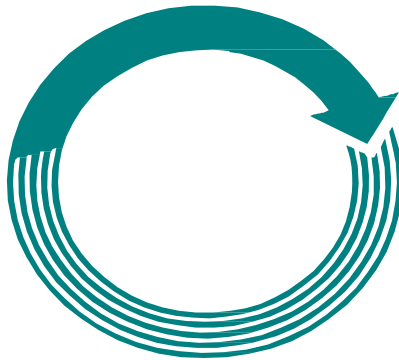


Ryan White Part A Quality Management



Integrated Primary Care & Behavioral Health Service Delivery Model

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Ryan White Part A Quality Management

Integrated Primary Care & Behavioral Health Service Delivery Model

Broward EMA Definition:

Integrated Primary Care and Behavioral Health is the systematic coordination of physical and behavioral health care. This includes the provision of professional diagnostic and therapeutic services and behavioral health services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, behavioral health screening, examination, medical history, diagnosis and treatment of common physical and mental health conditions, prescribing and managing medication therapy, education and counseling on health and mental health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Practitioner Definition:

Physicians, Nurse Practitioners, and Physician Assistants with current prescribing privileges in the State of Florida.

Practitioner Continuing Education Recommendation:

Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two years. When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year.

HRSA Definition:

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services directly to a client by a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

Client Outcome	Outcome Indicators	Inputs	Strategies	Data Source
1. Slow clients' HIV disease progression.	<p>1.1. 95% of clients are prescribed ART.</p> <p>1.2. 80% of clients on ART for >6 months will have a viral load <200 copies/mL.</p>	<p>Funding</p> <p>Staff</p> <p>Clients</p> <p>Tests/Labs</p>	<p>1.1.1. Complete appropriate diagnostic testing</p> <p>1.2.1. The clinician should refer to appropriate guidelines for treatment strategies</p> <p>1.2.2. Monitor and follow-up</p>	<p>1.1.1.1. Clients Health record</p> <p>1.1.2.1. PHS Guidelines, DHHS Guidelines, IAS Guidelines</p> <p>1.1.2.2. Clients Health record</p>

STANDARDS OF CARE

Note: Data source is client health record unless stated otherwise.

Documentation of HIV Infection

Standard	Indicator
1. Documentation of HIV infection ⁱ is in medical record.	1.1. 100% of client health records have documentation of HIV positive status. Diagnosed by a rapid HIV test or a conventional enzyme-linked immunosorbent assay (ELISA) and confirmed by Western blot, indirect immunofluorescence assay, or 4 th generation HIV-1/2 Antigen/Antibody Combination test OR a detectable viral load.

