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Part B Networking Meeting

April 27, 2022

Yasmin Andre, Director

Doris Huff, Planning & Evaluation

Whitney Marshall, Planning Council Support Manager

Mikaela Mendoza-Cardenal, Clinical Quality Manager

Introductions



Ryan White Part B Contact Directory will be sent out after the meeting with all materials

May 2022 Trainings



SEATC Webinars

- **Social Media, Marijuana, and Drug Use in Gen Z** on 05-18-2022 @ 12:00 PM (one hour)
- **HIV and Your Mental Health** on 05-24-2022 @ 10:00 AM (one hour)
- **Four Part Series @ 2:00 PM (1.5 hours)**
 - (1) **Medicare Eligibility** 05-03-2022
 - (2) **Medicare Enrollment & Coverage** 05-10-2022
 - (3) **Medicaid Eligibility & Enrollment** 06-01-2022
 - (4) **Medicaid-Medicare Dual Eligibility** 06-08-2022

www.seaetc.com/calendar/

Intensive Case Management

- Modules close on 06-03-2022



<https://aspiretraining.learnupon.com/dashboard>

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Central Florida HIV Planning Council


Upcoming Events

Whitney Marshall

Case Manager Town Hall



 **FRIDAY, MAY 6TH**

 **10:00AM-12:00PM**
12:00-12:30 PM CM ONLY Breakout Session

WebEx link:
<https://hfuw.webex.com/hfuw/j.php?MTID=m98dc3bb069ef33d4249bbcadf2bb7122>

Join us and share your feedback on the **successes, challenges, and opportunities to providing quality HIV care to Ryan White clients.**

Learn more about the **Integrated Plan** for our area and help us **decide** which strategies are a priority in ending the HIV epidemic.

Picnic with a Purpose



Carl T. Langford Park
1808 E Central Blvd.
Orlando, FL 32802

-  **Food**
-  **Games**
-  **Music**
-  **Prizes**
-  **Member Appreciation**
-  **Family Day**

HIV Care Needs Survey



Survey available online and via paper copy* in English, Spanish and Creole.

- Closes June 1, 2022
- Open to any person with HIV
- Client drawing for raffle prize!
- Provider recognition for exceeding target

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

Provider	Completed Surveys	Target
Burnham, Woods, Champa & Associates	1	5
Unconditional Love, Inc. dba Comprehensive Health Care	2	68
FDOH Brevard	0	5
FDOH Osceola	8	60
Hope & Help Center	0	115
Miracle of Love, Inc.	4	189
Project Response, Inc.	1	49

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Ryan White Updates

Medical Case Management Certification Program Reminder

Yasmin Andre

Certification Program

Intensive Case Management



Two components:

- 1. 8 virtual modules
- 2. Two days in-person training



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AIDS Drug Assistance Program

FDOH Brevard

Brianne Kane

ADAP – Direct Dispense

ADAP PROGRAM STEPS FOR ENROLLMENT AND RECERTIFICATION OF CLIENTS



The following Steps are involved in Enrolling and Recertifying clients in the **Direct Dispense** component of ADAP. Although there are sometimes variants to some of these steps that ADAP Staff will advise you on from time to time, these are standard.

