a client grievance process that shall be discussed with client during intake. Provider shall explain that if a client is dissatisfied after completing the agency grievance process, the client has a right to present a grievance to the Broward County Ryan White Part A Program Office. Provider shall briefly explain the process for filing a grievance with the Ryan White Part A Program Office including posted grievance instructions.

Assessment of Client Needs
The substance abuse clinician shall assess the client Biopsychosocial needs using the agency Biopsychosocial assessment. The licensed or certified practitioner shall complete the assessment by the third counseling visit. The Biopsychosocial evaluation must be reviewed and signed by a licensed or certified practitioner prior to providing treatment or intervention to a client. Assessments can be conducted at the substance abuse treatment program, in jail, in the client's home or hospital room.

Admission
Clients provided services with Ryan White Part A funds shall have a positive HIV diagnosis, and a substance dependency as defined in the DSM. An appointment for admissions shall be scheduled

Monday through Friday during agency operating hours. Client admission and/or continuation of treatment shall be allowed after the assessment, if deemed appropriate. A complete physical examination shall be completed by a physician as determined in the needs assessment. Clients needing detox shall be admitted to substance abuse treatment after completing detox.

Criteria for Intensive Day Treatment for HIV Positive Clients

- Meet criteria for substance dependency as defined in DSM or ICD-9-CM Diagnosis Code(s)
- Physical and cognitive capacity to participate and benefit from treatment
- Demonstration of failure at lower levels of treatment
- Treatment is condition of a court order or pretrial, probation or parole agreement
- Relapse after maintaining over thirty (30) days of sobriety
- Homeless and in need of a stable living environment
- Current lack of basic planning, problem solving and organizational skills, impulse control to function in an open environment where movement is not restricted, and previously had higher functioning
- HIV positive client in need of stabilization and/or rehabilitation
- Seven days a week and living in a structured housing environment (long term)

Criteria for Day Treatment for HIV Positive Clients

- Meet criteria for substance dependency as defined in DSM or ICD-9-CM Diagnosis Code(s)
- Capable of abstaining from the use of mood or mind altering substances during non-program hours between the hours of 5:00 p.m. and 8:00 a.m. Monday through Friday and 24 hours a day on Saturday and Sunday
- Physical and cognitive capacity to participate and benefit from treatment
- Capacity to verbalize willingness to cooperate in treatment

Criteria for Outpatient Treatment for HIV Positive Clients

- Meet criteria for substance abuse or dependency as defined in DSM or ICD-9-CM Diagnosis Code(s)
- Demonstration of ability to abstain mood or mind altering substances for a minimum of 30 days
- Have intact, positive social support network
- Vocational and/or educational, and/or social stability
- Physical and cognitive capacity to participate and benefit from treatment
- Demonstration of motivation to change and improve, be self directed and open

Treatment Plan

Individualized

The licensed or certified practitioner shall complete a Treatment Plan for each client based on the needs identified in the bio-psychosocial. A formal review of active treatment plans must be conducted at least once every six (6) months. The electronic treatment plan may be reviewed more often than once every six months when significant changes occur with patients. Treatment plans and quarterly updates shall be completed with client participation as evidence by client signature. Objectives shall be reviewed and updated with necessary modifications reflecting any

The treatment plan must contain all of the following components:

- The recipient's ICD-9-CM or DSM diagnosis code(s) consistent with assessment(s);
- Goals that are appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences and needs expressed by recipient(s);
- Measurable objectives and target dates;
- A list of the services to be provided (Treatment Plan Development, Treatment Plan Review, and Comprehensive Behavioral Health Assessment need not be listed);

- It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Signature of the recipient;
- Signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18);
- Signatures of the treatment team members who participated in development of the plan;
- A signed statement by the treating licensed practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs; and
- Transition or discontinuation of services.

***Note-See the following for exceptions to the requirement for signature of participant, parent, guardian, or legal custodian:**

If the recipient's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided.

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian. Documentation and justification of the exception must be provided in the recipient's medical record. The following are exceptions:

- As allowed by Chapter 397, F.S., recipients less than 18 years of age seeking substance abuse services from a licensed service provider.
- As stated in Chapter 394.4784 (1 & 2), F.S., recipients age 13 years or older, experiencing an emotional crisis to such a degree that he or she perceives the need for professional assistance. The recipient has the right to request, consent to, and receive mental health diagnostic and evaluation services, outpatient crisis intervention services, including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, or in a mental health facility licensed by the state. The purpose of such services is to determine the severity of the problem and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services will not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services will not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.
- Recipients in the custody of the Department of Juvenile Justice that have been court ordered into treatment; or require emergency treatment such that delay in providing treatment would endanger the mental or physical well being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.
- For recipients in the care and custody of the Department of Children and Families (foster care or shelter status), the child's DCF or CBC caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases in which the Department of Children and Families is working toward reunification, the parent should be involved and should sign the treatment plan.

