Ambulatory Outpatient Medical Care (includes Medical Case Management, Local Medication Program & Service Linkage)	**Pg**
Service Category Definition – Part A: CBO	**1**
Service Category Definition – Part A: Public Clinic	**15**
Service Category Definition – Part A: Rural	**31**
Service Category Definition – Part A: Pediatric	**47**
Client Satisfaction Report, 2016	**59**
FY15 Primary Care Chart Review, RWGA December 2016	**73**
FY15 Performance Measures Report ⇨ Highlights ⇨ Local Pharmacy Assistance ⇨ Medical Case Management ⇨ Primary Care	**107** 108 109 110 111
HIV Care Outcomes Among Blacks with Diagnosed HIV – MMWR, February 2017	**115**
Trauma Informed Care for HIV+ Homeless Patients – Harris Health System	**123**
Health-Related Quality of Life Among People Living with HIV/AIDS Receiving Case Management - Journal of HIV/AIDS & Social Services, 2016, Vol. 15, No. 2, 202–215	**125**

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2017 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service

	component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of

	Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic 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, 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 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. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment

	adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services

(either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order).

Outpatient/Ambulatory Primary Medical Care must provide:

- Continuity of care for all stages of adult HIV infection;
- Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems);
- Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems);
- Access to the Texas ADAP program (either on-site or through established referral systems);
- Access to compassionate use HIV medication programs (either directly or through established referral systems);
- Access to HIV related research protocols (either directly or through established referral systems);
- Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible.
- On-site Outpatient Psychiatry services.
- On-site Medical Case Management services.
- On-site Medication Education.
- Physical therapy services (either on-site or via referral).
- Specialty Clinic Referrals (either on-site or via referral).
- On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral.
- On site Nutritional Counseling by a Licensed Dietitian.

Services for women must also provide:

- Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications.
- Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.

- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.

	• Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients

	with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-

	site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.

	Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical**

	Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire. **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in

	order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS.

	Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance

	Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per

	day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic 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, 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 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. • **AIDS Pharmaceutical Assistance (local)** includes local

	pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**

ocal Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services.

- On-site Medication Education.
- Physical therapy services (either on-site or via referral).
- Specialty Clinic Referrals (either on-site or via referral).
- On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral.
- On site Nutritional Counseling by a Licensed Dietitian.

Women's Services must also provide:

- Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications.
- Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their

medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Local Medication Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the

	counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service

	Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is

	subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive

	ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those**

	Medical Case Managers by 03/30/15, and thereafter within 15 days after hire. **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore,

	potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g.

	weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2017 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2017 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding.

	Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other

	allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic 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, 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 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. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The

	coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed

	dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education

and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:
- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.

	• Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a

	comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines.

	Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation

	throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and

	certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary

	Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements):

	Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will

	utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See FY 2017 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of

	direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic 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, 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 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. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

	• **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability

	to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for females of child bearing age must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or

Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Medical Case Management Services: Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan.

Service Linkage: The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-

	needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.

Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to**

	RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire. **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for

	services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers

	shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

SUMMARY FOR HOW TO BEST MEET THE NEED

Harris County
Public Health
Building a Healthy Community

RYAN WHITE PART A QUALITY MANAGEMENT PROGRAM
HOUSTON EMA
CLIENT SATISFACTION REPORT, 2016
PREPARED BY HARRIS COUNTY PUBLIC HEALTH
RYAN WHITE GRANT ADMINISTRATION

MARCH 2017

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SERVICE CATEGORIES

OUTPATIENT/AMBULARTORY CARE SERVICES -- PAGE 2

Five agencies administering surveys provide outpatient/ambulatory care services to adult clients. Approximately one hundred eighty-seven (187) clients returned client satisfaction surveys about their outpatient/ambulatory care services. See the Attachments section for the comprehensive output for outpatient/ambulatory care services.

DRUG/PHARMACY SERVICES -- PAGE 7

Overall, there were 58 clients who responded in the pharmacy services. The responses were favorable in general however, the volume of clients surveyed was relatively low. In order to gauge client satisfaction levels, RWGA-QMD will focus on assisting sub-recipients with data collection during the FY 2017 – 2018 grant year. See the *Attachments* section for the comprehensive output for pharmacy services.

CASE MANAGEMENT SERVICES -- PAGE 11

There were 252 respondents for case management services and the general consensus was favorable. See the *Attachments* section for the comprehensive output for case management services.

CLIENT SATISFACTION SURVEY SERVICE CATEGORY SUMMARY

OUTPATIENT/AMBULARTORY CARE SERVICES

HOW OFTEN	ALWAYS	MOST OF THE TIME	SOMETIMES	NOT VERY OFTEN	NEVER	NOT APPLICABLE	TOTAL
does the doctor/clinician treat you with dignity and respect?	160 86%	16 9%	6 3%	3 2%	1 1%	1 1%	**187**
does the doctor/clinician seem to understand your disease?	155 83%	24 13%	6 3%	0 0%	1 1%	1 1%	**187**
do you feel comfortable asking your doctor/clinician questions?	141 75%	31 17%	10 5%	2 1%	1 1%	2 1%	**187**
does the doctor/clinician answer your questions?	154 82%	17 9%	12 6%	3 2%	0 0%	1 1%	**187**
are you given the opportunity to participate in decisions about your	137 74%	25 13%	11 6%	4 2%	5 3%	4 2%	**187**

treatment? For example: Telling the doctor which meds work best for you, asking about new treatments, etc.							
does the doctor/clinician or staff talk to you about nutrition and foods you eat?	79 43%	46 25%	34 18%	9 5%	15 8%	1 1%	**187**
does the staff ask if you have other problems or needs that are not being addressed?	107 58%	42 23%	21 11%	7 4%	5 3%	1 1%	**187**
do you find the information provided to you by the staff to be correct and helpful?	130 71%	40 22%	11 6%	2 1%	0 0%	0 0%	**187**
If you make appointments, how often are you able to get	112 62%	49 27%	16 9%	3 2%	1 1%	1 1%	**187**

them scheduled for a reasonable date and during hours that are convenient for you?							
HOW SATISFIED	**VERY SATISFIED**	**SATISFIED**	**NOT SATISFIED**	**UNSATISFIED**	**VERY UNSATISFIED**	**NOT APPLICABLE**	**TOTAL**
are you with how well the doctor/clinician explains your medications to you? For example: Discusses possible side effects, correct dosage, purpose of meds, etc.	138 74%	41 22%	2 1%	3 1%	2 1%	0 0%	**187**
are you with the staff's efforts to make sure that all of your personal information stays confidential?	136 74%	43 23%	1 1%	2 1%	1 1%	0 0%	**183**
are you with the quality of the service you	141 78%	36 20%	3 2%	0 0%	1 1%	0 0%	**181**

