Ryan White Title I Service Delivery Policies Fiscal Year 2006-07 (Year 16)

Miami-Dade County
Office of Strategic Business Management

Effective March 1, 2006

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RYAN WHITE TITLE I PROGRAM SERVICE DELIVERY GUIDELINES
FY 2006-07 (YEAR 16)

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Ryan White Title I
Service Delivery Policies
Fiscal Year 2006-07
(Year 16)

Section I –
Service Definitions

Miami-Dade County
Office of Strategic Business Management

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I. GENERAL REQUIREMENTS – All Service Categories

A. Service Delivery Standards: All providers will adhere to the *Ryan White Title I System-wide Standards of Care* and other applicable standards and guidelines that are relevant to individual service categories (i.e., Coordinated Case Management Standards, Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, etc.) (Please refer to Section III of this booklet for details.)

B. Client Eligibility Criteria: Providers must document that clients who receive Title I funded services have a Title I Certified Referral or have documentation on file that the client:

- Is HIV positive
- Has a documented household income that does not exceed 300% of the Federal Poverty Level
- Is a permanent resident of Miami-Dade County
- Is documented as having been properly screened for Medicaid, Medically Needy, Medicaid Waiver, Medicare, and other public sector funding as appropriate. While clients qualify for and can access Medicaid, Medicaid Waiver, Medicare, or other public funding for services, they will not be eligible for Ryan White Title I funding, except for those service, tests, and/or procedures, etc. not covered by the other funding sources.

PLEASE NOTE: Some service categories (i.e., day care, home health care, home – delivered meals, utility assistance, legal assistance, transportation services, etc.) may have more restrictive client eligibility criteria. Carefully review the service category descriptions for additional information.

C. Performance Improvement and Outcome Measures: All providers will develop internal performance improvement programs and collaborate with the Miami-Dade County Title I Quality Management Program. Providers will be evaluated against the outcome measures contained in the Performance Improvement Plan (PIP) and its addenda. They will be responsible for collecting and reporting on specific data to measure performance, as detailed in the PIP.

Outpatient medical care, case management, dental care, substance abuse counseling, and mental health therapy/counseling providers must participate in external quality assurance reviews, utilizing individual standardized tools as developed by the Miami-Dade HIV/AIDS Partnership.

D. Reporting: Providers must report monthly activity according to the recorded number of client visits, dates of services, type of procedures (if applicable) and units of service provided, and unduplicated number of clients served.

II. MINORITY AIDS INITIATIVE (MAI) REQUIREMENTS – The following requirements will apply to the following services if funded with MAI resources: Outpatient Medical Care, Prescription Drugs, Case Management, Substance Abuse Counseling, and Outreach Services.

Funding available under the MAI for outpatient medical care (primary and specialty care), prescription drugs, case management, substance abuse (residential), and outreach services are identical to standard Title I funded services, except that MAI services provide culturally sensitive services that target minority communities exclusively.

Title I MAI funds are designated to reduce the HIV-related health disparities and improve the health outcomes for HIV+ minorities such as Black/African-Americans (including Haitians), Hispanics, Native Americans, etc. The over-arching purpose of the MAI Initiative is to achieve 100% access to quality care and 0% disparity in health outcomes.

Special consideration will be given to providers who qualify as "Minority Community Based Organizations" by:

1) Having more than 50% of positions on the executive board or governing body filled by persons of the racial/ethnic minority group(s) to be served **AND**

2) Having more than 50% of key management, supervisory, and administrative positions (e.g., executive director, program director, fiscal director) and more than 50% of key service provision positions (e.g., outreach worker, case manager, counselor, group facilitator) filled by persons of the racial/ethnic population(s) to be served.

In addition, per Federal requirements, organizations funded to provide MAI services **MUST** meet the following criteria:

1) Are located in or near to the targeted community they are intending to serve;

2) Have a documented history of providing services to the targeted community(ies);

3) Have documented linkages to the targeted populations, so that they can help close the gap in access to service for highly impacted communities of color; and

4) Provide services in a manner that is culturally and linguistically appropriate.

Providers must clearly specify the target population(s) to be served [i.e., Black/African-American (including Haitians), Hispanic, Native Americans, etc.]. If more than one racial/ethnic group is targeted, the percentage that each group will represent of the total number of clients to be served must be identified.

OUTPATIENT MEDICAL CARE (General HIV/AIDS Population & MAI)
(Year 16 Service Priority #1)

This service category includes **Primary Medical Care** and **Outpatient Specialty Care** required for the treatment of individuals who have HIV/AIDS. It focuses on timely/early medical intervention and continuous health care and disease treatment over time, as patient conditions progress.

I. Primary Care

1. Primary Medical Care **Definition and Functions:** Primary medical care includes general management of acute and chronic medical conditions and/or prevention of such conditions through initial visit and intake, complete history and physical examination, lab tests necessary for evaluation and treatment, immunizations, follow-up visits, health maintenance, and referrals to medical specialists as necessary.

If the client is eligible for ADAP, that program must be accessed first for genotype testing. Genotype and phenotype lab tests may be paid for under Ryan White Title I only when no other funding source is available to cover the expense. If a genotype and/or phenotype lab test is needed, the following document(s) will be required:

A Title I Letter of Medical Necessity, completed by a physician, for Antiretroviral HIV Genotype Resistance Assays: Treatment Intent Study or for Antiretroviral HIV Genotype Resistance Assays: Antiretroviral Failure or for Antiretroviral Phenotype Resistance Assays for Experienced Patients

2. Patient Education: Providers of primary care services are expected to provide the following basic education as part of patient care:

- Treatment options, with benefits and risks, including information about state of the art combination drug therapies and reasons for treatment
- Self-care and monitoring of health status
- HIV/AIDS transmission and prevention methods
- Significance of CD4 counts, viral load and related disease aspects, adherence and resistance concepts

3. Adherence Education: Medical care providers are responsible for assisting clients with adherence in the following ways:

- Adherence with medication regimens in order to reduce the risk of developing and spreading a resistant virus and to maintain health

- Taking medications as prescribed and following recommendations by physicians, nutritionists, and pharmacists

- Client involvement in the development and monitoring of treatment and adherence plans

- Ensuring immediate follow-up with clients who miss their prescription refills and/or who experience difficulties with adherence

4. Coordination of care: Providers are responsible for ensuring continuity and coordination of care. They must:

- Maintain contact as appropriate with other caregivers (case manager, nutritionist, home health care nurse, specialty care physician, pharmacist, counselor, etc.) and with the client in order to monitor health care and adherence

- Ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives

- Identify a single point of contact for case managers and other agencies who have a client's signed consent and other required information

5. Additional primary care services may include:

- Respiratory therapy needed as a result of HIV infection

- Consumable medical supplies that are not available through home health care or prescription drugs and that have been prescribed or ordered by the patient's primary care physician. Providers must submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Providers may submit a supplemental list for items that are not identified by Medicare first, or by Medicaid second.

II. Outpatient Specialty Care

1. Specialty Care Definition and Functions: This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for HIV+ clients who are referred by a primary care provider. Specialty medical care includes outpatient rehabilitation, dermatology, oncology, optometry, ophthalmology, obstetrics and gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, occupational therapy, speech therapy, respiratory therapy, developmental assessment, psychiatry, and other specialties as needed.

Note: primary care provided to persons with HIV disease is not considered specialty care.

2. Patient Education: Providers of specialty care services will be expected to provide the following basic education as part of patient care:

- Basic education to clients on various treatment options offered by the specialist
- Taking medications pertaining to specialty care treatment as well as adhering to treatment recommendations made by the primary care physician
- Educating clients about HIV/AIDS and its relationship to the specialty care service being provided

3. Coordination of Care: The specialist must communicate, as appropriate, with the primary care physician and client for results, follow up, and/or to re-evaluate the client in order to coordinate treatment.

4. Additional specialty care may include:

- Consumable medical supplies that are not available through home health care or prescription drugs and that have been prescribed or ordered by the patient's specialist. Providers must also submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Providers may submit a supplemental list for items that are not identified by Medicare first, or by Medicaid second.

B. Program Operation Requirements (for both Primary and Specialty Care):

- Providers must offer and post walk-in hours to ensure maximum accessibility to outpatient medical care
- Providers must demonstrate a history and ability to serve Medicaid eligible clients
- Providers must ensure that medical care professionals have a minimum of three (3) years of experience treating HIV patients or have served a high volume of HIV patients in the past year

Additionally, for outpatient specialty care only:

- A referral from the client's primary care physician is required for all specialty care services.

C. Additional Service Delivery Standards: Providers of these services will also adhere to the following guidelines and standards:

- Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses

- Minimum Primary Medical Care Standards for Chart Review (please refer to Section III of this booklet for details)

D. Rules for Reimbursement: Providers will be reimbursed for outpatient primary care and specialty care services as follows:

- Reimbursements for medical procedures and follow-up contacts to ensure clients' adherence to prescribed treatment plans will be no higher than the rates found in the 2006 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule (Participating, Locality 04), dated November 18, 2005.

- Evaluation and management visits and psychiatric visits will be reimbursed at rates no higher than the Medicare "allowable" rates times a multiplier of up to 1.5.

- Reimbursements for lab tests and related procedures will be based on rates no higher than those found in the 2006 Medicare Clinical Diagnostic Laboratory Fee Schedule, dated November 16, 2005. If the client is eligible for ADAP, that program should be accessed for genotype and phenotype testing. A letter of medical necessity is required for Ryan White Title I payment for these tests.

- Reimbursements for injectables will be based on rates no higher than those found in the January 2006 Payment Allowance Limits for Medicare Part B Drugs fee schedule, January 2006 Average Sales Price (ASP) pricing file, dated January 1, 2006.

- Reimbursement for consumable medical supplies will be based on rates no higher than those found in the Florida Medicare Durable Medical Equipment [and] Supplies 2006 Fee Schedule, revised November 16, 2005. In the absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates no higher than those found in the most current Florida Medicaid's Durable Medical Equipment for All Medicaid Recipients, as of March 1, 2006.

- No multiplier will be applied to reimbursement rates for laboratory tests and related procedures, for non-evaluation and management procedures, for injectables, or for consumable medical supplies.

Additional rules for reimbursement:

- Medical procedures and consumable medical supplies excluded from the Medicare (or Medicaid, for consumable supplies) Fee Schedules may be provided on a supplementary schedule. A flat rate along with a detailed cost justification for each supplemental procedure must be included in the provider's submission to the County.

- Ryan White Title I will not reimburse providers for TB or follow-up treatment if the client is eligible to receive these services from any other funding source.

E. **Additional Rules for Reporting:** Provider monthly reports for consumable medical supplies must include the number of patients served, medical supply distributions per patient, and dollar amounts per patient.

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PRESCRIPTION DRUGS (General HIV/AIDS Population & MAI)
(Year 16 Service Priority #2)

This service includes the provision of medications and related supplies prescribed or ordered by a physician to prolong life, improve health, or prevent deterioration of health for HIV+ persons who do not have prescription drug coverage and who are ineligible for Medicaid, ADAP, or other public sector funding.

1. Medications Provided: This service pays for injectable and non-injectable Prescription Drugs, pediatric formulations, and non-prescription nutritional supplements, appetite stimulants, and/or related supplies. Medications are provided in accordance with the Title I Formulary and also include assistance for the acquisition of non-Medicaid or ADAP reimbursable drugs, as well as the purchase of consumable medical supplies that are required to administer prescribed medications.

2. Patient Education and Adherence:

- Providers are expected to educate clients on the importance of adhering to their medication regimen with the objectives of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client.

- Providers are expected to offer basic education to clients on various treatment options, including information about state of the art combination drug therapies.

- Clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by physicians, nutritionists, and pharmacists regarding medication management.

3. Coordination of Care:

- Providers must maintain appropriate contact with other caregivers (i.e., the client's case manager, physician, nutritionist, home health care nurse, counselor, etc.) and with the client in order to monitor that he/she adheres to his/her medication schedule and ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives.

- Providers will be expected to immediately inform case managers when clients are not adhering to their medication regimen (i.e., the client misses prescription refills or is having any other difficulties with adherence).

- Providers are expected to ensure immediate follow-up with clients who miss their prescription refills and/or who experience difficulties with adherence.

B. Program Operation Requirements:

- Providers are required to provide county-wide delivery
- Providers must specify provisions for home delivery of medications and related supplies and equipment for eligible Title I clients who require this service
- Provision of this service may not be limited to an agency's own clients
- The service provider must be linked to an existing case management system through agreements with multiple case management providers
- A Title I Certified Referral Form for Prescription Drug Services must be completed by a case manager and must be attached to the prescription presented by the client or a designee. The Certified Referral Form must include a client ID number traceable to the case management agency initiating the referral and a client CIS number assigned by the Title I Service Delivery Information System. The referring case management agency is responsible for collecting and reporting all required client eligibility documentation, release of information, consent for services, and demographic information.
- Providers will be contractually required to enter into formal referral agreements that will detail responsibilities of both parties and penalties for not complying with the referral agreement.
- **Miami-Dade County Public Health Medications (State of Florida AIDS Drug Assistance Program - ADAP):** Ryan White Title I funds may not be used to purchase medications available free of charge from the Miami-Dade County Health Department to clients who qualify for and can access this service.
- **Ryan White Title I funds** may not be used to pay for the delivery of medications or consumable medical supplies unless one of the following conditions is met by the client and is documented by the client's physician:

  (1) The client is permanently disabled (condition is documented once);

  (2) The client has been examined by a physician and found to be suffering from an illness that significantly limits his/her capacity to travel [condition is valid for the period indicated by the physician or for sixty (60) days from the date of certification].