Medicaid Reimbursement

Medicaid reimburses one treatment plan development per provider per state fiscal year (July 1- June 30) Medicaid reimburses a maximum total of two per fiscal year. **Note: Reimbursement will be based upon the contract year (March 1 – Feb. 28) instead of state fiscal year.**

Medicaid reimburses a maximum of four treatment plan reviews, per recipient per state fiscal year (July 1 – June 30). **Note: Reimbursement will be based upon the contract year (March 1 – February 28) instead of state fiscal year**.

Group Therapy
Clients are to participate in group therapy only as a result of an individualized treatment plan intervention. Group therapy documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan.

Expected Outcomes
The substance abuse shall assist the client to define outcomes for the needs addressed in the Treatment Plan. The strategies to achieve the outcomes shall be documented. The licensed or certified practitioner shall document the progress and specific assistance provided to the client in the progress notes. Notes must be entered into the PE system within 3 business days of interfacing with the recipient.

Client Participation
The licensed or certified practitioner shall ensure client participation in the development of the Treatment Plan. The client signature on the Plan shall evidence the client participation in the agreements stated. Clinician shall sign the Treatment Plan.

Referral and Coordination
The licensed or certified practitioner shall refer clients to appropriate resources to assist in the resolution of other client needs. Referrals shall be followed up at least quarterly. Coordination of client care shall be documented in the Treatment Plan/Progress Notes.

Review/Follow-up
Follow-up of the Treatment Plan shall be completed, minimally quarterly (90 days) and documented in the progress notes.

Discharge
Clients shall be discharged from an outpatient, intensive outpatient, day/night treatment or intensive day/night treatment or residential treatment program based on the following criteria:
- Successful completion of the treatment program
- Client failure to adjust to or benefit from the treatment program, after a period of time
- Lack of continuous client cooperation, participation, disruptive hostile behavior
- Violation of a major rule or continual breaking of rules

Clients successfully completing treatment shall be referred to after care programs.

Transfer of Clients
Clients shall be transferred to other more appropriate programs if they cannot adequately participate in the current treatment program. All clients discharged from treatment will be referred elsewhere as appropriate or necessary after all attempts have been made to retain the client in treatment.

Retention in Treatment
The licensed or certified practitioner shall assess the potential barriers to retention in treatment and shall strategize with the client to identify the necessary action steps to assist the client to remain in treatment.

Adherence to Treatment
The licensed or certified practitioner shall assist the client to adhere to substance abuse treatment. The licensed or certified practitioner shall discuss with the client the reasons for not adhering to treatment, and with client participation, determine how the licensed or certified practitioner can help him/her to adhere. The licensed or certified practitioner shall discuss with the client what needs to happen so he/she can adhere to treatment.

The licensed or certified practitioner shall detail the assistance provided in the progress notes. The licensed or certified practitioner shall document any coordination conducted to assist the client to adhere to treatment.

Medical Care Status
The licensed or certified practitioner shall assess client's current participation in the health care system and shall document the status in the progress notes.

Access to Outpatient/Ambulatory Medical Care
The substance abuse licensed or certified practitioner shall assess any client barriers to access Outpatient/Ambulatory Medical care, including cultural issues and offer a referral to the Medical Case Manager to facilitate access. The substance abuse licensed or certified practitioner shall ensure that consenting clients are referred to get an appointment and coordination is secured to ensure continuity of services.

Assessment of Medications Adherence
The licensed or certified practitioner shall assess client adherence to medications monthly and document in progress notes.

Retention in Outpatient/Ambulatory Medical Care
The licensed or certified practitioner shall assist client to remain in care. The licensed or certified practitioner shall discuss with the client the reasons the client had to access care in the first place and assess if those are still valid. The licensed or certified practitioner shall discuss what the client thinks needs to happen so the client can remain in care.

The licensed or certified practitioner shall detail the assistance provided in the progress notes. The licensed or certified practitioner shall document any coordination conducted to assist client to remain in care.

Reassessment
The licensed or certified practitioner shall conduct a Biopsychosocial evaluation of each active client a minimum of once a year. The licensed or certified practitioner shall document the bio-psychosocial evaluation in the progress notes.

Inactive Client
The licensed or certified practitioner shall determine through a reassessment if an active client shall be rendered inactive. Inactivation shall be completed under the following conditions:

- Client expires
- Client refuses services
- Client relocates

The licensed or certified practitioner shall give the client the names of other agencies that provide substance abuse treatment services and ask if the client desires to have the record transferred once he/she has selected another provider. The licensed or certified practitioner shall document the reasons for client's refusal of services. If the client does not express a reason, the licensed or certified practitioner shall document this.

Documentation
The licensed or certified practitioner shall document any coordination and/or intervention with the client and/or on the client's behalf, including multidisciplinary case staffing.

