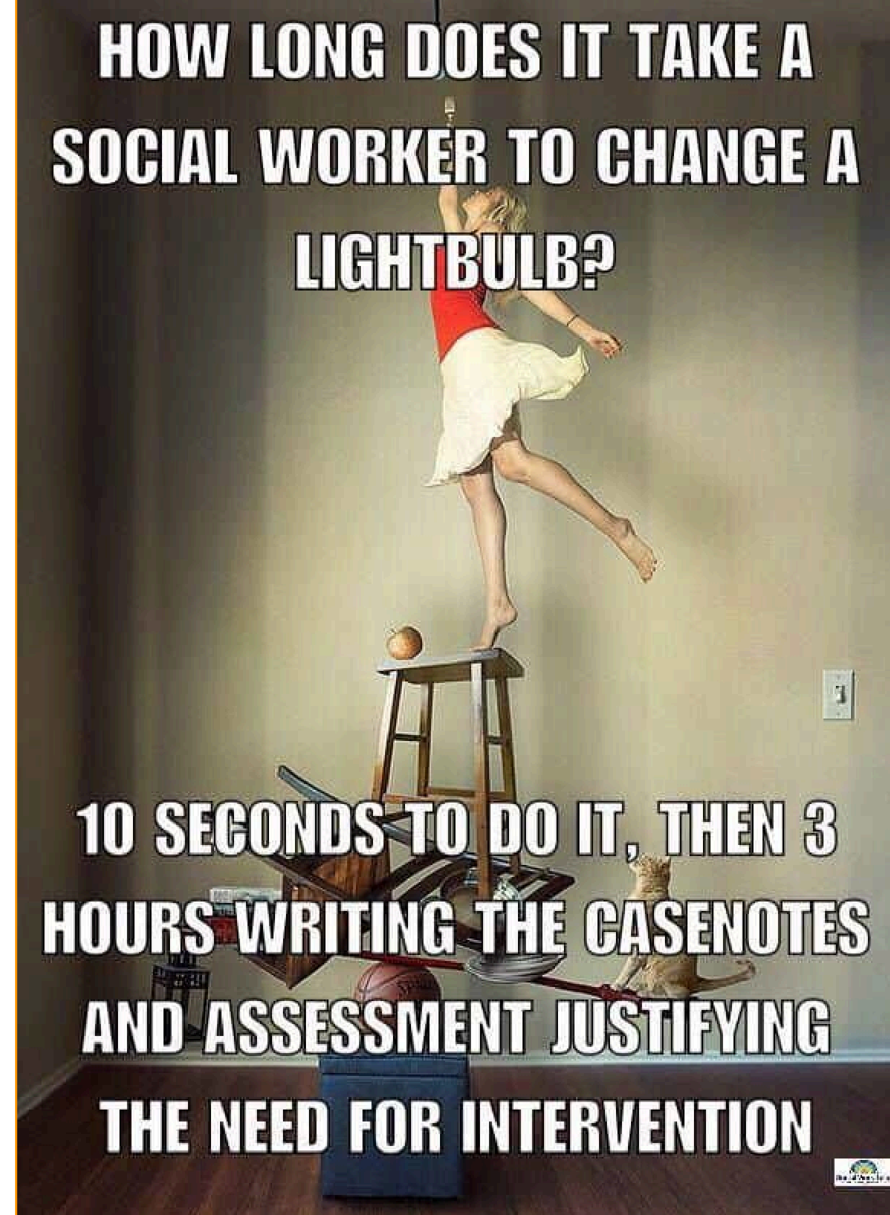
Part B Networking Meeting

June 22nd, 2022

Yasmin Andre, Director
Doris Huff, Planning & Evaluation
Whitney Marshall, Planning Council Support Manager
Mikaela Mendoza-Cardenal, Clinical Quality Manager

Welcome!

Please drop your name, role, and agency in the chat ☺



Central Florida HIV Planning Council

Survey & Upcoming Events

Whitney Marshall

HIV Care Needs Survey

Extended – STILL OPEN

- Open to any person with HIV
- Client drawing for raffle prize!
- Survey available online and via paper copy* in English, Spanish and Creole

** Paper copies of the survey may be requested from and returned to Planning Council Support* (whitney.marshall@hfuw.org)

Upcoming Town Halls

Seminole County & Lake County

- Seminole County on Wednesday, July 20th
- Lake County in late July
- In-person community Town Hall
  - Transportation available for clients
- Virtual option available

Ryan White Updates

Mika Mendoza

MCM Training

New Dates

Tuesday, October 4th and Wednesday, October 5th

Comprehensive Health Care

1495 N. Harbor Blvd.

Melbourne, FL 32935

Keep an eye out for e-mailed Calendar invitations

RW Portal
Update

THANK YOU
for your patience and flexibility!

- Area 7 clients still not imported
- Updates will come via e-mail
- Please continue to use CAREWare to complete eligibility
- Reach out to HIVAppSupport@flhealth.gov or HFUW with any questions or concerns

Care Plans

Touching Base

Mika Mendoza

Care Plans

Poll

1. My clients are aware of their acuity level/case management level
2. I have been able to start using the new Care Plan
3. I have completed at least one Care Plan update using the new template
4. I am comfortable using the new template

Care Plans

Space for questions or discussion on:

- ? Contact frequency
- ? Care Plan template
- ? Interventions
- ? ICM-level needs
- ? Case notes

