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

MEETING AGENDA

COMMITTEE: Quality Management Committee
Date/Time: September 21st, 2020, 12:30 p.m.
Location: WebEx Virtual Conference Room
Chair: Vacant **Vice Chair: Bisiola Fortune-Evans**

Meeting Purpose: To use client-level demographic, clinical, and utilization data to assess quality of care, identify health disparities, and client satisfaction.

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

2. **APPROVALS**: 9/21/20 Agenda, 7/20/20 Minutes

3. **STANDARD COMMITTEE ITEMS**

   I. FY2020 CQM Workplan Review

   a. *Work Plan Activity Objective 4.1: 1. Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.*
   b. ACTION ITEM**:** Review FY2020 CQM Workplan for progress towards annual goals.

4. **UNFINISHED BUSINESS**

5. **MEETING ACTIVITIES/NEW BUSINESS**

   I. Service Delivery Model Review- Non-Medical Case Management Service Delivery Model (NMCM)

   a. *Work Plan Activity Objective 3.1: Review SDMs annually to ensure standards of care and protocols are consistent with HHS guidelines and best practice models.*

   b. ACTION ITEM: Members will review and approve the changes made to the Non-Medical Case Management Service Delivery Model.

   II. Service Delivery Model Review- Food Services Service Delivery Model

   a. *Work Plan Activity Objective 3.1: Review SDMs annually to ensure standards of care and protocols are consistent with HHS guidelines and best practice models.*

   b. ACTION ITEM: Members will review and approve proposed Food Services Service Delivery Model.

   III. Service Delivery Model Review- Mental Health Service Delivery Model

   a. *Work Plan Activity Objective 3.1: Review SDMs annually to ensure standards of care and protocols are consistent with HHS guidelines and best practice models.*

   b. ACTION ITEM: Members will review and approve Mental Health Service Delivery Model.

   IV. Service Delivery Model Review- Substance Abuse-Outpatient Service Delivery Model

   a. *Work Plan Activity Objective 3.1: Review SDMs annually to ensure standards of care and protocols are consistent with HHS guidelines and best practice models.*

b. ACTION ITEM: Members will review and approve Substance Abuse-Outpatient Service Delivery Model.

V. HIV/AIDS Bureau (HAB) Performance Measure Review

a. *Work Plan Activity Objective 1.1: Analyze and report on performance measures including client demographic and utilization data, HHS/HAB measures, and locally adopted outcomes and indicators.*

b. *Work Plan Activity Objective 4.2: Review CQM Program performance measures for efficacy and relevance and make changes as needed.*

c. ACTION ITEM: Review quarterly HAB performance measure data for FY18-20

VI. Network and Agency QIP Update

a. *Work Plan Activity Objective 3.2: Provide Network updates to the QMC and gather feedback/suggestions for Networks.*

b. ACTION ITEM: Review update regarding Networks and agency-level QIPs.

6. RECIPIENT REPORT

7. PUBLIC COMMENT

8. AGENDA ITEMS/TASKS FOR NEXT MEETING: Date: 10/19//20 Venue**:** TBD

9. ANNOUNCEMENTS

10. ADJOURNMENT

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE GUIDING PRINCIPLES OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

Clinical Quality Management (CQM) Update FY2020 Q1 & Q2

Service Delivery Models (SDM)

Reviewed and Approved by HIVPC:	Under Review by QMC/HIVPC:	In Development/Revision:
Universal (7/2020) Legal Services (7/2020) Health Insurance Continuation Program-HICP (7/2020) Oral Health Services (7/2020)	Non-Medical Case Management (9/2020) Food Services (9/2020) Mental Health (9/2020) Substance Abuse- Outpatient (9/2020)	Disease Case Management-DCM Integrated Primary Care and Behavioral Health Centralized Intake and Eligibility Determination-CIED

Networks

- **Quality Network**
  - Meeting regularly (every six weeks) since end of July
  - Completing QIPs using QI Toolkit, most agencies are on target or working with CQM support staff
- **Support Services Network**
  - Peers have been invited to this network starting in this FY
  - Met: 3/3/20, 9/3/20 (reviewed SDMs and discussed challenges to service delivery related to COVID-19)
- **Oral Health Network**
  - Met: 7/8/20 (reviewed oral health SDM)
  - Network had scheduled motivational interviewing training for April/May 2020, this was postponed due to COVID-19
- **Behavioral Health Network**
  - Met: 7/17/20 (reviewed mental health SDM)
- **Medical Network**
  - Met: 4/9/20, 9/3/20
- **DCM Network**
  - Met: 8/7/20 (reviewed DCM SDM)

