BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Integrated Primary Care & Behavioral Health Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Outpatient/Ambulatory Health Services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable OAHS activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Local Definition

Integrated Primary Care and Behavioral Health (IPCBH) is the systematic coordination of outpatient/ambulatory medical care and behavioral health care services. This includes the provision of professional diagnostic, therapeutic services, behavioral health services rendered by a physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse provider, psychiatrist, psychologist, licensed clinical social worker, or other mental health professional licensed or authorized within the State of Florida to render such services in an outpatient setting. Settings include clinics, medical offices, mobile clinics, and telehealth. Emergency department and urgent care services are not considered outpatient settings.

Services provided include diagnostic testing, early intervention and risk assessment, preventive care and screening, behavioral health screening, physical examination, medical history, diagnosis and treatment of common physical and mental health conditions, prescribing and managing medication therapy, education and counseling on health, behavioral 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). Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

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

II. Key Service Components and Activities

All IPCBH service providers must adhere to the minimum requirements stated in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Provision of IPCBH – Primary Medical Care services must align with the U.S. Department of Health and Human Services (HHS) and U.S. Preventative Services Taskforce Recommendations (USPSTF) best practices and recommendations. Provision of IPCBH – Behavioral Health services must be consistent with Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook. Providers of IPCBH are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Primary Medical Care

ART Initiation

The current federally approved medical practice Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV[2] endorse immediate initiation of antiretroviral therapy (ART). Patients who are candidates for rapid ART initiation[3]:

- Have a new reactive point-of-care HIV test result or a new HIV diagnosis (confirmed through the Centers for Disease Control and Prevention HIV testing algorithm[4]) or acute HIV infection (HIV antibody negative and HIV RNA positive) or known HIV, and
- Are treatment-naive, or
- Have a history of limited ART use (e.g., a person who stopped first-line therapy for reasons other than regimen failure), as long as concern for acquired drug resistance is low (requires a case-by-case determination).

Laboratory Tests

Providers are expected to conduct testing in compliance with HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV[2]. The following laboratory tests are included as a standard treatment of care:

Baseline Visit (Initiation of Medical Care)

- HIV-1/2 Antigen and Antibodies, 4th Gen *(if prior HIV serostatus labs not available)*
- Absolute CD4 cell count with percentage CD4
- CBC with differential and platelets
- Resistance Testing *(HIV-1 RNA Quant PCR)*
- Syphilis Antibody w/cascading reflex

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[2]Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf . Accessed 10/9/2020.

[3] This material was accessed on 10/09/2020 on the HIV Clinical Resource website (https://www.hivguidelines.org/antiretroviral-therapy). The HIV Clinical Guidelines Program is a collaborative effort of the New York State Department of Health AIDS Institute and the Johns Hopkins University Division of Infectious Diseases. Copyright © Johns Hopkins University HIV Clinical Guidelines Program 2000-2016.

[4] Centers for Disease Control and Prevention. Laboratory testing for the diagnosis of HIV infection: updated recommendations. https://stacks.cdc.gov/view/cdc/23447

- Comprehensive Metabolic Panel (CMP) *(Basic Chemistry: including ALT, AST, and Total Bilirubin)*
- Hepatitis A Antibody total
- Hepatitis B Serology *(HBsAb, HBsAg, HBcAb total)*
- Hepatitis C Screening *(HCV antibody or, if indicated, HCV RNA)*
- Toxoplasma Antibody (IgG) (*when indicated)*[5]
- Urinalysis
- Chlamydia/Gonococcus, NAAT (s*ite specific swabs as indicated and urine)*
- Random or Fasting Lipid Profile
- Random or Fasting Glucose
- Resistance Testing *(HIV-1 Genotype)*
- Quantiferon TB Gold *(when indicated)*[5]
- HLA-B*5701 *(when initiating abacavir-containing regimen)*
- Pregnancy test *(for people of childbearing potential)*

Every Six Months

- Basic Chemistry: including ALT, AST, and Total Bilirubin *(when indicated)*
- Absolute CD4 cell count with percentage CD4 *(during first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm^3)*
- CBC with Differential *(when monitoring CD4 cell count; perform CBC cell count and CD4 concurrently)*
- Resistance Testing *(HIV-1 RNA Quant PCR)*
- CMP *(while on Tenofovir containing regimen)*
- Urinalysis (*for clients on tenofovir disoproxil fumarate and tenofovir alafenamide containing regimens)*