Continuous Quality Improvement
Chart reviews shall be completed quarterly to ensure appropriate documentation of service, referrals, follow-up and to assess the progress of the Treatment Plan.

Professional Requirements
Education
Minimum of a Master degree in Mental Health Counseling, Marriage and Family Therapy, Social Work or Psychology

Credentials
- Active Florida license in any of the above
- Florida registered clinical intern

~~Graduate level student currently enrolled in an accredited university in Mental Health Counseling, Marriage and Family Therapy, Social Work or Psychology.~~

Experience
- Licensed mental health or one year experience as a Florida registered clinical intern
- Doctor in medicine
- Bachelors Degree with completed Certified Addictions Professional (CAP)

Practitioner
A minimum of one year experience as an addiction counselor

Supervisor

Licensed practitioner and State of Florida Qualified Supervisor
AND
A minimum of two years of experience as an addiction counselor plus one year supervisory experience in a substance abuse setting

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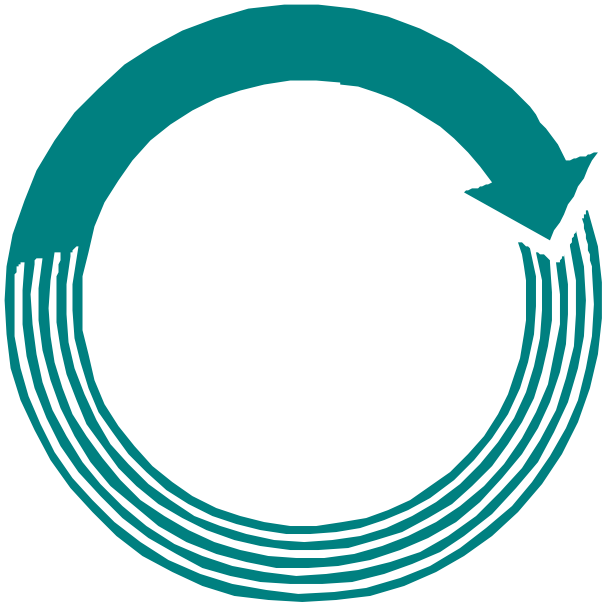


Outreach Services
Service Delivery Model

Broward Regional Health Planning Council, Inc.

Ryan White Part A Quality Management

Outreach Services
Service Delivery Model

Definitions:

Outreach Services are designed to identify individuals who know their status and are not in care and help them learn their status and enter care. Outreach programs have as their principal purpose identification of individuals who are newly diagnosed with HIV/AIDS and are not receiving medical care, HIV+, individuals who are lost to care, HIV+ individuals who are at risk of being lost to care, and HIV+ individuals never in care.

Outreach programs must be:

- Planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection
- Targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior
- Conducted at times and in places where there is a high probability that individuals with HIV infection will be reached
- Designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness

It is the provider's responsibility to document: The design, implementation, target areas and populations, and outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care

Ryan White Part A funds may not be used to pay for HIV counseling or testing.

The creation of this public document is fully funded by a federal Ryan White CARE Act Part A grant received by Broward County and sub-granted to Broward Regional Health Planning Council, Inc.

OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

System Level Outcome: Increase access to outpatient/ambulatory medical care for persons living with HIV receiving outreach

Client Outcomes	**Outcome Indicators**	**Input**	**Strategies**	**Data Source**
1. Facilitate client access to outpatient/ambulatory medical care and/or medical case management	1.1-80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder). 1.2-25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).	Funding Staff Clients	1.1.2. Assessment of client participation in outpatient/ambulatory medical care 1.1.3 Assess barriers to Outpatient/Ambulatory Medical Care Referral of consenting clients to Outpatient/Ambulatory medical care or medical case manager Documentation of referral and follow-up in client chart	Progress Notes

STANDARDS FOR SERVICE DELIVERY

Standard	Indicator	Data Source
1. Client confidentiality is discussed.	1.1. 100% of charts of clients referred to medical case management show discussion of client confidentiality.	1.1.1. Progress Notes
2. Outreach workers will orient and assist clients with enrollment and Part A funded services.	2.1. 100% of client charts show documentation needed by CIED for Part A enrollment.	2.1.1. Progress Notes
3. Client is assessed for current participation in outpatient/ambulatory medical care.	3.1. 100% of clients are assessed for their participation in outpatient/ambulatory medical care.	3.1.1. Outreach Assessment Tool
4. Client grievance process is discussed at point of contact.	4.1. 100% of client charts show discussion of the grievance process.	4.1.1. Grievance Form 4.1.2. Progress Notes
5. Client Rights and Responsibilities are discussed at point of contact.	5.1. 100% of client charts show discussion of the client Rights and Responsibilities.	5.1.1. Rights and Responsibilities Form
6. Clients newly diagnosed are linked to CIED	6.1. 100% of client charts show documentation	6.11. Progress Notes
7. Client linkage is followed-up.	7.1. 100% of charts of clients linked to medical case management and/or outpatient/ambulatory medical care show follow-up of referral given within 3 months of referral. 7.2. 100% of charts will document client status of attending referred appointment.	7.1.1. Progress Notes (Indicate if PE was checked) 7.2.1. Progress Notes (Indicate if PE was checked)
8. As appropriate, outreach staff will make appointments, provide information and meet clients at appointments.	8.1. 100% of clients met by Outreach Staff at the appointments will be documented.	8.1.1. Progress Notes

