

**GIVE. ADVOCATE. VOLUNTEER.
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Heart of Florida United Way

Part B Networking Meeting

January 26, 2022

Yasmin Andre, Director

Doris Huff, Planning & Evaluation

Whitney Marshall, Planning Council Support Manager

Mikaela Mendoza-Cardenal, Clinical Quality Manager

Introductions

- Name
- Pronouns
- Agency
- Role
- Share: a recent small success



Upcoming SAETC Webinars



- Sex Positivity - Sexual Health - Sexual History on 02-09-2022 @ 1:00 PM (one hour)
- Surviving and Thriving: Celebrating Long Term HIV Survival on 02-10-2022 @ 4:00 PM (1.5 hours)
- MCM: Substance Use Disorder Making the Connection: Engagement and Rapport as Therapeutic Tools on 02-18-2022 @ 9:00 AM (three hours)
- HIV Youth Summit for National Black HIV/AIDS Awareness Day on 02-15-2022 @ 12:00 PM (1.5 hours)

<https://www.seaetc.com/calendar/>

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Central Florida HIV Planning Council

Updates

HIV Stigma Study

University of Central Florida

<p>We are gathering experiences to create educational materials that will help providers avoid practices that might make people with HIV feel discriminated against.</p>			
	<p>Participate in interviews and/or focus groups.</p> <p>What you share will be kept confidential.</p>		
	<p>Eligibility:</p> <ul style="list-style-type: none"> - Over 18 - English speaking - HIV Positive 		<p>total time: 60 - 90 minutes</p> <p>\$ 30</p> <p>compensation</p>

Have you been treated differently when seeking services related to HIV?

If so, we'd like to hear about it.

For questions about the study, or to report a problem, contact:

Dr. Christa Cook, Associate Professor of Nursing,
407-823-5457, or christa.cook@ucf.edu,
or Dr. Blake Scott, Professor, Department of Writing and Rhetoric,
407-718-1721, or bscott@ucf.edu.

IRB contact about your rights in this study:

If you have questions about your rights as a research participant, or have concerns about the conduct of this study, please contact Institutional Review Board (IRB), University of Central Florida, Office of Research, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246, or by telephone at 407-823-2901, or email irb@ucf.edu.

HIV Community Assessment Survey

City of Orlando



“The City of Orlando is working with health organizations to understand our community's beliefs about HIV. Your responses will help us create programs and educational materials that will reflect the needs of our community. Your feedback is valuable, and we appreciate the time you're spending on this survey.”

<https://www.orlando.gov/HIV-Survey>

HIV Care Needs Survey

Central Florida HIV Planning Council



“The HIV Care Needs Survey was developed with input and feedback from PWH and stakeholders across the state... Results from this survey guide patient care lead agencies and planning councils in meeting community unmet needs and determining where to distribute monies for services.”

- Final version will be approved at tonight’s Business Meeting (6:00 PM, accessible online at www.addevent.com/event/lj10715960)

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Ryan White Updates

Provide Enterprise, Eligibility Process, Formulary, and Delta Dental

Provide Enterprise

Read-Only Access



- All Ryan White Part B staff to be provided with a Florida Department of Health-sponsored license to FL Provide Enterprise System.
- Licenses are read-only for the purpose of eligibility continuity and coordination with Florida ADAP.
- Active users will receive a temporary password from elighelp@providecm.net.
- Once received, open the Provide system and enter your username, password, the server name and database name.
- For questions or technical assistance with sign in - please contact Lacandria.Churchill@flhealth.gov.

Eligibility Process

RW Eligibility Portal

Available at: <https://rwces.floridahealth.gov>

Using this portal, CLIENTS may:

- Submit eligibility forms for enrollment and recertification
- Upload supporting eligibility documentation
- Assign eligibility forms to a case manager in their county of residence – via drop down menu
- Sign up for an online account and track eligibility status
- Receive an electronic Notice of Eligibility (must have an online profile)

Using this portal, RWB ELIGIBILITY STAFF may:

- Sign up to receive notifications when eligibility forms are assigned to them
- Manage forms in the dashboard and reassign cases as needed
- Connect to CHD eligibility contacts
- Send support requests
- Access training videos

For assistance with sign-in, please contact tammy.cuyler2@flhealth.gov

Eligibility Process

Zero Income Affidavit

Ryan White HIV/AIDS Program Part B (Area 7)
Zero Income Affidavit

I, _____, have applied for assistance through the Area 7 Ryan White HIV/AIDS Program. Program regulations require verification of all income from participating households.