Laboratory Testing

2. Basic laboratory tests shall be obtained.	2.1. 100% of client health records have basic screening labs done by second visit. 2.2. 100% of client health records have complete labs per protocol. 2.3. 100% of client health records screen for Hepatitis A, B, and C.
3. CD4 T-cell count ⁱⁱ laboratory tests shall be obtained before and after start of antiretroviral therapy (ART).	3.1. 100% of clients have documentation of CD4 T-Cell count at entry into care and at/before ART initiation or modification. 3.2. 100% of clients have documentation of CD4 T-Cell count at least every 12 months if client is documented as adherent with suppressed HIV viral load and stable clinical and immunologic status for ≥2 years and CD4 count is 300-500 cell/mm ³ . If CD4 is >500 cells/mm ³ , CD4 monitoring is optional. 3.3. 100% of clients have documentation of CD4 T-Cell count every 3-6 months for all patients not meeting criteria in 3.2.
4. HIV RNA ⁱⁱ laboratory tests shall be obtained.	4.1. 100% of clients have documentation of HIV RNA at entry into care and at/before ART initiation or modification. 4.2. 100% of clients have documentation of HIV RNA every 3-6 months. Interval MAY be extended to 6 months only if patient is documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for >2 years. 4.3. 100% of clients have documentation of HIV RNA 2-8 weeks after ART initiation or modification. If HIV RNA is detectable at 2-8 weeks, repeat every 4-8 weeks until viral load is <200 copies/mL.
5. Resistance tests ⁱⁱ shall be obtained.	5.1. 100% of naïve clients have documentation of HIV-1 genotype resistance tests at entry into care. 5.2. 100% of clients have documentation of resistance tests at treatment failure with HIV viral load ≥ 1000 copies/mL. If patient is failing while on an INST, in addition to an HIV-1 Genotype, an INSTI resistance test should be ordered. If drug resistance is suspected, client should be on failing regimen at time of test or within 4 weeks of regimen discontinuation. For client with suspected treatment failure due to issues of adherence, medication intolerance, or pharmacokinetic reasons, resistance testing is not warranted until these reasons are addressed.
6. HLA-B*5701 ⁱⁱ laboratory test shall be obtained if considering start of abacavir.	6.1. 100% of clients have documentation of HLA-B*5701 if considering start of abacavir.
7. Tropism testing ⁱⁱ shall be obtained when considering use of CCR5 antagonist.	7.1. 100% of clients have documentation of Tropism testing if considering use of CCR5 antagonist.
8. Basic chemistry [Serum Na, K, HCO ₃ , Cl, BUN, creatinine, glucose (preferably fasting), and creatinine-based estimated glomerular filtration rate] ⁱⁱ , Liver function tests (ALT, AST, & T. bili) ⁱⁱ , CBC with differential ⁱⁱ shall be obtained.	8.1. 100% of clients have documentation of basic chemistry at entry into care. 8.2. 100% of clients have documentation of basic chemistry follow-up at least every 3-6 months. 8.3. 100% of clients have documentation of basic chemistry before ART initiation or modification. 8.4. 100% of clients have documentation of basic chemistry 2-8 weeks post-ART initiation or modification. 8.5. 100% of clients with chronic kidney disease who are on a TAF or TDF containing regimen will have serum phosphorous monitored with basic chemistry.
9. Fasting lipid profile ⁱⁱ shall be obtained.	9.1. 100% of clients have documentation of fasting lipid profile at entry into care and at ART initiation or modification. 9.2. 100% of clients have documentation of fasting lipid profile annually (if normal at last measurement) or every six months (if abnormal or borderline at last measurement).

10. Urinalysis ⁱⁱ shall be obtained.	10.1. 100% of clients have documentation of urinalysis at entry into care at ART initiation or modification. 10.2. 100% of clients have documentation of urinalysis at least every 12 months. 10.3. 100% of clients have documentation of urinalysis every 6 months if on TAF or TDF. 10.4. 100% of clients will have urine glucose and protein assessed before initiation with TAF or TDF containing regimen and will be monitored at least every 6 months while on regimen.
11. Hepatitis A screening ^v shall be obtained.	11.1. 100% of clients have documentation of Hepatitis A Screening - Hepatitis A total antibody (HAVAb) or IgG (not IgM).
12. Hepatitis B screening ^{iv} shall be obtained.	12.1. 100% of clients have documentation of Hepatitis B Screening - Hepatitis B core antibody (HBcAb) total or IgG (not IgM), Hepatitis B surface antibody (HBsAb), and Hepatitis B surface antigen (HBsAg). 12.2. 100% of clients with documentation of positive HBsAg, have further Hepatitis B testing; HBeAg, HBeAb and Viral Load by DNA PCR. 12.3. 100% of clients with chronic active hepatitis B are on combination ART that contains two active agents against HBV.
13. Hepatitis C screening ^{iv} shall be obtained.	13.1. 100% of clients have documentation of Hepatitis C Screening - Hepatitis C antibody (HCVAb). 13.2. 100% of clients with documentation of positive HCVAb, have Hepatitis C (HCV) Viral Load, HCV genotype, and a treatment plan in the record. If HCV antibody screening is negative, repeat annually or more frequently if at-risk.
14. Syphilis, N. gonorrhea (GC), and C. trachomatis (Chlamydia) screening shall be obtained ^{vi} .	14.1. 100% of clients have documentation of Syphilis screening at baseline and annually thereafter (specific testing includes Syphilis Serology as preferred approach ^{xvi}). 14.2. 100% of clients who report sexual activity since their last screening have documentation of N. gonorrhea (GC) and C. trachomatis (Chlamydia) screening annually (specific testing includes NAAT [as indicated by sexual history] as preferred approach ^{xvi}).