Note: Case managers requesting home delivery must have documentation on file that meets one of the conditions listed above.

C. Rules for Reimbursement: To accommodate anticipated changes in state law that will directly impact the drug pricing structure utilized by the county for the provision of this service, providers are required to develop and propose two (2) different unit costs for this service, utilizing the following methodologies:

NOTE: THE CURRENT REIMBURSEMENT STRUCTURE IS BASED ON AWP PRICING. PROVIDERS WILL BE NOTIFIED IN WRITING WHEN THE REIMBURSEMENT STRUCTURE IS CHANGED TO PHS PRICING.

- Providers will be reimbursed for prescription drugs, including protease inhibitors, based on the Average Wholesale Price (AWP) of the prescription provided to the Title I patient, minus a per-prescription discount rate. Total costs should include the cost of home delivery. Providers must stipulate the discount rate that they will be subtracting from the AWP, which may not be less than 7%. Please note that providers may utilize a discount rate higher than 7% (i.e., AWP - 10%). (For example, if the AWP of a prescription for Indinavir is $100, and your proposed discount rate is 10%, then the straight rate is equal to $90.00.) An estimate of the number of patients (unduplicated caseload) expected to receive these services must be included on the price form.

- Providers will be reimbursed for prescription drugs, including protease inhibitors, based on the Public Health Services (PHS) price of the prescription provided to the Title I patient, plus a flat dispensing fee. Total costs should include the cost of home delivery and other direct costs associated with the provision of this service. Providers must stipulate a flat rate that will be added to the PHS price. (For example, if the PHS price of a prescription for Indinavir is $50, and your proposed flat rate is $5.00 then the straight rate is equal to $55.00.) An estimate of the number of patients (unduplicated caseload) expected to receive these services must be included on the price form.

- Providers will be reimbursed for consumable medical supplies based on rates not to exceed the rates listed in the Florida Medicare Durable Medical Equipment [and] Supplies 2006 Fee Schedule, revised November 16, 2005. In the absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates not to exceed those listed in the most current Florida Medicaid's Durable Medical Equipment for All Medicaid Recipients Fee Schedule, as of March 1, 2006. No multiplier will be applied to Medicare or Medicaid rates for consumable medical supplies. Providers must also submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Consumable medical supplies excluded from Medicare and Medicaid may be provided on a supplementary fee schedule.

D. Additional Rules for Reporting: Providers must report monthly activity in terms of the individual drugs dispensed (utilizing federally assigned codes to be provided by the County), the number of prescriptions filled for each drug, the amount of Title I funds spent dispensing each drug, and the unduplicated number of clients that received each drug listed in the Ryan White Title I Prescription Drug Formulary.

Provider monthly reports for consumable medical supplies must include the number of patients served, medical supply distributions with HCPCS codes as appropriate per patient, and dollar amounts per patient.

E. Ryan White Title I Prescription Drugs Formulary: Ryan White Title I funds may only be used to purchase or provide vitamins, nutritional supplements, appetite stimulants, and/or other prescriptions to HIV/AIDS patients as follows:

- Prescribed medications that are included in the Ryan White Title I Prescription Drug Formulary. This formulary is subject to periodic revision.

- Medications, nutritional supplements, appetite stimulants, or vitamins that have been prescribed for the patient by his/her physician.

F. Letters of Medical Necessity: The following require a completed Title I Letter of Medical Necessity:

(1) **Nutritional Supplements** - A Title I Letter of Medical Necessity, completed by a physician, must be submitted for any nutritional supplements. The client must also have the Title I Letter of Medical Necessity signed by a Registered Dietitian/Nutritionist for nutritional supplements as indicated in the most recent release of the Title I Prescription Drug Formulary;

(2) **Androgel/Testim** - A Title I Letter of Medical Necessity, completed by a physician, must be submitted for Testosterone Gel (Androgel 1%) or Testim;

(3) **Sporanox** - A Title I Letter of Medical Necessity, completed by a physician, must be submitted for Sporanox;

(4) **Valacyclovir (new prescriptions)** - A Title I Letter of Medical Necessity, completed by a physician, must be submitted for Valacyclovir;

(5) **Pantoprazole** - A Title I Letter of Medical Necessity, completed by a Board certified gastroenterologist, must be submitted for Pantoprazole;

(6) **Appetite Stimulant** - A Title I Letter of Medical Necessity, completed by a physician, must be submitted for Appetite Stimulant;

(7) **Olanzapine** - A Title I Letter of Medical Necessity, completed by a physician, must be submitted for Olanzapine (Zyprexa);

(8) **Procrit** - A Prior Authorization Form, completed by a physician, must be submitted for Procrit (Epoetin);

(9) **Neupogen** - A Prior Authorization Form, completed by a physician, must be submitted for Neupogen (Filgrastim).

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CASE MANAGEMENT (General HIV/AIDS Population & MAI)
(Year 16 Service Priority #3)

The Title I Case Management service category has two (2) distinct components: **Case Management and Peer Education and Support Network (PESN).** *Providers are required to offer both types of services.*

Case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring, and evaluating available options and services. Case management addresses situational needs and promotes continuity of care for the client. Case management is predicated upon patient empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services. Case management addresses both individual and family entities and their needs, and both adults and children.

The purpose and goals of case management are: 1) to coordinate services across funding streams; 2) to reduce service duplication across providers; 3) to assist the client with accessing services; 4) to use available funds and services in the most efficient and effective manner; 5) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 6) to empower clients to remain as independent as possible; 7) to improve service and health outcomes; and 8) to control costs while ensuring that the client's needs are properly addressed.

CASE MANAGEMENT COMPONENTS

I. ***Case Management:*** Case managers must be knowledgeable about the diversity of programs and able to develop service plans from various funding streams. They are responsible for helping clients access all needed services, not just Ryan White Title I funded services.

Case managers are responsible for performing the following functions: 1) conducting a full assessment of the client's medical, financial, social, and other needs (initial intake); 2) care planning development; 3) managing and coordinating services (referrals, assisting with initial appointments, and coordinating services identified in the care plan, etc.); 4) monitoring client adherence to the care plan and medication regimens, as well as ensuring that service providers involved in the client's care are rendering services as requested; 5) evaluating services provided to the client by all sources to determine consistency with the established care plan; 6) reassessing and revising the care plan every six months for active clients; 7) conducting secondary prevention; and 8) coordinating and participating in the provision of permanency planning and counseling on parenting issues.

II. ***Peer Education and Support Network (PESN):*** At the option of the client, the case management agency will assign an HIV+ "Peer" (i.e., PESN, Case Aide, Peer Educator) to provide "peer support," including client orientation and education about health and social service delivery systems. The PESN Peer Educator may assist with initial client intake, paperwork and applications for financial and medical eligibility, educating new clients on the process and what to expect, as well as accompanying clients to initial appointments for medical care and other services.

The Peer will have basic knowledge of HIV/AIDS services and receive necessary training on HIV funding streams.

As incentives for productivity, providers are encouraged to provide the Peer with educational opportunities, as well as a standard living wage and medical benefits under contractual agreement with the County.

If the client decides not to access the PESN, then the case manager will also be responsible for providing the following services: 1) the presentation of information regarding the HIV service delivery system across funding streams, and 2) assistance to clients in preparing applications for other benefit programs.

The following requirements apply to both Case Management and PESN services (including Minority AIDS Initiative services) as indicated:

a. Program Operation Requirements:

Providers must ensure that case management services include, at a minimum, the following: peer support, assessment, follow-up, direction of clients through the entire spectrum of health and support services, and facilitation and coordination of services from one service provider to another. Providers of case management services are expected to educate clients on the importance of complying with their medication regimen, consistent with the Title I Case Management Handbook.

Case managers must maintain frequent contact with other providers (the client's physician, nutritionist, home health nurse, pharmacist, counselor, etc.) and with the client to help him/her adhere to medication regimens and ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives.

Case management providers are expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and to ensure that immediate follow-up is available for clients who miss their prescription refills and/or who experience difficulties with adherence. Case Management providers must ensure that

the client is knowledgeable about HIV/AIDS; understands CD4 count, viral load, adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors affecting adherence; and understands his/her treatment regimen to the best of the client's ability.

1. Case Manager Qualifications:

Providers of this service will adhere to the educational and training requirements of staff as detailed in the *Ryan White Title I System-wide Standards of Care* and the *Coordinated Case Management Standards of Service.*

2. Provider Requirements:

a) Contractual. Providers will be expected to document in the scope of services appearing in the Title I contract with Miami-Dade County the following:

- An explanation of the training that will be offered to case management staff, including "peers," and that should include cultural sensitivity issues.

- An explanation of how client's adherence to treatment will be monitored and how adherence problems will be identified and resolved;

- An explanation of how the provider will serve clients who speak English, Spanish, and Creole or who have limited language proficiency. **Case management providers must budget for the following expenses or otherwise accommodate client needs for: American Sign Language interpreter, foreign language interpreter, Braille, and other materials to accommodate clients with limited English language proficiency.**

- A description of linkage agreements in place with other HIV/AIDS service providers.

b) Required Forms. Case management staff will utilize Ryan White Title I standardized forms for all case management functions as developed by the Miami-Dade HIV/AIDS Partnership and the County.

c) ***Referrals.*** All referrals to Title I services must be made utilizing the Ryan White Title I Certified Referral Forms. Referrals cannot be made for services not documented in the client's needs assessment and care plan. However, in the case of emergency, care plans may be amended within one business day to allow for the referral. Referrals for non-Title I services will use the general referral form available in the Title I Service Delivery Information System (SDIS).

d) ***Caseload.*** Case managers should have a caseload of no more than 70 clients. Clients limited to only "situational needs" do not need to be included in the caseload count.

e) ***Peer schedules.*** Providers are reminded that some "peer" workers may be eligible for disability income and/or other supplemental income; consequently, a part-time working schedule should be well-planned to meet the needs and benefits of the peer employee.

b. Additional Service Delivery Standards: Providers of this service will also adhere to the *Ryan White Title I Coordinated Case Management Standards of Service.* (Please refer to Section III of this booklet for details.) **In addition, the Ryan White Title I Case Management Handbook provides details on case management activities.**

c. Rules for Reimbursement: The units of service used for Case Management and PESN reimbursements are as follows.

1. Case Management Services:

- *Face-to-Face encounter*: quarter-hour units (15 minutes), at rates not to exceed $12.50 per unit, defined as any time the case manager has direct contact with the client in person. In consultations with a child and one or more adults, encounters are billed for one HIV+ member only.

- *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed $12.50 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone contacts with the client and/or his/her representatives, development of a care plan, travel time (with documentation in the client file of reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan, contacts with other providers or representatives on behalf of the client, referral activities (setting up appointments, arranging transportation, etc.),

or intramural treatment planning meetings held on behalf of a client.

2. *Peer Education and Support Network (PESN) Services:*

   - *Face-to-Face encounter*: quarter-hour units (15 minutes), at rates not to exceed $6.25 per unit, defined as any time the "Peer" has direct contact with the client in person.

   - *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed $6.25 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone contacts with the client and/or his/her representatives, travel time (with documentation in the client file of reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan, or contacts with other providers or representatives on behalf of the client.

3. Providers are required to document in the client's file each unit of service performed (including the time spent) as face-to-face encounters or on behalf of a client. Units of service must be documented and reported separately for PESN and case management services.

4. Client eligibility screening for voucherable services is billable as a unit of service depending on the amount of time spent with the client. However, case managers may not distribute vouchers, with the exception of transportation vouchers. Costs related to the distribution of voucher services should be covered under the dispensing charge allowed for handling of vouchers under each respective voucherable service category.

d. **Additional Rules for Reporting:** Providers of PESN and general Case Management services must report, separately, their monthly activities according to quarter-hour (15 minutes) "Face-to-Face" encounters and quarter-hour (15 minutes) "Other" encounters. In addition, providers must report the number of unduplicated clients served.

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DENTAL CARE
(Year 16 Service Priority #4)

Services include routine **Dental Care** examinations and prophylaxis, X-rays, fillings, prosthetics, treatment of gum disease, oral surgery, and instruction on maintaining oral health.

a. **Program Operation Requirements:** Providers of primary or specialty outpatient care wishing to include dental care services under their scope of operations must either demonstrate on-staff clinical capacity or have letters of intent from specific dental care providers to provide these services under subcontract.