Income includes but is not limited to the following:

- Wages, Salaries, tips, etc. (Form W-2)
- Taxable Interest (1099-NT form)
- Tax-exempt Interest (Form 1099-INT box 8)
- Ordinary Dividends (1099-DIV box 1a)
- Taxable refunds of state/local income taxes
- Alimony or Other Spousal Support Received
- Capital gain or loss (Schedule D)
- Other gains/losses (Form 4797)
- IRA distributions – taxable amount
- Private Pensions and Annuities
- Private Pensions and Annuities EXEMPT
- Private/Employer Disability Payment
- Veteran's Service Related Disability Payment
- Veteran's Non-Service Related Disability Payment
- Business or Self Employed income/loss (Schedule C or C-EZ)
- Exempt Interest Dividends (Form 1099-INT box 10)
- Rental real estate, trusts (Schedule E)
- Farm income/loss (Schedule F)
- Unemployment Income
- Social Security Benefits
- Social Security Disability (SSDI)
- Supplemental Social Security Income (SSI)
- General Assistance
- Temporary Assistance for Needy Families (TANF)
- Other Client Income (Jury Duty Pay, Gambling Winnings)
- Child Support
- Worker's Compensation
- Monetary Gift or other exempt

I have stated during this certification/recertification process that I currently receive no income from any of the above sources.

I have not received income since: _____

I do not expect to receive income until: _____

I applied for _____ on _____

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the Ryan White HIV/AIDS Program Part B (Area 7), and may be grounds for termination of assistance.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income within ten (10) business days of such change.

Client Signature Date

Case Manager Signature Date

- Ryan White caps eligibility at 400% FPL
- Income must be updated every six months at redetermination, or within 10 days of a change in income
- Income *includes* monetary gifts from family or friends

If client is actually zero-income:

- Zero income affidavit must be accompanied by **letter of support** explaining how client accesses food, clothes, and shelter (does not have to be notarized)
 - *Requirement can be waived with approval*

ICYMI: Formulary Updates



Florida AIDS Drug Assistance Program (ADAP)

Formulary January 2022 - http://www.floridahealth.gov/diseases-and-conditions/aids/adap/_documents/adap_formulary.pdf

AIDS Pharmaceutical Assistance (APA)

Formulary – September 2021 - http://www.floridahealth.gov/diseases-and-conditions/aids/Clinical_Resources/_documents/APAFormulary.pdf

Other Clinical Resources - http://www.floridahealth.gov/diseases-and-conditions/aids/Clinical_Resources/index.html

Delta Dental Enrollment

- Enrollment caps at 170 and we are reaching that!
- Please keep eligibilities up to date – clients cannot use dental insurance if they have expired



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Case Notes

Their Importance, Required Elements, and Best Practices

The Importance of Case Notes

Overview

Case notes are documentation of ALL client interactions, including direct contact *and* actions taken on a client's behalf

For the agency:

- Provides program accountability for the quality provision of services

For the case manager:

- Helps in tracking client progress and intervention planning



The Importance of Case Notes

Agency Accountability



Case notes:

- Create a *medical record of events* during a client's participation in case management services
- Provide supportive documentation used during grievance processes
- Support invoicing and billing process
 - Used to verify information such as insurance coverage, eligibility, prescribing details for medications
- Provide evidence that services for which agency is contracted are being delivered appropriately

The Importance of Case Notes

Case Management



Case notes:

- Provide qualitative data used to develop successful interventions
 - Documents history of successful and maladaptive client behaviors, and results of past care plan goals
- Assist in reminding the case manager of needed follow-ups and referrals
- Provides context during invoicing processes if documentation is missing
- Supports continuity of care in case of client/agency transition

The Importance of Case Notes

NASW Code of Ethics 2021



Code of Ethics > Ethical Standards > 3.04 Client Records

- a) Social workers should take reasonable steps to ensure that documentation in electronic and paper records is accurate and reflects the services provided.
- b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
- c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.
- d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by relevant laws, agency policies, and contracts.

The Importance of Case Notes

NASW Code of Ethics 2021



Code of Ethics > Ethical Standards > 3.04 Client Records

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Required Elements

Overview



- Timeliness
- Accuracy
- Relevancy
- Standardization

Required Elements

Timeliness

- Case notes must be submitted within 72 hours of interaction per OSA Service Standards
- Build in time for case notes when scheduling appointments
- Maintain a calendar of kept/missed appointments to make sure all case notes are written



Required Elements

Accuracy



Case notes should provide an image of what client's current status of care looks like:

- Changes in insurance coverage, income/household, address
- New diagnoses, most recent labs, recent/upcoming appointments
- Last direct contact with case manager or agency
- Case manager or agency's most recent actions taken on behalf of client

Required Elements

Relevancy

“It is a privilege to be able to bear witness to someone’s story when they may not have had the chance to tell it before.”