Every Twelve Months

- Absolute CD4 cell count with percentage CD4 *(after 2 years CD4 and % CD4 in presence of undetectable viral load and CD4 300-500. If CD4 greater than 500, optional to repeat)*
- CBC with Differential *(when no longer monitoring CD4 cell count)*
- Hepatitis B Serology (HBsAb, HBsAg, HBcAb total) *(May repeat if patient is non-immune and does not have chronic HBV infection)*
- Hepatitis C Screening *(HCV antibody or, if indicated, HCV RNA)*
- Urinalysis
- CMP *(while on Tenofovir containing regimen)*

Viral Load Monitoring [2]

After initiation of ART or modification of therapy because of virologic failure: Plasma viral load (VL) should be measured before initiation of ART and within 2 to 4 weeks, but no later than 8 weeks, after treatment initiation or modification. Repeat VL measurement should be performed at 4- to 8-week intervals until the level falls below the assay's limit of detection.

[5] Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and Adolescents: Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/adult_oi.pdf . Accessed 10/09/2020.

Virologically suppressed patients whose ART was modified because of drug toxicity or for regimen simplification: VL measurement should be performed within 4 to 8 weeks after changing therapy.

Patients on a stable, suppressive ART regimen: VL should be repeated every 3 to 4 months, or as clinically indicated, to confirm continuous viral suppression. Clinicians may extend the interval to 6 months for adherent patients whose VL has been suppressed for more than 2 years and whose clinical and immunologic status is stable.

Patients with suboptimal response: The frequency of VL monitoring will depend on clinical circumstances, such as adherence and availability of further treatment options. In addition to VL monitoring, additional factors, such as patient adherence to prescribed medications, suboptimal drug exposure, or drug interactions, should be assessed. Patients who fail to achieve viral suppression should undergo resistance testing to aid in the selection of an alternative regimen (see Drug-Resistance Testing [6] and Virologic Failure and Suboptimal Immunologic Response [7] sections).

Referral Procedures for Behavioral Health Services

A hallmark of integrated primary medical care includes the use of the Patient Health Questionnaire (PHQ-9) as a part of measurement-based care to improve patient outcomes. The PHQ-9 shall be either provider-administered or self-administered.[8] If a client's score on the PHQ-9 is greater than 11 and/or the client demonstrates or reports signs and symptoms of mental illness or behavioral health concerns, the client must be introduced in person, by phone, or by telehealth platform to a behavioral health professional.[9] If the primary medical care provider is unable to provide the client with an immediate introduction to a behavioral health professional, the provider must immediately schedule an appointment with a behavioral health professional at the client's earliest convenience prior to leaving the facility. The primary medical care provider is required to follow-up via phone with the client to remind them of their first scheduled appointment and identify and discuss any barriers to the client attending the appointment.

If a client scores 5 – 10 on the PHQ-9, indicating mild depression, a plan for follow-up and rescreening must be noted in the medical care and treatment plan.

Specialist Referrals

Providers must refer clients to specialists for diagnostic and treatment services as determined by the client's clinical status. If the client utilizes Disease Case Management (DCM) services, their disease case manager must be contacted to ensure linkage of the specialist referral and conduct follow-up activities, accordingly.

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[6] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf . Accessed 10/09/2020 page C-12.

[7] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf . Accessed 10/09/2020 page I-1.

[8] Gelenberg, A.J. (2017) (J of Clinical Psychiatry), Kroenke, K. et al (2001) (J of General Internal Med) and VA/DoD (2016)

[9] Crane, P. K., Gibbons, L. E., Willig, J. H., Mugavero, M. J., Lawrence, S. T., Schumacher, J. E., Saag, M. S., Kitahata, M. M., & Crane, H. M. (2010). Measuring depression levels in HIV-infected patients as part of routine clinical care using the nine-item Patient Health Questionnaire (PHQ-9). AIDS care, 22(7), 874–885. https://doi.org/10.1080/09540120903483034

Providers may refer eligible clients to Medical Nutritional Therapy (MNT)[10]. Clients who receive an MNT referral must have the diagnosis of diabetes, chronic kidney disease, or have had a kidney transplant within the last 36 months. An MNT referral can also be made when a client reports any of the following concerns and agrees to an MNT referral:

- Physical changes, including weight concerns
- Oral or gastrointestinal symptoms
- Barriers to nutrition such as living environment, functional status, economic and geographic barriers such as living in a food desert
- Changes in diagnosis requiring nutrition intervention

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicators	Measures
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients are retained in Integrated Primary Care and Behavioral Health services.	1.1.1. Client appointment record in the designated HIV Management Information System (MIS).
	1.2. 90% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	1.2.1. Client prescription of ART documented in the designated HIV MIS.