Quality Improvement Projects (QIPs)

- **EMA QIP**
- **Quality Network Capacity Building-**
  - Quality Improvement Project (QIP) Toolkit has been distributed to the Network
  - This is a structured approach of guiding Broward Ryan White Part A Providers through their QI processes through the fiscal year.
- **Oral Health No-Show Project**
  - Data collection was completed in FY19
  - Final report on findings in progress

Agency QIPs	
QI Focus Area	**Number of Agencies Targeting Focus Area**
Telehealth	2
System Navigation and Linkage to Care	5
Retention in Care	1
Adherence	1
To Be Determined	2

Trainings and Events

Provider Appreciation Week

- Our goal for this event is to provide encouragement, education, and resources to Part A providers during this challenging time.
- Each day will feature a short webinar with information, updates, and tips relevant for Broward Ryan White Part A providers. Webinar sessions will be recorded for future viewing.

2020 National Ryan White Conference on Care & Treatment

- CQM Team presented at the conference, over 20 people attended the session

Broward EMA CQM Annual Work Plan FY 2020-2021- Updated 9/8/20

Goals and Objectives	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Responsible Party	Comment
Goal 1: Use client-level demographic, clinical, and utilization data to assess quality of care, identify health disparities, and client satisfaction.														
1. Analyze and report on performance measures including client demographic and utilization data, HHS/HAB measures, and locally adopted outcomes and indicators.	X			X			X			X			CQM Staff, QMC, Quality Network	
2. Review findings from the annual needs assessment, client and provider survey, and client satisfaction surveys.		X											CQM Staff, QMC, Quality Network	
3. Identify health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC Committees and Networks to address findings.													CQM Staff, QMC, Networks	
Goal 2: Implement quality improvement activities that enhance systemwide service delivery and improve client care, health outcomes, and satisfaction.														
1. Review Service Delivery Models and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.							X						CQM Staff, QMC, Networks	
2. Determine annual CQM Program goals and identify strategies to achieve goals.												X	CQM Staff, QMC	
3. Identify and conduct systemwide quality improvement activities and strategies.													CQM Staff, QMC	
4. Ensure the development, implementation, and evaluation of at least one quality improvement project per agency during the fiscal year.	X			X			X			X			CQM Staff, Quality Network	
5. Organize and conduct evidence-based trainings for providers and the QMC to expand knowledge on health disparities, HIV treatment and care, and quality improvement strategies.	X			X			X			X			CQM Staff	
6. Provide technical assistance to providers as needed.													CQM Staff	
Goal 3: Communicate CQM Program updates, data, and activities to the QMC, Networks, and community stakeholders.														
1. Disseminate Ryan White Part A Program data and activities to the HIVPC and Committees, providers, and community stakeholders.	X			X			X			X			CQM Staff	
2. Provide Network updates to the QMC and gather feedback/suggestions for Networks.	X			X			X			X			CQM Staff	
3. Publish the annual CQM Program Report.		X											CQM Staff	
4. Provide routine CQM Program updates to the HIVPC.	X			X			X			X			CQM Staff	
5. Hold an annual Networks Retreat and celebrate accomplishments.												X	CQM Staff	9/8/20- To be met with Virtual Provider Appreiciation Week
Goal 4: Routinely evaluate the CQM Program and identify areas for improvement.														
1. Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.												X	CQM Staff, QMC	
2. Review CQM Program performance measures for efficacy and relevance and make changes as needed.												X	CQM Staff, QMC, Networks	
3. Conduct surveys of all meetings and make suggested improvements.	X	X	X	X	X							X	CQM Staff	9/8/20- While network meetings are held virtually, evaluation will take place annually
4. Review agency-specific quality management plans to ensure compliance with HRSA CQM Program guidelines.					X								CQM Staff	
5. Survey efficacy of CQM Program communication methods.												X	CQM Staff	

X = goal for objective completion

= in progress

= completed

= planned

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	9/21/2020
Service Delivery Model	Non-Medical Case Management
Status	Update

Background/summary of service delivery model:

Case Management services support client achievement of wellness and autonomy by facilitating social service needs of clients. Case Management is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing client's medical and social needs 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 goals of this intervention are optimal retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

The intended outcomes of HIV/AIDS case management for persons living with HIV/AIDS include:

- Maintenance of comprehensive health care and social services.
- Improved integration of services provided across a variety of settings.
- Enhanced continuity of care.
- Prevention of disease transmission and delay of HIV progression.
- Increased knowledge of HIV disease.
- Greater participation in and optimal use of the health and social service system.
- Reinforcement of positive health behaviors.
- Personal empowerment.
- An improved quality of life.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision

- ☐ Approved
- ☐ Denied

Chair/ V. Chair Signature:

_X_____

Date: _____

Reason(s) for denial:

HIV Planning Council:

Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Chair/ V. Chair Signature: X _____ Date: _____	Reason(s) for denial:

BROWARD COUNTY RYAN WHITE PART A PROGRAM

Non-Medical Case Management Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Local Definition

NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs 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 goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

II. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Peer Counseling

Peer counseling is a required component of NMCM services. Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Management Information System (MIS).
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV MIS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's barriers to primary medical care, medication adherence, and service needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV MIS and include, at minimum, the following components:

- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Support service needs, including financial, support groups, legal assistance, food bank, vocational, and transportation
- Risk assessment, including knowledge of HIV and STD testing, prevention, and treatment
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

Relevant Areas of Concern

Following the completion of the assessment or reassessment, the designated HIV MIS generates a list of the clients "Relevant Areas of Concern." Providers must utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan
Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals. The action plan must be documented in the designated HIV MIS and contain, at minimum, the following components:

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)
    - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
    - Specified interventions to achieve the goal statement
    - Date goals are established
    - Target date for goal completion

Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress, assistance provided, and communication with clients in the designated HIV MIS, including phone calls, mail, face-to-face, and electronic communication. Checking lab reports (trending viral load and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. On a monthly basis, Case Management supervisors must review a sample of open client action plans to identify opportunities for improvement. All completed action plans must be reviewed, signed, and dated by Case Management supervisors.

Action Plan Review
An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV MIS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV MIS.

Standard	Measure
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV MIS.
4. Case Management supervisors review a sample of open client action plans each month to identify opportunities for improvement.	4.1. Open action plans in the designated HIV MIS. 4.2. Documentation of monthly reviews and identified opportunities for improvement.
5. Completed action plans are reviewed by Case Management supervisors.	5.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV MIS.
6. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV MIS.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	9/21/2020
Service Delivery Model	Food Services
Status	Update

Background/summary of service delivery model:

Food Services are provided to clients requiring supplemental nutrition. Food Services must be provided in consultation with a nutritionist or other health professional and must include a nutritional assessment and plan. The plan identifies dietary factors that impact Client health and is individualized and tailored to each client's needs. Food Services provide a nutritious and well-balanced food supplement to a client's nutritional intake and offer the Client choice in selecting menu options that support Client health needs (e.g.: nutritional deficiencies, metabolic conditions).

The provision of food services may be in the form of a food bank or food vouchers. A Food Bank is a central distribution center that warehouses and provides nutritious groceries for clients. Food Vouchers must be in the form of a certificate/gift card for a grocery store, allowing clients to purchase nutritious food. Alcohol and tobacco products cannot be purchased with vouchers. The provider must ensure that most of the food purchased by a client with a voucher is of nutritional value.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

This service confronts food and nutrition insecurities and barriers to food access. Poor nutritional status can affect immune function independent of HIV infection. Food security is important in maintaining the physical health of people with HIV. Additionally, access to food and nutritional sources are likely to support ARV medication adherence.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Chair/ V. Chair Signature: X _____ Date: _____	Reason(s) for denial:

HIV Planning Council:

Service Delivery Model Request for Approval Decision ☐ Approved	Reason(s) for denial:

☐ Denied Chair/ V. Chair Signature: X _____ Date: _____	

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Food Services
Service Delivery Model

Broward County Florida
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Food bank/home delivered meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Local Definition

Food Services are provided to clients requiring supplemental nutrition. Food Services must be provided in consultation with a nutritionist or other health professional and must include a nutritional assessment and plan. The plan identifies dietary factors that impact client health and is individualized and tailored to each client's needs. Food Services provide a nutritious and well-balanced food supplement to a client's nutritional intake and offer the client choice in selecting menu options that support health needs (e.g. nutritional deficiencies, metabolic conditions).

The provision of food services may be in the form of food bank or food vouchers. **Food Bank** services are provided at a central distribution center that warehouses and provides nutritious groceries for clients. **Food Voucher** services are provided in the form of a certificate/gift card for a grocery store, allowing clients to purchase nutritious food. Clients receiving food vouchers must be able to shop for and prepare their meals. Alcohol and tobacco products cannot be purchased with food vouchers.