DIRECT DISPENSE CLIENT

- STEP 1: ADAP PRE-ENROLLMENT PROCESSING**
ADAP Receives Documentation Required for Enrollment
- Notice of Eligibility (*See by RW Case Management Agency*)
 - Copy/Original RX or Prescribing Information of an ARV Regime from a Licensed Florida Prescriber (*See by Prescribing Doctor via Client Case Manager*)
 - Laboratory Results (*Not required but preferred to track Unsuppressed VL Clients*) - CD4 within 1 year, HIV V-L within 6 months
- STEP 2: ADAP PROGRAM ENROLLMENT – CLIENT DATA PROCESSING**
1. Client is Assigned to an ADAP Coordinator
 2. An Enrollment Appointment is Made within 3-7 Days – Face to Face Preferred (HIPAA and other paperwork is completed/signed)
At Enrollment:
 - i. Client Data is Entered into ADAP Statewide Database (Provide)
 - ii. Client Sets Up Enrollment and Verification with Dispensing Pharmacy for Monthly Dispense Information
- STEP 3: ADAP DISPENSE ENROLLMENT**
- RX Order Process – INITIAL**
1. ADAP Contacts Prescribing Agency to Call in, Escrib or Fax RX to the Dispensing ADAP Pharmacy OR
 2. ADAP Staff sends Fax to the Dispensing ADAP Pharmacy – if Prescribing Agency prefers local ADAP to be responsible for sending in *initial* RX
- RX Order Process – ONGOING**
1. Prescribing Agency Escribes or Faxes RX refills as Required
 2. Changes in RX regime to Dispensing ADAP Pharmacy may Require Client Verification
- STEP 4: UPDATE INFORMATION/DOCUMENTATION**
ADAP Receives Documentation Required for Re-Certifications Every 5-6 Months
- Notice of Eligibility (*See by RW CM Agency or Uploads from CAREWare*)
 - Laboratory Results (*Not required but preferred to track Unsuppressed VL Clients*) - CD4 within 1 year, HIV V-L within 6 months

***An ARV RX is needed to enroll an individual into the Provide system.**



ADAP – Copay/Deductible

ADAP PROGRAM STEPS FOR ENROLLMENT AND RECERTIFICATION OF CLIENTS



The following Steps are involved in Enrolling and Recertifying clients in the **Copay/Deductible** components of ADAP. Although there are sometimes variants to some of these steps that ADAP Staff will advise you on from time to time, these are standard.

COPAY/DEDUCTIBLE CLIENT – CLIENT WITH INSURANCE

- STEP 1: PRE-ENROLLMENT PROCESSING**
ADAP Receives Documentation Required for Enrollment
1. Notice of Eligibility (*See by RW Case Management Agency*)
 2. Copy/Original RX or Prescribing Information of an ARV Regime from a Licensed Florida Prescriber (*See by Prescribing Doctor via Client Case Manager*)
 3. Insurance Information – Policy information and Type
 - Summary of Benefits
 - Formulary Information
 - Insurance Card
 - Premium Information (*if applicable*)
 4. Laboratory Results (*Not required but preferred to track Unsuppressed VL Clients*) - CD4 within 1 year; HIV V-L within 6 months
- STEP 2: ADAP PROGRAM ENROLLMENT – CLIENT DATA PROCESSING**
- 1) Client is Assigned to an ADAP Coordinator
 - 2) An Enrollment Appointment is Made within 3-7 Days – Face to Face Preferred (HIPAA and other paperwork is completed/signed)
At Enrollment:
 - Client Data is Entered into ADAP Statewide Database (Provide)
 - Client Sets Up Enrollment with Pharmacy (Local) for Dispense and ADAP Co-Pay Card is Sent
- STEP 3: ADAP DISPENSE ENROLLMENT**
- RX Order Process – INITIAL**
1. Prescribing Agency Calls, Escribes or Faxes RX to Retail Pharmacy of Client's Choice (Client's Insurance pays Primary and ADAP pays for Deductible and Copay)
 2. ADAP Staff sends Fax to the Dispensing Pharmacy – if Prescribing Agency prefers ADAP to be responsible for sending in *initial* RX
- RX Order Process – ONGOING**
1. Prescribing Agency Escribes, Calls or Faxes RX refills or changes to RX regime to Dispensing Pharmacy
 2. Review of Insurance Formulary for Coverage will Verify ADAP Copay Dispense Coverage
- STEP 4: UPDATE INFORMATION/DOCUMENTATION**
ADAP Receives Documentation Required for Re-Certifications Every 5-6 Months
- Notice of Eligibility (*See by RW CM Agency or Uploads from CAREWare*)
 - Laboratory Results (*Not required but preferred to track Unsuppressed VL Clients*) - CD4 within 1 year, HIV V-L within 6 months