   Provision of dental care services for any one client is limited to an annual cap of $3,000 per the Ryan White Title I fiscal year. No exceptions will be allowed.

   Patients referred for dental care by a Ryan White Title I case manager require a Ryan White Title I certified referral form, as approved by the Miami-Dade HIV/AIDS Partnership. If the client is referred by a non-Title I provider, a general referral form must be submitted accompanied by the required medical, financial, and permanent Miami-Dade County residency documentation. Patients coming without a referral, but with necessary documentation, to agencies with the capacity to do an intake are also able to access Ryan White Title I dental care services.

b. **Additional Service Delivery Standards:** Providers of this service will also adhere to the *Ryan White Title I Dental Standards*. (Please refer to Section III of this booklet for details.) Providers will be required to demonstrate that they will adhere to generally accepted clinical guidelines for dental treatment of AIDS-specific illnesses.

c. **Rules for Reimbursement:** Providers will be reimbursed for all routine and emergency examination, diagnostic, prophylactic, restorative, surgical and ancillary dental procedures, as approved by the Miami-Dade HIV/AIDS Partnership and included in the Ryan White Title I Dental Formulary, using the American Dental Association Current Dental Terminology (CDT-5), (© 2004), codes for dental procedures, at rates that represent a constant multiple of the most current State of Florida Medicaid Dental Services Coverage and Limitations Handbook reimbursement rates for each procedure, as of March 1, 2006. The constant multiple may not exceed 3.0 times this Medicaid Dental Services rate. Providers must stipulate the multiplier they will be applying to the Medicaid Dental Services reimbursement rates during the program year. An estimate of the number of patients (unduplicated caseload) expected to receive these

services must be included on the price form. Provider negotiated Medicaid rates will not be accepted.

Necessary tests or procedures that have a CDT-5 procedure code and are excluded from Medicaid must be submitted on a supplementary fee schedule. A flat rate for each procedure and a detailed cost justification must be included in the proposal.

d. **Children's Eligibility Criteria:** Providers must document that HIV+ children who receive Title I funded dental services are permanent residents of Miami-Dade County and have been properly screened for Medicaid and other public sector funding (i.e., the Medically Needy program), as appropriate. While children qualify for and can access Medicaid or other public sector funding for dental services, they will not be eligible for Ryan White Title I funding, except those tests or procedures excluded by Medicaid.

e. **Ryan White Title I Dental Formulary:** Ryan White Title I funds may only be used to provide dental services that are included in the most recent release of the Ryan White Title I Dental Formulary. The Ryan White Title I Dental Formulary is subject to periodic revision.

SUBSTANCE ABUSE COUNSELING
RESIDENTIAL AND OUTPATIENT TREATMENT
(General HIV/AIDS Population & MAI)
(Year 16 Service Priorities #5 and #6)

Two types of substance abuse treatment programs are included under this service category, **Residential and Outpatient**. Services must be provided to HIV+ clients in state licensed treatment facilities, and should be limited to the pre-treatment program of recovery readiness and relapse, as well as harm reduction, conflict resolution, anger management, relapse prevention, family group and intensive counseling to reduce depression, anxiety and other related disorders, drug-free treatment and treatment for alcohol and other drug addictions.

Both **Residential and Outpatient Treatment** programs shall comply with the following requirements:

a. **Program Operation Requirements:** Special emphasis is placed on programs that provide services that are highly accessible to target populations.

Special emphasis is placed on programs that can demonstrate linkages with other services relevant to the needs of HIV+ persons in substance abuse treatment programs.

Service must be provided in settings that foster the client's sense of self-control, dignity, responsibility for his/her own actions, relief of anxiety, and mutual aid.

Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. Special consideration will be given to programs offering services to families without separating the family unit. If the client is participating in a residential treatment program the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in residential treatment with the client during the treatment process. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to Title I (maximum of $125 per day). *Note: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

Individual treatment plans must be documented in the client's file and linked to the provision of primary medical care.

Providers must ensure that clients adhere to their treatment plan, including prescription drug regimens.

Providers of substance abuse treatment must offer flexible schedules that accommodate nutritional needs in order to facilitate clients' compliance with medication regimens.

Providers are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically indicated.

Residential and outpatient substance abuse providers must coordinate billing so that outpatient counseling services provided as a result of a referral by a residential facility are only reimbursed once as part of the outpatient facility's billing.

Providers are expected to adhere to super-confidentiality procedures. Providers must include their organization's definition of confidentiality, staff confidentiality training, and procedures for maintaining confidentiality.

Providers should demonstrate linkages with other services relevant to the needs of people in substance abuse treatment programs.

I. Substance Abuse Counseling – Residential Treatment

This service program calls for the provision of substance abuse treatment, including alcohol addiction, and counseling to HIV+ clients in state licensed treatment facilities. Residential Substance Abuse Treatment provides room and board, substance abuse treatment, including specific HIV counseling, in a secure, drug-free, state licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Title I funds may not be used for hospital inpatient detoxification.

Residential treatment programs shall comply with the following requirements:

a. **Rules for Reimbursement:** The unit of service for reimbursement of substance abuse counseling - residential treatment is a *patient-day* of care, at a rate not to exceed $125 per day [includes the cost of family member(s) participating in the substance abuse counseling session provided during a day of treatment]. If the provider anticipates that clients may be referred to a separate Title I funded outpatient HIV substance abuse counseling agency, then the cost of such activities should not be included as part of the residential provider's per day rate.

b. **Additional Rules for Reporting:** Monthly activity reporting for residential substance abuse treatment is per *patient-day* of care and number of unduplicated clients served.

c. **Linkage/Referrals:** Providers of residential substance abuse treatment must document the progress of each patient's care through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the patient's case manager and primary care physician, when that is found to be appropriate. Providers are required to determine if the client is currently receiving case management services; if not, the provider must seek enrollment of the client in a case management program while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the case management provider must be established in order to ensure coordination of services while the client remains in treatment. *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.

II. Substance Abuse Counseling - Outpatient Treatment

Provides regular, ongoing substance abuse monitoring and counseling on an individual and group basis in a state-licensed outpatient setting. Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The ratio of support group participants to counselors should be no higher than 15:1. One unit is equal to one half-hour. Please note that there is no limit on individual or group counseling sessions.

- **Substance Abuse Counseling Level I - Professional Substance Abuse Treatment.** This service includes *general and intensive* substance abuse therapy and counseling (individual, family, and group) provided by trained mental health or certified addiction professionals. Direct service providers must possess at least *postgraduate degrees* in the appropriate counseling-related field, and preferably, be a *certified addiction professional* (CAP).

- **Substance Abuse Counseling Level II - Counseling and Support Services.** This service includes supportive and crisis substance abuse counseling by trained and supervised counselors, peers, and facilitators. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Non-certified personnel providing this service will be supervised by professionals with Level I credentials.

a. **Additional Service Delivery Standards:** Providers of these services will also be required to adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. (Please refer to Section III of this booklet for details.)

b. **Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed $29.00 per unit for Level I individual counseling; $32.00 per unit for Level I group counseling; $26.00 per unit for Level II individual counseling; and $29.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and family member(s) receiving the therapy, whereas, reimbursement for group sessions are calculated for the counselor that provided the group therapy. Coverage for all administrative costs may not exceed 10% of the total budget for each level of counseling.

c. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a *one half-hour session* provided to the client and the number of unduplicated clients served. Providers must also report, on a monthly basis, the number of group counseling units provided by each counselor.

d. **Linkage/Referrals:** Providers of outpatient substance abuse treatment must document the progress of each patient's care through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the patient, his/her case manager, and primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving case management services; if not, the provider must seek enrollment of the client in a case management program while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the case management provider must be established in order to ensure coordination of services while the client remains in treatment.

MENTAL HEALTH THERAPY/COUNSELING
(formerly known as Psychosocial Counseling)
(Year 16 Service Priority #7)

This service offers non-judgmental psychological/pastoral care treatment and counseling services including individual, group, crisis intervention counseling, and permanency planning provided by mental health or accredited pastoral care counseling professionals, as well as unlicensed experienced paraprofessionals under the supervision of licensed professionals. Mental Health Therapy/Counseling services may be delivered in individual or group settings. **Please note that Title I funds may not be used for bereavement support for uninfected family members or friends.**

Mental Health Therapy/Counseling services reimbursed under Title I are limited to conditions stemming from and treated within the context of the client's HIV/AIDS diagnosis. This service is not intended to be general psychosocial practice, but is intended to address HIV-related issues and strengthen coping skills to increase adherence and access to treatment.

NOTE: All initial assessments and assignments to subsequent therapy/counseling levels will be done by a licensed Level I professional. Additionally, if therapy/counseling is provided by a non-licensed professional and/or peer counselor, oversight and supervision must be conducted by a licensed professional or a professional exempt from licensing under F.S. 491.014. The supervisor will approve and sign progress notes, mini-evaluations, and referrals.

Reimbursement will be differentiated according to the level of intensity of the service and the training of the direct service practitioner, as follows:

- **Mental Health Therapy/Counseling Level I** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *postgraduate degrees* in psychology, or counseling (PhD, EdD, Psy.D, MS, MA, MSW, M.Ed.) and must be *licensed by the State of Florida* to provide such services.

- **Mental Health Therapy/Counseling Level II** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess Master's or *postgraduate degrees* in psychology, psychotherapy or counseling (MS, MA, MSW, M.Ed., and must be *licensed by the State of Florida* as LCSW, LMHC or LMFT to provide such services.

- **Mental Health Therapy/Counseling Level III** - Mental Health Counseling: This service includes *general* mental health therapy and counseling (individual, family and group) provided by a Bachelor's *degree* level provider in the appropriate

counseling-related field. Non-licensed personnel providing this service will be supervised by licensed professionals or professionals exempt from licensing under F.S. 491.014.

- **Pastoral Care and Support Services -** Pastoral Care and Support Services is equivalent to Level III mental health therapy/counseling with respect to the qualifications of counseling staff. Pastoral care counselors must: (1) hold a masters or doctoral degree in theology, philosophy, social work, psychology, or a related field from an accredited institution; (2) have completed at least four units (1,600 hours or one full year) in clinical pastoral education (CPE) in an institution accredited by one of the following professional associations: the Association of Clinical Pastoral Education, National Association of Catholic Chaplains, National Association of Jewish Chaplains, American Institute of Islamic Studies, or Canadian Association of Pastoral Education. At least one CPE unit must be in HIV or a life-threatening disease.

- **Mental Health Therapy/Counseling Level IV** - Counseling and Support Services: This service includes supportive counseling by trained and supervised peers. Activities include forming or strengthening support groups and other areas appropriate for individual and group socio-emotional support. Non-licensed personnel providing this service will be supervised by licensed professionals or professionals exempt from licensing under F.S. 491.014.

Mental Health Therapy/Counseling Components:

Counseling services **(Level I)** provided to clients by licensed professionals will include psychosocial assessment and evaluation, testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments and reevaluations of plans and goals documenting progress, and referrals to psychiatric and other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to psychosocial and medical treatments, depression, panic, anxiety, maladaptive coping, safe sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically indicated. Permanency planning will be addressed with individuals as appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per fiscal year and five (5) units (maximum of 2 ½ hours) per session].

Counseling services **(Level II)** include crisis counseling, reevaluations of plans and goals documenting progress, and referrals to psychiatric and other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to psychosocial and medical treatments, depression, panic, anxiety, maladaptive coping, safe sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically indicated. Permanency

planning will be addressed with individuals as appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per fiscal year and five (5) units (maximum of 2 ½ hours) per session].

Level III – Provides supervised mental health therapy/counseling designed to improve clients' mental health and promote feelings of well-being. Services will include crisis counseling, periodic reassessments and reevaluations of plans and goals documenting progress. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to mental health and medical treatments, depression, and safe sex will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically indicated. Permanency planning will be addressed with individuals as appropriate. Counseling at this level may include relationship difficulties, client-centered advocacy, stress management and coping skills, personal and social adjustments as they relate to HIV/AIDS, and the provision of needed information and education to clients to enhance their quality of life. Services at this level are provided for clients experiencing mild to moderate mental or emotional health problems and are generally not long term [individual counseling shall not exceed 32 encounters per fiscal year and five (5) units (maximum of 2 ½ hours) per session].

Pastoral Care and Support Services - This service assists HIV+ persons, members of their immediate family and of their household, in the clarification/identification of their own resources/tasks/priorities and in the development and/or enhancement of their resources through individual or family/household pastoral care sessions. Pastoral Counselors will work with clients to clarify the spiritual and pragmatic options that order and validate the client's individual life experiences, strengthen their belief systems, purpose, and values. Pastoral counseling is an intervention at a point of need in a client's life that strives to progressively move the client along a continuum of self-acceptance and responsibility.