II. Key Service Components and Activities

In addition to the Food Services Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Food Services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category, including state and local health codes. Additionally, providers must provide services in accordance with the USDA Dietary Guidelines and standards of Dietitians in AIDS Care and the American Dietetic Association.

Provision of Food Bank Services

Providers of Food Bank services must maintain a list of available foods for clients to select their weekly food provisions and document the foods selected by the client at each distribution. Menu and food choice development must occur under the direction of a Registered Dietician to ensure food packages contain a variety of nutritious foods, align with the nutritional needs of the client, and are culturally/ethnically appropriate, when possible. Providers must ensure that the client's

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

food selections are in the food pick-up/delivery package. Clients must confirm receipt of all food distributions as evidenced by the client signature and date of pick up.

Provision of Food Voucher Services

Providers of Food Voucher services must develop and implement policies and procedures for receiving, distributing, and tracking the food voucher inventory. Policies and procedures must ensure that no prohibited items are purchased, purchases support the client's nutritional needs, and no cash is exchanged between the vendor and the client. Food vouchers must clearly state that the use of food vouchers to purchase alcohol, tobacco, lottery, and non-food products is prohibited. Providers must document client acceptance and understanding of the Food Voucher Policy, as evidenced by client signature, in the designated HIV Management Information System (MIS).

Food vouchers must be tracked using a voucher identification number. Clients must return receipts showing purchases made with the numbered food voucher distributed to them. Providers must confirm the purchases made meet food voucher guidelines before another voucher is issued. The provider must implement a corrective action for clients who purchase ineligible items. Corrective actions may include warnings and suspension from the Food Voucher Program. Providers must document food vouchers distributed to each client by identification number and returned receipts in the designated HIV MIS.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients are retained in primary medical care.	1.1.1. Client appointment record in designated HIV MIS.
2. Increased viral suppression.	2.1. 80% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	2.1.1. Client viral load test result in designated HIV MIS. 2.1.2. Client prescription of ART documented in designated HIV MIS.

IV. Assessment

Nutritional Assessment

Clients receiving Food Services must complete a nutritional assessment within 60 days of initial encounter with the provider, and annually thereafter. The nutritional assessment must be completed by or under the supervision of a Registered Dietitian, be signed by the provider and client, and documented in the designated HIV MIS. The nutritional assessment must include, at minimum:

- Type of food or meal services being requested, i.e., grocery/pantry bags or food vouchers
- Medical issues that require a therapeutic or modified diet due to diabetes, renal (kidney) disease, high blood pressure, food allergies or intolerances, metabolic complications, and other medical conditions that impacts nutritional need
- Current weight and history of significant weight loss or gain in the past six months

- List of current medications (HIV-related and other, including vitamins and minerals, and herbal and complementary/alternative therapies)
- Daily physical activity level
- Interest in or need for nutritional education
- Access to adequate and safe food storage and meal preparation

V. Standards for Service Delivery

Table 2. Food Services Standards for Service Delivery

Standard	Measure
1. Clients complete a nutritional assessment, by or under the supervision of a Registered Dietitian, within 60 days of initial encounter, and annually thereafter.	1.1. Nutritional assessment signed and dated by the provider and client in the designated HIV MIS.
2. Foods selected by clients align with the needs identified in the nutritional assessment and are culturally/ethnically appropriate, when possible.	2.1. Receipt of food distribution with client signature and date in the designated HIV MIS. 2.2. Nutritional assessment signed and dated by the provider and client in the designated HIV MIS.
3. Clients confirm receipt of all food distributions as evidenced by the client signature and date of pick up.	3.1. Receipt of food distribution with client signature and date in the designated HIV MIS.
4. Clients receive nutritional education by or under the supervision of a Registered Dietitian when needed.	4.1. Documentation of need for nutritional education and education provided in the designated HIV MIS. 4.2. Referral documented in the designated HIV MIS if the need for Medical Nutrition Therapy is identified.
5. Clients demonstrate acceptance and understanding of the Food Voucher Policy prior to receiving Food Voucher services.	5.1. Food Voucher Policy signed and dated by the client in the designated HIV MIS.
6. Clients utilize food vouchers to purchase foods that support the client's nutritional needs.	6.1. Receipt showing purchases made with the numbered food voucher in the designated HIV MIS.
7. Providers confirm purchases made with food vouchers meet set guidelines before another voucher is issued.	7.1. Receipt showing purchases made with the numbered food voucher in the designated HIV MIS.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	9/21/2020
Service Delivery Model	Mental Health
Status	Update

Background/summary of service delivery model:

Mental health services are provided to clients requiring outpatient mental health care. Mental health care services provided under this service category are provided in a trauma-informed manner. This service delivery model was updated to align with Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, and applicable state statutes.