receive from this agency overall?							
Access [Wait-Time]	**VERY SATISFIED**	**SATISFIED**	**NOT SATISFIED**	**UNSATISFIED**	**VERY UNSATISFIED**	**NOT APPLICABLE**	
How satisfied are you with the amount of time that usually passes between the time of your appointment, and the time you actually receive service?	50 27%	94 52%	24 13%	7 4%	5 3%	2 1%	**183**
	VERY SATISFIED	**SATISFIED**	**NOT SATISFIED**	**UNSATISFIED**	**VERY UNSATISFIED**	**NOT APPLICABLE**	
How would you rate the convenience of the office hours here?	97 53%	55 30%	25 14%	4 2%	1 1%	1 1%	**182**
RECOMMEND	**VERY HIGHLY**	**HIGHLY**	**NOT HIGHLY**	**RELUCTANTLY**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
would you recommend this agency to others?	128 71%	46 25%	2 1%	2 1%	1 1%	1 1%	**182**
HOW MUCH	**VERY MUCH**	**SOME**	**A LITTLE**	**NOT AT ALL**	**NOT APPLICABLE**		**TOTAL**
How much would you say that the	164 88%	13 7%	8 4%	0 0%	1 5%		**181**

primary care you receive from this agency has helped you to improve your health status?							
CULTURAL COMPETENCY	**VERY MUCH**	**A LOT**	**SOME**	**A LITTLE**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	117 63%	44 24%	17 9%	3 2%	3 2%	1 1%	**184**
If English is not your primary language, how well does the staff communicate with you in your language?	50 28%	17 10%	7 4%	2 1%	0 0%	101 57%	**185**

DRUG/PHARMACY SERVICES

HOW OFTEN	ALWAYS	MOST OF THE TIME	SOMETIMES	NOT VERY OFTEN	NEVER	NOT APPLICABLE	TOTAL
does pharmacy staff treat you with dignity and respect?	54 93%	3 5%	1 2%	0 0%	0 0%	0 0%	**58**
does the staff ask if you have other problems or needs that are not being addressed?	33 59%	11 20%	7 12%	1 2%	3 5%	1 2%	**56**
do you find the information provided to you by the staff to be correct and helpful?	48 86%	7 12%	1 2%	0 0%	0 0%	0 0%	**56**
If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?	37 67%	15 27%	1 2%	2 4%	0 0%	0 0%	**55**

How satisfied	Very Satisfied	Satisfied	Not Satisfied	Very Unsatisfied	Not Applicable		Total
are you with the pharmacy staff's ability to answer your questions completely?	49 88%	6 11%	0 0%	0 0%	1 2%		**56**
are you with the staff's efforts to make sure that all of your personal information stays confidential?	49 88%	6 11%	0 0%	1 2%	0 0%		**56**
are you with the quality of the service you receive from this agency overall?	47 84%	8 14%	0 0%	0 0%	1 2%		**56**
Medication	**Yes**	**No**	**Not Applicable**				**Total**
Does a pharmacy staff person explain to you any side effects that may be associated with your medications?	52 93%	3 5%	1 2%	0 0%	0 0%		**56**
Does a pharmacy staff person discuss drug	51 93%	2 4%	2 4%	0 0%	0 0%		**56**

interactions with you?							
	YES	**NO**	**NOT APPLICABLE**				**TOTAL**
Does a pharmacy staff person talk to you about foods you should or should not eat with your medications?	46 82%	3 5%	7 12%				**56**
CULTURAL COMPETENCY	**VERY MUCH**	**A LOT**	**SOME**	**A LITTLE**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	46 82%	6 11%	2 4%	0 0%	1 2%	1 2%	**56**
If English is not your primary language, how well does the staff communicate with you in your language?	28 53%	10 19%	2 4%	0 0%	0 0%	13 25%	**53**
RECOMMEND	**VERY HIGHLY**	**HIGHLY**	**NOT HIGHLY**	**RELUCTANTLY**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
How highly would you	48 86%	6 11%	1 2%	0 0%	0 0%	1 2%	**56**

recommend this agency to others?							
WAIT TIME	**A LOT**	**SOME**	**A LITTLE**	**NONE**	**NOT APPLICABLE**		**TOTAL**
If you call, how long does it usually take to get information you need over the phone?	44 80%	3 5%	1 2%	6 11%	1 2%		**55**
How much time passed between the time of your intake, and the time your prescription was filled?	30 56%	4 7%	7 13%	12 22%	1 2%		**54**
Where was your last medical appointment?	3 6%	43 80%	2 4%	0 0%	3 6%		**54**

CASE MANAGEMENT SERVICES

HOW OFTEN	ALWAYS	MOST OF THE TIME	SOMETIMES	NOT VERY OFTEN	NEVER	NOT APPLICABLE	TOTAL
does your case manager treat you with dignity and respect?	231 92%	9 4%	4 2%	0 0%	1 0%	7 3%	**252**
are your meetings with your case manager at times and locations that are based on your preferences? (How often do you have a "say so" on when and where you meet?)	162 65%	47 19%	16 6%	3 1%	9 4%	11 4%	**248**
does the staff ask if you have other problems or needs that are not being addressed?	168 69%	45 18%	18 7%	4 2%	8 3%	1 0%	**244**
do you find the information provided to you by the staff to be correct and helpful?	180 72%	46 19%	10 4%	5 2%	0 0%	0 0%	**241**
HOW SATISFIED	VERY SATISFIED	SATISFIED	NOT SATISFIED	VERY UNSATISFIED	NOT APPLICABLE		TOTAL
are you with your case manager's knowledge of community services and	193 78%	43 17%	5 2%	1 0%	5 2%		**247**

his/her ability to connect you with those services?							
are you with the staff's efforts to make sure that all of your personal information stays confidential?	206 85%	30 12%	1 0%	2 1%	3 1%		**242**
are you with the quality of the service you receive from this agency overall?	192 80%	42 18%	2 1%	0 0%	4 2%		**240**
CULTURAL COMPETENCY	**VERY MUCH**	**A LOT**	**SOME**	**A LITTLE**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	178 72%	48 20%	9 4%	4 2%	3 1%	4 2%	**246**
If English is not your primary language, how well does the staff communicate with you in your language?	89 37%	24 10%	6 3%	1 0%	0 0%	118 50%	**238**
HELPFULNESS	**VERY MUCH**	**SOME**	**A LITTLE**	**NOT AT ALL**	**NOT APPLICABLE**		**TOTAL**