Level IV – This service provides supervised support and advice through coaching, information sharing, listening, and role modeling in groups and limited individual settings. Its primary goal through group support is the promotion of an independent living philosophy wherein the client becomes his or her own self-advocate. Individual support counseling will be provided only within the guidelines and goals of a treatment plan developed by a professional mental health counselor with assistance and consultation from the peer support worker. The peer support counselor will provide timely feedback and information to the originator of the plan in order to monitor client progress. Support counseling will address adherence to mental health and medical (HIV/AIDS) treatments. Support counselors will not make referrals themselves, but will consult and make known to his or her supervisor, information/changes in the client's condition that may require a referral. Appropriate referrals will then be made by the supervisor.

Group Counseling (Levels I, II, III, and Pastoral Care) - a group of individuals (maximum of 15) with similar problems meeting under the expert guidance of a trained mental health professional. Members of the group will be selected by the mental health professional in order to maximize the interaction, learning and benefits derived from the group dynamic. Group counseling provides therapy in a social context, reduces the feeling of isolation many clients experience, provides an opportunity for clients to share methods of coping with problems and allows the therapist an opportunity to observe how an individual interacts with others.

Support (Group) Counseling (Level IV) – a group of individuals (maximum of 15) with similar problems meeting with a peer. These groups provide emotional support and validation through discussion of shared problems and feelings. Such support may be largely psychological in nature, taking the form of ego-empowering, compliments, encouragement, positive affirmation or more objective, as in helping to plan specific courses of action, giving advice on how to solve an immediate problem. Services at this level are provided for clients experiencing mild functional or emotional problems and are generally not long term.

a. **Program Operation Requirements:** Providers must demonstrate knowledge of HIV disease, its psychosocial dynamics and implication, including cognitive impairment and generally accepted treatment modalities and practices. Services may be delivered to non-HIV family members (as defined by the client) only if the HIV+ client is also being served. Providers must permit the Grantee access to client records that document the services provided. Providers and the County will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of support group participants to counselors should be no higher than 15:1. One visit is equal to one half-hour.

b. **Additional Service Delivery Standards:** Level I, Level II, Level III, and Level IV providers will be required to demonstrate that they will adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV/AIDS-illnesses. (Please refer to Section III of this booklet for details.)

c. **Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed $32.50 per unit for Level I individual counseling; $35.00 per unit for Level I group counseling; $32.50 per unit for Level II individual counseling; $35.00 per unit for Level II group counseling; $25.00 per unit for Level III and Pastoral Care individual counseling; $27.00 per unit for Level III and Pastoral Care group counseling; $15.00 per unit for Level IV individual counseling; and $20.00 per unit for Level IV group support counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for the counselor that provided the group therapy (i.e., number of group counseling units per counselor).

d. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a one-half-hour session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level I, Level II, Level III, Level IV and pastoral care counseling services.

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INSURANCE SERVICES
(Year 16 Service Priority #8)

There are three types of assistance under this service category: **AIDS Insurance Continuation Program (AICP), Insurance Deductibles, and Prescription Drugs Co-Payments.**

I. AIDS Insurance Continuation Program

This service provides assistance to clients who already have private health insurance but are not financially able to pay the premiums. This service does not provide new health insurance policies to eligible clients; it allows them to continue with their current insurance carrier. This service does not include coverage of disability or life insurance payments and does not provide assistance with deductibles and/or co-payments. The maximum amount of assistance a client may receive each month is $650. Title I will be able to assist the client in making back payments of premiums as long as the insurance policy has not been terminated. Assistance may also be provided to facilitate conversion of group coverage (i.e., COBRA) to an individual insurance policy. Title I may only be utilized to pay for a dependent's health insurance premium if the dependent meets the eligibility requirements specified below.

Title I supplements the state AICP when the primary funding sources, Title II and Florida General Revenue, exhaust their funds. Title I support depends on the amount allocated to this service. This service description covers only those services paid for by Ryan White Title I funds.

a. **Program Operation Requirements:** Providers may not reimburse clients directly for their premium expense.

   Providers are required to inform clients of their rights regarding insurance coverage and to ensure they use their private health insurance to obtain care. Clients will not be eligible for Title I services if such services are available under their existing health insurance, private or public.

b. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended per insurance premium plus a dispensing rate of $15 per month.

c. **Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *expended per insurance premium per client.*

d. **Special Client Eligibility Criteria:** Clients receiving Title I assistance for this service must also: 1) have liquid assets (cash) that do not exceed $4,500 (or $5,500 if married or a recognized couple); 2) have active health insurance under a group, individual or COBRA policy; and 3) be willing

to sign all required forms and provide all requested eligibility information. A complete financial assessment and disclosure are required.

II. Insurance Deductibles

a. **Program Operation Requirements:** The goal of this service is to maintain a client's private health insurance coverage, thereby minimizing the client's reliance on the Title I program for services. Under no circumstances shall payment be made directly to recipients of this service. The maximum amount of assistance a client may receive annually is $2,500. Other methods may be proposed to assist clients with the financial resources necessary to cover a client's health insurance deductibles that the client could otherwise not afford.

b. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per deductible plus a dispensing rate.*

c. **Units of Service for Reporting:** Monthly activity reporting for this service must be in dollars expended *per deductible per client.* The service provider must also report the number of unduplicated clients served each month and the dollars spent per client.

III. Prescription Drugs Co-Payments and Co-Insurance

a. **Program Operation Requirements:** This type of assistance is available to privately insured clients who are required to pay a fee for their medications. The pharmaceutical provider will bill the insurance carrier for a portion of the cost of the prescription plus the dispensing fee and Title I will cover the remaining portion of the cost for clients who meet the eligibility criteria. Assistance for both co-insurance and co-payments is restricted to those medications on the currently approved Ryan White Title I Prescription Drug Formulary.

b. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per co-payment plus a dispensing rate.*

c. **Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per co-payment per client.*

OUTREACH SERVICES (General HIV/AIDS Population & MAI)
(Year 16 Service Priority #9)

I. Definition and Purposes of Title I Outreach

Outreach services target clients in need of assistance accessing HIV treatment who are:

- HIV+, never in care
- Newly diagnosed with HIV/AIDS, not receiving medical care
- HIV+, formerly in care, currently not receiving medical care (lost to care)
- Believed to be HIV+ based on documentation

Outreach services to people already identified as HIV+ consist of activities to introduce them to the system of care and assist them in accessing care and treatment services. Outreach includes an initial encounter to identify whether the person is currently receiving health care and support services. For high-risk people not known to be HIV+, a referral should be made to a testing site to determine if the client is HIV+.

Once the client is determined to be HIV+, a referral must be made to a case management agency, medical provider or, if necessary, to a substance abuse treatment facility. The outreach worker may accompany the person to the point of entry into the system and assist in obtaining necessary documentation to receive services. Referrals must be followed up to ensure that the client is enrolled in care.

a. Targeted Outreach

1. Providers must conduct targeted outreach with key points of entry. Targeted outreach involves the establishment of formal relationships between providers and key points of entry including the following:

- STD clinics
- HIV counseling and testing sites
- blood banks
- hospitals
- substance abuse treatment providers
- mental health clinics
- adult and juvenile detention centers
- Community Jail Linkage Coalition
- homeless shelters

2. Linkage agreements form the basis of the formal relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the key points of entry to the system of care listed above.

b. Street Outreach

This outreach should be directed to populations known through local needs assessment data, local epidemiological data, or through review of service data, to be at disproportionate risk for HIV infection.

1. **Use of objective data.** Providers conducting street outreach must target known high-risk areas, venues where significant numbers of people can be found who are believed to be HIV+. In addition, workers must conduct street outreach during hours when the targeted groups are likely to be on the streets.

2. **Outreach to people lost to care.** Outreach workers may work with service providers to locate people lost to care and bring them back to care. If after repeated attempts to contact the client by phone and mail without success, the case manager or practitioner may refer the case to an outreach worker. There must be clear documentation of attempts to contact the client and why the case is being referred to an outreach worker.

3. Examples of clients considered lost to care or non-compliant include:
   - Missing two (2) consecutive medical appointments
   - Checking oneself out of residential treatment
   - Not "reporting" to residential treatment
   - Missing the first medical care appointment after hospital discharge.

c. Outreach Activities

1. Outreach workers may engage in the following activities:

   - conduct brief intakes for new clients
   - Obtain from the client all required consents to access the Service Delivery Information System (SDIS)
   - review data in the Title I SDIS for existing clients
   - assess risk behaviors
   - accompany newly diagnosed, lost to care, or otherwise unconnected clients to the doctor, case manager, or substance abuse provider for the purpose of enrolling them in service or reconnecting them to care, or to collect documentation until successful engagement occurs
   - assist client to obtain necessary documentation for entry into the service system
   - make home visits to meet a client and to connect them to care
   - accompany a client to HIV testing or until successful engagement occurs

- provide HIV education related services (i.e., education on available treatment options and services available to HIV+ individuals) if directly linked to increasing access of the target population to existing HIV/AIDS service programs
- In the event that outreach workers spend more than 2½ hours (10 units of service) on these activities, it must be thoroughly documented.

2. **Inappropriate Outreach Activity.** Funds awarded under Title I of the Ryan White CARE Act may not be used for outreach programs that exclusively promote HIV counseling and testing; condom distribution, and/or that have as their purpose HIV prevention education. Additionally, broad-scope awareness activities about HIV services that target the general public (i.e., poster campaigns for displays on public transit, TV or radio public service announcements, etc.) will not be funded.

3. **Documentation.** All outreach workers must maintain documentation which includes the following:

- name of outreach worker
- description of any encounter with a client and/or work done on behalf of the client
- the date and time of the encounter
- type of encounter (i.e., telephone, face-to-face, travel, referral, or coordination of care)
- name and signature of client
- client's date of birth
- client's gender
- client's race and ethnicity
- client's address or follow-up information
- site where client was identified (i.e., a specific geographic region and/or key point of entry into the system of care)
- time spent on the encounter in minutes
- total units documented
- referral to a testing site to determine if the client is HIV+
- document "initial contact" and "follow-up" contacts, receipt or non-receipt of lab results
- if lost to care, who requested the outreach or note how the client was encountered, (e.g. during street outreach)
- once the client is determined to be HIV+, a referral or documented attempt to make a referral must be made to a case management agency, medical provider, and/or residential substance abuse provider, if appropriate
- indicate risk behavior and, if a street encounter, outreach worker's reason for approaching particular individual

- referrals must be followed up to ensure that the client is enrolled in care
- Final disposition of the client must be documented including whether or not the client was connected to care (i.e., referral was made, client was taken to a medical, case management, or substance abuse provider, etc.) or if the case was closed and why.

II. Outreach Worker Incentives, Program Operation Requirements, and Staff Training Requirements

As incentives for productivity, providers are encouraged to provide outreach workers with educational opportunities, as well as a standard living wage and medical benefits as required by contractual agreement with the County.

a. Program Operation Requirements:

1. **Location.** Providers of outreach services must focus their efforts on geographic regions of the county with high incidence of HIV infection and clearly identified unmet needs.

2. **Staff Training.** Outreach workers must attend a minimum of 40 hours of training approved by the county. In addition, all staff providing outreach services must be certified through the state of Florida's Department of Health HIV/AIDS 104, 500, and 501 courses, as well as Orasure training courses or equivalent counseling and testing curricula. Outreach workers must also receive training related to Limited English Proficiency (LEP) and detoxification programs. Outreach workers must attend periodic training provided by the Ryan White Title I program.

   Outreach providers must ensure that outreach workers are knowledgeable about resources and providers of medical care, substance abuse treatment, case management, and other support services. At a minimum, the outreach provider should have reference material on hand which provides intake requirements, services offered, hours of operation, and contact personnel.

3. **Hours.** Outreach services must be offered during non-traditional business hours at least 15 hours per week. Traditional business hours are defined as 9 AM to 5 PM, Monday through Friday.

4. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target sub-populations (i.e., substance abusers, illiterate persons, hard of hearing, etc.). It is desirable that outreach workers reflect the community in which

they are working. Special consideration will be given to providers that utilize peer models and indigenous workers in the community.

5. **Documentation.** Providers are required to document in the client's file each unit of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact, coordination of care, travel, or referral activity on behalf of a client.

6. **Connection to Care.** Providers are expected to demonstrate that at least three (3) percent of people contacted and billed for are actually brought into care.

b. **Rules for Reimbursement:** Providers will be reimbursed on the basis of a line-item budget for Title I funded outreach services. Outreach services will be paid on the basis of full-time employees (FTE) at a salary to be negotiated between the service provider and the County, as well as on the basis of other direct and administrative costs. Reimbursement of salaries will be based on the approved budget and productivity as recorded by hours spent doing outreach activities, people contacted, their risk factors, and the number of people connected to care. All administrative and/or indirect expenses (other than those associated with the delivery of outreach services) are capped at 10%.

c. **Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of an outreach contact.

Reimbursement requests will be continuously evaluated on the basis of productivity, locales used, people contacted and connected to medical care, case management, and/or residential substance abuse treatment.

d. **Special Client Eligibility Criteria:** Outreach Workers must target outreach activities to connect HIV+ clients who are newly diagnosed with HIV/AIDS and not receiving medical care, HIV+ formerly in care, currently not receiving care (i.e., lost to care), or those persons who are believed to be HIV+.