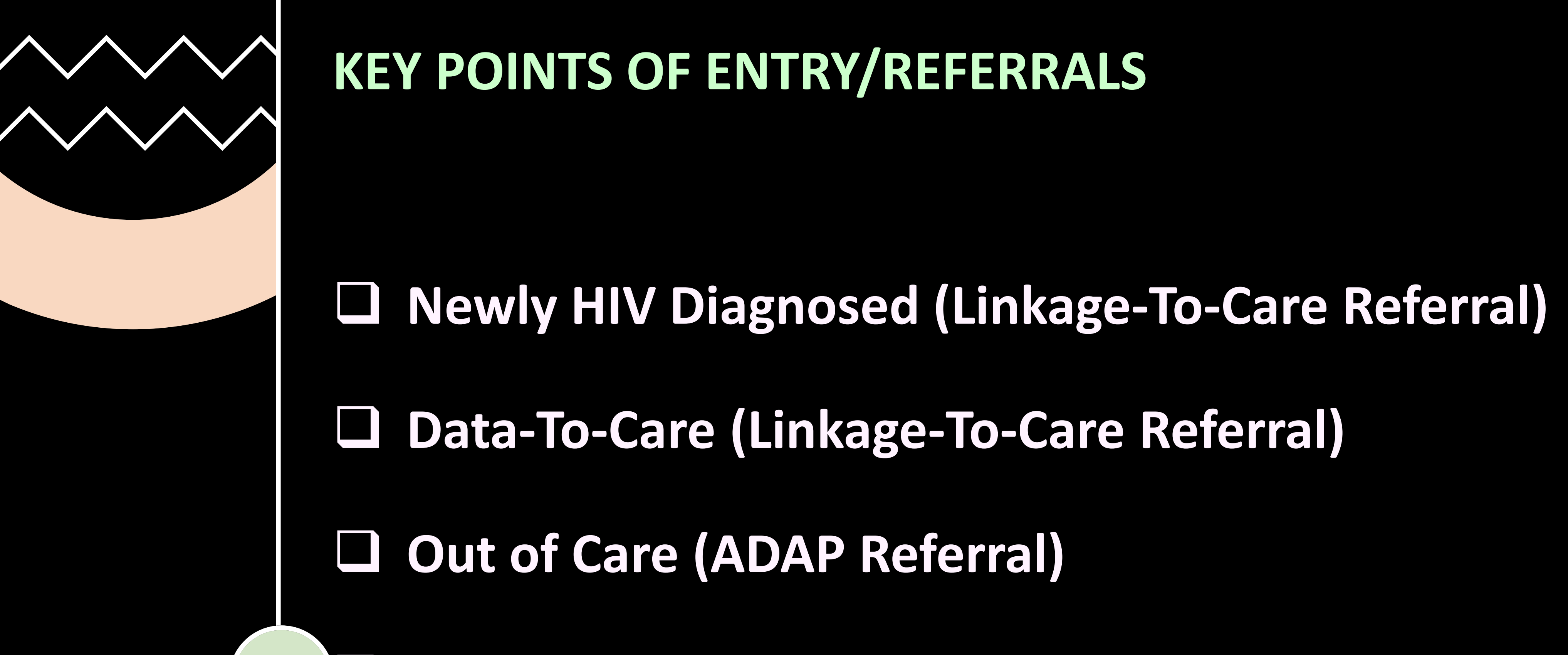
Early Intervention Services

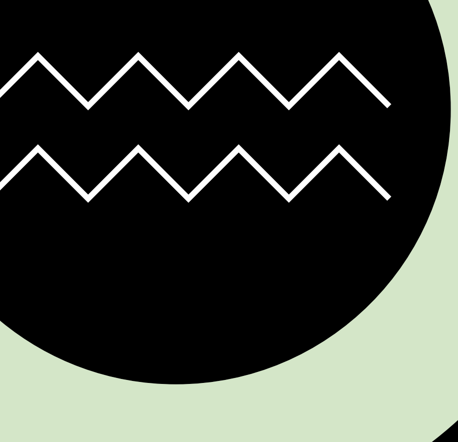
Brianne Kane
Amaya Vinuela
Yaitte Gomez

Early Intervention Services
FDOH, Brevard

Basic Tenets

- Targeted HIV Testing and Referral Services
- Access and Linkage to HIV Care and Treatment Services
- HIV Outreach Services and Health Education/Risk Reduction


KEY POINTS OF ENTRY/REFERRALS
❑ Newly HIV Diagnosed (Linkage-To-Care Referral)
❑ Data-To-Care (Linkage-To-Care Referral)
❑ Out of Care (ADAP Referral)
❑ Lost to Care (RW Case Management Agency Referral)



Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Newly HIV Diagnosed (Linkage-To-Care Referral)

Individual shows up in DOH database STARS. After notified of HIV status, EIS will contact client within 72 hours to follow up on treatment adherence. EIS coordinator will develop Plan of Care with client and follow client for at least 3 months and 3 medication (ARV) pick ups with goal of having client have HIV viral load of <200 (suppressed).

Key Points of Entry

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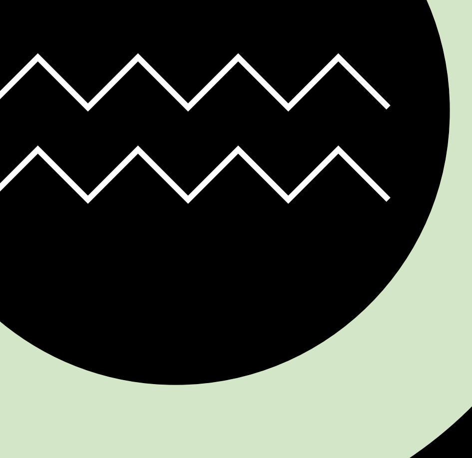

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Data-To-Care (Linkage-To-Care Referral)

Individual shows up in DOH database STARS. Linkage Coordinator refers to EIS. EIS Coordinator will contact client within 72 hours to follow up on treatment adherence. EIS coordinator will develop Plan of Care with client and follow client for at least 3 months and 3 medication (ARV) pick ups with goal of having client have HIV viral load of <200 (suppressed).