Immunizations/Treatments

15. Clients are offered immunizations.	15.1. 100% of clients are offered pneumococcal vaccine (both PCV13 and PPSV23) ^{vii} . 15.2. 100% of clients are offered influenza immunization ^{viii} . 15.3. 100% of non-immune clients are offered Hepatitis A and B vaccine ^{vii} . 15.4. 100% of males and females ages 11-26 years have received human papillomavirus vaccination. 15.5. 100% of clients who have not previously been vaccinated should receive meningococcal vaccination (two dose primary series of MenACWY) at least two months apart and revaccinate every 5 years.
16. Antiretroviral therapy shall be prescribed.	16.1. 100% of clients have documentation of consideration and discussion of ART at/before the times of CD4 T-Cell count and HIV RNA monitoring.
17. Treatment for opportunistic infections and prophylaxis for opportunistic infections shall be provided ^x .	17.1. 100% of clients have documentation of treatment, when indicated, for opportunistic infections. 17.2. 100% of clients have documentation of prophylaxis for opportunistic infections, when indicated, and prophylaxis is discontinued, when indicated.

Mental Health Assessments

18. A biopsychosocial evaluation and treatment plan are completed prior to treatment (treatment is defined as an intervention).	18.1. 100% of clients have completed biopsychosocial needs assessment by the third counseling session.
19. Complete clinical scales where appropriate.	19.1. 100% of biopsychosocial evaluation where depression, anxiety, schizophrenia, adjustment disorder with mood disorder, or bipolar disorder are suspected will have Mental Health/Substance Abuse QI Network approved clinical screening tool(s) administered.

20. Client has Treatment Plan based on the needs identified through biopsychosocial assessment and/or clinical screening tool.	20.1. 100% of client health records have a completed Treatment Plan. 20.2. 100% of client needs identified on the needs assessment are addressed in the Treatment Plan.
21. Re-assessment is ongoing and driven by client need.	21.1. 100% of clients will be reassessed every six months, at minimum.

Additional Assessments

22. Consenting female clients are given PAP test ^{xi} ^{xii} , at least annually.	22.1. 100% of health records of female clients show a PAP test and pelvic exam completed annually unless clinically not indicated or refused. 22.2. 90% of female clients for which a PAP test and pelvic exam were appropriate are successfully completed. 22.3. 100% of health records of female clients with abnormal PAP tests or with lesions present show referral to a gynecologist and the outcome will be documented.
23. Client is tested for Tuberculosis ^{ix} annually.	23.1. 100% of client health records document Tuberculin skin test (TST) reading or result of interferon-gamma release assay (IGRA) within 48-72 hours. 23.2. 100% of health records of clients with a positive PPD or IGRA reading are assessed for evidence of active TB or a prior treatment for active TB or LTBI or close contact with a person with infectious TB. 23.3. 100% of client health records show client with a positive PPD or IGRA reading is referred for chest x-ray and prophylactic treatment.
24. Mammogram ^{vi} (females) shall be provided.	24.1. 100% of female clients, starting at age 40, have documentation of offering mammogram annually. 24.2. 100% of female clients with documentation of abnormal mammogram have documented plan of care in record.
25. Colon and Rectal Cancer Screening ^{ix} shall be provided.	25.1. 100% of clients have documentation of colorectal cancer screening by being offered a colonoscopy starting at age 50. If unable to perform or if patient refuses, a fecal immunochemical test (FIT) or fecal occult blood test (FOBT) ^{xiii} should be performed every year (Hemoccult SENZA preferred). For FOBT used as a screening test, the take-home multiple sample method should be used. A FOBT done during a digital rectal exam in the practitioner's office is not adequate for screening. High risk groups should have screening earlier or more frequently based on USPSTF guidelines. 25.2. 100% of clients with documentation of abnormal screening have documented plan of care in record.