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

Mental health concerns are commonly reported among people with HIV and may act as a barrier to linkage, engagement, retention, and viral suppression. Mental health services may help clients remain engaged in care and achieve positive mental health and HIV outcomes.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Chair/ V. Chair Signature: X _____ Date: _____	Reason(s) for denial:

HIV Planning Council:

Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied	Reason(s) for denial:

Chair/ V. Chair Signature: X _____ Date: _____	

BROWARD COUNTY
RYAN WHITE PART A PROGRAM
Mental Health
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Mental Health Services (MHS) are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such mental health professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Local Definition

MHS are psychotherapeutic 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 of Florida to render such services. These services are grounded in an understanding of and responsiveness to the impact of trauma; emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for clients to rebuild a sense of control and empowerment.

II. Key Service Components and Activities

In addition to the Mental Health Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook,[3] individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of MHS are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Trauma-Informed Approach to Service Delivery

MHS must be rendered with a trauma-informed approach, acknowledging that traumas may have occurred or be active in clients' lives and can manifest physically, mentally, and/or behaviorally. Trauma-informed services are grounded in an understanding of and responsiveness to the impact of trauma; emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for clients to rebuild a sense of control and empowerment. Providers must focus on prevention strategies that avoid re-traumatization in treatment, promote resilience, and prevent the development of trauma-related disorders.

---

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02.* Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

[2] FLA. STAT. § 394.

[3] Agency for Health Care Administration. *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.* 2014.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary mental health diagnosis.	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in the designated HIV Management Information System (MIS).
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HIV MIS.

IV. Assessment and Treatment Plan

Assessment[3]

During the first encounter with a client, the provider must establish a provisional diagnosis and treatment plan goal. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HIV MIS within three counseling sessions and reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[4]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Treatment Plan[3]

Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client.

Treatment plans must contain, at minimum, the following components:

[4] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identify the client's readiness to transition to a new level of care or out of care)

Treatment Plan Review[3]

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed professional and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed professional who participated in the review of the plan
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Mental Health Standards for Service Delivery

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within three counseling sessions.	2.1. Completed biopsychosocial assessment signed by licensed professional in the designated HIV MIS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed professional and client in the designated HIV MIS.
4. Provider conducts a formal treatment plan review at least every six months.	4.1. Updated treatment plan with signature and date of licensed professional and client in the designated HIV MIS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the designated HIV MIS.
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the client file.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HIV MIS.

Fort Lauderdale/Broward County EMA

Service Delivery Model Request for Approval Form

Date	9/21/2020
Service Delivery Model	Substance Abuse
Status	Update

Background/summary of service delivery model:

Substance Abuse – Outpatient services are medical or other treatment and/or counseling services provided to clients to address substance use disorders (SUDs) (i.e. recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or impairment in physical, social or occupational functioning).

How this service delivery model addresses identifying, engaging, and retaining clients in care and ensures all steps of the HIV Care Continuum are met:

Substance use and abuse are common among HIV positive individuals, with nearly 50% of persons living with HIV/AIDS reporting current or past histories of drug or alcohol disorders. Substance use is associated with key health behaviors and outcomes including non-adherence, immunosuppression, increased sexual risk behaviors, and increased burdens on health care systems. In general, HIV seropositive drug users have higher age matched morbidity and mortality when compared to non-drug using HIV seropositive cohorts. Substance abuse treatment programs allow a platform for care providers to openly address not only substance abuse but also adherence to ARV treatment.

THIS SECTION IS INTENDED FOR STAFF USE ONLY.

Quality Management Committee

Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied Chair/ V. Chair Signature: X_____ Date: _____	Reason(s) for denial:

HIV Planning Council:

Service Delivery Model Request for Approval Decision ☐ Approved ☐ Denied	Reason(s) for denial:

Chair/ V. Chair Signature: X _____ Date: _____	

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Substance Abuse – Outpatient
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care include screening, assessment, diagnosis, and/or treatment of substance use disorder, including:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Outpatient drug-free treatment and counseling
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Local Definition

Substance Abuse – Outpatient services are medical or other treatment and/or counseling services provided to clients to address substance use disorders (SUDs) (i.e. recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or impairment in physical, social or occupational functioning). These services will be provided by appropriately credentialed and/or licensed treatment professionals. Substance Abuse – Outpatient services include psychological assessment and evaluation, drug testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments, outpatient day treatment, intensive day/night treatment, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate to improve adherence to treatment and improve client health outcomes.