How much would you say that the case management you receive from this agency has helped you to improve the problems, feelings, or situations that brought you here?	203 83%	28 11%	8 3%	5 2%	2 1%		**246**
WAIT TIME	**VERY MUCH**	**A LOT**	**SOME**	**A LITTLE**	**NONE**	**NOT APPLICABLE**	**TOTAL**
How much time usually passes between the time of your appointment, and the time you actually receive service?	135 56%	70 29%	19 8%	6 2%	5 2%	5 2%	**240**
CONVENIENCE	**VERY OFTEN**	**A LOT**	**SOMETIMES**	**NOT OFTEN**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?	155 64%	61 25%	16 7%	4 2%	0 0%	6 2%	**242**
RECOMMEND	**VERY HIGHLY**	**HIGHLY**	**NOT HIGHLY**	**RELUCTANTLY**	**NOT AT ALL**	**NOT APPLICABLE**	**TOTAL**
How highly would you recommend this agency to others?	191 80%	40 17%	2 1%	0 0%	1 0%	5 2%	**239**
CONVENIENCE	**VERY CONVENIENT**	**CONVENIENT**	**SOMEWHAT**	**A LITTLE**	**INCONVENIENT**	**NOT APPLICABLE**	**TOTAL**
How would you rate the convenience of the office hours here?	141 58%	64 26%	25 10%	4 2%	3 1%	5 2%	**242**

Primary Care Chart Review Report FY 2015

Ryan White Part A Quality Management Program – Houston EMA

December 2016

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2015 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Medical Services to five organizations. Approximately 7,800 unduplicated-HIV positive individuals are serviced by these organizations.

Harris County Public Health (HCPH) must ensure the quantity, quality and cost effectiveness of primary medical care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

Introduction

On April 13, 2015, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV/AIDS. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

- evaluating the extent to which primary care services adhere to the most current United States Department of Health and Human Services (DHHS) HIV treatment guidelines;
- provide statistically significant primary care utilization data including demographics of individuals receiving care; and,
- make recommendations for improvement.

A comprehensive review of client medical records was conducted for services provided between 3/1/15 and 2/28/16. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents: May 1, 2014*, were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Management (CQM) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, 2014* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

All charts were reviewed by a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to treatment guidelines. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

If documentation on a particular element was not found a "no data" response was entered into the database. Some elements require that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was it repeated at the prescribed interval? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to get at quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider? For some data elements, the primary issue was not the final report per se, but more of whether the requisite test/exam was performed or not, i.e., STD screening or whether there was an updated history and physical.

The specific parameters established for the data collection process were developed from national HIV care guidelines.

Tale 1. Data Collection Parameters

Review Item	Standard
Primary Care Visits	Primary care visits during review period, denoting date and provider type (MD, NP, PA, other). There is no standard of care to be met per se. Data for this item is strictly for analysis purposes only
Annual Exams	Dental and Eye exams are recommended annually
Mental Health	A Mental Health screening is recommended annually screening for depression, anxiety, and associated psychiatric issues
Substance Abuse	Clients should be screened for substance abuse potential annually and referred accordingly

Tale 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	CD4, Viral Load Assays, and CBCs are recommended every 3-6 months. Clients on ART should have a Liver Function Test and a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Annual screening is recommended, either PPD, IGRA or chest X-ray
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the study period
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV/AIDS Education	Documentation of topics covered including disease process, staging, exposure, transmission, risk reduction, diet and exercise
Pneumocystis carinii Pneumonia Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis

The Sample Selection Process

The sample population was selected from a pool of 6,819 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/15 and 2/28/16. The medical charts of 635 clients were used in this review, representing 9.3% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV/AIDS health issues, women were over-sampled, comprising 46.6% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System

(CPCDMS) was used to generate the lists of client codes for each site. The demographic make-up (race/ethnicity, gender, age) of clients who accessed primary care services at a particular site during the study period was determined by CPCDMS. A sample was then generated to closely mirror that same demographic make-up.

Characteristics of the Sample Population

Due to the desire to over sample for female clients, the review sample population is not generally comparable to the Part A population receiving outpatient primary medical care in terms of race/ethnicity, gender, and age. No medical records of children/adolescents were reviewed, as clinical guidelines for these groups differ from those of adult patients. Table 2 compares the review sample population with the Ryan White Part A primary care population as a whole.

Table 2. Demographic Characteristics of Clients During Study Period 3/1/15-2/28/16

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	315	49.6%	5,010	73.47%
Female	296	46.6%	1,742	25.55%
Transgender Male to Female	24	3.8%	64	.94%
Transgender Female to Male	0	0%	3	.04%
TOTAL	**635**		**6,819**	
Race				
Asian	5	.8%	86	1.26%
African-Amer.	309	48.7%	3,440	50.45%
Pacific Islander	0	0%	8	.12%
Multi-Race	2	.3%	44	.65%
Native Amer.	4	.6%	24	.35%
White	315	49.6%	3,217	47.18%
TOTAL	**635**		**6,819**	
Hispanic				
Non-Hispanic	400	63%	4,407	64.63%
Hispanic	235	37%	2,412	35.37%
TOTAL	**635**		**6,819**	
Age				
18-24	38	6%	519	7.61%
25-34	150	23.6%	1,854	27.19%
35-44	189	29.8%	1,986	29.12%
45-54	181	28.5%	1,711	25.09%
55-64	69	10.9%	675	9.9%
65 and older	**8**	1.3%	74	1.09%
Total	**635**		**6,819**	

Report Structure

In November 2013, the Health Resource and Services Administration's (HRSA), HIV/AIDS Bureau (HAB) revised its performance measure portfolio[1]. The categories included in this report are: Core, All Ages, and Adolescents/Adult. These measures are intended to serve as indicators for use in monitoring the quality of care provided to patients receiving Ryan White funded clinical care. In addition to the HAB measures, several other primary care performance measures are included in this report. When available, data and results from the 2 preceding years are provided, as well as comparison to national benchmarks. Performance measures are also depicted with results categorized by race/ethnicity.

[1] http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html Accessed November 10, 2013

Findings

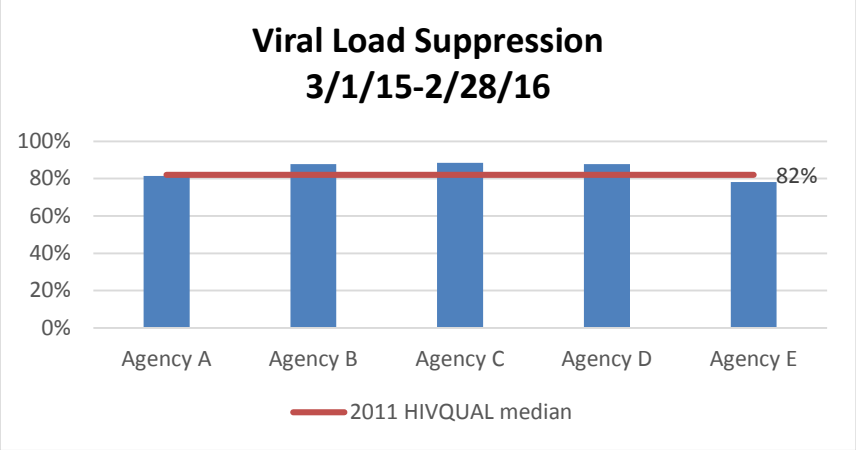
Core Performance Measures

Viral Load Suppression

- Percentage of clients with HIV infection with viral load below limits of quantification (defined as <200 copies/ml) at last test during the measurement year