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FOOD SERVICES
(Year 16 Service Priorities #10 and #11)

Food services include **Food Bank** and **Home Delivered Meals**. Providers will offer nutritional counseling to all food service clients through qualified staff supervised by a licensed dietitian or nutritionist. Clients may not be enrolled in more than one Ryan White Title I food service program simultaneously, except if the client needs to access food bank services only for the purpose of obtaining personal hygiene products while enrolled in the home delivered meals program.

I. Food Bank

This service program is a central distribution center providing groceries, including personal hygiene products when available, for indigent HIV+ clients. The food is distributed in cartons or bags of assorted products to Ryan White Title I clients.

a. Program Operation Requirements:

Standard Provisions

Providers of food bank services must also demonstrate the ability to match and document a minimum of 10¢ (at retail market value) of food and personal hygiene product funding/donations for every dollar of Ryan White Title I funding used for the purchase of food and personal hygiene products. Efforts to obtain matching funds, donations, or any supplemental assistance must be documented.

Food bank services may be provided only on an emergency basis. An emergency is defined as an extreme change: loss of income (i.e., job loss, death or departure of person providing support), loss of housing, or release from institutional care (substance abuse treatment, hospital, jail, or prison) within the last two weeks. Duration of food bank service provision is to be temporary. Other emergencies, as defined by the client's case manager, must be documented in the client's record as they arise. A severe change to the client's medical condition, as defined below under the provision for additional occurrences, may also be considered an emergency.

Case managers must conduct initial and on-going assessment of each client to determine if the client is eligible for food related services under any other public and/or private funding source, including food stamps.

The provision of this service will be limited to twelve (12) occurrences within the Ryan White Title I fiscal year. One (1) occurrence is defined as all food bank services provided within one (1) calendar week.

Groceries, including personal hygiene products when available, can be picked up on a weekly or monthly basis. If groceries will be picked up on a **weekly** basis, the client will be limited to groceries valued at $30 per week at each pick-up. A client accessing food bank services on a weekly basis may not pick up groceries sooner than seven (7) days from the prior pick-up day.

If the client chooses to pick up his/her groceries on a **monthly** basis, the client will be limited to $30 per week multiplied by the number of times the original day of pick-up occurs in the month. A client accessing food bank services on a monthly basis may not pick up groceries in a new month prior to the same pick-up day from the previous month.

Providers must demonstrate their capacity to provide ethnic foods and food suited to special client needs.

Provision for Additional Occurrences:

A severe change to the person's medical condition (i.e., new HIV related diagnosis/symptom, wasting syndrome, protein imbalance, recent chemotherapy, etc.) may also warrant additional occurrences of food bank services. However, additional occurrences require certification in the form of a completed Ryan White Title I Nutritional Assessment Letter for Food Bank Services. This Letter of Nutritional Assessment must be completed by an independent physician or registered dietician not associated with the Title I food bank provider. The client must be reassessed for the "warranting" medical condition every three (3) months. The physician or registered dietitian must specify the frequency and number of additional food bank visits (occurrences) that should be allowed for the client (maximum of twelve).

Provision for Families:

In addition to the maximum amount defined above of groceries available per month to eligible clients, each additional adult who is HIV+ and lives in the same household is eligible to receive $30 per week subject to the same service guidelines. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is HIV+) is also eligible to receive $10 per week in groceries, subject to the same service guidelines above. The client must provide documentation to prove the dependent's age and place of residence.

b. **Rules for Reimbursement:** Providers will be reimbursed on the basis of a line-item budget. All indirect expenses (other than those associated with the purchase of food and personal hygiene products) are capped at 10%.

c. **Additional Rules for Reporting:** Providers must report monthly activities according to client visits.

d. **Special Client Eligibility Criteria:** Clients must have a case management referral to receive this service. Each case management referral must document the number of eligible dependents (i.e., minors). The client must be reassessed for the "warranting" medical condition every three (3) months. Providers must document that HIV+ clients who receive Title I funded food bank services have a household income that does not exceed 150% of the Federal Poverty Level (FPL). Clients receiving food bank services must be documented as having been properly screened for Food Stamps, Medicaid Waiver, or other public sector funding as appropriate. While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Title I food bank services, unless it is for the purpose of obtaining personal hygiene products. Similarly, while clients qualify for and can access other public funding for food services, including Food Stamps, they will not be eligible for Ryan White Title I funding for food bank service, unless the provider is able to document that the client has applied for such benefits and eligibility determination is pending (a copy of benefit application must be kept in the client's record). In addition, referrals for food bank services must clearly state that the client is not currently receiving Title I funded home delivered meals.

II. Home Delivered Meals

This service provides nutritionally balanced home delivered meals for persons living with AIDS, or under certain circumstances HIV symptomatic, who are indigent, disabled and homebound, as defined by Medicaid Project AIDS Care (PAC Waiver) and as certified by a physician. PAC Waiver defines a homebound individual as one who is "confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals." In addition, clients accessing this service must be functionally impaired. A functional impairment means difficulty performing one or more activities of daily living (i.e., bathing, dressing, walking, eating), and may not be capable of preparing meals. No other person in the client's household may be able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation.

This service includes the provision of both frozen and hot meals. Providers of hot meals must indicate the criteria and procedures used in determining and documenting the client's eligibility for receiving hot (rather than frozen) meals, and must provide justification for the use of those criteria.

A physician's certification of a client's homebound status is required.

a. **Program Operation Requirements:** Providers must demonstrate their capacity to provide ethnic foods and food suited to special client needs. A meal must be defined according to current ADA guidelines (minimum daily requirements).

b. **Rules for Reimbursement:** Providers will be reimbursed on the basis of a delivered meal that meets commonly accepted nutritional guidelines, at a bid rate not to exceed $5.00 per meal (frozen or hot). The projected cost per meal must include the cost of nutritional counseling. A detailed description of all items covered by the cost of a unit of service must be provided.

c. **Additional Rules for Reporting:** Providers must report monthly activity on the basis of a delivered meal meeting the nutritional guidelines indicated above under program operations requirements.

d. **Special Client Eligibility Criteria:** Clients must have a case management referral to receive this service, and client eligibility for this service must be certified by a case manager every three (3) months. Providers must document that persons receiving Title I funded home delivered meals services: (1) are homebound as defined by Medicaid Project AIDS Care (PAC) Waiver and as certified by a physician. (PAC Waiver defines a homebound individual as one who is "confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals."). In addition, clients accessing this service must be functionally impaired. A functional impairment means difficulty performing one or more activities of daily living (i.e., bathing, dressing, walking, eating), and may not be capable of preparing meals. No other person in the client's household may be able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation; (2) are permanent residents of Miami-Dade County; (3) have AIDS (as defined by the CDC) or are HIV symptomatic with a condition (certified by a physician) that makes home delivered meals necessary; and (4) have a household income that does not exceed 300% of the Federal Poverty Level. While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Title I home delivered meals.

Clients receiving home delivered meals must be documented as having been properly screened for other public sector funding as appropriate. While clients qualify for and can access Medicaid Waiver, or other public funding for home delivered meals, they will not be eligible for Ryan White Title I funding. In addition, referrals for home-delivered meals

must clearly state that the client is not currently receiving Title I food bank services, except for personal hygiene products.

NOTE: Where the HIV status of the client is symptomatic and a medical condition renders the client homebound, physicians must indicate whether the condition is temporary or permanent, and if temporary, the period of time that home delivered meals service is authorized. If no such time indication is provided, such certification will be treated as a temporary 30-day certification.

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HOME HEALTH CARE
(Year 16 Service Priority #12)

Home Health Care services encompass a full range of therapeutic, nursing, supportive and personal care/support services in the home, provided by licensed home health agencies and available 24 hours, seven days a week. Home Health Care services include the following:

- Skilled nursing care
- Infusion Care and IV Therapy
- Intensive home health aide/homemaker
- Physical, occupational and speech therapies
- Respiratory therapy
- Respite Care
- Consumable medical supplies

Providers of home health care services will also be allowed to purchase consumable medical supplies and durable medical equipment required in order to provide home health care services to the HIV+ client as prescribed by a physician.

a. **Program Operation Requirements:** With the exception of respiratory therapy services, which is optional, providers of Home Health Care must offer the full range of services listed above.

   Skilled home health care providers will be expected to collaborate with other caregivers (i.e., client's physician, case manager, nutritionist, adherence counselor, etc.) to ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives. Skilled home health care providers will also be expected to empower clients to be actively involved in the development and monitoring of their treatment adherence plans.

   Providers of home health care services must report to the client's case manager, at least quarterly, the condition of the client. The report must include the type of services being provided to the client by the home health care agency, an update on the client's plan of care developed by the home health care provider, progress made by the client during the quarter, and information on additional treatment needed by the client, if applicable. This information will be utilized by the case manager to update the client's needs assessment and care plan.

b. **Additional Service Delivery Standards**: Providers of this service will also adhere to the current home health industry principles known as Outcome and Assessment Information Set (OASIS), as required by

Medicare and Medicaid, including initial assessment of the client's condition, re-certification every 60 days, assessment at periods of significant changes in the client's condition, and discharge assessment.

c. **Rules for Reimbursement:** With the exception of therapy visits, providers will be reimbursed for all home health services using the most current State of Florida Medicaid Project AIDS Care Waiver Coverage and Limitations Handbook procedure codes and corresponding reimbursement rates current as of March 1, 2006, times a multiplier not to exceed 2.0. Reimbursement for respiratory therapy will be based on the State of Florida Medicaid Therapy Services Coverage and Limitations Handbook procedure codes and corresponding reimbursement rates current as of March 1, 2006, times a multiplier not to exceed 2.0. Provider negotiated Medicaid rates will not be accepted. Necessary procedures or services excluded from Medicaid may be submitted on a supplementary schedule.

Reimbursement for physical, occupational, and speech therapy visits will be based on the Associated Home Health Industries of Florida, Inc.'s Low Utilization Payment Adjustment (LUPA) Visit Payment Cost Calculations for MSA 5000 (Miami-Dade County), dated January 1, 2006. No multiplier rate will be applied to reimbursement for physical, occupational, and speech therapy visits.

Providers will be reimbursed for consumable medical supplies based on rates not to exceed the rates listed in the most current Florida Medicare Durable Medical Equipment [and] Supplies 2005 Fee Schedule, as of March 1, 2006, times a multiplier of up to 1.10. In the absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates not to exceed those listed in the most current Florida Medicaid's Durable Medical Equipment for All Medicaid Recipients Fee Schedule, as of March 1, 2006, times a multiplier of up to 1.5. Equipment and supplies excluded from Medicare and Medicaid may be provided on a supplementary schedule.

d. **Additional Rules for Reporting:** The unit of service for reporting monthly activity for this service is one hour of in-home service and the unduplicated number of clients served. Providers must account for each hour of home health care rendered based on the assistance categories listed above.

Provider monthly reports for consumable medical supplies must include the number of patients served, consumable medical supply distributions per patient, and dollar amounts per patient. Providers must also submit to the County a list of the consumable medical supplies that will be available to the HIV+ client through home health care services. This list must

identify each piece of equipment and medical supplies using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate as defined in Section C above. Providers may submit a supplemental list for items that are not identified by Medicare first, or by Medicaid second.

e. **Special Client Eligibility Criteria:** Providers must document that HIV+ clients who receive Title I funded home health care services: (1) are permanent residents of Miami-Dade County; (2) have been determined homebound by their physicians (as defined by Medicaid Waiver) and have been referred for this service [eligibility certification must occur every six (6) months]; (3) have AIDS, as defined by the CDC, or a condition that makes home health care medically necessary as certified by a physician; (4) have been re-certified, every six (6) months, as homebound as stated by the physician in the client's care plan following Medicare re-certification guidelines; (5) have a household income that does not exceed 300% of the Federal Poverty Level; and (6) have been screened for eligibility under the Medicaid Waiver home health care program. Clients receiving home health care services must be documented as having been properly screened for Medicaid, Medicaid Waiver, or other public sector funding (i.e., the Medically Needy Program) as appropriate. Clients who qualify for Medicaid, Medicaid Waiver or other public sector funding, for home health services will only be eligible for Ryan White Title I funding for those units of service that exceed the limitations defined by Medicaid, Medicaid Waiver, or other public sector funding.

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LEGAL ASSISTANCE
(Year 16 Service Priority #13)

This service provides **Legal Assistance** to individuals living with HIV or AIDS who would not otherwise have access to these services. Services include assistance with estate planning, permanency planning, guardianship, and access to benefits, health care surrogates and other civil legal services, including issues faced by immigrants.

a. **Program Operation Requirements:** Funds may be used to support and complement pro bono activities. All legal assistance will be provided under the supervision of an attorney licensed by the Florida Bar Association. Only civil cases are covered under this Agreement. Therefore, the service provider will assist eligible Title I clients with civil legal HIV-related problems which will benefit the overall health of the client and/or the Ryan White care delivery system in the following areas:

- Collections/Finance – issues related to unfair or illegal actions by collection agencies, banks, utilities, or other lending/service organizations; or financial concerns relating to hospitalization.