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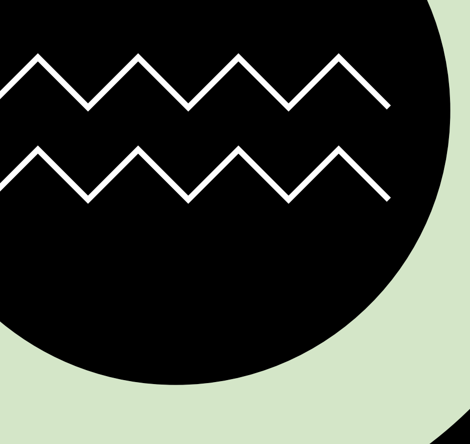

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Out of Care (ADAP Referral)

Individual is referred by ADAP coordinator prior to becoming suspended due to not picking up medications or not recertifying with the ADAP program. ADAP Coordinators follow adherence steps prior to EIS referrals. EIS Coordinator also runs reports on ADAP enrolled clients to follow viral loads and pick up history to assist ADAP with intervention management. EIS coordinator follows ADAP referred client for at least 3 months and 3 medication (ARV) pick ups with goal of having client have HIV viral load of <200 (suppressed). EIS Coordinator will send client's CM the *EIS Client New Placement Information Form*.

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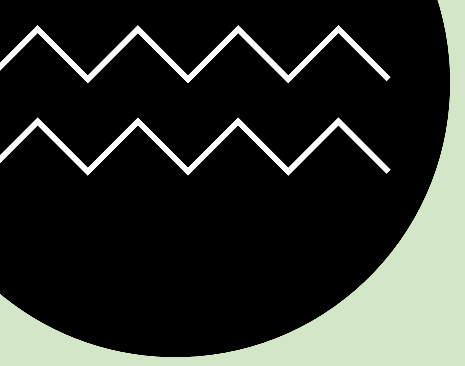

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Out of Care (ADAP Referral)

RWB HIV CASE MANAGEMENT AGENCY
EIS CLIENT NEW PLACEMENT INFORMATION FORM

The following client has been identified as a candidate for FDOH, Brevard's Early Intervention Services. Our program will attempt to reach out to this client to arrange for first-time medical care or to link back into medical care and they may also require case management. If you disagree with this individual's enrollment in EIS, please inform the Contact Person checked next to EIS Contact.

FDOH BREVARD (Community Health)/EIS Contact
☐Amaya Viñuela: 321-690-6459 ☐Yaitte Gomez: 321-690-6495 ☐Diane Franta: 321-690-6485

Enrollment Date: ____/____/_______

PROGRAM ENROLLMENT
☐ Newly HIV Diagnosed ☐ RW CM Lost-To-Care
☐ ADAP Out-of-Care ☐ Linkage-To-Care/Data-To-Care

Client Information

Client Name: _______________________________ Preferred Name: _________________________

Date of Birth: ____/____/______ Telephone #: ____-____-______ Telephone #:____-____-______

Adherence Information

ADAP - OUT OF CARE
☐ Never Enrolled with ADAP ☐ Out of Care/ADAP Suspension ☐ Out of Care/ADAP Closed
Barriers to Care Identified: ☐ NOE needed ☐ Lab Needed ☐ RX Needed (Medical Appointment)
Date of Last ADAP Eligibility: ___/____/_______

RW CASE MANAGEMENT - LOST TO CARE
☐ RW CM Lost-To-Care Date of Last NOE: ___/___/____
Case Manager Referral Date: ___/___/_____ Case Manager: ___________________
Barriers to Care Identified: ☐ NOE needed ☐ Lab Needed ☐ RX Needed (Medical Appointment)
☐ Other ____

LINKAGE TO CARE – DATA TO CARE
Linkage Referral Date: ___/___/_____
Barriers to Care Identified: ☐ New to Area ☐ Medical Appointment (RX)
☐ Other____

NEWLY HIV DIAGNOSED
Date of Diagnosis: ___/___/____
☐ RW Eligibility/NOE with RW Agency: ___/___/____ ☐ Enrolled with MCM ☐ 1st Medical Appointment
☐ Labs ☐ ADAP Enrolled ☐ Other: ____

Additional Information for Assisting with Linkage

Please include any information that may assist with re-engagement in care, help identifying client or additional living information (i.e. living arrangements, homelessness, physical identifies, etc. Also, if the client has signed any releases for allowing third-party contacting/emergency contact, please let us know.)

FOR CASE MANAGEMENT AGENCY INPUT

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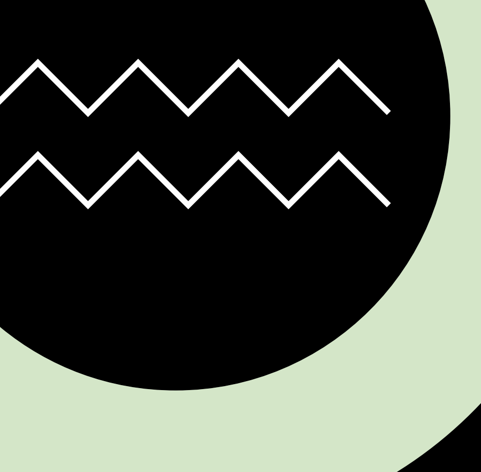

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Lost to Care (RW Case Management Agency Referral)