	2013	2014	2015
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	509	539	519
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	579	586	601
Rate	**87.9%**	**92%**	**86.4%**
	1.6%	**4.1%**	**-5.6%**

2015 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	210	202	105
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	253	228	117
Rate	**83%**	**88.6%**	**89.7%**



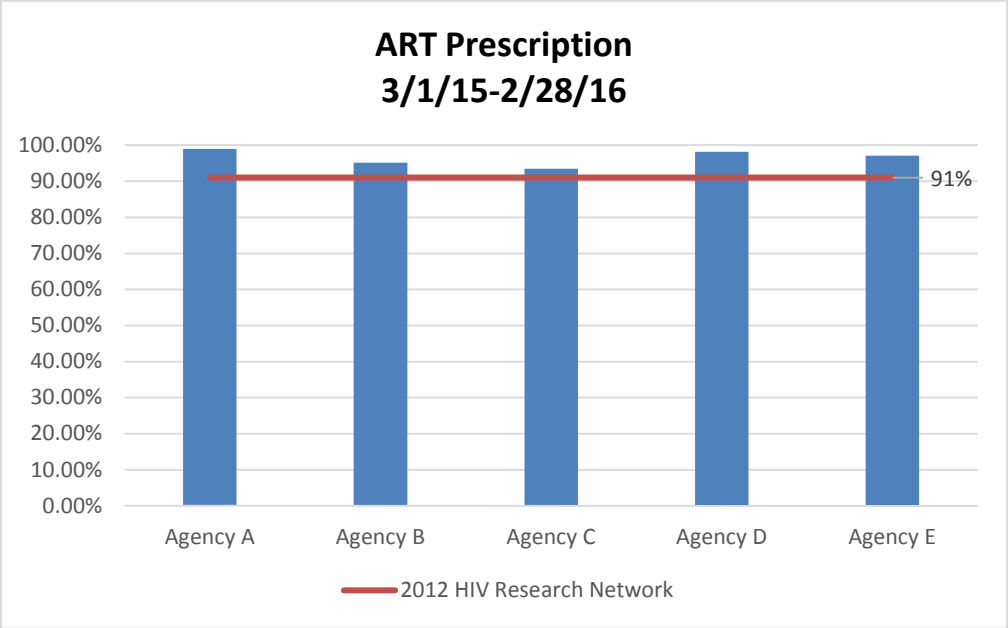
ART Prescription

- Percentage of clients who are prescribed antiretroviral therapy (ART)

	2013	2014	2015
Number of clients who were prescribed an ART regimen within the measurement year	609	605	613
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**95.9%**	**95.3%**	**96.5%**
Change from Previous Years Results	**2.6%**	**-.6%**	**1.2%**

- Of the 22 clients not on ART, none had a CD4 <200

2015 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	260	231	118
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	275	235	121
Rate	**94.5%**	**98.3%**	**97.5%**



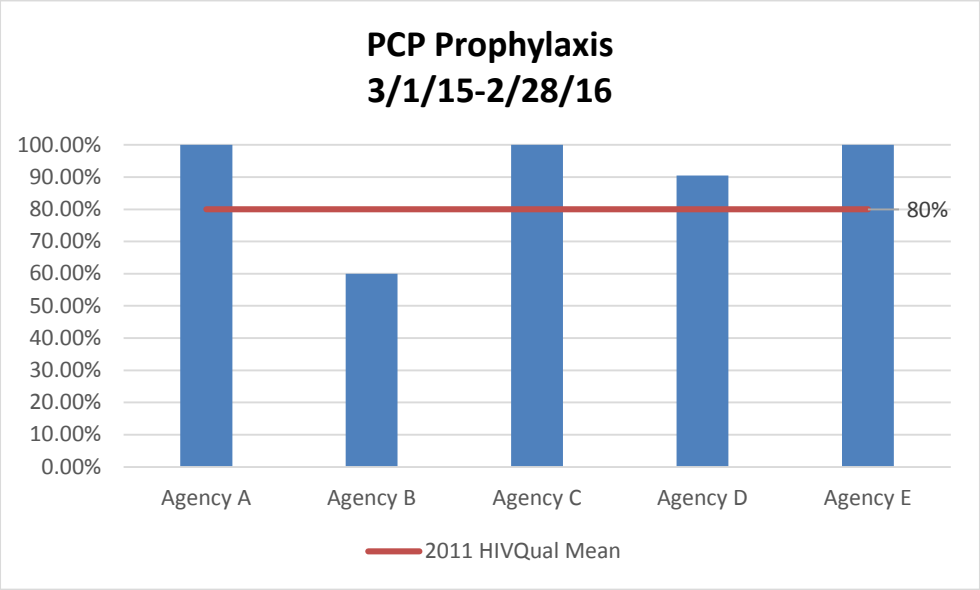
PCP Prophylaxis

- Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm^3 who were prescribed PCP prophylaxis

	2013	2014	2015
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	75	45	53
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	76	45	57
Rate	**98.7%**	**100%**	**93%**
Change from Previous Years Results	**.9%**	**1.3%**	**-7%**

*Two clients refused PCP prophylaxis

2015 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	29	15	8
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	31	17	8
Rate	**93.5%**	**88.2%**	**100%**



All Ages Performance Measures

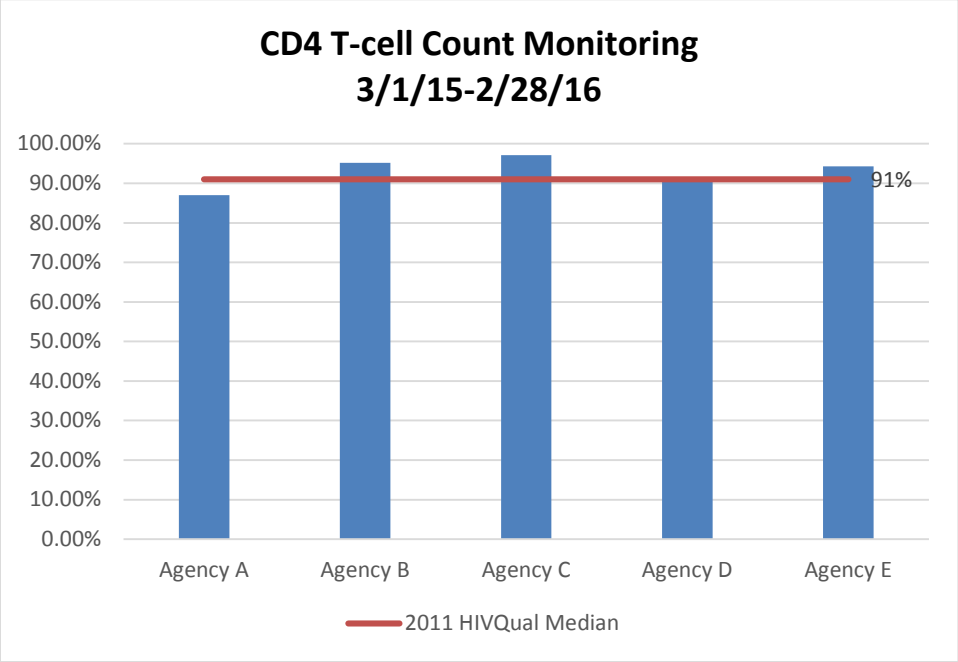
CD4 T-Cell Count

- Percentage of clients with HIV infection who had a CD4 T-cell count performed at least every six months during the measurement year

	2013	2014	2015
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	575	581	590*
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**90.6%**	**91.5%**	**92.9%**
Change from Previous Years Results	**18.1%**	**.9%**	**1.4%**

*Includes 5 clients for whom only 1 CD4 count test was indicated.