II. Key Service Components & Activities

In addition to the Substance Abuse – Outpatient Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook [3], individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Substance Abuse – Outpatient services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

---

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

[2] FLA. STAT. § 394.

[3] Agency for Health Care Administration. *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.* 2014.

Outpatient Care
Outpatient substance abuse care treats ameliorate negative symptoms from SUDs and restores effective functioning in persons diagnosed with substance-use dependency or addiction. Outpatient care is appropriate as an initial level of care for clients with less severe disorders, in early stages of change (as a "step down" from intensive outpatient substance abuse services), or stable and ongoing monitoring or disease management. Outpatient care is provided less than nine hours weekly.

Intensive Outpatient Services
Intensive outpatient services provide essential addiction education and treatment to clients with SUDs and have gradations of intensity. Intensive outpatient services are a step down from substance abuse day treatment. At a minimum, intensive outpatient services provide a support system including medical, psychologic, psychiatric, laboratory, and toxicology services.

Day Treatment
Day treatment services are the highest intensity of treatment for substance use disorders that are directly provided in the Broward County Ryan White EMA. Day treatment is appropriate for clients who are living with unstable medical and psychiatric conditions. Day treatment, at a minimum, meets the same treatment goals as described in *Intensive Outpatient Services*, with psychiatric and other medical consultation services available more expediently and longer in duration.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in designated HIV Management Information System (MIS).
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HIV MIS.

IV. Assessment and Treatment Plan

Assessment[3]
Providers will schedule first appointment for client within 3 business days of initial contact. During the first encounter with a client, the provider must establish a provisional diagnosis and treatment plan goal. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HIV MIS within three counseling sessions and reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems

- Primary care post-traumatic stress disorder (PC-PTSD) screening[4]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Treatment Plan[3]

Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client. Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)

Treatment Plan Review[3]

For clients utilizing outpatient treatment for substance use disorders, a formal review of the treatment plan must be conducted every six months, at a minimum. For clients utilizing intensive outpatient services or day treatment, a formal review of the treatment plan must be conducted every three months, at a minimum.

[4] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

Treatment plans may be reviewed more frequently when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed practitioner and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Substance Abuse – Outpatient Service Delivery Standards

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within three counseling sessions.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HIV MIS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed practitioner and client in the designated HIV MIS.
4. Provider conducts a formal treatment plan review at least every three months (intensive outpatient treatment, or day treatment) or at least every six months (outpatient)	4.1. Updated treatment plan with signature and date of licensed practitioner and client in the designated HIV MIS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the designated HIV MIS.

Standard	Measure
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the designated HIV MIS.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HIV MIS.

HAB Measure Review

QUALITY MANAGEMENT COMMITTEE (QMC)
9/21/20
PREPARED BY CQM SUPPORT STAFF

1

Workplan

- Objective 1.1- Analyze and report on performance measures including client demographic and utilization data, HHS/HAB measures, and locally adopted outcomes and indicators.
- Objective 4.2- Review CQM Program performance measures for efficacy and relevance and make changes as needed.

2

HIV/AIDS Performance Measures

- Focuses on critical areas of HIV care and treatment
- Aligns with milestones along the HIV care continuum
- Consistent with US Preventative Services Taskforce (USPSTF), US Health and Human Services Guidelines

3

U.S. Department of Health & Human Services Guidelines for Screening

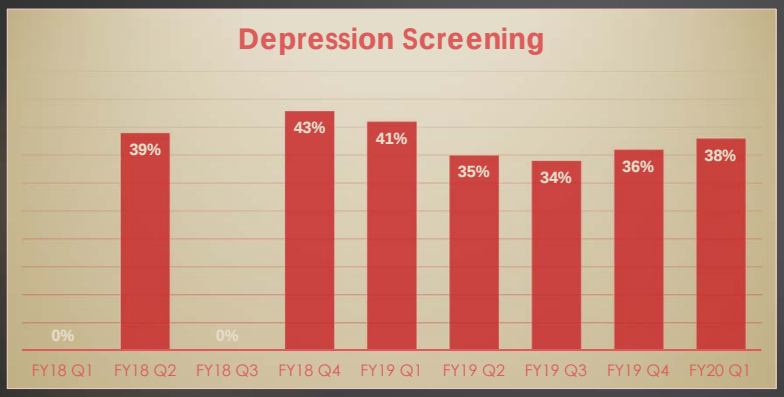
"Patients living with HIV infection often must cope with many social, psychiatric, and medical issues that are best addressed through a patient-centered, multi-disciplinary approach to the disease.