Care Assessments

26. Clients are educated about medication adherence.	26.1. 90% of clients with HIV infection, as part of their primary care, will be assessed and counseled for adherence at every visit.
27. Clients with HIV infection attend 2 or more medical visits annually.	27.1. 90% of clients with HIV infection attend 2 or more medical visits annually. 27.2. 100% of clients not adherent to 27.1 have documentation of attempts to re-establish in care.
28. Clients with CD4 T-cell counts below 200 are prescribed PCP prophylaxis.	28.1. 95% of clients with CD4 T-cell counts below 200 are prescribed PCP prophylaxis. 28.2. 95% of clients with IgG positive Toxoplasma gondii and CD4<100, are prescribed prophylaxis.
29. Pregnant women are prescribed antiretroviral therapy.	29.1. 100% of pregnant women are prescribed ART.
30. Cytomegalovirus (CMV) screening for patients with CD4 T-cell count < 50mm ³ .	30.1. 100% of clients with CD4 T-cell count < 50mm ³ , have documentation of education to notify providers if they experience increased floaters, and to assess their visual acuity regularly by reading newsprint or self-testing with an Amsler's grid.
31. Nutritional health education shall be assessed.	31.1. 100% of clients have documentation of annual nutritional assessment.
32. Oral health education/care shall be provided.	32.1. 100% of clients have documentation of annual oral health assessment referral to a dentist.

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33. Mental health assessment/care shall be provided.	33.1. 100% of clients have documentation of annual mental health assessment/care. 33.2. 100% of clients with documentation of depression have documented plan of care in record.
34. Drugs/Alcohol/ assessment/education shall be performed.	34.1. 100% of clients have documentation of drug/alcohol education/assessment at least annually.
35. Tobacco (including smokeless tobacco) assessment/education shall be performed.	35.1. 100% of clients who have used tobacco products within one year have documentation of tobacco (including smokeless tobacco) education/assessment at least annually.
36. Sexual health education, to include birth control method, discussion of condom use, and risk identification, shall be provided.	36.1. 100% of clients have documentation of sexual health education, to include birth control method, discussion of condom use, and risk identification, once a year.
37. Transgender ^{xy} health care.	37.1. 100% of transgender clients will have documentation of birth sex and self-reported gender identity. 37.2. 100% of transgender clients will receive routine health care within this document's standards appropriate for their birth sex as anatomically permitted. 37.3. 100% of transgender clients are assessed for additional medical and mental health needs in addition to those inherent in birth sex and including those incurred from additional anatomical changes.

Health Record Documentation

38. Current Medication List is in medical record.	38.1. 100% of client health records have a current Medication List in the client health record. (Data Source: Medication List)
39. Clients sign a written informed consent for vaccinations.	39.1. 100% of client health records show consent for each vaccine. 39.2. 100% of health records for incapacitated clients, show consent signed by a legal guardian or health care surrogate.
40. Client health record shall contain problem list.	40.1. 100% of client health records contain a problem list.
41. Client health record shall contain allergy list.	41.1. 100% of client health records contain an allergy list.
42. Client health record shall contain immunization list.	42.1. 100% of client health records contain an immunization list.