Marketplace enrollment involves additional steps at Enrollment

***An ARV RX is needed to enroll an individual into the Provide system.**



Importance of Labs – ADAP



STRATEGIC PRIORITIES SET BY FDOH

2.1.5 Reduce the incidence of HIV	A. Increase the percentage of ADAP clients enrolled in the program for at least 6 months and who achieve HIV viral loads less than 200 copies/mL, at last viral load test, from 92.10% (2019) to 95% by December 31, 2025. Lead: HIV
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Priority	Goals	Strategy	Objectives	Measures (Quarterly)	Owner	Performance					Linkage	
						Actual	21	22	23	24		25
2. Long, Healthy Life	2.1 Increase healthy life expectancy, including the reduction of health	2.1.5 Reduce the incidence of HIV	A. Increase the percentage of ADAP clients enrolled in the program for at least 6 months and who achieve HIV viral loads less than 200 copies/mL, at last viral load test, from 92.10% (2019) to 95% by December 31, 2025.	% ADAP Provide Enterprise database system CHD Snapshot	HIV	92.10% (2019)	92.50%	93%	93.50%	94%	95%	ASP Goal 1.1 ASP Goal 2.1 CHIP HP1.3.3 SHIP ID2.1 SHIP ID2.2

Actual

Importance of Labs – ADAP

Viewing Labs in Provide



Open Provide and Search for Client

The screenshot shows a software interface with a search menu open. The menu items include: Find All, Find Client, Find Client by Prescription, Find Drug, Find High Priority Assessment, Find High Priority Assessment Date, Find Provider, Find Provider, and Find by Diagnosis. The background of the interface is dimmed.

Importance of Labs – ADAP

Viewing Labs in Provide



Enter Client's Last Name and Service County

Provide Enterprise - [Find Client]

File Find View Actions Tools Reports Windows Help

Close Search

Find Client

Find Client

Legal Last Name
Legal First Name
Legal Middle Initial
Birth Date
Current Gender
Birth Gender
SSN
ADAP Client ID
Old ADAP Client ID
Medicaid ID
Private Policy ID
Service County
County of Residence
Find Client Results

Find Client Results

Importance of Labs – ADAP

Viewing Labs in Provide



Client's Profile Screen

Client Profile - Florida Health - ADAP: pascijm [11/17/2014]

File Find View Actions Tools Reports Windows Help

Close Search Edit Create Activity Create Sub Record Add View Action Print

Profile Demo Address Care Team Income Medical Benefits Insurance | Enroll Eligibility Notes

Status: Open

Legal Last Name: [Redacted]
Legal First Name: [Redacted]
Legal Middle Initial: A
Name Suffix: [Redacted]
Also Known As: [Redacted]
SSN: [Redacted]
Birth Date: [Redacted]
Current Age: 50
Current Gender: Male
Birth Gender: Male
ADAP Client ID: [Redacted]
Old ADAP Client ID: [Redacted]
Surveillance Status: No
Applied to ADAP because financial situation changed due to COVID-19? No
Pop-up Alert Message: NEW PHARMACY AS 02/2022 IS BROWNING'S AS PER CLIENT Y.GOMEZ

E-Messaging Setup
Okay to send email? No
Okay to send text messages? No

Web Account
Web Account History

Date Status Form Email Okay Email Address Text Okay Call Phone

Help Requests
Help Request History

Status	Date Open	Date Close	Days Open	Requester	Type	Brief Description	Assignee	Ticket ID	Service County	Close Reason
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Importance of Labs – ADAP

Viewing Labs in Provide



Choose Medical Tab – Labs are Automatically Entered (Lab Interface)

Date	Test Name	Original Test Name	Result	Source
2022/03/23	CD4 Count	ABSOLUTE CD4+ CELLS	561 cells/uL "cells/uL" L	Lab Interface
2022/03/23	HIV 1 Viral Load	HIV 1 RNA, QN PCR	< Not detected	Lab Interface
2021/11/04	CD4 Count	ABSOLUTE CD4+ CELLS	751 cells/uL "cells/uL" L	Lab Interface
2021/11/04	HIV 1 Viral Load	HIV 1 RNA, QN PCR	< 20 Copies/mL "Copies/mL" L	Lab Interface
2021/06/25	CD4 Count		587 /uL	Manual
2021/06/25	CD4 Count	ABSOLUTE CD4+ CELLS	587 cells/uL "cells/uL" L	Lab Interface
2021/06/25	HIV 1 Viral Load		< 20 copies/mL	Manual
2021/06/25	HIV 1 Viral Load	HIV 1 RNA, QN PCR	< 20 copies/mL "copies/mL" L	Lab Interface
2021/04/05	CD4 Count	ABSOLUTE CD4+ CELLS	658 cells/uL "cells/uL" L	Lab Interface
2021/04/05	HIV 1 Viral Load	HIV 1 RNA, QN PCR	< 20 copies/mL "copies/mL" L	Lab Interface
2020/11/09	CD4 Count	ABSOLUTE CD4+ CELLS	822 cells/uL "cells/uL" L	Lab Interface

