CAPITAL
HEALTH PARTNERS

SCREENING STEPS

1. Modify the Practitioner Letter and Practitioner Fax Back Form with your medical group/IPA information. This can be hand-written in the blanks provided.

2. Annually and at the time of initial contracting or credentialing of new practitioners, identify practitioners within your roster that possibly qualify as HIV/AIDS specialists. Annual screening is required because:

   - Some of the qualifications are good only for 12 months
   - Qualifying practitioner may decide to change his preference regarding being listed as a qualifying practitioner.

3. Fax or mail the Practitioner Letter and Practitioner Fax Back Form to all identified practitioners within your medical group. Potentially qualified practitioners may be:

   - Primary Care Physicians – Family Practice, Internal Medical, Pediatrics, etc.
   - Internal Medicine specialists
   - Infectious Disease specialists

4. Follow-up with practitioners to ensure all Practitioner Fax Back Forms are completed and returned to the medical group/IPA. Completion requires:

   - Either a yes or a no answer regarding their wish to be designated for your medical group as an HIV/AIDS specialist according to the definition in the state regulations.
   - If they answer "Yes," then they must also indicate HOW they qualify by selecting one or more of the qualifications as defined by the state regulations. If the practitioner modifies their response, then they do NOT qualify.

5. Have the documentation of the process and responses available at the time of health plan credentialing annual assessments.

As always, notify all health plans with which you participate when the standing of a provider in your medical group/IPA changes, including the self-designation of HIV/AIDS specialist.

Identification of Qualified HIV/AIDS Practitioners

Date:

[Insert practitioner's name]
[Insert address]
[Insert City, State Zip]

Dear Doctor ____,

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, we need to routinely identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist. Please complete the attached form indicating:

- Your preference to be listed as a qualifying HIV/AIDS specialist for the purpose of receiving standing referrals for members whose condition requires ongoing treatment by a practitioner with the specified expertise in treating their condition.
- If you state you wish to be listed for purposes of standing referrals, then please indicate the criterion or criteria, as defined by state regulation, under which you qualify. You must meet at least one of these criteria as written in order to qualify.

We will use your information for internal referral procedures.

As always, please notify us promptly if information about your practice changes.

Thank you for your cooperation. We appreciate your continued dedication to our patients.

From: Calibrated Health Care Network

Medical Group Name: Capital Health Physicians, Inc.,

Contact Person: Isela Ochoa

Contact Person Telephone Number: (909) 242-8194 Ext. 8124

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Email To: Iochoa@calibratedhealthcare.org **Return by:** ________________

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on one of the criteria below :

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified, or have earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; **OR**

☐ I am board certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ Meet the following qualifications:
In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patientes who are infected with HIV; **AND**
Completed any of the following:

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of infectious disease from a member board of the American Board of Medical Specialties; **OR**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**

3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (Print): ________________________________ Date: ____________________

Physician's Signature: ___________________________________ License #________________

Telephone #: ____

Name of Person Submitting Form: ____

Title of Person Submitting Form: ____

Calibrated Healthcare Network