IV. Assessment and Treatment Plan

Primary Medical Care Assessment and Screening Process

The provision of primary medical care assessments and behavioral health screenings must be consistent with the current HHS treatment guidelines and U.S. Preventative Services Taskforce Recommendations (USPSTF). Primary medical care providers must ensure client completion of the PHQ-9 at every primary medical care visit.

Primary Medical Care Comprehensive Health Assessment

The provider must complete an initial comprehensive health assessment within three (3) sessions from the time of a client's initial visit. The purpose of the initial comprehensive health assessment is to evaluate the client's clinical status, social/lifestyle issues, sexual and emotional health, knowledge of HIV, ability to adhere to prescribed medication regimens, immunization records/needs, and prevention needs for recommended health screenings, including but not limited to, prostate-specific antigen (PSA) screening, mammogram and pap smear, colon cancer screening, or Dual-Energy X-ray Absorptiometry (DEXA) Scan.

Clients must be reassessed within six months after completion of the initial comprehensive health assessment or sooner if the client's circumstances change significantly. Thereafter, reassessments

[10] The Los Angeles County Commission on HIV. *MEDICAL NUTRITION THERAPY SERVICES.* Accessible at http://hiv.lacounty.gov/LinkClick.aspx?fileticket=q1l1KKC-ACQ%3d&portalid=22

are conducted, at minimum, every six months. The initial assessment and reassessment must include, at a minimum:

- General medical history, including sexual history
- Medication reconciliation
- Screening for opportunistic infections
- Comprehensive HIV-related history
- Comprehensive physical examination
- Nutritional assessment
- PHQ-9
- Psychosocial screening, including alcohol and substance use, domestic violence, and housing status
- Tobacco use screening
- Additional screenings as clinically indicated, such as vision and hearing

Medical Care and Treatment Plan

Primary medical care providers must develop a medical care and treatment plan with the client's input based on the results of the client's comprehensive health assessment findings. Providers must update medical care and treatment plans at every client visit, at minimum. If a client declines a treatment, such as vaccination, documentation of the client's denial and reason for the denial must be documented. The client medical care and treatment plan must document:

- Chief complaint
- Vital signs
- Presenting symptoms list
- Assessment/diagnosis
- Current medications and adherence
- Vaccinations
- Proposed treatment in accordance with current HHS Treatment Guidelines
- Follow-up protocol and actions to be taken if client does not attend follow-up appointment
- Referrals and recommendations for treatment and/or intervention
- Client decision to accept offers for treatment, referrals, and recommended support services

Behavioral Health Assessment

Clients referred to Behavioral Health services must complete a biopsychosocial assessment within three treatment sessions. The biopsychosocial assessment must be reviewed and signed by a licensed professional and documented in the designated HIV MIS. During the first encounter with a client, the Behavioral Health provider must establish a provisional diagnosis and treatment plan goal. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[11]
- Biological factors
- Psychological factors

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

- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

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

Behavioral Health Treatment Plan[12]

Providers must work with each client to develop a detailed behavioral health treatment plan that directly addresses the primary diagnosis(es) that is(are) consistent with the assessment. The behavioral health treatment plan must be an individualized, structured, and goal-oriented schedule of services with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Behavioral health treatment plans become effective on the date the plan is signed and dated by the licensed behavioral health practitioner and the client.

Behavioral health treatment plans must contain, at minimum, the following components:

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

Behavioral Health Treatment Plan Review

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

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

modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed professional and the client.

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

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

V. Standards for Service Delivery

Table 2. IPCBH - Primary Medical Care Standards for Service Delivery

Standard	Measure
1. Clients have documentation of HIV+ status in their medical record.	1.1. Documentation of HIV+ test and results in the client chart.
2. Client complete initial comprehensive health assessment within three sessions from the time of a client's initial visit, and every six months thereafter.	2.1. Documentation of initial comprehensive health assessment in the client chart.
3. Clients complete a PHQ-9 at every primary medical care visit.	3.1. Documentation of PHQ-9 score in the client chart.
4. Clients whose score on the PHQ-9 is greater than 11 are referred to Behavioral Health services.	4.1. Documentation of PHQ-9 score in the client chart. 4.2. Referral documented in the designated HIV MIS.
5. Providers follow-up via phone with the clients referred to behavioral health services to remind them of their first scheduled appointment.	5.1. Documentation of referral follow up in the designated HIV MIS.
6. Providers develop a medical care and treatment plan with the client's input based on the results of the client's comprehensive health assessment findings.	6.1. Documentation of medical care and treatment plan in the client chart.
7. Clients are offered immunizations in accordance with HHS guidelines, including: • Pneumococcal vaccine and a follow up booster 5 years later	7.1. Documentation of immunizations in the client chart.