Importance of Labs – HFUW: MCM



Labs are used to track the viral load suppression of ADAP-enrolled clients

- Not required, but strongly **preferred**
- Please ensure that client's labs are up-to-date in CAREWare
- Best practices:
 - *Always emphasize importance of labs!*
 - Set reminders in your calendar to follow-up on faxed lab requests
 - Review monthly Viral Load Due reports sent by FDOH Brevard



Importance of Labs – ADAP

Monthly Report Sent to Case Managers



VIRAL LOADS DUE REPORT EXAMPLE

- Sent to Hilda at Comprehensive Health Care
- Sent to Michael at Project Response
- Clinics also receive reports

VL DUE CHC 4/22

Last Name	First Name	Viral Load Due	VL Due date	Agency	MCM
		Yes	12/07/2021	CHC	TIM
		Yes	12/07/2021	CHC	ERICA
		Yes	12/22/2021	CHC	INGA
		Yes	12/22/2021	CHC	MICHELLE
		Yes	01/13/2022	CHC	ERICA
		Yes	01/28/2022	CHC	CHRISTIAN
		Yes	02/04/2022	CHC	MICHELLE
		Yes	02/17/2022	CHC	SUZANNE
		Yes	03/02/2022	CHC	MICHELLE
		Yes	03/04/2022	CHC	MICHELLE
		Yes	03/09/2022	CHC	MICHELLE
		Yes	03/20/2022	CHC	ERICA
		Yes	03/24/2022	CHC	HILDA
		Yes	03/28/2022	CHC	BLANCA
		Yes	03/30/2022	CHC	INGA
		Yes	04/01/2022	CHC	BLANCA
		Yes	04/06/2022	CHC	CHRISTIAN
		Yes	04/06/2022	CHC	INGA
		Yes	04/08/2022	CHC	HILDA
		Yes	04/09/2022	CHC	MICHELLE

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Eligibility Documentation

Touching Base

Mika Mendoza

Eligibility Documentation

Touching Base



Space for questions or clarifications on:

- ? Forms
- ? Collecting documents
- ? Explaining documents to clients
- ? Frequency

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Payor of Last Resort

Communicating to Providers & Clients

Mika Mendoza

Payor of Last Resort

Overview



- All services (except case management) must adhere to HRSA's **Payor of Last Resort** requirement
- Examples of non-RW Payors:
 - Employer-sponsored health insurance
 - Private insurance/Marketplace insurance
 - Patient Assistance Programs (PAPs)
 - Medicaid/Medicare
 - SNAP benefits/Section 8
- Example of RW Payor: ADAP
 - Prioritize linking eligible clients to ADAP ACA
 - Clients enrolled in ADAP Direct Dispense must access ADAP medications through CVS Specialty, not LPAP (Local Pharmacy)

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.

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Payor of Last Resort

New Documents



Provider Letter

- A letter from HFUW explaining Payor of Last Resort standard for RWHAP clients
- Intended to be given to client's provider in order to ensure services are billed to the proper entity

Client Acknowledgement Form

- Newly required form
- Must be completed **annually** and signed by both client and case manager
- Begin collecting Client Acknowledgement Form for all intakes and recertifications on **May 1st, 2022**

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Individualized Care Plans

Yasmin Andre
Mika Mendoza

Service Categories Case Manager Responsibilities



	Non-Medical Case Management (All Clients)	Referral for Healthcare Support (Level 1)	Medical Case Management (Level 2)
CM Responsibilities	Eligibility Determination & Recertification	Brief Intake	Brief Intake
	Referral Determination Assessments (RDA)	Referral support for clients who are not eligible for MCM	Referral support for eligible MCM clients
	Case Notes	Case Notes	Acuity Assessments
	Consents		Case Notes
			Comprehensive Needs Assessment & Reassessment
			Care Plans
			Treatment and Adherence Counseling
			Linkage and Retention Support

Note: Total caseload represented by **Non-Medical Case Management**. This category will be synonymous with *eligibility*.