9. Outreach workers will maintain (or attempt) contact at least bi-monthly with clients until linked referrals are complete or client is no longer reachable.	9.1. 100% of charts document client contact or attempts.	9.1.1. Progress Notes
10. Clients referred from outpatient/ambulatory medical care who have fallen out of care will be located and relinked to care by outreach.	10.1. 100% of charts will document attempts to be located and relinked to care.	10.1.1. Progress Notes

PROTOCOLS

The Outreach Protocol identifies the specific ways to implement the outreach standards and processes inherent to the outreach services. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories.

Access to Service
Outreach must be conducted at all Health Resources and Service Administration (HRSA) Key Points of Entry. Under-served populations shall be identified using the latest Needs Assessment conducted by the Broward County HIV Health Services Planning Council.

Outreach subgrantee management staff should identify agencies with which to negotiate and establish MOAs. Outreach workers should not negotiate MOAs.

Based on the identification and triage of key points of entry, subgrantees' outreach supervisors should establish referral relationships and MOAs with all hospitals in Broward County, including ERs, inpatient units, labor and delivery units, and adult ambulatory care departments. To address turnover of personnel at these agencies, quarterly contacts should be made to ensure that current staff are aware of the availability of outreach services.

Client Intake
The outreach worker completes the client intake after the client consents to disclose HIV status. Outreach workers shall provide an orientation to the client at point of contact to include:

- Client Confidentiality (document in Progress Note)
- Client Grievance Process (client signature required)
- Client Rights and Responsibilities (client signature required)
- Release of Information Document (used for referrals only and client signature required)
- HIPAA (client signature required)
- PCIS Consents (client signature required)

All clients must sign a Release of Information document prior to completion of referrals.

Outreach worker will inform the client of the current Ryan White Part A Core and Support Service Providers. The Progress Notes will document that the client was informed of the current available Ryan White Part A Services.

Assessment
Outreach workers shall discuss the Outreach Services Program, outreach worker's role and confidential nature of client self-reported personal health information (PHI). Request client's consent before assessing client's HIV status and current participation in outpatient/ambulatory medical care. The outreach worker shall assess the client's HIV status using the Outreach Assessment Tool.

If the client is HIV positive, the outreach worker shall assess enrollment in outpatient/ambulatory medical care. If the client is in care, the outreach worker shall assess if the client keeps medical and scheduled laboratory appointments. If the client is not in outpatient/ambulatory medical care, the outreach worker shall assess and document the barriers to care using the Outreach Assessment Tool. The outreach worker shall summarize the benefits of outpatient/ambulatory medical care, the resources available and how a medical case manager can assist the client 1) with resolution to barriers, 2) to facilitate access to outpatient/ambulatory medical care, and 3) with access to support services. The outreach worker shall provide the client with a list of Ryan White Medical Case Managers and a list of Ryan White outpatient/ambulatory Medical Care Providers.

An HIV+ individual is eligible for Part A-funded outreach if he/she has been out of care for at least six months. Individuals that have been out of care for less than six months should be referred back to their HIV medical provider or provided a list of HIV clinics in Broward County if they have relocated from another jurisdiction. HIV+ clients that are eligible for similar services, such as ARTAS or Part B-funded retention services, should be referred to those programs and not to Part A-funded outreach.

Referrals received by outreach workers for hospitalized patients should be immediately transferred to a medical case manager for intake. If an outreach client is hospitalized during the course of the outreach case, the client should be referred immediately to a medical case manager for follow-up.

Only one outreach worker should be assigned to a client at any time. Prior to enrolling a client in outreach, subgrantees should query Provide Enterprise to ensure that the client is not enrolled. If a client wishes to disenroll from an outreach program and enroll elsewhere, a signed note from the client should be included in the chart and the case should be closed in Provide Enterprise.

Linkage
Outreach worker will assist client in collecting all documents required for eligibility determination. Documents collected shall include the following:

- Proof of HIV
- Proof of Income
- Proof of Broward County Residency

To engage the client into medical care, the Outreach worker will connect the client to Centralized Intake and Eligibility Determination (CIED). Outreach worker will schedule appointment with CIED and accompany client to initial outpatient/ambulatory medical care and/or medical case management appointment if needed.