References

- i Aberg, et al. Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2009 Update by the HIV Medicine Association of the Infectious Diseases Society of America. 1 September 2009. CID 2009;49. p656.
- ii Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. November 3, 2008; Page 6; Table 3. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed October 10, 2009.
- iii Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. November 3, 2008; Page 6; Table 3. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed October 10, 2009.
- iv <http://www.clinicalcalculator.com/english/nephrology/cockroft/cca.htm>. Accessed October 11, 2009.
- v <http://www.aidsetc.org/pdf/workgroups/pcare/pcwg-heptools.pdf>. Accessed October 11, 2009.
- vi Counseling for Patients with HIV Infection and Referral to Support Services, page 18, Sexually Transmitted Diseases Treatment Guidelines, 2006, <http://www.cdc.gov/MMWR/PREVIEW/MMWRHTML/rr5511a1.htm>. Accessed July 21, 2009.
- vii http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp. Accessed July 21, 2009.
- viii <http://www.faetc.org/PDF/Newsletter/Newsletter-Volume10-2009/HIVCareLink-Vol10-Issue-5-April-15.pdf>
- ix <http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>. Accessed July 22, 2009.
- x Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.
- xi Routine pelvic examination and cervical cytology screening. ACOG Committee Opinion No. 431. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:1190–3.
- xii <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/womenHiv.htm> Accessed July 22, 2009.
- xiii http://my.clevelandclinic.org/services/fecal_occult_blood_test/hic_fecal_occult_blood_test.aspx. Accessed July 22, 2009.
- xiv Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents: Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2009;58(No. RR-4):20
- xv Definition by representatives of TLCA forum, January 2001.
- xvi The MMWR series of publications is published by the Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30329-4027. <https://www.cdc.gov/std/tg2015/tg-2015-print.pdf>

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PROTOCOL

The Integrated Primary Care and Behavioral Health Protocol identifies the specific ways to implement the integrated care standards and processes required in this service category. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, HAB HIV Core Clinical Performance Measures for Adults Clients Florida Medicaid Behavioral Health Handbook etc.) The delivery of primary medical care shall be conducted by culturally competent service providers.

Provider staff shall have a client grievance process that shall be discussed with client during intake. Provider staff shall explain that if a client is dissatisfied after completing the agency grievance process, the client has a right to present a grievance to the Broward County HIV Health Services Planning Council.

Accessing OAMC and Mental Health Care

The provider shall verify client's eligibility is established by reviewing the certification in the designated HIV MIS. The purpose of the verification is to ensure 1) client's access to all services that the client may be eligible for and 2) the status of Ryan White HIV/AIDS Program (RWHAP) as payer of last resort.

A staff person within the OAMC sub-client's agency will be required to complete the Patient Health Questionnaire-2 (PHQ-2) at every physician visit. If the score on the PHQ-2 is positive and/or the client shows signs of other mental health difficulties, such as hearing voices, paranoia, and/or situation anxiety, a warm hand off will be provided to a mental health staff person. If a warm handoff is not possible, the consenting client shall receive an appointment with a registered clinical intern or licensed practitioner within three (3) business days of the time the client is determined eligible to receive RWHAP Part A-funded mental health services.

Additional Intake Procedures for Mental Health Services

Agency staff shall collect client data using the agency intake form at which time the client shall receive an orientation of the RWHAP-funded service system. The Behavioral Health Services Combined Consent and Acknowledgment form consisting of *the General Consent for Evaluation, Referral and Treatment; Client Confidentiality; Consent for Urine Collection and Analysis (if applicable), Client Grievance Procedure, Client Rights, Client Responsibilities, Orientation and Freedom of Choice Provider List; and Consent for Research* shall be discussed and signed by the client and the registered clinical intern or licensed practitioner. A Consent to Release Information and Obtain Information shall be discussed with the client and signed by the client and the registered clinical intern or licensed practitioner.

Integrated Assessment of Client Needs

The clinical interview, laboratory testing and vital signs will be the modalities used for the integrated assessment of client medical and mental health needs.

Basic Vital Signs

- Blood Pressure
- Height
- Weight
- Basal Metabolic Index (BMI)
- Depression Score on PHQ 2
- Substance Use/Abuse Score on CAGE-AID

Complete Laboratory Tests

- Complete blood count
- Chemistries

State law all pregnant women should be recommended to receive HIV counseling and testing early during their pregnancy. Subsequently, all women with HIV infection should be offered an antiretroviral treatment regimen in accordance with USPHS, Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Prenatal HIV-1

Transmission in the United States.