Frequency of Contact

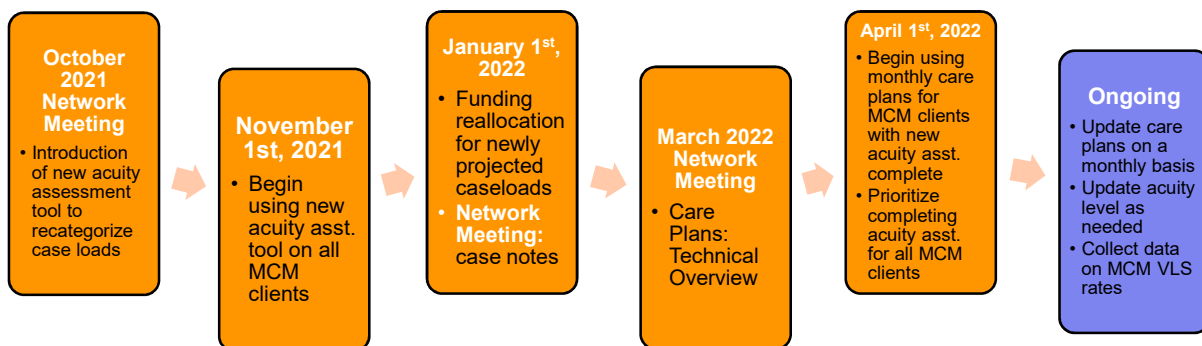
Based on RDA



Level (Weighted)	Care Plan	Acuity Reassessment	Collaboration	Frequency of Contact
RS – 1 (0-46)	N/A	RDA every 6 months	Recommended as needed	Every 6 months and as needed
MCM – 2 (47-62)	Reviewed and updated monthly	Acuity every 6 months	Case conferencing required	1 Face-to-face contact required every 3 months and 2 additional contacts required monthly.
MCM – 2 (63-78)	Reviewed and updated monthly	Acuity every 6 months	Case conferencing required	1 Face-to-face contact and 2 additional contacts required monthly.
MCM – 2 (79-93)	Reviewed and updated monthly	Acuity every 6 months	Case conferencing required	2 Face-to-face contacts and 2 additional contacts required monthly.

Care Plans

Path to Monthly Care Plans



Care Plans

March Network Meeting Recap



Who needs a care plan?

All clients who score level 2 on the acuity assessment and are determined to be appropriate for medical case management.

What should a care plan look like?

Use newly revised Individualized Care Plans sent out after March's Network Meeting

Where do we keep the care plan?

CAREWare → Unique IDs

When do we update care plans?

Care plans should be updated on a monthly basis for all MCM clients. Updates can be completed over the phone.

Why do we use care plans?

Supportive, intensive one-on-one environment supplemented with actionable interventions leads to better health outcomes

→ **Viral load suppression**

→ **Annual retention in care**

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Care Plan Components

Need · Problem · Goal · Tasks · Time Frame · Barriers



- Unmet **Service Need** category
- **Problem** resulting from unmet Service Need
- **Goal** aimed to resolve Problem
- **Tasks & Action Steps** to achieve Goal
- **Realistic Time Frames** to complete Tasks
- **Barriers** to completion of Goal

Each component will be relative to acuity, individual needs, health literacy, social support, etc.

What is a goal for one client could be an action step for another client!