The Centralized Eligibility Worker will assess the client's decision making process on their medical care by using the Access to Care Schedule. Wherein, the Centralized Eligibility worker will assist the client in determining whether a 1st Initial Medical Appointment or Emergency (non-ER) appointment should be scheduled. This process will help to ensure high acuity patients are addressed appropriately.

Outreach clients with public or commercial insurance should be informed about Ryan White Program-funded HIV clinics, rather than referred only to community-based providers.

Payer of Last Resort
An applicant may not be eligible for services from Ryan White Part A Program if the applicant is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White may be utilized for HIV related services only when no other source of payment exists.

An applicant cannot be receiving services or be eligible to participate in local, state, or federal programs where the same type service is provided or available. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state, or federal programs, or pending determination of eligibility from other local, state or federal programs.

Access to Outpatient/Ambulatory Medical Care
Outreach worker shall assess any client barriers to access outpatient/ambulatory medical care, including cultural issues. The outreach worker shall discuss with the client the ways in which the medical case manager can assist him/her to access outpatient/ambulatory medical care. The outreach worker shall explain to the client how the referral system works in Ryan White Part A to access outpatient/ambulatory medical care. Outreach worker shall discuss with client other services that are available under Ryan White Part A and other related HIV services to overcome any barriers to outpatient/ambulatory medical

care. The outreach worker shall document any assistance given to the client to access outpatient/ambulatory medical care in the Progress Notes.

Follow-Up
Outreach staff shall record all referrals in the Progress Notes. Outreach staff will document the transition to case management or outpatient/ambulatory medical care and close the file for outreach services.

Documentation
All services provided to the client shall be documented in the client chart. Outreach worker shall document per indications in any part of this protocol.

Continuous Quality Improvement
Chart reviews shall be completed quarterly to ensure appropriate documentation of service, referrals and follow-up.

System-wide
Outreach supervisors/coordinators of outreach programs (Ryan White Part A and other HIV services) shall meet quarterly to strategize outreach activities.

Ryan White Part A outreach programs shall also coordinate efforts with other outreach programs to avoid duplication of efforts and collaboration.

Outreach workers will collaborate with HIV testing agencies to provide:

a. Psychological support and/or refer the client for additional counseling; ensure that the individual knows where and how to obtain more information and services, the individual with information about free OAMC and other HIV services; assistance in scheduling intake at the CIED.
b. Linkage services to OAMC funded by Part A or a provider affiliated with the individual's health insurer; assistance with arranging transportation.
c. Prevention messages about way to prevent secondary HIV transmission; information to correct misperceptions about HIV and STI transmission risk.
d. Counseling about who to notify about HIV+ test results to avoid inadvertent disclosure, and partner notification services.

Agency Responsibilities
Outreach supervisor shall assign weekly schedules for outreach workers based on assigned areas/zip codes for each quarter. The outreach supervisor shall document the individual outreach worker schedule on the Weekly Schedule form (Exhibit 11). Outreach staff and supervisors shall jointly identify appropriate venues to access target populations and shall develop an itinerary with time and location where HIV+ target populations can be reached. Coordination shall be established with HIV prevention outreach programs.

Conduct quarterly coordination meetings with outreach staff to coordinate their activities, identify gaps in outreach, and participate in training. Quarterly coordination meeting topics could include (but are not limited to):

- Outreach plan/services
- Data from key points of entry
- Training needs
- Service barriers
- Programmatic issues
- Review Plan to Address Turnover Rates

Agencies shall participate in Outreach QI Network to systematically review the list of the agencies making up key points of entry. They should identify priorities for efforts to engage those agencies in outreach, determine which outreach subgrantees will be assigned to agencies to avoid duplication of effort, develop a schedule for these activities, and identify a process for reporting back to the Network their successes and challenges in establishing MOAs and implementing with those agencies. This effort would be aided by development of a work plan by BRHPC, which should be reviewed and updated monthly with the Network.

Supervision
Formal supervision should occur for new staff at a minimum weekly for at least three (3) months. After the first three months, formal supervision should occur at a minimum monthly for both new and experienced staff.

When an outreach worker is promoted or transferred to another program, the worker should be required to complete outreach activities for active clients and close the cases before they completely transition to their new job. If this action cannot be undertaken or if a worker resigns, active clients should be notified about the assignment of a new case worker.

Training Manual (Common Elements):
The training shall be developed by the agency receiving funds for outreach activities and/or shall be coordinated with other outreach programs with the same purpose or that can accommodate the specific definition of outreach under Ryan White Part A.