Case Management Out of Care Referrals in Brevard County

Yaitte Gomez	**321-637-7319**
Amaya Viñuela	**321-690-6459**

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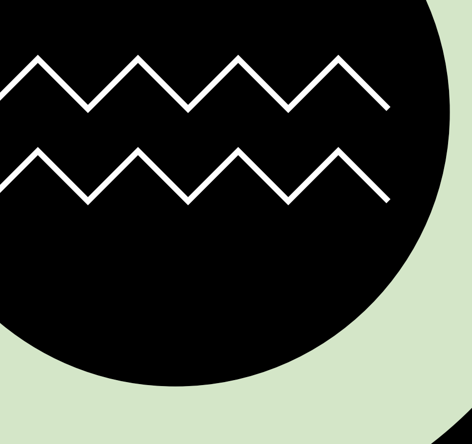

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Lost to Care (RW Case Management Agency Referral)

- **Individual is referred to EIS by RWB Case Management Agency.**
- **Case managers should follow basic adherence steps prior to EIS referrals (see checklist on form)**
- **Case Managers use *Lost To Care/Case Management Client Referral* form. Fax this form to EIS Program.**
- **Notes of referral to EIS should in be in EMR/CAREWare.**

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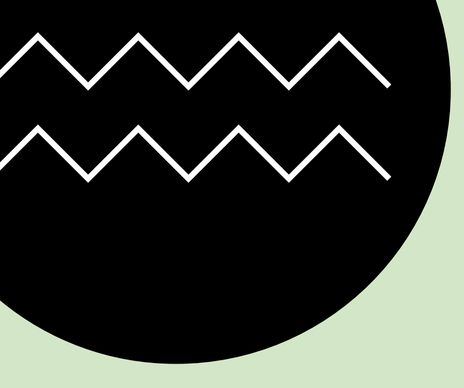

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Lost to Care (RW Case Management Agency Referral)

LOST TO CARE/CASE MANAGEMENT CLIENT REFERRAL — Ryan White Part B

Early Intervention Service — FDOH, BREVARD

FAX to EIS Coordinator: 321-690-3286

☐ Amaya Viñuela: 321-690-6459 ☐ Yaitte Gomez: 321-690-6495

Client Name: ______________________________

Preferred Name: ______________________________

DOB: ____/______/_______

EIS Referral Date: ___/___/____

CM Contact: ______________________ CM Contact #: ______________________

REASON FOR REFERRAL

NEVER ENROLLED WITH CASE MANAGEMENT
☐ Not Able to Contact to Make Appointment
Reason: ____

LOST TO CARE WITH CASE MANAGMENT
Date of Last Contact: _____/___/_______ Type of Contact: ☐ Phone ☐ CM F2F ☐ Medical OV
☐ NOE Eligibility Expiration (Date: ______/______/_______)
☐ Lost To Care/Closed (Date: ______/______/______)
Lab Dates: CD4__________/VL ___________ Last Medical Appt: ______/______/________ ☐ NA

ADHERENCE ACTIVITIES (Performed By NMCM/MCM)
☐ 3 Contact Attempts Made To Reach Client
☐ RW Case Manager Contacted for Client Information

☐ Notes in CAREWare
☐ Note in CAREWare (*"EIS Referral"*)

BARRIERS TO CARE IDENTIFIED:
☐ NOE needed ☐ Lab Needed ☐ RX Needed (Medical Appointment)

EIS/REVIEW OF ADHERENCE

☐ Client Out of Care for >___ months and can no longer be reached - Hold off for POC until client located

☐ Client Contacted Before EIS Enrollment Initiated - No need for POC

Transportation Required: ☐ Yes ☐ No

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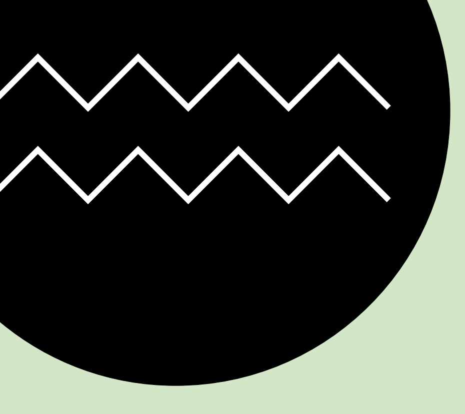

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Lost to Care (RW Case Management Agency Referral)

- **EIS Coordinator will contact Case Manager if more information needed.**
- **EIS Coordinator will attempt contact with referred individual within 72 hours of referral.**
- **EIS Coordinator will develop a Plan of Care, identifying needs (barriers to care , EIS acuity level, cultural requirements) within 72 hours of client contact. The POC is scanned into CAREWare.**

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Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Lost to Care (RW Case Management Agency Referral)

- **EIS identifies in CAREWare (EIS Case Manager) and notes interactions.**
- **EIS Coordinator follows client for approximately three months.**
- **EIS Coordinator updates POC as necessary and scans into CAREWare updates of POC as appropriate.**
- **EIS Coordinator provides HIV Education and Health Equity assessment of individual needs.**

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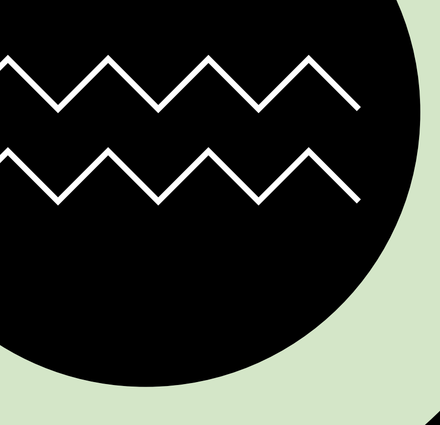

Early Intervention Services, FDOH in Brevard

KEY POINT OF ENTRY

Lost to Care (RW Case Management Agency Referral)