Reminder:

Three goals maximum, with one relating to VLS

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Care Plans



Need · Problem · Goal · Tasks · Time Frame · Barriers

Service Need Categories	
• Adherence	• Medication
• Clinical Screenings	• Mental Health
• Dental	• Non-Medical Case Management
• Financial	• Nutrition
• Housing	• Peer Navigator
• Legal	• Pharmacy
• Linkage (ADAP)	• Risk Reduction
• Medical	• Substance Abuse
• Medical Case Management	• Transportation

- This section identifies the overarching category of **Need** for the following **Problem**
- **Service Need** can be repeated across **Goals**
- Collaborate *with the client* to establish top Service Needs that must be addressed *within the month*

Care Plans



Need · **Problem** · Goal · Tasks · Time Frame · Barriers

- This section specifies the **Problem** that results from the unmet **Service Need**
- Identify either an environmental or behavioral problem that can be improved through **Goal** setting
 - Look to the acuity assessment!
- A few words or a short phrase is appropriate

Need	Problem (Example)
Risk Reduction	<ul style="list-style-type: none"> • Unwillingness to use condoms • Current cigarette smoker (pack a day)
Clinical Screenings	<ul style="list-style-type: none"> • No history of mammograms • Male aged 50+ (colon screening)
Nutrition	<ul style="list-style-type: none"> • SNAP benefits expired • Underweight
Pharmacy	<ul style="list-style-type: none"> • Cannot afford HIV co-pays • Out of mental health medication
Transportation	<ul style="list-style-type: none"> • Missing medical appointments

Care Plans

Need · Problem · **Goal** · Tasks · Time Frame · Barriers



SPECIFIC
MEASURABLE
ACHIEVABLE
RELEVANT
TIME-SENSITIVE

- **Goals** should specifically work to resolve the client's **Problem**
- Follow SMART goal guidelines
- Be sensitive to client's reactions during care planning and adjust goals

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Care Plans

Need · Problem · Goal · **Tasks** · **Time Frame** · Barriers



Tasks

- Break down **Goal** into achievable **Tasks & Action Steps**
- These should take into account the client's:
 - ✓ Motivation
 - ✓ Capacity

Time Frame

- **Tasks** to achieve each **Goal** should be completed within a 30-day **Time Frame**
- If a **Goal** cannot be achieved within 30 days, think about shifting it to a **Problem**

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Care Plans

Need · Problem · Goal · Tasks · Time Frame · **Barriers**



Barriers	
• Child Care	• Mental/Social Impairments
• Distance to Provider	• No Referral Source Available
• Family Support	• Other (specify in Summary of Care)
• Functional Limitations	• Physical Limitations
• Income	• Safety Issues
• Language	• Stigma
• Limited Access to Available Services	• Substance abuse
• Vision/Hearing Impairments	

- This section identifies the **Barrier** corresponding to the preceding **Goal**
- Follow up on whether **Barriers** impacted client's ability to complete tasks during Care Plan updates

Care Plans

Case Study Update



Identify:

- Service need
- Problem
- Goal
- Tasks & action steps
- Realistic time frames
- Barriers

Initial Care Plan created on 03-23-2022

Client Alexis is a college-educated, single, heterosexual black cis woman who was diagnosed with HIV (not AIDS) and herpes in 2010. She has not yet disclosed her status to her family or friends, and has not had sex in over five years. Alexis recently reached out to a RW agency because she lost her job, health insurance, and dental insurance eight months ago. Client is currently living with her elderly mother and is able to borrow her mother's car for appointments.

During intake, Alexis admitted to the case manager that she has been stretching out the last of her Biktarvy, and sometimes not taking it at all due to depression from being unemployed. Intake labs were completed on 02-14-22 and reflect HIV viral load = 229 copies/mL, CD4 = 410. Labs were reviewed by medical provider on 02-23-2022.

Client also admits to drinking a bottle of wine a day and has been isolating for a few months. She reports no issues with her appetite or oral health concerns.

Care Plan Update

Alexis has returned for her one month Care Plan Update appt on 04-27-2022. She reports that she downloaded a medication reminder app and missed five ART doses in the month, which she said was an "improvement."

Client admits in a frustrated manner that she hasn't made any progress towards her mental health goals because she "never got a call" from the MH provider. She went out with an old friend for coffee, but otherwise has remained isolated. Client recently fought with her mother and said in an emotional manner that she "needed" to move out.

Alexis reports that after the fight, she updated her resume and began looking for jobs. She says she is worried about starting a new job while she is still drinking (still one bottle of wine a day).

Care Plans

Conclusion



Questions or clarifications?

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Evaluation

Mika Mendoza

Evaluation

Mentimeter



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

Code: 3542 2192

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Provider Announcements & Updates

Meeting Attendees