- Housing Discrimination Services – issues related to wrongful evictions, evictions based upon financial reasons, refusals to rent/sell, or hostile living environment.

- Employment Discrimination Services – issues related to discrimination while at work, unfair terminations, unfair promotion policies, or hostile work environment.

- Accommodation Discrimination Services – issues related to denials of public accommodations/services.

- Adoption/Guardianship Services – issues relating to adoption and guardianship.

- Health Care Related Services – issues relating to ensuring that the client is treated in a fair manner, and issues relating to breach of confidentiality by divulging HIV status or other confidential medical/income information without client consent.

- Insurance Services – issues relating to seeking, maintaining, and selling of private insurance. This includes health and life insurance. Issues may also relate to refusal of coverage based upon "pre-existing conditions."

- Housing Services – issues relating to other than non-discrimination matters as defined above.

- Permanency Planning Services – issues relating to permanency planning as well as issues relating to will, power of attorney, health care surrogate, nomination of guardians, and estate planning.

- Dissolution of Marriage Services – issues relating to divorce proceedings.

- Child Custody/Visitation Services – issues relating to child custody and visitation litigation for parties who are already divorced or were never married.

- Child Custody/Visitation Services with Dissolution – issues relating to a divorce proceeding which involves child custody or child visitation. These cases will be designated as Child Custody/Visitation Services due to the amount of time and resources required for the child custody/visitation issues.

- Government Benefit Services – issues relating to obtaining or retaining public benefits which the client has been denied and is eligible to receive, including but not limited to Social Security Disability and Supplemental Income Services benefits, Unemployment Compensation, as well as welfare appeals, HOPWA appeals and similar public/government services.

- Individual Rights Services – this is a general service category that is used as the designation when another aforementioned service does not accurately reflect a client's legal issue.

- Rights of the Recently Incarcerated Services – this primarily relates to a client's right to access and receive medical treatment upon release from a corrective institution.

- Immigration Services – HIV+ clients will receive assistance with legal issues faced by immigrants who meet the eligibility criteria specified in this document.

Providers should demonstrate experience in providing similar services and the ability to meet the multi-lingual needs of the HIV/AIDS community.

b. **Special Client Eligibility Criteria:** Providers must document that HIV+ clients receiving Title I funded legal assistance are permanent residents of Miami-Dade County and have a household income that does not exceed 200% of the Federal Poverty Level.

c. **Rules for Reimbursement:** The unit of reimbursement for this service is *one hour* of consultation and/or advocacy at a rate not to exceed $85.00 per hour.

d. **Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of *one hour* of consultation and/or advocacy.

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DAY CARE SERVICES
(Year 16 Service Priority #14)

Services must be provided in state licensed facilities relieving caregivers of HIV+ children on a temporary or continuing basis; or temporarily relieving indigent HIV+ individuals with children of their responsibilities for care, allowing them to keep health and social service appointments. There are two types of day care services: **standard day care services** and **intensive day care services.**

I. Standard Day Care Services

This level of day care provides comprehensive and developmentally appropriate childcare to HIV+ asymptomatic children or children of HIV+ parents. These day care services include educational and social support to children requiring minimal medical care on a day-to-day basis. Please note that a child needing medications dispensed on a daily basis may be included in this standard day care program.

a. **Program Operation Requirements:** These services are to be provided at state licensed day care centers on a continuing basis if the child is HIV+; but temporarily if the child is HIV negative and the caregiver is HIV+ and requires this service only to attend medical and/or social service appointments. Agencies that are funded for this service must provide two (2) snacks and one (1) lunch to each child attending on a full-time basis (i.e., 8+ hours per day). Transportation for children to and from the day care program is a required service that providers may include as an allowable expense as part of their line item budget.

b. **Rules for Reimbursement:** The unit of service for reimbursement is the *number of filled day care slots per hour*. The rate for standard day care services may not exceed $3.75 per hour for each child. Children are enrolled in the day care program on a weekly basis. Providers must develop criteria, to be approved by the County, for determining limits on the number of reimbursable days for child absences, including vacation and sick days. At a minimum, this criteria must include: (1) the number of hours per day care day (e.g., if the agency's day consists of 8 hours, the number of reimbursable units per day care slot will be 8 per day); (2) the number of days per week that standard day care services are provided; (3) the total number of standard day care slots approved by the Department of Children and Families; (4) the number of standard day care slots assigned to the Title I program; and (5) the number of absences allowed before a client is removed from the day care slot.

c. **Additional Rules for Reporting:** Monthly activity reporting for child day care will be based on the number of *hours* of day care services provided by the agency.

d. **Special Client Eligibility Criteria:** Services are available to children from birth to and including age five (5). Providers must document that HIV+ asymptomatic clients receiving Title I funded day care services are 1) permanent residents of Miami-Dade County, and 2) have a household income that does not exceed 300% of the Federal Poverty Level. Clients receiving day care services must be documented as having been properly screened for Medicaid, Medicaid Waiver, and that the efforts have been made to enroll the Child in Head Start, subsidized day care or other public sector funding as appropriate. While clients qualify for and can access other public funding for day care services, they will not be eligible for Ryan White Title I funding for this service.

II. Intensive Day Care Services

This level of day care provides comprehensive and developmentally appropriate childcare focusing on medically involved children who are HIV+ symptomatic and/or have AIDS. This day care service includes educational and social support to children requiring medical care on a day-to-day basis. Day care service staff, at a minimum, must include a Registered Nurse and certified staff to provide medical care on an as needed basis (i.e., administer medications, speech therapy, monitor feeding tubes, etc.).

a. **Program Operation Requirements:** These services are to be provided at state licensed day care centers. Agencies that are funded for this service must provide two (2) snacks and one (1) lunch to each child attending on a full-time basis (i.e., 8+ hours per day). Transportation for children to and from the day care program is an optional service that providers may include as an allowable expense as part of their line item budget. Providers must specify plans to individualize the provision of care in an effort to satisfy the medical and social needs of each child. Each plan must incorporate parent participation. Agencies must demonstrate existing linkages with medical, special immunology, social services, and other providers.

b. **Rules for Reimbursement:** The unit of service for reimbursement is the *number of filled day care slots per hour*. The rate for intensive day care services may not exceed $7.00 per hour for each child. Children are enrolled in the day care program on a weekly basis. Providers must develop criteria, to be approved by the County, for determining limits on the number of reimbursable days for child absences, including vacation and sick days. At a minimum, this criteria must include: (1) the number of hours per day care day (e.g., if the agency's day consists of 8 hours, the number of reimbursable units per day care slot will be 8 per day); (2) the number of days per week that intensive day care services are provided; (3) the total number of intensive day care slots approved by the Department of Children and Families; (4) the number of intensive day care slots assigned

to the Title I program; and (5) the number of absences allowed before a client is removed from the day care slot.

c. **Additional Rules for Reporting:** Monthly activity reporting for child day care will be based on the number of *hours* of day care services provided by the agency.

d. **Special Client Eligibility Criteria:** Services are available to children from birth to and including age five (5). Providers must document that clients receiving Title I funded intensive day care services: 1) are permanent residents of Miami-Dade County; (2) are HIV+ symptomatic or have AIDS (as defined by the CDC); and (3) have a household income that does not exceed 300% of the Federal Poverty Level. Clients receiving day care services must be documented as having been properly screened for Medicaid, Medicaid Waiver, or other public sector funding as appropriate. While clients qualify for and can access other public funding for day care services, they will not be eligible for Ryan White Title I funding for this service.

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UTILITIES ASSISTANCE
(Year 16 Service Priority #15)

This service includes the provision of short-term emergency payments to vendors on behalf of HIV+ clients for **utilities (water & sewer, gas, electricity, and basic local telephone service)**. Under no circumstances shall payment be made directly to clients. It is important to note that maximum allowances are contingent on voucher availability, and client need relative to the documented need of other eligible clients.

a. **Program Operation Requirements:** Programs offering utility assistance must specify the total dollar amount of utility payments allocated for each month. This monthly allocation must be consistent throughout the duration of the contract period and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. For any given month, once an allotment of utility payments has been exhausted, providers may **not** continue to provide utility assistance for that month. If the monthly allocation has been exhausted prior to the end of the month, providers must report this information to the County. Outbound referrals may not be made for utility assistance, unless the required documentation has been reported (via fax) to the County. Providers are responsible for verifying County receipt of this information.

Providers must inform clients that this type of assistance is **not** an entitlement and is only available on an emergency basis. Therefore, the level of assistance provided to individual clients is based on relative need. Clients must also be informed that the availability of utility assistance is contingent upon funding availability and, therefore, the continuance of this type of assistance is not guaranteed.

Providers are required to assist clients who demonstrate the greatest need for these services. Therefore, providers must take into account not only minimum eligibility requirements, but also the following ranking system and definition of emergency to determine relative need:

Definition of Emergency

An emergency is an extreme change: loss of income (i.e., job loss, death or departure of person providing support), loss of housing, release from institutional care (substance abuse treatment, hospital, jail or prison) within the last two weeks. Duration is to be short. Other emergencies, as defined by the client's case manager, must be documented in the client's record as they arise.

System for Assessing/Ranking Relative Need

Case managers are required to apply the following ranking system to each client when a request for utility assistance is received and prior to making a referral for this service:

Factor	Number of Points Assigned
Extreme change (emergency)	15
Income less than 100% of the Federal Poverty Level	3
Income less than 75% of the Federal Poverty Level	4
Income less than 50% of the Federal Poverty Level	5
Undocumented Client	2
Client has dependents (1 point for each dependent to a maximum of 3)	1-3

Providers must also ensure that payment to utility vendors on behalf of clients is done in a timely manner in order to avoid interruption of utility services.

Case management providers who wish to offer utility assistance services must clearly state how a complete separation between case management and utility assistance services will be maintained, other than eligibility screening and processing six (6) month referrals. Case managers will in no way be involved in processing utility assistance payments on behalf of Title I clients.

b. **Rules for Reimbursement:** Providers will be reimbursed based on properly documented invoices from vendors for vouchers or client accounts. Dispensing charges, not to exceed 15%, will be reimbursed after services have been provided, client utilization and disbursement information is submitted to the County, and vendor payment has been documented.

d. **Additional Rules for Reporting:** The unit of service for monthly reporting is dollars per client. Programs must also report the number of unduplicated clients served each month, and the dollars spent per client on detailed utility payments.

e. **Special Client Eligibility Criteria:** Clients must have a case management referral to receive this service. Client eligibility for this service must be certified by a case manager every six (6) months. Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs (i.e., HOPWA). This type of assistance will be limited to a combined maximum of $1,200 per year (Title I and HOPWA combined), and a Title I maximum of $100 per month, and may only be accessed after the client has exhausted HOPWA's twenty-one week utility assistance benefits for payment of monthly or final utility bills, or if the client is denied HOPWA assistance. Clients who are not able to access HOPWA utility assistance must document such circumstances and a copy of such documentation must be kept in the client's file. Providers must document that HIV+ clients who receive utility assistance: (1) are permanent residents of Miami-Dade County; (2) have AIDS (as defined by the CDC); (3) have a household income that does not exceed 150% of the Federal Poverty Level; and (4) have been screened for eligibility under the Life Line Program for telephone services. Clients receiving utility assistance must be

documented as having been properly screened for other public sector funding as appropriate. While clients qualify for and can access other public funding for utility assistance, they will not be eligible for Ryan White Title I funding for this service.

Clients who meet minimum eligibility requirements for Ryan White Title I utility assistance may receive one-month of utility assistance services. No additional utility assistance will be given until the client presents the case manager with proof of completed eligibility screening for other programs and the case manager has obtained proof of eligibility or documentation of non-eligibility.

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TRANSPORTATION SERVICES (VANS)
(Year 16 Service Priority #16)

This service provides free transportation to and from HIV service programs, Miami-Dade HIV/AIDS Partnership functions, and/or home for HIV+ patients and their qualified dependents and/or caregivers in cars or vans operated directly by service providers.

Providers of **Transportation Services (Agency Based Transportation/Vans)** must demonstrate coordination with Miami-Dade transportation agencies and services, Medicaid Special Transportation and Special Transportation Services (STS) and other existing transportation programs to avoid duplication of services.

a. **Program Operation Requirements:** These services are provided in combination with core services to clients of HIV service programs.

b. **Rules for Reimbursement:** The unit of service for reimbursement for this service will be a one-way trip at a rate not to exceed $12.00 per one-way trip (i.e., each way).

c. **Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of one-way trips.

d. **Special Client Eligibility Criteria:** Providers must document that HIV+ clients who receive Title I funded agency based transportation services: (1) are permanent residents of Miami-Dade County; (2) have a household income that does not exceed 150% of the Federal Poverty Level; and (3) have been documented as having been properly screened for other public sector funding as appropriate. Qualified dependents and/or caregivers are eligible to receive free agency based transportation with the client. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Title I funding for this service.