Lindy Alexander

- Case notes should document provision of services:
 - Referrals made and required follow-up
 - Recent and upcoming appointments
 - Observed changes in behaviors
- Case notes should relate back to plan of care as much as possible
 - Avoid intimate details and irrelevant anecdotes

Required Elements

Relevancy

WHO: The name, qualifications, and/or title of staff involved

WHAT: What conversations took place and what actions were taken by or on behalf of the client

WHERE: The physical or digital location in which services were rendered

WHEN: Date and time of day of relevant actions

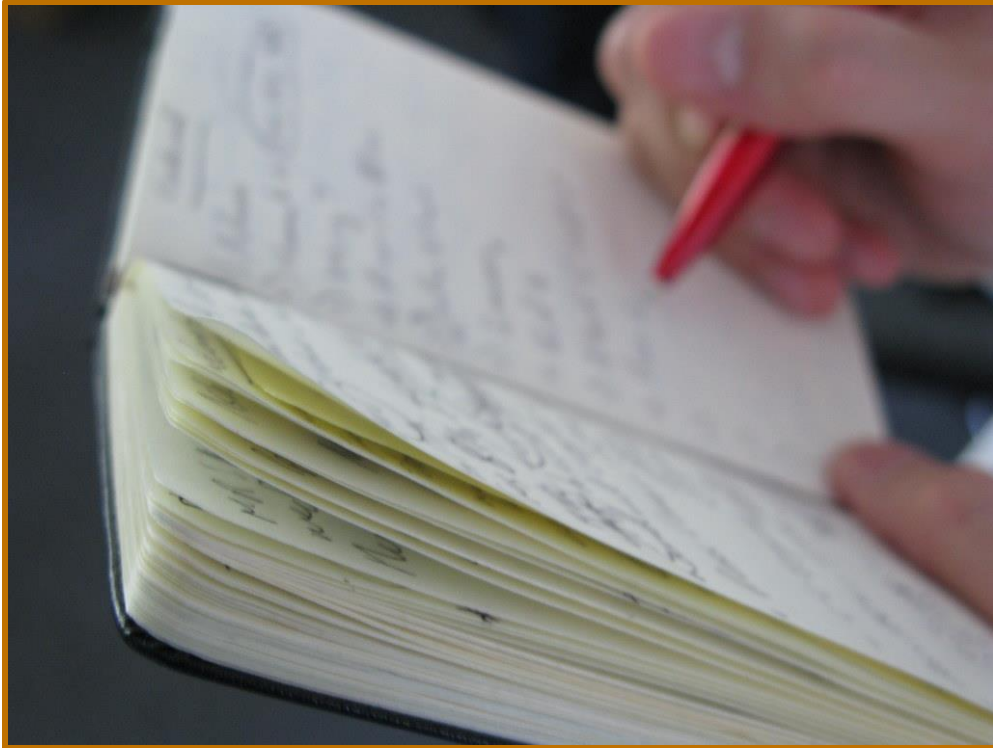


HOW: Measurable and concrete description of interventions implemented/action taken

WHY: The intended outcome related to the intervention/action

Required Elements

Standardization



- Please avoid excessive use of abbreviations as they compromise the readability of case notes
- Case notes should follow an agency-wide standard per OSA Service Standards
- DAP (preferred) vs. SOAP

Required Elements

Standardizations: Abbreviations

Acceptable abbreviations:

- **ADAP:** AIDS Drug Assistance Program
- **ART:** antiretroviral therapy
- **BWCA:** Burnham, Woods, Champa & Associates
- **CHC:** Comprehensive Health Care
- **CW6:** CAREWare 6
- **EIS:** early intervention specialist/ services
- **FDOH:** Florida Department of Health (Osceola/Brevard)
- **FPL:** federal poverty level
- **H&H:** Hope & Help Center of Central Florida, Inc.
- **HOPWA:** Housing Opportunities for People with AIDS
- **MCM:** medical case manager/ management
- **MMSC:** male-to-male sexual contact
- **MOL:** Miracle of Love, Inc.
- **NMCM:** nonmedical case manager/ management
- **NOE/NOI:** notice of eligibility/ineligibility
- **PAP:** patient assistance program
- **PCCER:** Patient Care Core Eligibility Recertification
- **PCP:** primary care provider
- **PO:** purchase order
- **PR:** Project Response
- **PWID:** person/people who injects drugs
- **RDA:** referral determination assessment
- **ROI:** release of information
- **RS:** referral specialist
- **RWHAP:** Ryan White HIV/AIDS Program
- **SNAP/EBT:** Supplemental Nutrition Assistance Program/Electronic Benefits Transfer
- **SS(A):** Social Security (Administration)
- **STD/STI:** sexually transmitted disease/infection
- **VL:** viral load