- **EIS Coordinator "graduates" individual when goals on POC have been met, specifically – medications (ARVs) have been picked up for three consecutive months.**
- **EIS "closes" individual when three attempts to contact client have been made unsuccessfully.**
- **EIS puts some clients on a "watch." This can be an individual that has "graduated" but still may be vulnerable to barriers to care. This can also be an individual who had not been contacted: incarceration, recent loss of housing.**

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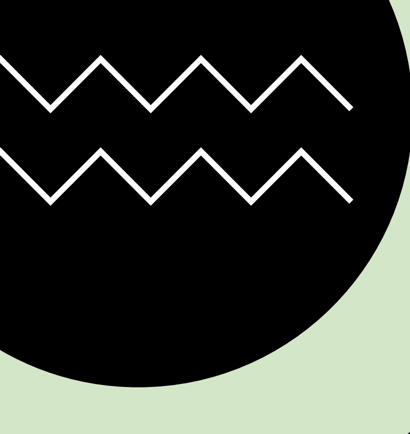


Early Intervention Services, FDOH in Brevard

- **EIS Coordinators identify Barriers To Care that keep individuals from entering into HIV care and/or staying in medical care.**

- **EIS Coordinators network with community resource groups to keep updated information to be efficient in assisting referred individuals identifying Steps to meet objectives to overcome the barriers in the EIS Plan of Care.**

- **EIS develops *Plan of Intents* with crisis intervention agencies in Brevard County in order to improve coordination of individuals referred to our services. The *Plan of Intent* identifies contacts within the agencies; application procedures, and policies and protocols for eligibility for program accessibility. These are updated regularly. (Examples of crisis intervention agencies: Women's Center of Brevard, Circles of Care, S.T.E.P.S.)**

Questions?

ADAP & Insured Clients

Ensuring Payor of Last Resort

Mika Mendoza

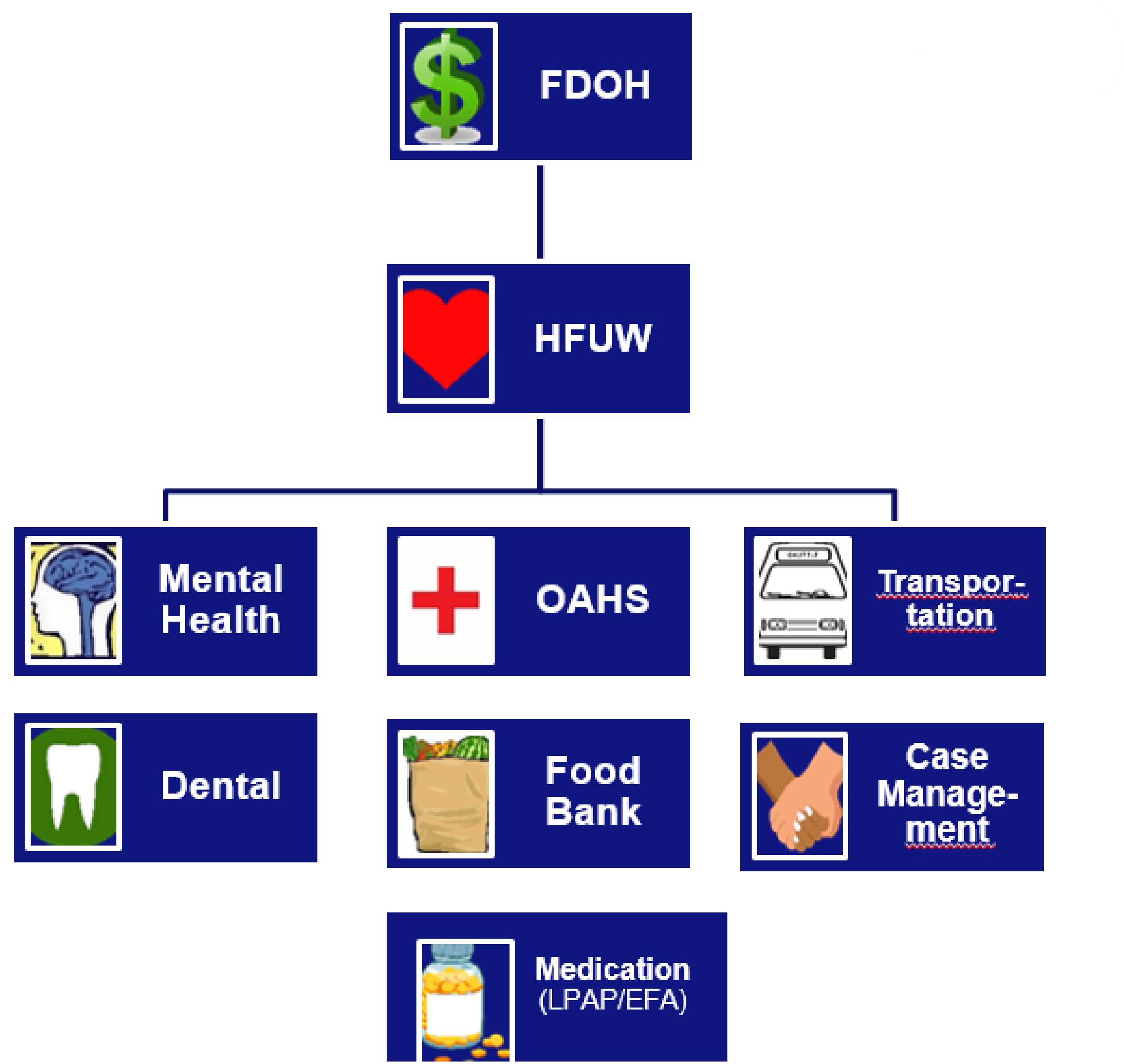
Review

Funds may not be used for any item or service "to the extent that payment has been made, or can reasonably be expected to be made under… any State compensation program, under an insurance policy, or under any Federal or State health benefits program… or by an entity that provides health services on a pre-paid basis."

Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) of the Public Health Service (PHS) Act. See also 2671(i) of the PHS Act.

Funded Services

- FDOH awards $1.45 million to Area 7 for different medical and support services
  - Distributed by HFUW
- Unspent funds can be moved to another service, approved by the Planning Council
  - *Compared to ADAP, whose services are more limited*



Medication Co-Pays

External & Ryan White Payors

United Way
Heart of Florida United Way

- All clients are eligible for medication co-pay assistance, either through
  - AIDS Drug Assistance Program
  - External sources, such as patient assistance programs
  - Health Insurance budget through HFUW

Opportunity: Refer all insured clients to ADAP for co-pay/premium assistance assessment

Medication Co-Pays

Moving Forward

HFUW will
no longer pay
for ADAP-formulary
medication co-pays
***if* client is eligible for**
ADAP and has *not*
been referred

- Please refer intakes to ADAP
- Insured clients not currently enrolled should be referred to ADAP
  - Including: Medicare, employer-sponsored individual, and ADAP-sponsored Marketplace
  - Excluded: Medicaid, employer-sponsored family, and individual Marketplance
- Clients who choose not to enroll must provide valid justification (case notes)

Medication Co-Pays

Process if Medication is on ADAP Formulary

Medication on ADAP formulary

- **Client *is* enrolled in ADAP** → Client provides pharmacy with co-pay card → Pharmacy will process payment via co-pay card
- **Client is *not yet* enrolled in ADAP** → CM submits referral to ADAP (documented in case notes)
  - CM applies for Patient Assistance Programs (PAP) if available
  - **If no PAP available:** Co-pay can be billed to HFUW until client is enrolled in ADAP

Medication Co-Pays

Process if Medication is on APA/LPAP Formulary

Billed through Health Insurance category

Medication Co-Pays

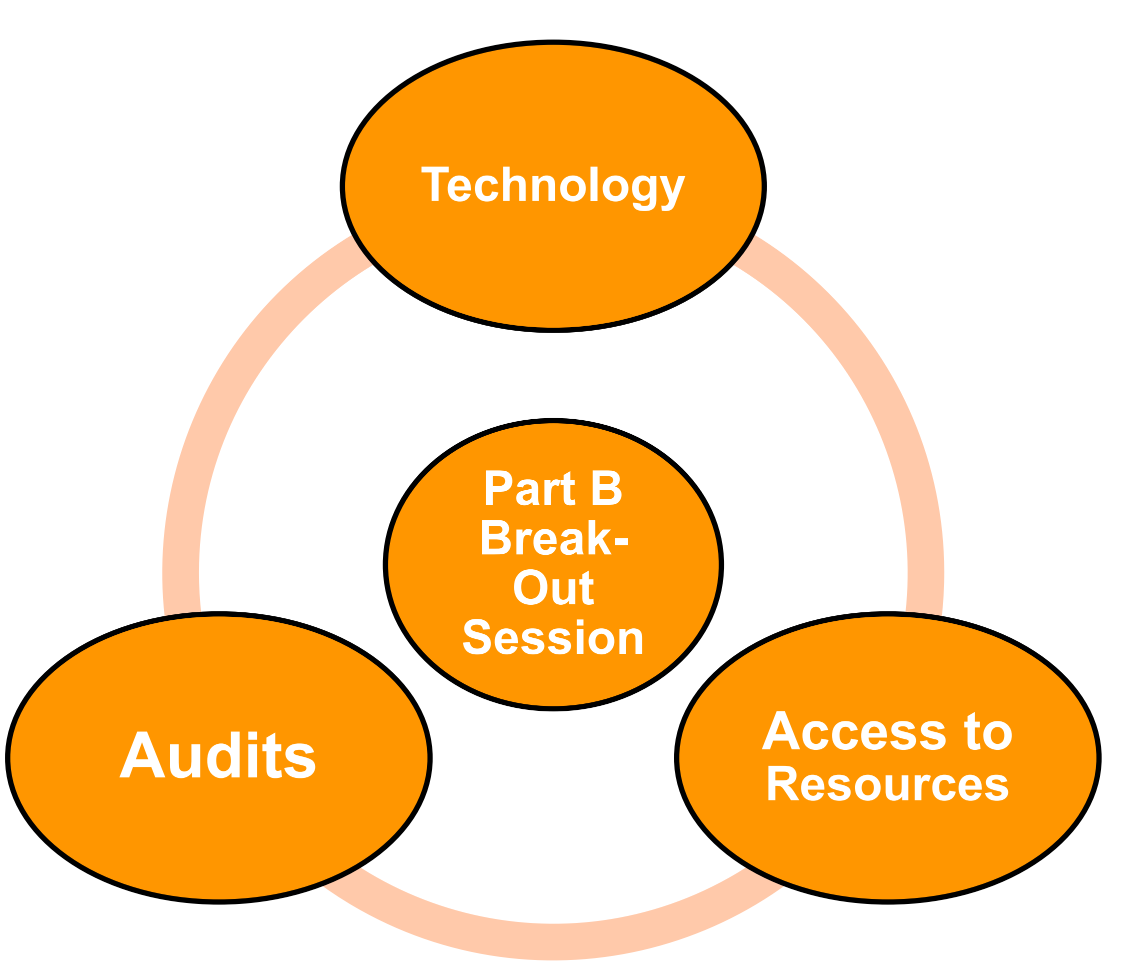
Benefits of Referring Clients to ADAP

- ✓ Clients can remain with their local pharmacy
- ✓ Monitoring of client's medication pick-ups
- ✓ Additional support for noncompliant clients
- ✓ Simple enrollment & renewal process
- ✓ Less purchase orders to process
- ✓ Part B funds are freed up to apply to other service categories

Part B Break-Out Session

Mika Mendoza

Part B Break-Out Session



Thank you for your feedback!