2015 CD4 by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	255	215	116
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	275	235	121
Rate	**92.7%**	**91.5%**	**95.9%**

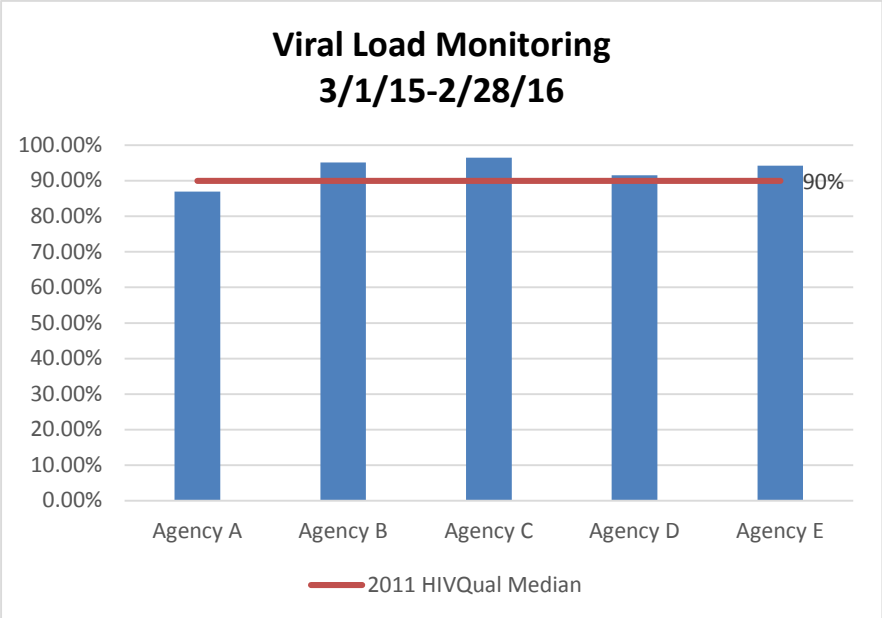


Viral Load Monitoring

- Percentage of clients with HIV infection who had a viral load test performed at least every six months during the measurement year

	2013	2014	2015
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year*	573	580	590
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**90.2%**	**91.3%**	**92.9%**
Change from Previous Years Results	**17.3%**	**1.1%**	**1.4%**

2015 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year	255	215	116
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	275	235	121
Rate	**92.7%**	**91.5%**	**95.9%**

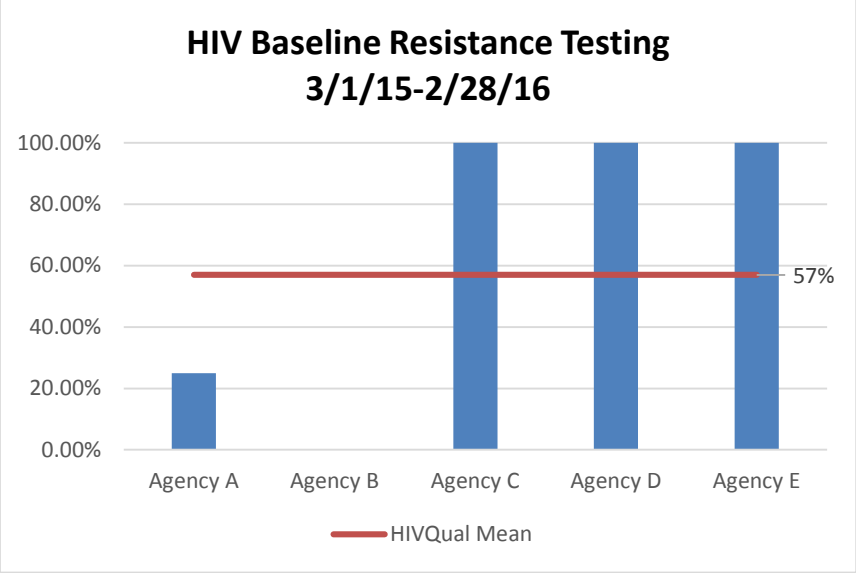


HIV Drug Resistance Testing Before Initiation of Therapy

- Percentage of clients with HIV infection who had an HIV drug resistance test performed before initiation of HIV ART if therapy started in the measurement year

	2013	2014	2015
Number of patients who had an HIV drug resistance test performed at any time before initiation of HIV ART	14	17	7
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	21	20	10
Rate	**66.7%**	**85%**	**70%**
Change from Previous Years Results		**18.3%**	**-15%**

2015 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of patients who had an HIV drug resistance test performed at any time before initiation of HIV ART	3	2	2
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	4	3	3
Rate	**75%**	**66.7%**	**66.7%**



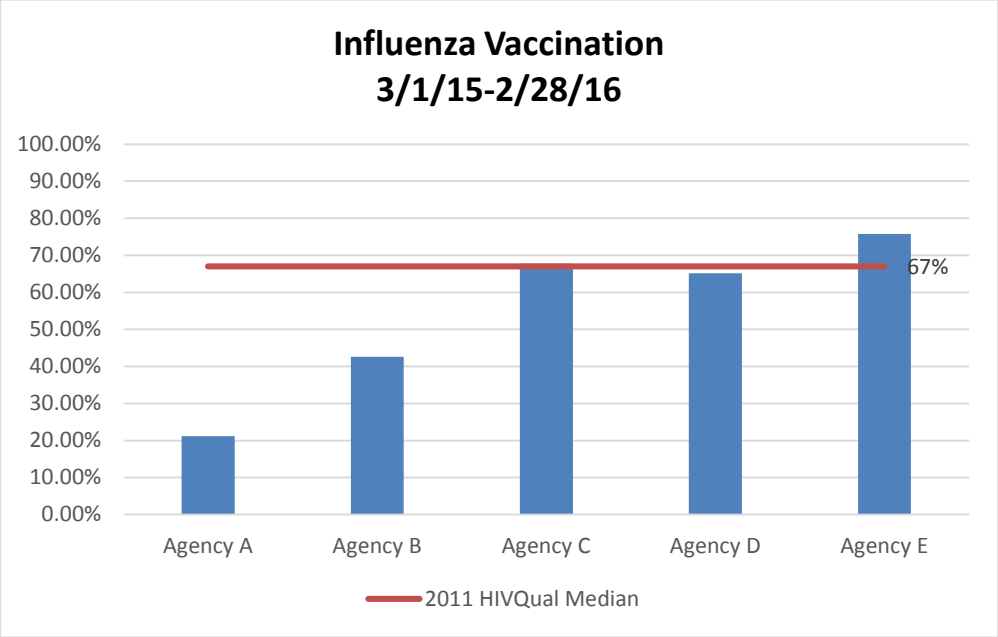
Influenza Vaccination

- Percentage of clients with HIV infection who have received influenza vaccination within the measurement year