Standard	Measure
• Annual influenza immunization • Hepatitis A and B vaccine as clinically indicated.	
8. ART is prescribed as clinically indicated.	8.1. Documentation of prescribed ART in the client chart.
9. Treatment for opportunistic infections and prophylaxis for opportunistic infections is provided when clinically indicated.	9.1. Documentation of treatment in client chart.
10. Female clients receive cervical cancer screenings as clinically indicated. Clients with an abnormal PAP test result or documented cervical lesion present receive a referral to a gynecologist.	10.1. Documentation of screening and results in the client chart. 10.2. Referral documented in the designated HIV MIS.
11. Female clients, starting at age 40, receive a mammogram annually. Clients with an abnormal mammogram are referred to a specialist and have a plan of care.	11.1. Documentation of screening and results in the client chart. 11.2. Referral documented in the designated HIV MIS.
12. Clients receive colon and rectal cancer screenings as clinically indicated.[13]	12.1. Documentation of screening and results in the client chart.
13. Clients are assessed and counseled for medication adherence at every primary medical care visit.	13.1. Documentation of assessment and counseling provided in the client chart.
14. Clients with CD4 T-cell counts below 200 and/or CD4 percentage less than 14% are prescribed PJP prophylaxis as clinically indicated. [14]	14.1. Documentation of laboratory test results in the client chart. 14.2. Documentation of prescription in the client chart.
15. Clients with potential to be pregnant must receive pregnancy test at ART initiation and as clinically indicated be prescribed ART as clinically indicated.	15.1. Documentation of pregnancy screening in the client chart. 15.2. Documentation of ART prescription in the client chart.
16. Clients are referred to oral health care, if not engaged in the last six months.	16.1. Referral documented in the designated HIV MIS.
17. Clients receive an annual oral examination.	17.1. Documentation of oral health examination in the client chart.
18. Clients receive sexual health education annually, including birth control methods, pregnancy planning, discussion of condom use, risk identification, and PrEP for partners.	18.1. Documentation of sexual health education in the client chart.

[13] National HIV Curriculum. *Primary Care Management.* Accessible at National HIV Curriculum, Basic HIV Primary Care, Primary Care Management, Cancer Screening.
[14] National HIV Curriculum. *Opportunistic Infections: Treatment.* Accessible at https://www.hiv.uw.edu/page/qb/topic/co-occurring-conditions/opportunistic-infections-treatment

Standard	Measure
19. Transgender-inclusive healthcare is provided, including: • Documentation of birth sex and self-reported gender. • Routine healthcare clinically appropriate for client' birth sex as anatomically permitted. • Assessment of additional medical and mental health needs, in addition to those inherent in birth sex and incurred from additional anatomical changes.	19.1. Documentation of transgender-inclusive healthcare provided in the client chart.

Table 3. IPCBH – Behavioral Health Standards for Service Delivery

Standard	Measure
1. Client is asked to give expressed and informed consent for treatment.	1.1. Signed informed consent form in the client chart.
2. Providers conduct a biopsychosocial assessment with each client prior to the development of a treatment plan within three treatment sessions.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HIV MIS.
3. Providers conduct additional behavioral health clinical scales, when clinically indicated.	3.1. Completed clinical scales signed by the licensed practitioner in the client chart.
4. Providers work with each client to develop a detailed treatment plan.	4.1. Treatment plan signed and dated by licensed professional and client in the designated HIV MIS.
5. Providers conduct a formal treatment plan review at least every six months.	5.1. Updated treatment plan with signature and date of licensed professional and client in the designated HIV MIS.
6. Assistance provided to clients and progress made toward achieving treatment plan goals is documented in the client chart within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client chart.
7. All client communication is documented in the client chart and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	7.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the client chart.
8. Progress notes in the client chart is linked to a treatment plan goal.	8.1. Progress notes in the client chart.