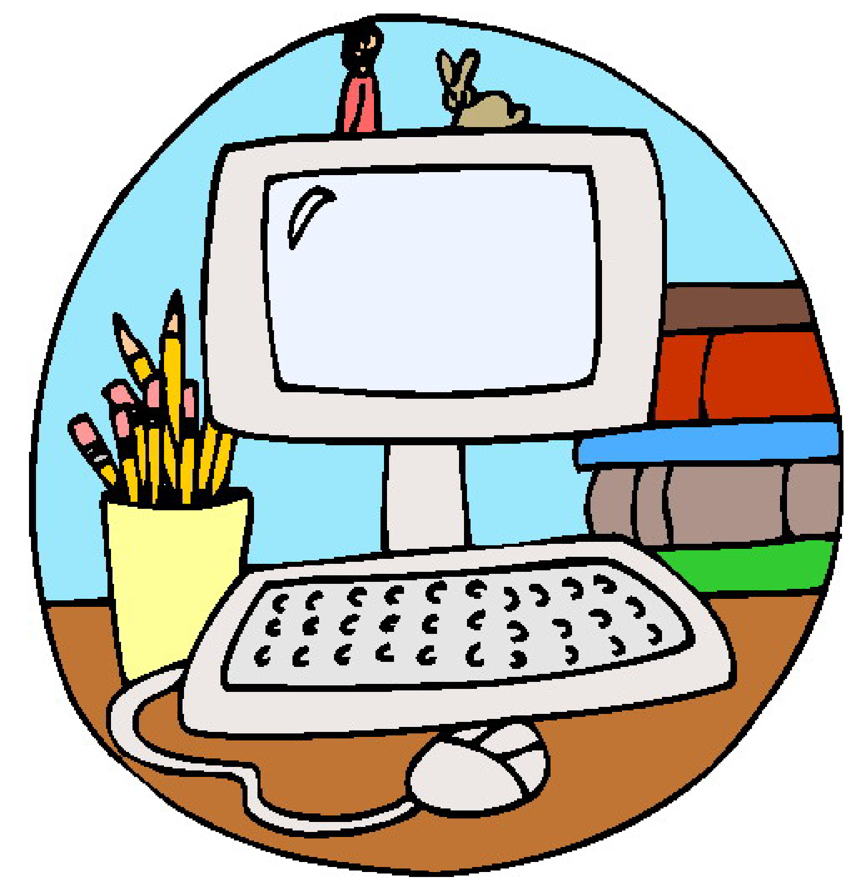
- Some issues need to be addressed at the agency level (work schedules, PTO policies)
- Some policies are mandated by the state (case loads)

Technology

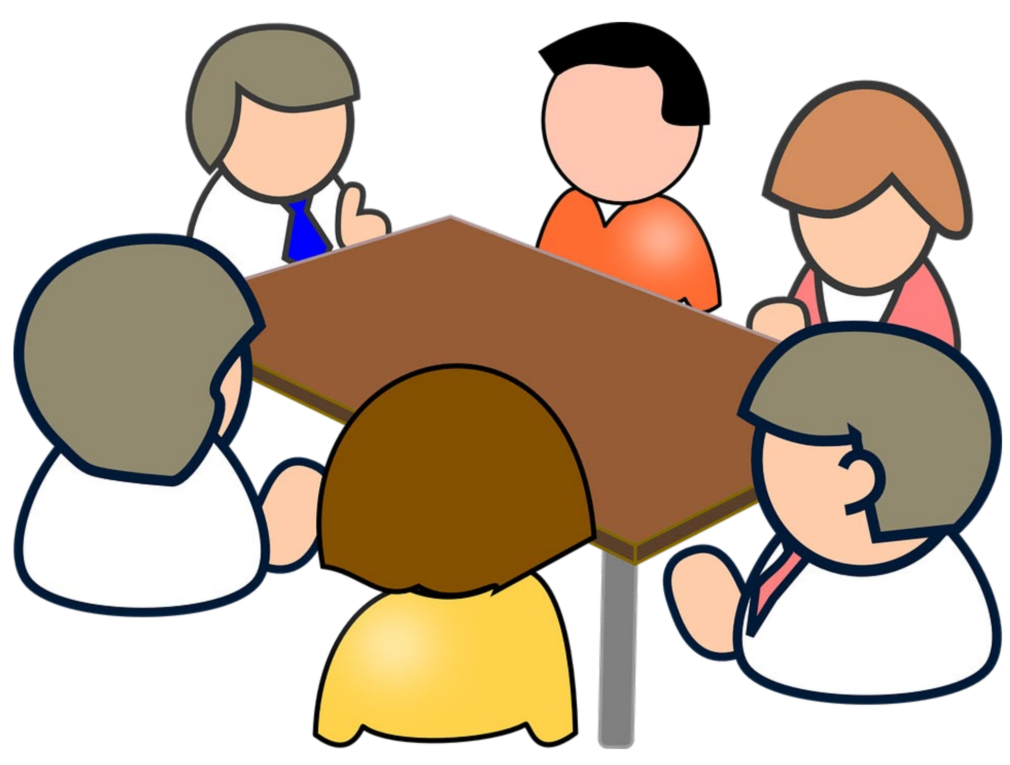
- FDOH establishes preferred database system (CAREWare, RW Portal)
- Different operating systems across agencies introduce unique issues
- RW Portal should resolve some concerns:
  - Streamlined eligibility procedure
  - Telehealth platform
- Resource directory for forms and training materials in the works

Let us know:

What processes are burdensome?
What steps can be condensed?