Required Elements

Standardization: DAP vs. SOAP

DAP

- Used by Part A
- Three components:
 - **Data:** What occurred & who was present, when & where did it happen
 - **Assessment:** Why & how an action/behavior happened, why & how an outcome was either achieved or missed
 - **Plan:** Proposed resolutions, assignment of tasks, follow-up

SOAP

- Four components:
 - **Subjective:** Subjective input from the client; qualitative observations, such as information on a client's hygiene
 - **Objective:** Measurable data, such as lab values; indisputable information such as appointments
 - **Assessment:** Why & how an action/behavior happened, why & how an outcome was either achieved or missed
 - **Plan:** Proposed resolutions, assignment of tasks, follow-up

Required Elements

Standardization: Data – Assessment – Plan (DAP)



EXAMPLE 1A – REFERRAL SPECIALIST

D. CM met with client for recert. Income: unchanged. Residence: unchanged. Insurance: new insurance through job. Client has been renewed with RW. Client completed labs recently and has lab review appointment coming up. Client asked for help applying for food stamps, so CM submitted application for client.

A. It appears client is eligible until July 2022.

P. Client will keep upcoming appointments.

EXAMPLE 1B – REFERRAL SPECIALIST

D. RS met with client for redetermination at main office. Client provided utility bill and two recent paystubs. Client now qualifies for health insurance at work due to increasing hours and is fully enrolled with Insurance Company (card uploaded to CW6). RS completed RDA and client scored a level 1.

After redetermination, client requested assistance with SNAP recertification (\$94 monthly) due to vision issues and low computer literacy (username/password). RS provided client with ACCESS Florida phone number to check on status. Client recently completed labs with his PCP and has a lab review via telehealth on 01-28-2022 at 3:15 PM. Client reports no additional diagnoses, symptoms, housing, or emotional concerns.

A. It appears client remains at acuity level 1. It appears client has increased self-advocacy by enrolling in his own insurance.

P. RS will request copy of labs from PCP. Client will keep upcoming appointment.

Required Elements

Standardization: Data – Assessment – Plan (DAP)

EXAMPLE 1A – Referral Specialist

D. CM met with client for recert. **Income: unchanged. Residence: unchanged. Insurance: new insurance through job.** Client has been renewed with RW. Client completed labs recently and has lab review appointment coming up. Client asked for help applying for food stamps, so CM submitted application for client.

A. It appears client is eligible until July 2022.

P. Client will keep upcoming appointments.

Both examples provide similar information, but Example 1A neglects to include acuity level, insurance details, appointment information, or analysis on client behavior.

Example 1B provides location detail, reason for insurance change, acuity level, reason for application assistance, appointment details, and assessment of client behaviors.

EXAMPLE 1B – Referral Specialist

D. RS met with client for redetermination **at main office. Client provided** utility bill and two recent paystubs. Client now qualifies for health insurance at work **due to** increasing hours and is fully enrolled with **Insurance Company** (card uploaded to CW6). RS **completed RDA and client scored** a level 1.

After redetermination, client requested assistance with SNAP recertification (\$94 monthly) **due to** vision issues and low computer literacy (**username/password**). **RS provided client with** ACCESS Florida phone number to check on status. Client recently completed labs **with** his PCP and has a **lab review via telehealth on 01-28-2022 at 3:15 PM.** Client **reports no additional** diagnoses, symptoms, housing, or emotional concerns.

A. It appears client **remains** at acuity level 1. It appears client has **increased self-advocacy** by enrolling in his own insurance.

P. **RS will request** copy of labs from PCP. Client will keep upcoming appointment.

Required Elements

Standardization: Data – Assessment – Plan (DAP)



EXAMPLE 2A – Medical Case Management

D. CM received a voicemail from client, rx was missing. CM called doctor, rx will be ready today.

A. CM linked client to medication.

P. Client will pick up meds.

EXAMPLE 2B – Medical Case Management

D. Medical case manager (MCM) received a voicemail from client that their ART prescription was not available at their pharmacy (Pharmacy Information) even though client had left a voicemail for their provider (Provider Information). MCM reached out to provider's office and confirmed prescription would be sent this morning. Client has upcoming appointment on 02-07-2022 at 8:40 AM. MCM called client, provided medication update, and reminded client of appointment. Client said they had set up a new calendar in their kitchen. MCM suggested getting a planner as well, as client prefers physical reminders to using their phone.