The baseline evaluation should include an evaluation of the patient's readiness for ART, including an assessment of high-risk behaviors, substance abuse, social support, mental illness, comorbidities, economic factors (e.g., unstable housing), medical insurance status and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission. Once evaluated, these factors should be managed accordingly."

https://aidsinfo.nih.gov/

4

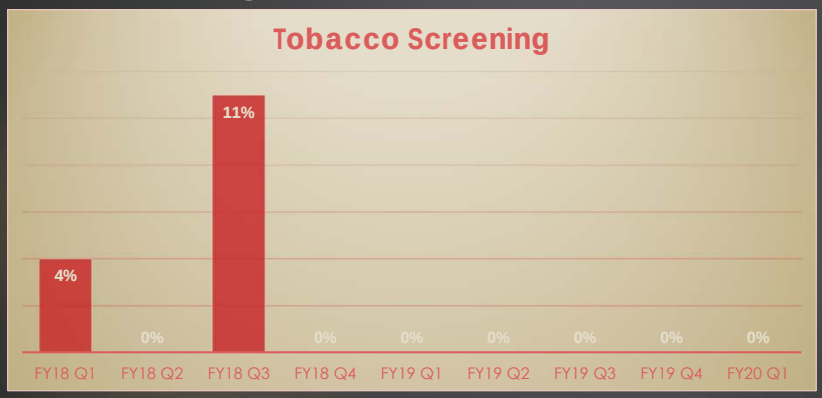
Performance Measure: Preventive Care and Screening for Clinical Depression and Follow- Up Plan



- Percentage of patients aged 12 years and older **screened for clinical depression** on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, **a follow-up plan** is documented on the date of the positive screen
- IPCBH SDM standard

5

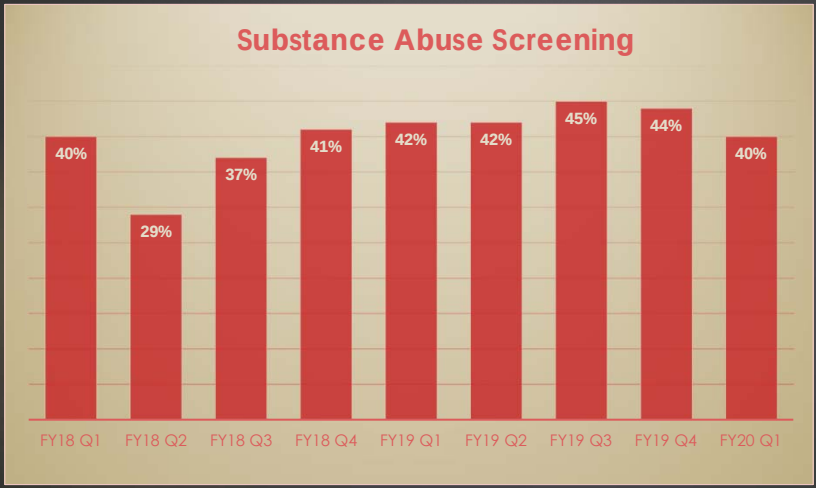
Performance Measure: Preventive Care and Screening Tobacco Use Smoking Cessation Intervention



- Percentage of patients aged 18 years and older who were **screened for tobacco use** one or more times within 24 months AND who **received cessation counseling** intervention if identified as a tobacco user
- USPSTF recommendation (Grade A)

6

Performance Measure: Substance Abuse Screening



- Percentage of new patients1 with a diagnosis of HIV who have **been screened for substance use** (alcohol & drugs) in the measurement year

7

Vaccinations

Table 2.
2020 ACIP Recommended Immunizations for Adults with HIV[1]