	2013	2014	2015
Number of HIV-infected clients who received influenza vaccination within the measurement year	383	404	326
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	615	607	579
Rate	**62.3%**	**66.6%**	**56.3%**
Change from Previous Years Results	**3.2%**	**4.3%**	**-10.3%**

- The definition excludes from the denominator medical, patient, or system reasons for not receiving influenza vaccination

2015 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who received influenza vaccination within the measurement year	132	125	67
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	248	217	110
Rate	**53.2%**	**57.6%**	**60.9%**

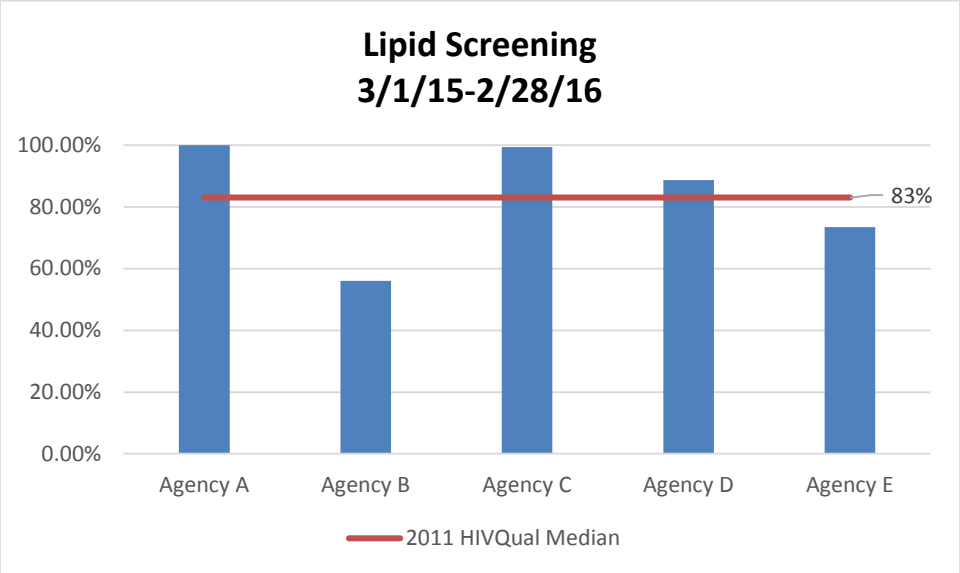


Lipid Screening

- Percentage of clients with HIV infection on ART who had fasting lipid panel during measurement year

	2013	2014	2015
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	562	563	542
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	609	605	613
Rate	**92.3%**	**93.1%**	**88.4%**
Change from Previous Years Results	**5.2%**	**.8%**	**-4.7%**

2015 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	219	210	110
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	260	231	118
Rate	**84.2%**	**90.1%**	**93.2%**

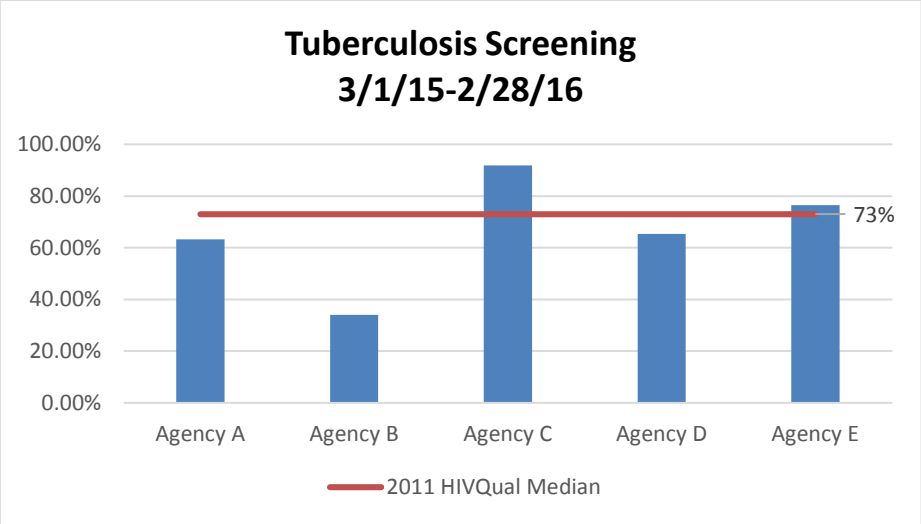


Tuberculosis Screening

- Percent of clients with HIV infection who received testing with results documented for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis

	2013	2014	2015
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	355	404	376
Number of HIV-infected clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	573	568	560
Rate	**62%**	**71.1%**	**67.1%**
Change from Previous Years Results	**5.6%**	**9.1%**	**-4%**

2015 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	157	144	72
Number of HIV-infected clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	245	206	105
Rate	**64.1%**	**69.9%**	**68.6%**



Adolescent/Adult Performance Measures

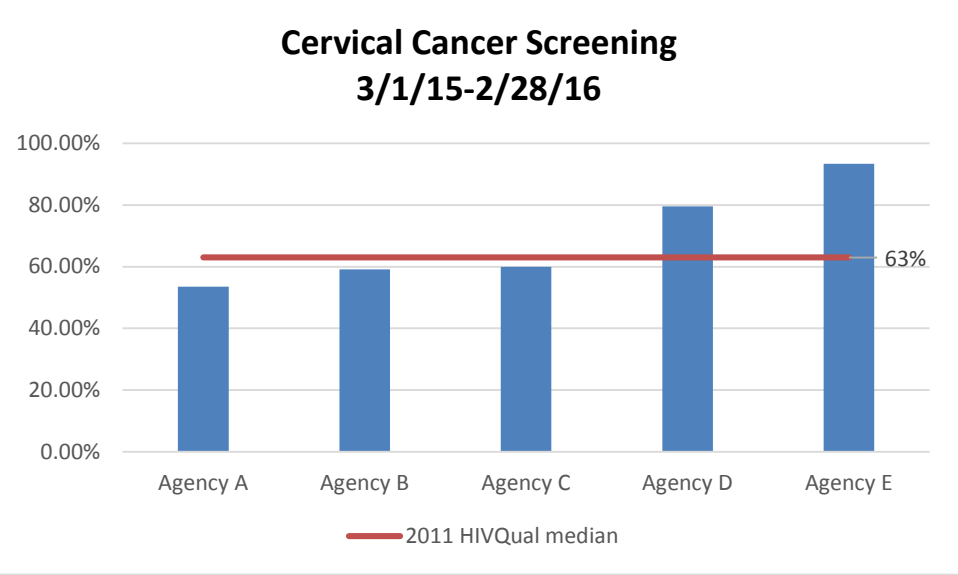
Cervical Cancer Screening

- Percentage of women with HIV infection who have Pap screening results documented in the measurement year