A. It appears client is intending to stay adherent to medication and compliant with appointments.

P. Client will pick up medication and attend upcoming appointment.

Required Elements

Standardization: Data – Assessment – Plan (DAP)

EXAMPLE 2A – Medical Case Management

D. CM received a voicemail from client, rx was missing. CM called doctor, rx will be ready today.

A. CM linked client to medication.

P. Client will pick up meds.

Both examples provide similar information (that the missing prescription will be filled by today and the client has been informed), but Example A is devoid of context that characterizes this interaction as a MCM service.

Example B supplies additional information that is useful in maintaining continuity of care and analyzes client behavior against MCM goals (adherence & retention in care).

EXAMPLE 2B – Medical Case Management

D. Medical case manager (MCM) received a voicemail from client that their ART prescription was not available at their pharmacy (Pharmacy Information) even though client had left a voicemail for their provider (Provider Information). MCM reached out to provider's office and confirmed prescription would be sent this morning. Client has upcoming appointment on 02-07-2022 at 8:40 AM. MCM called client, provided medication update, and reminded client of appointment. Client said they had set up a new calendar in their kitchen. MCM suggested getting a planner as well, as client prefers physical reminders to using their phone.

A. It appears client is intending to stay adherent to medication and compliant with appointments.

P. Client will pick up medication and attend upcoming appointment.

Required Elements

Standardization: Data – Assessment – Plan (DAP)



EXAMPLE 3A – Early Intervention Services

D. EIS received referral, called client but no answer. EIS used data research software to get a new number for client (999-999-9999). EIS spoke to client and made appointment for intake.

A. It appears client has a new number.

P. Client will keep appointment on 01-28-2022.

EXAMPLE 3B – Early Intervention Services

D. EIS received referral from Agency, last Agency contact with client was on 11-02-2021. EIS called client, but no answer. EIS used data research software to find a new phone number (999-999-9999), and established contact. Client said their mother had died recently, they were feeling depressed, and had not picked up their medication since 10-2021. Client reported slight fever and skin rashes. EIS set redetermination appointment and provided information on gathering required documents. Client agreed to call provider to request prescription/appointment.

A. It appears client has been experiencing difficulties with grief but is willing to re-engage in care.

P. EIS will meet client at main office on 01-28-2022 at 9:00 AM.

Required Elements

Standardization: Data – Assessment – Plan (DAP)

EXAMPLE 3A – Early Intervention Services

D. EIS received referral, called client but no answer. EIS used data research software to get a new number for client (999-999-9999). EIS spoke to client and made appointment for intake.

A. It appears client has a new number.

P. Client will keep appointment on 01-28-2022.

Example A provides basic relevant information, including new phone number and appointment date.

Example B provides more specific clinical information (symptoms and last ART pick-up date) that is relevant in linking client to medical services. It also provides enough context on client's emotional state and willingness to return to care that client's referring case manager can easily follow up on EIS efforts.

EXAMPLE 3B – Early Intervention Services

D. EIS received referral from Agency, last Agency contact with client was on 11-02-2021. EIS called client, but no answer. EIS used data research software to find a new phone number (999-999-9999), and established contact. Client said their mother had died recently, they were feeling depressed, and had not picked up their medication since 10-2021. Client reported slight fever and skin rashes. EIS set redetermination appointment and provided information on gathering required documents. Client agreed to call provider to request prescription/appointment.

A. It appears client has been experiencing difficulties with grief but is willing to re-engage in care.

P. EIS will meet client at main office on 01-28-2022 at 9:00 AM.

Best Practices

Dos and Don'ts

DO:

- Refer back to plan of care
- Include only relevant details
- Be specific when necessary (e.g., appointment details, contact information)
- Avoid slang and overuse of abbreviations
- Use professional language, grammar, punctuation, and capitalization
 - Make use of spell-check, macros, Google

DON'T:

- Include irrelevant personal details
- Take shortcuts at the cost of clarity
- Use medical diagnoses unless verified by an appropriate provider (e.g., “client has been depressed” vs. “client says he is in a depressed mood”)
- Allow personal biases to be reflected

Best Practices

Self-Assessment

After writing, ask yourself, “Does my note...”

- ✓ Indicate client needs?
- ✓ Indicate any changes since last encounter?
- ✓ Address client’s current disease status?
- ✓ Clearly assign tasks for follow-up?
- ✓ Identify client strengths and achievements?
- ✓ Address who, what, when, where, how, and why?
- ✓ Support appropriate provision of services?

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Evaluation

Evaluation Code



Please go to [menti.com](https://www.menti.com)

Code: 4674 5082

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Provider Announcements & Updates