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TRANSPORTATION VOUCHERS
(Year 16 Service Priority #17)

This service provides Metro transportation passes or tokens to eligible HIV+ clients attending medical and/or social service appointments and their qualified dependents and caregivers. This includes monthly and daily passes.

Providers of **Transportation Vouchers (Passes and/or Tokens)** must demonstrate coordination with Miami-Dade transportation agencies and services, Medicaid Special Transportation and Miami-Dade Special Transportation Services (STS) and other existing transportation programs to avoid duplication of services. In addition, providers of transportation vouchers must apply to the Miami-Dade Transit Transportation Disadvantaged Program in order to obtain assistance for clients eligible under that program.

a. **Program Operation Requirements:** Programs offering transportation vouchers must specify the total dollar amount of vouchers allocated for distribution each month. This amount must be consistent throughout the duration of the contract period and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. For any given month, once an allotment of vouchers has been exhausted, providers may not distribute additional vouchers for that month. If the monthly voucher allocation has been exhausted prior to the end of the month, providers must report this information to the County. Outbound referrals may not be made for transportation vouchers unless the required documentation has been reported (via fax) to the County. Providers are responsible for verifying County receipt of this information.

   Providers must inform clients that this type of assistance is **not** an entitlement and is only available on an emergency basis. Therefore, the level of assistance provided to individual clients is based on relative need. Clients must also be informed that the availability of transportation vouchers is contingent upon funding availability and, therefore, the continuance of this type of assistance is not guaranteed.

   Providers must specify criteria, policies, and procedures utilized to determine transportation voucher allotments for clients, that must take into account not only minimum requirements, but also consideration for those clients who demonstrate the greatest need for these services.

   Documentation of monthly medical and social service appointments must be submitted by the client to the case manager before the client can receive transportation vouchers.

b. **Rules for Reimbursement:** Providers will be reimbursed based on properly documented invoices from vendors for vouchers or client accounts. Dispensing charges, not to exceed 15%, will be reimbursed after services have been provided, client utilization and disbursement information is submitted to the County, and vendor payment has been documented.

c. **Additional Rules for Reporting:** Providers must report monthly activity according to the dollar amount of the vouchers issued, the number of vouchers, and the unduplicated number of clients served.

d. **Special Client Eligibility Criteria:** Clients must have a case management referral to receive this service, and client eligibility for this service must be certified by a case manager every six (6) months. Providers must document that HIV+ clients who receive Title I funded transportation vouchers: (1) are permanent residents of Miami-Dade County; (2) have AIDS (as defined by the CDC); and (3) have a household income that does not exceed 150% of the Federal Poverty Level. Clients receiving transportation vouchers must be documented as having been properly screened for other public sector funding as appropriate. Qualified dependents and caregivers are eligible to receive transportation vouchers as long as they are not eligible to receive and cannot access this service under another funding source [i.e., Miami-Dade County Golden Pass Program, Special Transportation Services (STS), Medicaid, etc.]. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Title I funding for transportation services.

Clients who meet minimum eligibility requirements for Ryan White Title I transportation voucher services may receive a one-month supply of transportation vouchers. No additional vouchers will be given until the client presents the case manager with proof of completed eligibility screening for other programs and the case manager has obtained proof of eligibility or documentation of non-eligibility.

MIAMI-DADE HIV/AIDS PARTNERSHIP (PLANNING COUNCIL) STAFF SUPPORT
(Year 16 Service Priority #18)

Background

Staff support facilitates the functions and responsibilities of the Miami-Dade HIV/AIDS Partnership (Planning Council), County Board established by Ordinance No. 02-35 in accordance with the requirements of the Ryan White C.A.R.E. Act and other federal and state HIV-related grant programs. The Partnership's powers, duties, functions, and responsibilities include:

- Establish methods for obtaining input on community needs and priorities which may include public meetings, conducting focus groups, and convening ad-hoc panels.
- Develop a community-wide comprehensive plan for the Partnership and health services that is compatible with the State of Florida and the County's plan regarding the provision of health services to individuals with HIV/AIDS.
- Establish housing, and care and treatment recommendations, including priorities.
- Establish priorities for the allocation of Title I funds within the County, including how best to meet each such priority and individual factors that the County should consider in granting funds under Title I of the Ryan White C.A.R.E. Act based on the following:

  a. documented needs of the HIV-infected population with the County;

  b. cost and outcome effectiveness of proposed strategies and interventions, to the extent that such data are reasonably available;

  c. priorities of the HIV-infected communities for whom the services are intended; and

  d. availability of other governmental and non-governmental resources.

a. Program Operations Requirement

Providers of this service are required to have extensive experience in health care planning, website development and maintenance, research skills, grant writing, experience in board development, and knowledge of HIV/AIDS issues.

b. **Staff Support Activities**: These services include, but are not limited to the following staff functions:

Planning, Coordination, and Staffing of Partnership Activities

1) Provision of clerical and professional staff support services to the Partnership, its standing committees, ad-hoc committees, the Chair of the Partnership, the Chair-Elect, Committee Chairs, grantees and the County as it relates to the business of the Partnership and its committees.

2) The staff support entity will be responsible for securing meeting rooms for Partnership and committee meetings. Meeting locations should be accessible by public transportation or the staff support entity will be responsible for making alternative arrangements. Facilities must also be accessible to persons with disabilities as required by the Americans with Disabilities Act (ADA) and meetings must be conducted in accordance with Miami-Dade County's policies regarding ADA compliance.

3) The staff support entity will assist the Chair of the Partnership, Chair-Elect, and the Chairs of committees with scheduling of meetings and the preparation of meeting agendas. Staff is specifically responsible for all meeting logistics, including scheduling, notification to the public, identification of meeting site, acquisition of meeting supplies and necessary equipment, preparation and duplication of meeting materials (as needed), the provision of refreshments to Partnership members at meetings to conduct Partnership business.

4) The staff support entity will be responsible for publicly noticing all meetings of the Partnership and its committees in accordance with the Government in the Sunshine Law, tape recording of all meetings, production of written minutes for all meetings, distributing meeting notices and other documents, drafting correspondence, and all record keeping and reporting functions for the Partnership.

5) The provider of staff support services must also be able to respond to requests for information from the public pertaining to Partnership business.

6) Partnership staff, in addition to those duties outlined above, will be required to have at least one staff member attend all meetings of the Partnership and committees to provide assistance to the various groups. Partnership staff must at all times act in accordance with the County Ordinance which established the Partnership, the Partnership's bylaws, and the Partnership's Policies and Procedures Manual and monitor the Partnership's compliance with same. Specific staff responsibilities will vary from committee to committee based on the responsibilities of each

specific group. The provider will also be required to provide guidance to the committee Chairs regarding Robert's Rules of Order and the proper conduct of a meeting.

7) The provider will be responsible for performing analysis of policy changes made by the Partnership and its committees and report any findings to the Partnership for its consideration. In addition, staff must follow directions given in the form of a motion by a committee or the full Partnership. Staff will be required to follow-up on such directives and requests in a timely manner and report back to the County, the Partnership or committee regarding progress, etc.

8) The provider will be responsible for coordinating and facilitating all Partnership activities pertaining to grievance resolution in accordance with the Miami-Dade HIV/AIDS Partnership's Grievance Procedures (for grievances against the Partnership). In addition, the provider of this service will be expected to assist the Partnership with evaluating and modifying its grievance policies and procedures as necessary.

9) The Partnership staff support entity must also budget sufficient resources to provide support and assistance to Partnership members in accordance with the Partnership's Reimbursement Policies and Procedures, as well as County and federal guidelines.

Research, Data Collection, Reporting & Document Production

This component of staff support services includes document production and periodic updates to the Partnership's Needs Assessment and Comprehensive Plan for the delivery of HIV/AIDS services in Miami-Dade County; preparation of the County's annual Ryan White Title I grant application; and preparation of other reports as necessary. These responsibilities will involve extensive research and data collection, in addition to report preparation and document production. The provider will be expected to conduct research, analysis, report findings, and make recommendations, to the Partnership, its Committees, and the County in response to Partnership directives.

Assessment of HIV/AIDS Service Needs in Miami-Dade County

Needs assessment is the cornerstone of the Ryan White C.A.R.E. Act planning process. It is an essential component of the Miami-Dade HIV/AIDS Partnership's process of determining service priorities and funding allocations on an annual basis. The provider will be responsible for conducting the needs assessment and all related activities as directed by the Partnership and its committees. At the conclusion of these activities a final needs assessment document summarizing these activities and findings must be published and provided to Partnership members and the County. This document will serve as the basis for the

determination of service priorities and funding allocations to be established by the Partnership.

Needs assessment activities must include processes to determine the needs of those individuals who know their HIV status and are not receiving primary medical care. Findings and recommendations regarding this population must be incorporated in the Title I grant application, the HIV/AIDS Comprehensive Plan, and other documents as appropriate.

The provider of this service must incorporate in the needs assessment activities conducted for the Miami-Dade HIV/AIDS Partnership any and all applicable federal legislative requirements.

The preparation of the Needs Assessment require extensive experience in research methods; data analysis and presentation; survey design and methodologies; statistical and policy analysis; health planning; and general knowledge of HIV/AIDS issues.

Preparation of the Ryan White Title I Grant Application

The specific elements of Miami-Dade County's annual Ryan White Title I grant application that the provider of this service will be responsible for preparing vary slightly from year to year based on the application guidance issued by the Federal government. The performance of this duty requires excellent grant writing skills and the ability to access statistical data related to HIV epidemiology in Miami-Dade County. The provider of this service must work closely with the County. The provider must also meet all deadlines, produce high quality work products, and be able to quickly revise drafts based on input from the County and the Partnership. In addition, the provider of this service must be able to incorporate information on the Needs Assessment process (see description below) and the HIV/AIDS Comprehensive Plan, in its entirety, in the Title I grant application.

Updates to the HIV/AIDS Comprehensive Plan

The Partnership's HIV/AIDS Comprehensive Plan is composed of the following elements: a vision statement; statements of shared values; major goals with specific objectives; and a master schedule that includes specific dates of implementation or completion of each objective.

The provider will be responsible for updating the HIV/AIDS Comprehensive Plan as necessary. In addition, the provider will also be expected to furnish technical assistance to the Partnership in the implementation of the Comprehensive Plan and assist in the development and revision of the implementation schedule as necessary.

The provision of these services requires extensive experience in research methods; data analysis and presentation; survey design and methodologies; statistical and policy analysis; health planning; and general knowledge of HIV/AIDS issues.

Outreach, Public Relations, Recruitment, & Training

This component of staff support services include outreach and public relations activities that would increase community awareness of the importance of participating in the Title I HIV/AIDS planning process, and specifically focus on improving the level of involvement from persons living with HIV. One of the primary objectives of these activities is to recruit new members to the Partnership. The provider of this service will be required to conduct culturally sensitive outreach efforts with special emphasis on parity, inclusiveness and representation and engaging persons living with HIV and consumers of Title I services. The service provider must identify specific strategies to reach out to special target groups of the HIV/AIDS community.

The provider will also be responsible for assisting the County with orientation sessions for new Partnership members, as well as developing and maintaining training workshops for current members of the Partnership. Workshop topics for Partnership members will address various issues ranging from updates on HIV/AIDS research to subjects such as health policy and program planning. Providers will be required to schedule, coordinate, and arrange for training workshop logistics and provide appropriate written and visual materials as necessary.

The provision of the services included in this component require experience working with the HIV/AIDS community; experience in implementing effective media and outreach campaigns; experience in developing and conducting effective training programs; and general knowledge of HIV/AIDS issues.

Miami-Dade HIV/AIDS Partnership Website Development and Maintenance

This component of staff support services requires the continuous development and maintenance of the Miami-Dade HIV/AIDS Partnership's Internet website (www.aidsnet.org) to foster public interest in Partnership activities, and make important information on HIV/AIDS services and programs easily accessible to the community, including consumers, health care and social services providers, and representatives of State and local governments. The provider will be responsible for updates to the information posted on the website.

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SERVICE DELIVERY INFORMATION SYSTEM
(Year 16 Service Priority #19)

The Ryan White Title I Service Delivery Information System (SDIS) is a centralized computer network that facilitates coordination of services and communication across Title I funded providers of HIV/AIDS medical and social support services.

Key features of the SDIS include:

1. An on-line mechanism that facilitates standardized, systematic data collection from all Title I service providers.

2. Core functions that facilitate the collection of client demographic data, medical and financial eligibility information, service utilization data, and the preparation and production of standard reports, including service providers' monthly reimbursement requests (billing).

3. Task management and communication by case managers through tools such as mailbox, E-Mail, Follow-up, and Referrals.

4. User access to an on-line resource directory.

5. Serves as the backbone of the Ryan White Title I Coordinated Case Management System by:

    - Allows case managers immediate access to client information via the system's Service Delivery/Utilization option, including client eligibility for Title I funded services.

    - Reduces duplication and fragmentation within the service delivery system.

    - Assures greater continuity of the client's care plan and adherence to eligibility requirements under the Title I program.