	2013	2014	2015
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	167	183	197*
Number of HIV-infected female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	273	288	289
Rate	**61.2%**	**63.5%**	**68.2%**
Change from Previous Years Results	**6.7%**	**2.3%**	**5.3%**

- 20.3% (40/197) of pap smears were abnormal
- *Includes 30 women who had screening within 3 years as indicated

2015 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	133	56	8
Number of HIV-infected female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	189	74	24
Rate	**70.4%**	**75.7%**	**33.3%**



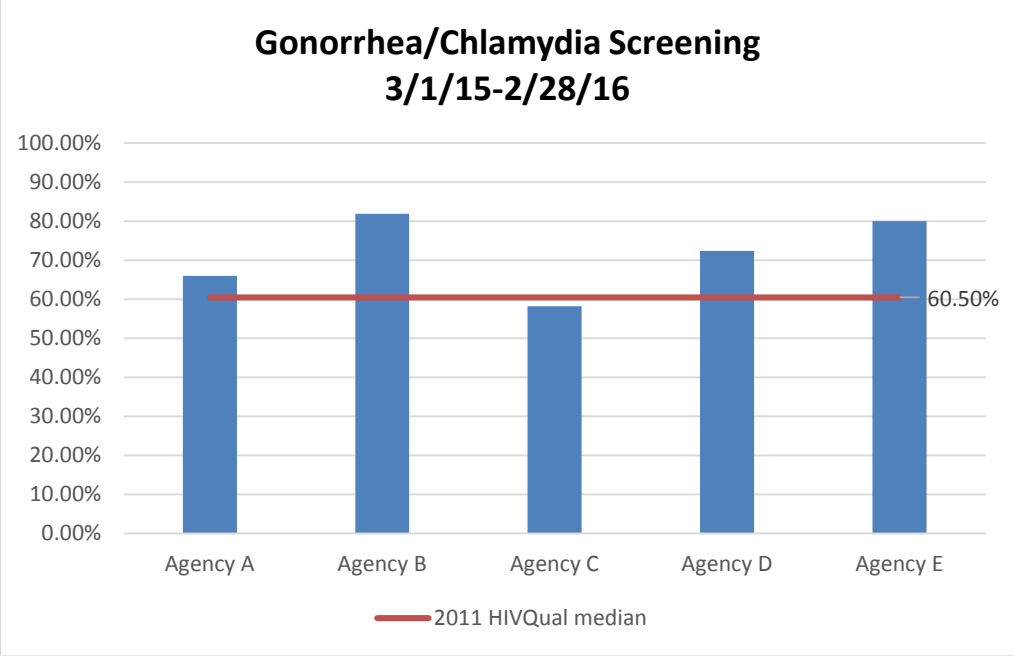
Gonorrhea/Chlamydia Screening

- Percent of clients with HIV infection at risk for sexually transmitted infections who had a test for Gonorrhea/Chlamydia within the measurement year

	2013	2014	2015
Number of HIV-infected clients who had a test for Gonorrhea/Chlamydia	396	424	442
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	631	635
Rate	**62.4%**	**67.2%**	**69.6%**
Change from Previous Years Results	**8.1%**	**4.8%**	**2.4%**

- 19 cases of CT and 13 cases of GC were identified

2015 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	198	160	83
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**72%**	**68.1%**	**68.6%**



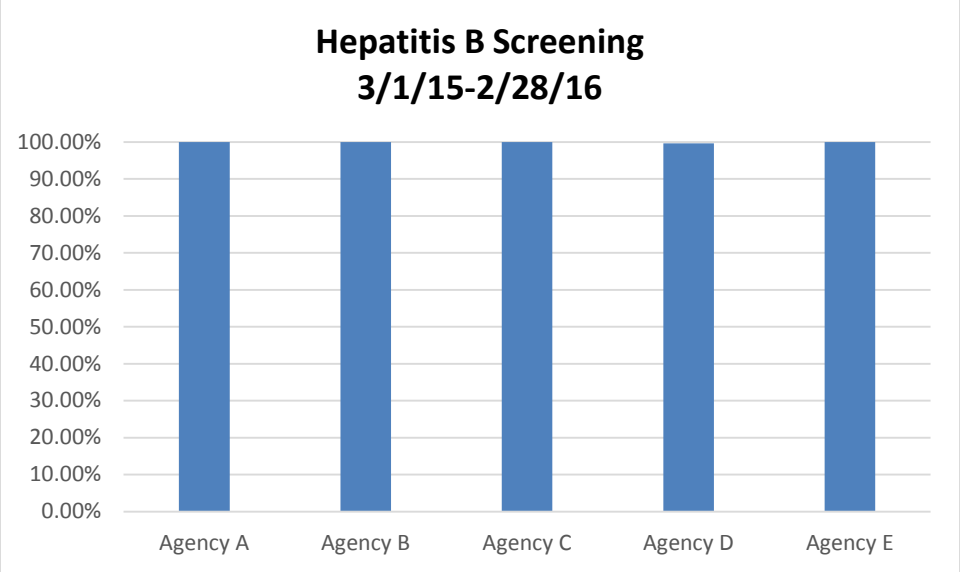
Hepatitis B Screening

- Percentage of clients with HIV infection who have been screened for Hepatitis B virus infection status

	2013	2014	2015
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	620	627	634
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**97.6%**	**98.7%**	**99.8%**
Change from Previous Years Results	**-.4%**	**1.1%**	**1.1%**

- 2.2% (14/635) were Hepatitis B positive

2015 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	274	235	121
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**99.6%**	**100%**	**100%**