Vaccines	Abbreviations	CD4 count <200 cells/mm³	CD4 count ≥200 cells/mm³
Haemophilus influenza type b	Hib	Recommended with an additional risk factor or other indication 1 dose	
Hepatitis A	HepA	**Recommended** 2 or 3 doses depending on vaccine	
Hepatitis B	HepB	**Recommended** 2 or 3 doses depending on vaccine	
Human papillomavirus, female Human papillomavirus, male	9vHPV	**Recommended** 3 doses through age 26 years (0, 1-2, and 6 months)	
Influenza inactivated, or Influenza recombinant	IIV RIV	**Recommended** 1 dose annually	
Influenza live, attenuated	LAIV	**NOT RECOMMENDED**	
Measles-mumps-rubella	MMR	**NOT RECOMMENDED**	[5]**Recommended** 2 doses (at least 4 weeks apart)
Meningococcal serogroups A, C, W, Y	MenACWY-D MenACWY-CRM	**Recommended** 2 doses (at least 8 weeks apart), then revaccinate every 5 years	
Meningococcal serogroup B	MenB-4C MenB-FHbp	Recommended with an additional risk factor or other indication 2 or 3 doses	
Pneumococcal 13-valent conjugate	PCV13	**Recommended*** 1 dose	
Pneumococcal 23-valent polysaccharide	PPSV23	**Recommended*** 2 doses before age 65 years and 1 dose after age 65 years	
Tetanus-diphtheria-acellular pertussis Tetanus-diphtheria	Tdap Td	**Recommended** 1 dose Tdap then Td or Tdap booster every 10 years	
Varicella	VAR	**NOT RECOMMENDED**	**Recommended** 2 doses (3 months apart)
Zoster, recombinant (preferred)	RZV	**No recommendation/Not applicable** 2 doses at age 50 and older (2-6 months apart)	
Zoster, live	ZVL	**NOT RECOMMENDED**	**No recommendation/Not applicable** 1 dose at 60 and older

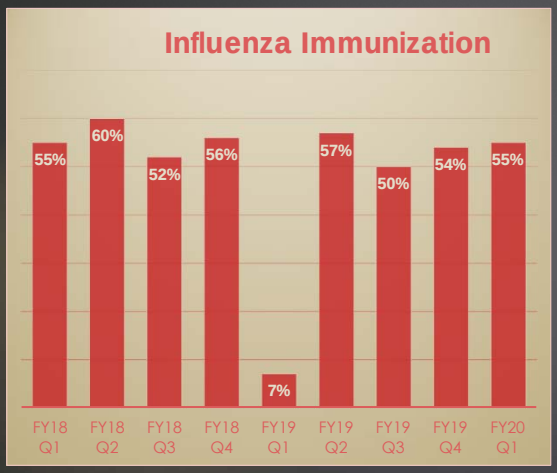
- This table is based on the 2020 ACIP Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States.

Source Link

- https://www.hiv.uw.edu/go/basic-primary-care/immunizations/core-concept/all#background

8

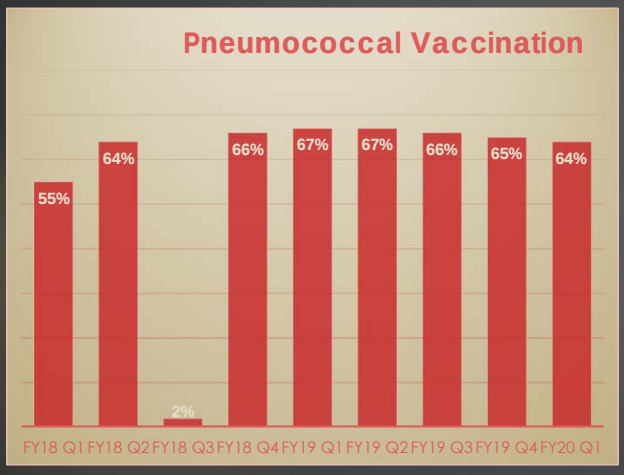
Performance Measure: Influenza Immunization



- Percentage of patients age 6 months and older seen for a visit between **October 1st and March 31st** who **received an influenza immunization** OR who reported previous receipt of an influenza immunization
- Routine annual influenza vaccination of all persons aged ≥6 months without contraindications continues to be recommended.

9

Performance Measure: Pneumococcal Vaccination



- Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine
- Recommended for all, regardless of age and CD4 count
- CDC recommends for all adults 65 years or older, people less than 64 years old with HIV, and adults 19 through 64 years old who smoke cigarettes
- https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/57/hiv-and-immunizations

10

Summary and Next Steps

- Screenings
  - Depression- decreasing
  - Tobacco Cessation- very low
  - Substance Abuse- decreasing
- Vaccinations
  - Influenza- increasing
  - Pneumococcal- decreasing slightly

- Depression screening (PHQ-9) is being built into PE

11

Questions and Data Source

- Data Source: PE HAB HIV Performance Measures Report

12