- 500 and 501 training and annual updates
- Key Points of Entry
    - Identify
    - Coordination/strategies development
    - MOUs
    - Evaluation
- Field/Site visits to Key Point of Entry (s)
- Referral Sources
    - Outreach Assessment and referrals
- Provide Enterprise
- Intake and Eligibility
- Quality Management and chart reviews
    - Review chart documentation
- Outreach QI Network Service Delivery Model
- Cultural Competence
- Ongoing Supervision
    - Updates to policies and procedures
    - Billing
- Motivational Interview Skills training

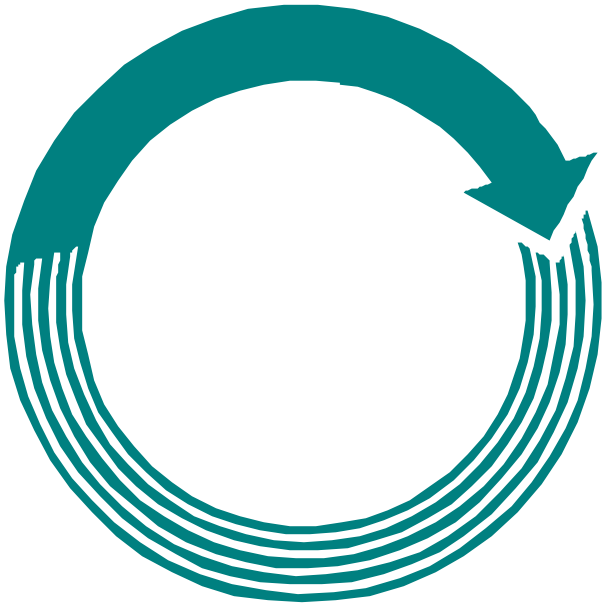
Safety
Each agency receiving funds for outreach services shall develop a plan to ensure the safety of the outreach workers and to detail the actions to be taken in case of an emergency. The plan shall include at a minimum the following:

- Outreach workers shall be assigned a cellular phone when working in the field.
- Outreach workers shall report to the agency any suspicious activity that can interfere or jeopardize the safety of any staff.

Professional Requirements
- Outreach staff has evidence of professional requirements in file, as established in outreach protocol.
- Staff has a minimum of 5 hours of HIV/AIDS training annually and has documentation in their personnel files showing HIV/AIDS training.
- Education:
    - High School Graduate (worker)
    - Bachelors degree in one of the following fields: Education, Sociology, Psychology, Health related field (supervisor)
- Experience:
    - Minimum of one year working with the public (worker)
    - One year experience working in outreach or health education (supervisor)
    - One year working with diverse populations (supervisor)
- Knowledge:
    - Community resources for HIV/AIDS (worker)
    - Diverse populations (worker)
    - Conducting outreach (supervisor)
    - HIV/AIDS community resources (supervisor)
    - Diverse populations (supervisor)
- Skills:
    - Good verbal and written communication skills
    - Linguistically and culturally competent
    - Flexibility
    - Time management
    - Good verbal and written communication skills
    - Organization
    - Documentation

Outreach Worker Roles and Responsibilities
Activities of outreach include, but are not limited to:
- Locating and interacting with HIV positive populations who are unaware of their status at Key Points of Entry
- Address situational issues, prior to eligibility being established, that prevent a potential client from attempting to enter the system of care (e.g. shelter for the homeless, transportation, etc.)
- Assisting clients in gathering their Ryan White eligibility documentation
- Accompanying clients to Centralized Eligibility
- Linking clients to medical care by making an appointment & accompanying clients to their 1st appointment
- Addressing barriers to medical care by linking clients to medical case management & accompanying clients to their 1st appointment
- Locating clients lost to care and reengaging them back into medical care.
- Locating clients at risk of falling out of care and reengaging them back into medical car

Ryan White Part A Quality Management



AIDS Pharmaceutical Assistance (Local) Service Delivery Model

Broward Regional Health Planning Council, Inc.

The creation of this public document is fully funded by a federal Ryan White CARE Act Part A grant received by Broward County and sub-granted to Broward Regional Health Planning Council, Inc.

Ryan White Part A Quality Management

AIDS Pharmaceutical Assistance (Local)
Service Delivery Model

The Service Delivery Model serves as a minimum set of standards that every provider should follow.

Definition:

AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.

OUTCOMES, OUTCOME INDICATORS, INPUTS, STRATEGIES, DATA SOURCES

STANDARDS FOR SERVICE DELIVERY

Standard	Indicator	Data Source
1-Improve access to medication.	*1.1-Attempts will be made to contact 100% of clients who do not pick up medications within 7 to 14 days of filling the prescription.* *(Clients can call in a prescription up to 7 days early. The maximum window between filling and picking up a medication will not exceed 14 days as each pharmacy will conduct a review of the Return to Stock list once a week).*	1.1.1. Tracking Log 1.1.2. Return to Stock Log
2-Clients provided an opportunity to improve medication adherence.	2.1-100% of those clients who were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, Clinical pharmacist, prescribing physicians, Treatment Adherence) *(Identifying clients who have difficulty with adherence and referring to appropriate provider for intervention with a goal of improving adherence).*	2.1.1. Referral Log

PROTOCOL

The AIDS Pharmaceutical Assistance (local) Protocol identifies the specific ways to implement AIDS Pharmaceutical Assistance (local) Program standards and processes inherent to this service category. The delivery of AIDS Pharmaceutical Assistance (local) service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e, Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, etc.). Staff hired by provider agencies will possess skills and the ability to interact with clients in a culturally and linguistically competent manner; convey necessary information to clients; manage detailed, time-sensitive, and confidential information; and complete documentation as required by their position.