- **Sexually Transmitted Diseases**

Biopsychosocial Assessment

- The registered clinical intern or licensed practitioner shall assess the client's biosychosocial needs using the Biopsychosocial Evaluation Form. The registered clinical intern or licensed practitioner shall complete the assessment in one session after intake. The biosychosocial evaluation must be reviewed and signed by a licensed practitioner prior to providing treatment or intervention to client.
- Use of the stages of change in assessing the readiness for treatment will be part of the assessment.
- Upon completion of the biopsychosocial evaluation the medical provider and behavioral health provider shall collaborate to:
 - Review client assessment results
 - Adjust medical treatment plan based on behavioral health status
 - Develop an integrated treatment plan
- Information from the complete blood chemistry panel shall be used to determine the risk of metabolic syndrome for persons with mental health services.

Integrating Existing Treatment Planning Processes

The Medical Practitioner will devise a treatment plans that addresses the findings of the medical assessment completed above. The Behavioral Health Practitioner will complete a treatment in accordance with the information below. The Disease Case Manager shall meet with the client and synthesized the findings of those two plans into an integrated treatment plan for and with the client. That integrated treatment plan will be shared with the treatment team at a regularly scheduled team meeting on an at least annual basis. Should the Disease Case Manager identify any urgent or emergent needs during the meeting with the client, those will be shared immediately within the team. The Disease Case Manager will secure the clients signature on the integrated treatment plan.

**Note-See the following for exceptions to the requirement for signature of participant, parent, guardian, or legal custodian:*

An explanation must be provided if the client's age or clinical condition precludes participation in the development and signing of the treatment plan.

There are exceptions to the requirement for a signature by the client's parent, guardian, or legal custodian. Documentation and justification of the exception must be provided in the client's medical record. The following are exceptions:

- As allowed by Chapter 397, F.S., clients less than 18 years of age seeking substance abuse services from a licensed service provider.
- As stated in Chapter 394.4784 (1 & 2), F.S., clients age 13 years or older, experiencing an emotional crisis to such a degree that he or she perceives the need for professional assistance. The client has the right to request, consent to, and receive mental health diagnostic and evaluation services, outpatient crisis intervention services, including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, or in a mental health facility licensed by the state. The purpose of such services is to determine the severity of the problem

and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services will not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services will not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

- Clients in the custody of the Department of Juvenile Justice that have been court ordered into treatment; or require emergency treatment such that delay in providing treatment would endanger the mental or physical well-being of the client. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.
- For clients in the care and custody of the Department of Children and Families (foster care or shelter status), the child's DCF or CBC caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases in which the Department of Children and Families is working toward reunification, the parent should be involved and should sign the treatment plan.

Unique Mental Health Treatment Planning Requirements

Individualized

The licensed or certified practitioner shall complete a Treatment Plan for each client based on the needs identified in the Biopsychosocial evaluation. A formal review of active treatment plans must be conducted at least once every six (6) months. The electronic treatment plan may be reviewed more often than once every six months when significant changes occur with patients. Treatment plans and quarterly updates shall be completed with client participation as evidence by client signature. Objectives shall be reviewed and updated with necessary modifications reflecting any new agreements.

The Treatment Plan must contain all of the following components:

- The client's ICD-10-CM or DSM diagnosis code(s) consistent with assessment(s);
- Goals that are appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences and needs expressed by client(s);
- Measurable objectives and target dates;
- A list of the services to be provided (Treatment Plan Development, Treatment Plan Review, and Comprehensive Behavioral Health Assessment need not be listed);
- It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week."
- Signature of the client;
- Signature of the client's parent, guardian, or legal custodian (if the client is under the age of 18);
- Signatures of the treatment team members who participated in development of the plan;
- A signed statement by the treating licensed practitioner that services are medically necessary and appropriate to the client's diagnosis and needs; and
- Transition or discontinuation of services.

Expected Outcomes

The registered clinical intern or licensed practitioner shall assist the client to define outcomes for the mental health needs addressed in the Treatment Plan. The strategies to achieve the outcomes shall be documented. The registered clinical intern or licensed practitioner shall document the progress and specific assistance provided to the client in the Progress Notes. Notes must be entered into the Client Information Software System within three (3) business days of interfacing with the client.