    - Allows users to input, at a minimum, Ryan White Title I required intake client data through the Registration/Intake option.

    - Allows entry of units of services provided (client encounters).

The functions and features listed above will only be available for clients who have completed in full and signed the SDIS Consent to Release and Exchange Information Form.

The Service Delivery Information System is and will remain complaint with Year 2K requirements and with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

On-going Maintenance Activities and Frequency:

The SDIS System Manager will continue to maintain the System for Miami-Dade County and Title I funded providers. The following are on-going activities and duties associated with the daily operations of the SDIS:

- Create and update system dictionaries and tables, including service provider specific fee schedules.

- Respond to, diagnose, and report system errors in hardware, software, and those generated by users. System management staff will diagnose and correct errors as they occur.

- Perform system backups to tape. This process includes backups of key databases.

- Verify database integrity and structure on the main server and backup server by running a comprehensive batch job.

- Run various reports to ensure the integrity of the data. These reports include, but are not limited to: Duplicate Clients Report, Service Delivery Report (# of units per service category), Service Delivery Costs by Service Category Report, Aggregate Demographics Report.

- Check hard disks for errors, de-fragment the hard disks, and compress the datasets.

- Provide routine technical assistance to users, including assistance on issues ranging from a request for simple instructions to solutions to complex system operation problems.

- Provide users system documentation appropriate for each user level. System documentation must be updated as system modifications are implemented.

- Produce non-routine and non-standard reports. This includes reports for the Title I Needs Assessment, Title I grant application, the Miami-Dade HIV/AIDS Partnership, its committees and the Title I grantee.

- Provide the County and/or its designee all service utilization data and client demographic information in ASCII numeric format; fixed field format is preferred, but comma delimited is acceptable.

- Inventory of equipment: track movement of hardware components by location and date; file and maintain provider agreements for equipment loan/responsibility; maintain adequate insurance coverage on equipment; allow Miami-Dade County access to inventory records, conduct inventory of hardware, in the field and on-site, and provide OSBM a written inventory report upon request *(frequency: as needed and on-going).*

- Conduct duplicate client checks regularly and as requested by OSBM or Title I providers. Duplicate client checks should only include active clients. The System Manager and service providers will coordinate the merge of client records verified to be duplicates to create one unique record. Service providers will be expected to submit a record merge request indicating the following information: the client's CIS #, SFAN # (if available), JMH # (if available), Social Security #, and/or agency ID #. Active clients are defined are those individuals who have received at least one service during the current fiscal year *(frequency: as needed and on-going).*

- Assist Title I providers with uploading (transfer) information into the SDIS; examine data to ensure integrity, maintain a log of all data transfers conducted, and report this information to OSBM on a monthly basis.

- Allow Title I service providers' access to client records, only if the providers have an SDIS Consent to Release and Exchange Information Form signed by the client.

- Allow Title I service providers access to the following SDIS functions and other functions resulting from system enhancements performed under this agreement: Registration/Intake, Service Delivery/Utilization, Standard Reports, Billing, Mailbox, and case management functions which include Follow-Up, Progress Notes, Referrals, Eligibility Verifications, Resource Directory and Case Management reports.

- Update the SDIS Case Management Module (care plan) in accordance with the standard Client Needs Assessment tool to be adopted by the Miami-Dade HIV/AIDS Partnership and the County.

- Update the SDIS in accordance with standard forms adopted by the HIV/AIDS Partnership for collection of demographic data, medical and financial client eligibility information, as well as any other form specified below.

- Assist the County with maintaining and updating service codes available in the SDIS to identify specific services provided to Title I service recipients under each service category.

- Update and maintain the SDIS HIV/AIDS Resource Directory to include Title I and non-Title I services available in the community.

- Develop a plan for future system upgrades (i.e., software releases, and hardware enhancements) along with a preliminary budget.

- Perform a gap analysis (comparison) of existing system capabilities and newly developed specifications to identify needed modifications.

- Update user support policies and procedures as necessary; incorporate this information in documentation (i.e., training manual) distributed to users.

- Update report formats (i.e., reimbursement reports, CARE Act Data Reports, Progress Reports, etc.) based on new specifications to be provided by the County, as necessary.

- Develop a comprehensive user-training curriculum and provide training slots for Title I providers as necessary and as agreed upon by the System Manager and Miami-Dade County. Each training session should be approximately one half/full day in length. The sessions will accommodate up to six SDIS users. Three types of training sessions will be offered: Core, Case Management, and Billing. Miami-Dade County will be notified of the users and Title I service providers who participate in each training session. This information will be submitted monthly to Miami-Dade County .

- Provide an up-to-date SDIS training manual to each user attending the training sessions.

- Provide technical assistance site visits to Title I service providers. Site visits will be limited to resolving problems related to the hardware, software, and/or communications capabilities of the SDIS, as well as technical issues that cannot be diagnosed and/or corrected over the phone.

- Maintain existing communication ports [with room for expansion] for currently funded Title I providers for access to the SDIS, and provide new communication ports as needed.

- Maintain existing telecommunication lines [with room for expansion] to link currently funded Title I providers to the central system located at the System Manager's office, and provide new telecommunication lines as needed.

- Pick-up SDIS equipment from Title I providers once funding expires. This activity will be conducted by a mutually agreed upon date.

- Conduct SDIS User Group sessions on a semi-annual basis. Additional sessions will be scheduled based on user request.

- Update, as needed, and submit to Miami-Dade County the hardware criteria for the installation of equipment at provider sites. Equipment installation will be performed upon approval by the County at a date mutually agreed upon by the System Manager and the service provider. The System Manager will not install additional equipment at a service provider site without prior approval from the County.

Additional System Enhancements

Special Features

- Enhance the ability to generate a receipt for services rendered by individual providers, to include, at a minimum, the following information: service provider name, client CIS #, date of service, description of service rendered (service category),

units of service rendered, cost per unit, and total charge to the Title I program.

Data Verification/Quality Control

- Track by client, not by provider (i.e., across all providers), utilization of services with maximum limits or other types of restrictions. Warn users of instances when a client will exceed an established limit, while allowing for dependents when appropriate based on Title I service specifications.

- Update the SDIS to include specific service limitations as these change during the year (i.e., grocery vouchers weekly, monthly, and annual limits; utility assistance monthly and annual limits; transportation vouchers restrictions; dental care and prescription drug limitations; food service restrictions limiting client enrollment to only one food service program at a time, etc.) in order to facilitate monitoring of service utilization and providers' compliance with program specifications.

- Continue to alert users of a possible duplicate at the time of data entry, and add to the system a pop-up reminder that would prompt users to access the edit function to correct entry (i.e., two vouchers to one client on the same day).

- Increase reasonability checks, quality assurance and control, data integrity and error checks.

- Develop additional data verification prompts to ensure that users enter accurate information in the system (minimize entry of "out of range" data).

Case Management

- Continue to provide system capability to perform inter-agency referrals that are not certified.

- Continue to provide system capability to generate all referrals at the end of the Care Plan through the Standard of Care Print function.

Billing

- Maintain in the system three options for billing voucherable services:

    1. Regular monthly reimbursement requests;

    2. Request for an advanced payment of dollars needed to purchase vouchers only; dispensing fee to be reimbursed at a later time (partial pre-payment);

    3. Request for an advanced payment of dollars needed to purchase vouchers and the dispensing fee (full pre-payment usually done at the end of the contract period to allow bulk purchases).

All options must be available to all providers contracted to distribute vouchers; however, only one option may be selected at any given time. These options should also be available under each contract awarded to a provider, if the contract includes voucherable services.

System Security

- Develop and update a security and disaster recovery plan to include security profiles for all users and design templates, as needed and on-going, based on user utilization of the system.

Requests Not Included in the Scope of SDIS Maintenance Services

- This service covers all costs associated with initial installation and configuration of standard hardware and software necessary to access and operate the SDIS. Additional requests submitted to the System Manager by Title I service providers (i.e., move equipment; modify, change or upgrade equipment/software, etc.) are not covered under the scope of SDIS maintenance services funded by Title I, unless otherwise indicated by the County.

- Requests made to the System Manager by Title I service providers to perform site visits for problems not related to the hardware, software, or communication failures specific to the SDIS are not covered under the scope of SDIS maintenance services.

- Requests by individual providers for customized programming are not covered under the scope of SDIS maintenance services, unless the System Manager and Miami-Dade County agree to approve such request due to possible enhancements to the SDIS and potential benefits to other service providers.

- Requests made to the System Manager by Title I service providers to have additional training slots for Core, Case Management, Billing or any other hardware/software training not related specifically to the SDIS are not covered under this scope of SDIS maintenance services.

QUALITY MANAGEMENT
(Year 16 Service Priority #20)

Quality Management assesses the extent to which HIV health services provided with Title I grant funds are consistent with the most recent Public Health Services (PHS) guidelines for the treatment of HIV disease and related opportunistic infections, and to develop strategies for ensuring that such services are consistent with the guidelines for improving access to care and the quality of HIV health services.

a. Program Operations Requirement

Providers of this service are required to have extensive experience in quality management and improvement, research, data analysis, knowledge of health care administration, familiarity with the HIV system of care and knowledge of current HIV/AIDS issues.

b. Federal Requirements

The federal granting agency, the U.S. Health Resources and Services Administration (HRSA), has defined quality as follows:

"Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluations of the quality of care should consider (1) the quality of the inputs, (2) the quality of the service delivery process, and (3) the quality of outcomes, in order to continuously improve systems of care for individuals and populations."

Based on federal requirements, quality management programs must accomplish a three-fold purpose:

1) Assist direct service medical providers funded through the C.A.R.E. Act in assuring that funded services adhere to establish HIV clinical practice standards and Public Health Services guidelines to the extent possible.
2) Ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care.
3) Ensure that available demographic, clinical and health care utilization information is used to monitor the spectrum of HIV related illnesses and trends in the local epidemic.

While the focus and ultimate goal of quality management is improved health status for clients, the quality management program looks beyond clinical services to include consideration of both supportive services that link clients with health care and community/population outcomes.

Quality Management programs must conform to the following federal expectations:

1) Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks.
2) Focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement.
3) Be a continuous process that is adaptive to change and fits within the framework of other programmatic quality assurance improvement activities (i.e., Joint Commission on the Accreditation of Hospitals Organization [JACHO], Medicaid, and other HRSA programs).
4) Ensure that data collected is fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

c. Quality Management Activities

Providers of quality management services will be expected to perform, at a minimum, the following activities:

1) Develop and implement a quality management plan and performance improvement initiative that integrates service providers, consumers, the Miami-Dade HIV/AIDS Partnership, and the County in a coordinated, continuous quality improvement process. This initiative must include specific benchmarks and on-going activities such as assessment and training.

2) Recommend measurable system level outcomes, as well as client centered and process outcomes for services funded under Title I. Outcome measures should document the impact of Title I funds on improving access to quality care and treatment.

3) Evaluate the existing Title I system of care, including case management and system-wide standards of service, and identify problems in service delivery that affect health status outcomes at the client and system levels.

4) Evaluate the quality and effectiveness of Title I funded services and report to the Miami-Dade HIV/AIDS Partnership with recommendations on service policies, standards of care, and funding allocations.

5) Assist the Miami-Dade HIV/AIDS Partnership with the integration of quality management efforts in the HIV/AIDS Comprehensive Plan.

6) Evaluate service costs in relation to the quality of service delivery and make recommendations to the Miami-Dade HIV/AIDS Partnership and the County on appropriate reimbursement structures for specific services.

7) Utilize the Title I Service Delivery Information System (SDIS) to analyze the quality of services rendered by Title I providers and make recommendations to the Miami-Dade HIV/AIDS Partnership and the County on system modifications and data collection.

8) Assist the County, as needed, with monitoring activities pertaining to service providers' compliance with quality management and continuous quality improvement (CQI) requirements.

9) Develop appropriate methodologies and conduct client record reviews for Title I funded services. Report findings to service providers, the Miami-Dade HIV/AIDS Partnership, and the County.

10) Provide follow-up technical assistance to service providers with identified need for quality management improvements. Coordinate technical assistance efforts with the County to ensure comprehensive assistance to funded agencies.

d. Training Activities

Training Program for Case Management Staff

A primary goal of the case management training program is to enable case management staff to facilitate access to primary medical care and related HIV/AIDS services to persons infected with HIV through increased knowledge of case management and greater exposure to existing resources. To this end, the training program will include basic case management training as needed and monthly supplemental training. The curriculum will include the process of case management service provision (intake, assessment, care planning, monitoring), documentation, service coordination, effective referral and linkage practices, and HIV-related issues. Supervisors will also receive at least part of their required training through this Title I training series.

Training Program for Medical Staff

Training for this provider segment will include the PHS guidelines, Title I Standards of Care, Title I services as well as community resources to address client needs for supportive services, and coordination of care with other care providers.

Training Program for Outreach Workers

The training curriculum for outreach workers will include recognition of high risk behaviors and effective strategies for linking clients to care, negotiating and communication skills, documentation of service delivery, coordination with other care givers, and cultural sensitivity.

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