Eligibility
Standards for pharmaceutical services for persons living with HIV/AIDS (PLWHA) are defined by six major sources:

1. Florida Department of Professional Regulation, Board of Pharmacy
2. Florida Department of Health Comprehensive Pharmaceutical Services, Policies and Procedures Manual
3. State of Florida ADAP (AIDS Drug Assistance Program)
4. Broward County Health Department's Pharmacy and Therapeutics Committee
5. AIDS Education Training Curricula
6. Pharmacy QI Network
7. Local Pharmacy Advisory Committee

Eligibility Requirements for Ryan White Part A
The targeted populations for this program are indigent persons diagnosed with HIV/AIDS who meet the Ryan White Part A medical and financial eligibility criteria to obtain medications through the Broward County Health Department Network. Registration is available at all Broward County Health Department Pharmaceutical Network dispensing sites. The Pharmacist, or authorized designee, shall verify client's eligibility is established by reviewing the certification in the designated HIV MIS System. Pharmacist (or designee) shall perform an eligibility and financial assessment at each visit in addition to reviewing client's eligibility certification in the designated HIV MIS System. Pharmacist (or designee) will review client's eligibility for all funding streams and services for which client may qualify. The purpose of the assessment is to ensure 1) client's access to all services client may be eligible for and 2) the status of Ryan White as payer of last resort.

Due to the limited funds of the Ryan White Part A contract, not all Broward County Health Department patients will be eligible to receive benefits. Eligible patients will meet financial and medical criteria, per current contract language.

In order to utilize Ryan White funds most effectively, patients receiving these funds will be screened for Medicaid eligibility at every visit. Providers will direct client to the following resources: Medicaid [http://www.cms.hhs.gov/medicaideligibility/02_areyoueligible_.asp] and/or ADAP [http://www.doh.state.fl.us/disease_ctrl/aids/care/adap.html].

Intake
The staff doing the intake shall explain the information below to the client and shall secure the client initials or the provider specific strategy to document:

Client grievance process

Client confidentiality
Client Rights and Responsibilities

Provider shall have the client grievance process posted in a visible location with copies of the client Grievance Report Form available to clients upon request. Client Rights and Responsibilities shall be posted on a visible location.

Medication Adherence

Provider shall offer client medication counseling. Consenting clients shall receive counseling to assist them with their needs. Provider shall document counseling and/or other assistance (Prescription Counseling Log).

Formulary

The Ryan White Drug Formulary is a working document for practitioners to rely on that lists the medications that are available for the treatment of Ryan White eligible patients.

Process for Additions of Medications to the Part A Formulary

The process for additions of Medications to the Part A Formulary will be in accordance with the Local Pharmacy Advisory Committee process (see Formulary Change Request form at www.brhpc.org/hivpc).

Notification of Formulary Changes:

A memorandum (via Fax, e-mail, regular mail) from the Grantee to Prescribers and other concerned individuals will be distributed in a timely manner after addition or deletion of product(s).

Drug Utilization Review (DUR) – (*Network member will draft wording for this protocol and send to CQA support for review *)

Prospective Drug Use Review

(1) A pharmacist shall review the patient record and each new and refill prescription presented for dispensing in order to promote therapeutic appropriateness by identifying:
    (a) Over-utilization or under-utilization;
    (b) Therapeutic duplication;
    (c) Drug-disease contraindications;
    (d) Drug-drug interactions;
    (e) Incorrect drug dosage or duration of drug treatment;
    (f) Drug-allergy interactions;
    (g) Clinical abuse/misuse.
(2) Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the potential problems which shall, if necessary, include consultation with the prescriber.

Patient Counseling.

(1) Upon receipt of a new or refill prescription, the pharmacist shall ensure that a verbal and printed offer to counsel is made to the patient or the patient's agent when present. If the delivery of the drugs to the patient or the patient's agent is not made at the pharmacy, the offer shall be in writing and shall provide for toll-free telephone access to the pharmacist. If the patient does not refuse such counseling, the pharmacist, or the pharmacy intern, acting under the direct and immediate personal supervision of a licensed pharmacist, shall review the patient's record and personally discuss matters which will enhance or optimize drug therapy with each patient or agent of such patient. Such discussion shall be in person, whenever practicable, or by toll-free

telephonic communication and shall include appropriate elements of patient counseling. Such elements may include, in the professional judgment of the pharmacist, the following:

(a) The name and description of the drug;
(b) The dosage form, dose, route of administration, and duration of drug therapy;
(c) Intended use of the drug and expected action (if indicated by the prescribing health care practitioner);
(d) Special directions and precautions for preparation, administration, and use by the patient;
(e) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
(f) Techniques for self-monitoring drug therapy;
(g) Proper storage;
(h) Prescription refill information;
(i) Action to be taken in the event of a missed dose; and
(j) Pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug.