Client Participation

The registered clinical intern or licensed practitioner shall ensure client participation in the development

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of the Mental Health Treatment Plan. The client signature on the Treatment Plan shall evidence the client participation in the agreements stated. Registered clinical intern and licensed practitioner shall sign the Treatment Plan.

Review/Follow-up

Quarterly updates shall be completed with client participation. Objectives shall be reviewed and updated with necessary modifications reflecting any new agreements. This update shall be documented in Progress Notes.

Retention and Adherence to Medical and Mental Health Care

The Medical Practitioner and Mental Health provider shall assess and document adherence to treatment. Medical and mental health staff shall discuss with the client the reasons for not adhering to treatment, and with client participation, determine how staff can help him/her to adhere. The medical and mental health staff shall discuss and coordinate an intervention with the client and Disease Case Manager as to what needs to happen so he/she can adhere to treatment.

Appointment Adherence: If medical staff is unable to reach a client who has missed an appointment or when a client has missed two (2) appointments in a row, the medical provider will contact the Disease Case Manager first (if client receives this service).

- If the client is not receiving disease case management services, the medical provider will refer the client to outreach providers by telephone call, fax, or through the designated HIV MIS.
- If the client is receiving disease case management services and the client's medical case management provider cannot bring the client back to care, Disease Case Managers will refer the client to outreach providers by telephone call, fax, or through the designated HIV MIS.
- Within two (2) weeks, outreach providers will fax the final progress notes as follow-up on the case to the medical provider.

Medical and mental health staff shall assess and record the potential barriers to retention in medical and/or mental health and shall strategize with the client and coordinate with Disease Case Managers to identify the necessary action steps to assist the client to remain in treatment. The staff shall document all assistance given to the client in the Progress Notes.

Discharge

Medical

A client is considered out of medical care if they have not attended a medical appointment within the previous six (6) months.

Mental Health

Clients shall be discharged from mental health services based on the following criteria:

- Successful completion of the treatment program (13 sessions)
- Severity of trauma – referral to trauma informed care for clients in need of long term assistance
- Practitioner determines client is no longer adherent to treatment plan
- Transfer client to another registered clinical intern or licensed practitioner
- Disruptive or hostile behavior
- Client dies
- Client declines services
- Client relocates
- Client is referred to another provider
- Client leaves the jurisdiction before completing treatment

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The registered clinical intern or licensed practitioner shall complete a Transfer/Discharge Summary form to document client discharge or transfer to another registered clinical intern or licensed practitioner.

Medications

Medications will be documented in all clients' health records with start and end dates.

Specialist Referrals

The practitioner shall refer client to appropriate specialist based on the client clinical status. Disease Case Manager must be contacted to ensure linkage of the referral and conduct follow-up activities. Examples of referrals are: Female client health records show gynecology referral of patient with a cervical lesion or identifies atypical squamous cells (ASCUS and ASC-H), low-grade squamous intraepithelial lesion (LSIL, CIN1), high-grade squamous intraepithelial lesion (HSIL, CIN2-3, carcinoma-in-situ) and invasive carcinoma level PAP. Ophthalmology for patient with CD4 count less than 50/ul or with ocular manifestations. Psychological/psychiatric for patient presenting with mental health needs.

The practitioner may make appropriate Medical Nutritional Therapy (MNT) referral when client reports any of the following and agrees to a MNT referral:

1. Physical changes/weight concerns
2. Oral or gastrointestinal symptoms
3. Barriers to nutrition, living environment, functional status
4. Changes in diagnosis requiring nutrition intervention

Transgender Care

Transgender individuals are defined as individuals whose gender identity, expression, or behavior is not traditionally associated with their birth sex.

Professional Requirements

Medical

Practitioner must have current prescribing privileges within the State of Florida. Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two (2) years. When a new practitioner is working with a contracted provider, a new practitioner is encouraged to comply within one year.

Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:

- a. DHHS Clinical Guidelines
<http://www.aidsinfo.nih.gov/Guidelines/>
- b. American Association for the Study of Liver Diseases (AASLD)
<http://www.aasld.org/>
- c. ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults
http://www.onlinejacc.org/content/accj/63/25_Part_B/2889.full.pdf
- d. American Cancer Society Guidelines for the Early Detection of Cancer
http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp
- e. European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV
<http://www.ncbi.nlm.nih.gov/pubmed/18257770>
- f. Lipid Disorders subset of the AIDS Education and Training Centers
http://www.aids-ed.org/sites/default/files/resources_files/Dyslipidemia_Patient_Assessment.pdf
- g. CDC Recommended Adult Immunization Schedule
<http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf>
- h. Incorporating HIV Prevention into the Medical Care of Persons Living with HIV

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.html>

Mental Health

Education

Minimum of a Master degree in Mental Health Counseling, Marriage and Family Therapy, Social Work or Psychology

Credentials

- Active Florida license in any of the above
- Florida registered clinical intern

Experience

Clinician

Registered clinical intern or licensed practitioner AND minimum of one (1) year serving clients with a chronic medical condition preferred

Supervisor

Licensed practitioner and State of Florida Qualified Supervisor AND minimum of one (1) year in a supervisory role in a mental health program

Integrated Primary Care & Behavioral Health Service Delivery Model

Appendix A – Quick Guideline for Laboratory Testing (Current as of 10/11/09)

The following is a minimal guideline based upon the current DHHS Guidelines
Additional labs should be ordered as clinically needed and appropriate

Baseline labs

CD4 T-cell count
HIV RNA
Resistance testing (HIV-1 Genotype)
Basic chemistry - Serum Na, K, HCO₃, Cl, BUN, creatinine,
glucose (preferably fasting)
ALT, AST, T. bili, D. bili
CBC w/ differential
Fasting Lipid Profile (12 hours fasting)
Fasting Glucose or Hemoglobin A1c (12 hours fasting)
Urinalysis
Hepatitis A total antibody (HAVAb) or IgG (not IgM)
Hepatitis B core antibody (HBcAb) total or IgG (not IgM)
Hepatitis B surface antibody (HBsAb)
Hepatitis B surface antigen (HBsAg)
Hepatitis C antibody (HCVAb)
Syphilis (RPR)
N. gonorrhea (GC) (GC NAAT swab and urine test)
C. trachomatis (Chlamydia) (Chlamydia NAAT swab and
urine test)

3-6 month labs, post ART

CD4 T-cell count
HIV RNA
Fasting Lipid Profile (12 hours fasting)
Fasting Glucose (12 hours fasting)
Urinalysis (Urine protein and glucose if on TDF or TAF)

12 months

Prostate-specific antigen (PSA) Screening (males)
Syphilis (RPR)
N. gonorrhea (GC) (GC NAAT swab and urine test)
C. trachomatis (Chlamydia) (Chlamydia NAAT swab and
urine test)
Urinalysis

ART initiation or switch

CD4 T-cell count
HIV RNA
Resistance testing (HIV-1 genotype, INSTI genotype if
indicated)
Basic chemistry - Serum Na, K, HCO₃, Cl, BUN, creatinine,
ALT, AST, T. bili, D. bili
CBC w/ differential
Fasting Glucose (12 hours fasting)
Urinalysis

2-8 weeks post-ART initiation

HIV RNA
Basic chemistry - Serum Na, K, HCO₃, Cl, BUN, creatinine,
glucose (preferably fasting)
ALT, AST, T. bili, D. bili
CBC w/ differential

Treatment Failure

CD4 T-cell count
HIV RNA
Resistance testing

Special Circumstance

HLA-B*5701 - If considering start of abacavir and
document in record carrying data forward to most
current volume

Tropism testing – If considering use of CCR5 antagonist
(for trofile (R) HIV viral load must be ≥ 1000 ; trofile(R)DNA if
viral load is undetectable)
If performed, record carried forward to most current
volume

Pregnancy test (females) – if starting an efavirenz containing
regimen