Access to Resources



- Opportunity to build relations network with local medical providers and RWHAP
- Opportunity for the development of a local directory

Audits

- Auditing is a necessary process in the RWHAP system of care to ensure:
  - Quality services
  - Appropriate services
  - Proper billing entity
- Performed at every level, from HRSA to individual staff

- Complete files allow us to:
  - Track data to improve health outcomes
  - Comply with HIPAA, HRSA guidelines, and contracts
  - Maintain a culture of responsible record-keeping practices

Progress, not perfection!

Audits: Frequency

- All agencies are subject to periodic auditing
  - Annually = all agencies
  - Monthly = NMCM services; MCM services
- Sample of client files are reviewed for compliance with the contract and service standards
- Files are selected from that month's bill
  - Very important to ensure that you are billing for the appropriate acuity level/service!

Audits: Making Corrections

- Frequent audits also result from Part B's cost-reimbursement billing
- By the time HFUW is auditing a file, multiple services may have been provided to the client
  - **HFUW cannot provide payment for clients found ineligible**
  - **Agencies then become responsible for those unpaid costs**
  - **Corrections must be made ASAP!**

Audits: Tools

Eligibility Review Tool

- Completed monthly
- NMCM agencies are randomly audited three times a year
- Files are pulled from NMCM service codes CM003, CM004, CM0051
- 20 to 30 clients (3% of all clients served in the previous month)

Audits: Tools

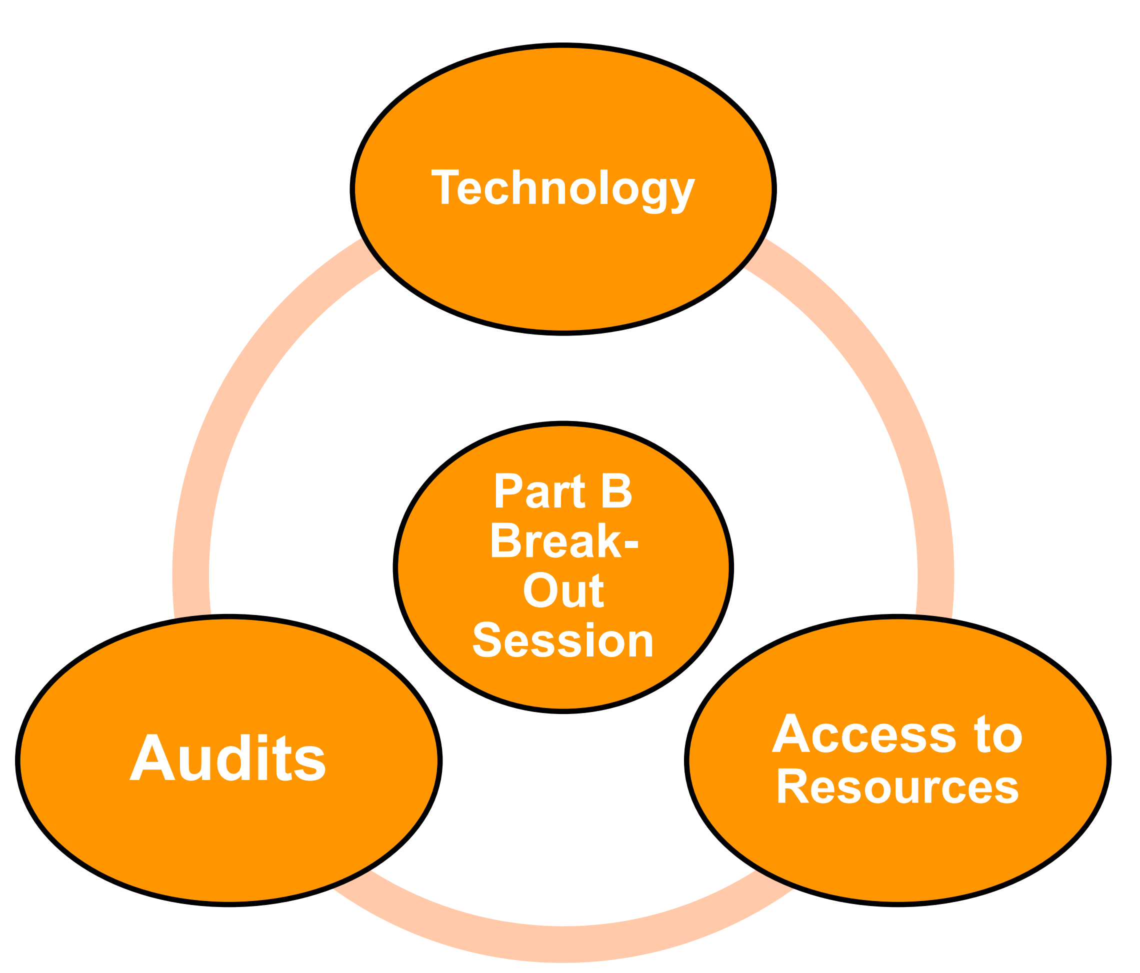
MCM QA Tool

- Completed monthly starting July
- MCM agencies are audited every other month
- Files are pulled from all MCM service codes
- 10 clients of those served in the previous month

Audits: Observable Improvement

- ✓ Fewer missing items per client
- ✓ More detailed case notes
- ✓ Services properly reflecting client acuity level
- ✓ Most recent eligibilities have returned complete client files

Part B Break-Out Session



Any questions, concerns, or suggestions?

Evaluation

Evaluation

Mentimeter

Please go to menti.com

Code: 2198 1968

Provider Announcements & Updates

Meeting Attendees