(2) Patient counseling as described herein shall not be required for inpatients of a hospital or institution where other licensed health care practitioners are authorized to administer the drug(s).
(3) A pharmacist shall not be required to counsel a patient or a patient's agent when the patient or patient's agent refuses such consultation.

Professional Requirements

The objectives for establishing standards of care for program staff is to ensure that clients have access to the highest quality of services through trained, experienced staff members. The Program Director or designee will possess experience in HIV/AIDS issues and the delivery of pharmaceutical services. Provider has a current Florida pharmacy license. Dispensing pharmacists have a current Florida pharmacist's license. Pharmacy technician, student pharmacist, or pharmacist intern is supervised by licensed pharmacist.

EXHIBITS

Exhibit 1
Current ADAP Enrollment Form

OBJECTIVE 1. REVIEW PERFORMANCE MEASURES AND SELECT ANNUAL DATA FOR REVIEW				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
1.1 Quarterly Data Reviews a) NQC In+Care Campaign Measures b) NHAS Indicators c) HAB Performance Measures d) Broward Client Level Outcomes and Indicators	• Review And Select Annual Data Measures • Identify Areas For Improvement • Provide Directives To The QI Networks	5/13 7/13 10/13 1/14	5/13 7/13 10/13 1/14	• Data reviews to begin in May as some March WP items were tabled for April
OBJECTIVE 2: CONDUCT ANNUAL EVALUATION OF QM PROGRAM, WORK PLANS, AND PROCESSES				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
2.1 Review Policies And Procedures(P&P) 2.2 Review, Update & Approve 3-Year Work Plan 2.3 Review, Update And Approve Annual QM Work Plan 2.4 Review Service Delivery Models Submitted By QI Networks 2.5 Review Accomplishments And Challenges	• Updated P&P As Needed • Updated 3-Year And Annual Work Plans That Include Short-Term And Long-Term Strategies To Achieve QM Objectives • Service Delivery Models Reflect Most Current National Guidelines And Best Practices • Annual Work Plan Addresses Challenges Identified In The Previous FY	4/13 4/13 3/13 3/13 3/13	4/13 4/13 4/13 3/13 3/13	• Tabled for April (No quorum) • Tabled for April (No quorum) • **Completed**
OBJECTIVE 3: MONITOR QI NETWORK ACTIVITIES AND PROVIDE DIRECTIVES AND GUIDANCE IN QIP DEVELOPMENT				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
3.1 Quarterly Network Update	1. Identify Areas For Improvement 2. Provide Guidance And Directives To Improve Network Activities and QIPs	3/13 6/13 9/13 12/13	3/13 6/13 9/13 12/13	• **Completed**
OBJECTIVE 4: REVIEW AND ANALYZE FINDINGS FROM NEEDS ASSESSMENT, CLIENT SURVY, SERVICE CATEGORY STUDIES, AND RECORD REVIEWS				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
4.1 Review Findings From: a) Needs Assessment b) Client Survey c) Service Category Assessment/Studies d) Record Reviews e) Identify Service Category For Annual Evaluation	• Identify Barriers To Care • Identify Areas For Improvement In Service Delivery • Recommend Service Category Evaluation	5/13 6/13	5/13 6/13	
OBJECTIVE 5: ASSESS LINKAGE TO CARE AND RETENTION PROCESSES				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
5.1 Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	• Linkage To Care And Retention Deficiencies Addressed	3/13 6/13 9/13 12/13	6/13 9/13 12/13 2/14	

2013-14 WORK PLAN CALENDAR FOR QM COMMITTEE

	March	April	May	June	July	August
QM	❖ Review Accomplishments And Challenges ❖ Quarterly Network Update ❖ Review Annual Summary of In+Care Data ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Review Policies and Procedures (P&P) ❖ Review, Update And Approve 3-Year WP ❖ Review, Update And Approve Annual QM WP (Tabled from March) ❖ Review Service Delivery Models Submitted By QI Networks (Tabled from March)	❖ Review Findings from Needs Assessment and Client Survey ❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators) (Tabled from April)	❖ Quarterly Network Update ❖ Review Findings (as available) From: ❖ Service Category Assessment/Studies ❖ Record Reviews ❖ Identify Service Category For Annual Evaluation ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators)	❖ Quarterly network update ❖ MH Record Reviews

	September	October	November	December	January	February
QM	❖ Quarterly Network Update ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators)	❖ HHS, HAB, Broward Outcomes and Indicators	❖ Quarterly Network Update ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators)	❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care ❖ Conduct Annual Evaluation of QM Program, Work Plans, and Processes