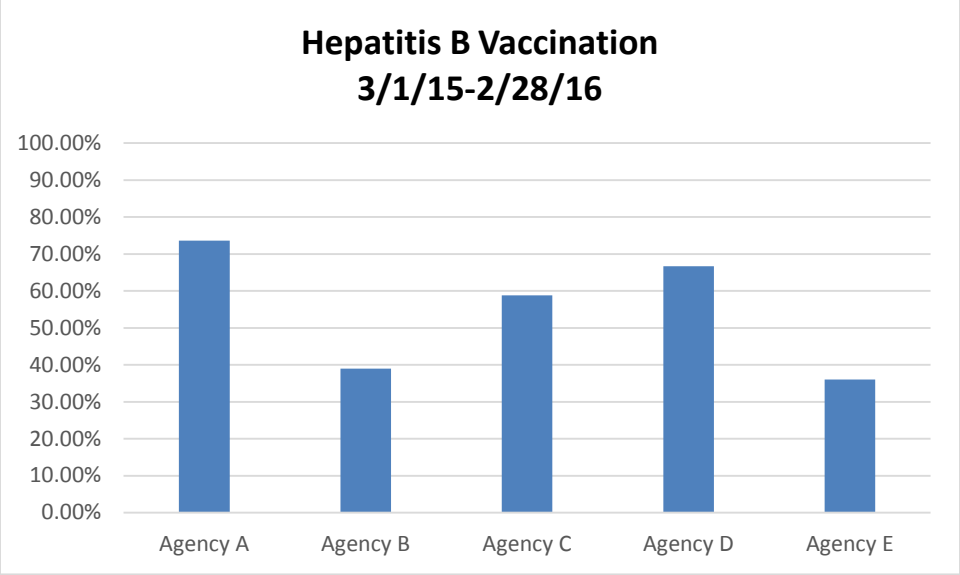


Hepatitis B Vaccination

- Percentage of clients with HIV infection who completed the vaccination series for Hepatitis B

	2013	2014	2015
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	165	179	184
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	328	322	307
Rate	**50.3%**	**55.6%**	**59.9%**
Change from Previous Years Results	**7.4%**	**5.3%**	**4.3%**

2015 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	63	90	31
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	124	132	50
Rate	**50.8%**	**68.2%**	**62%**



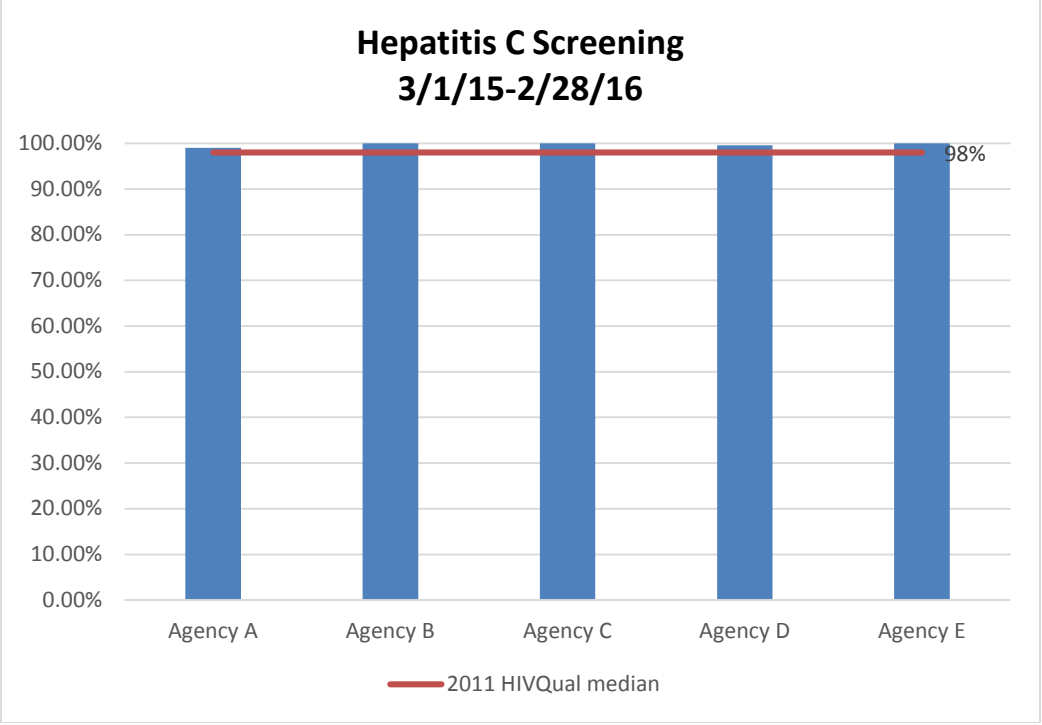
Hepatitis C Screening

- Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since diagnosis of HIV infection

	2013	2014	2015
Number of HIV-infected clients who have documented HCV status in chart	607	626	633
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**95.6%**	**98.6%**	**99.7%**
Change from Previous Years Results	**-2.9%**	**3%**	**1.1%**

- 6% (38/635) were Hepatitis C positive, including 6 acute infections only and 13 cures

2015 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who have documented HCV status in chart	273	235	121
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**99.3%**	**100%**	**100%**

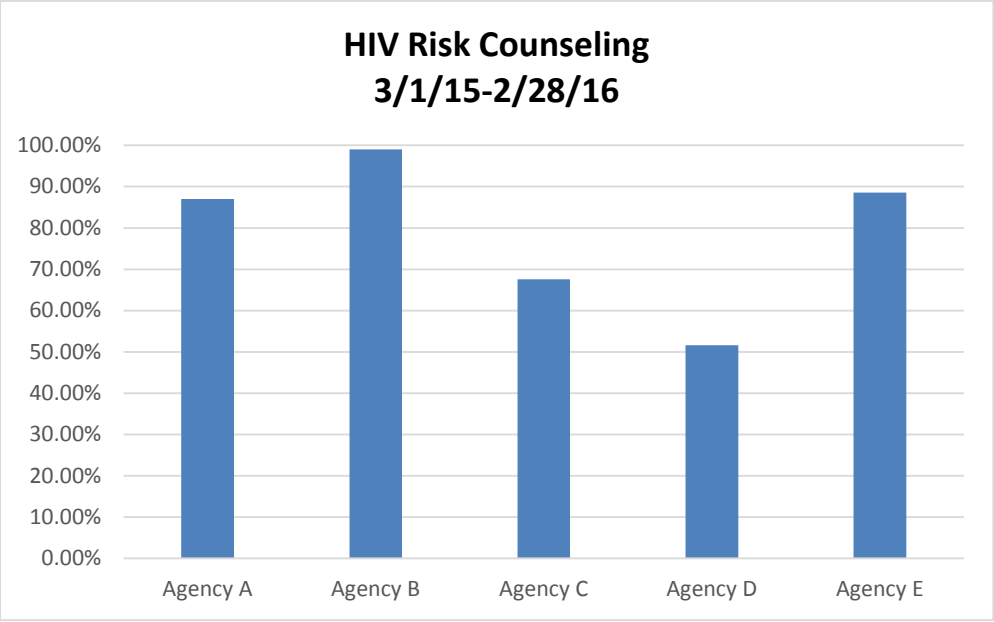


HIV Risk Counseling

- Percentage of clients with HIV infection who received HIV risk counseling within measurement year

	2013	2014	2015
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	526	489	453
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**82.8%**	**77%**	**71.3%**
Change from Previous Years Results	**-2.6%**	**-5.8%**	**-5.7%**

2015 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	204	170	76
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**74.2%**	**72.3%**	**62.8%**

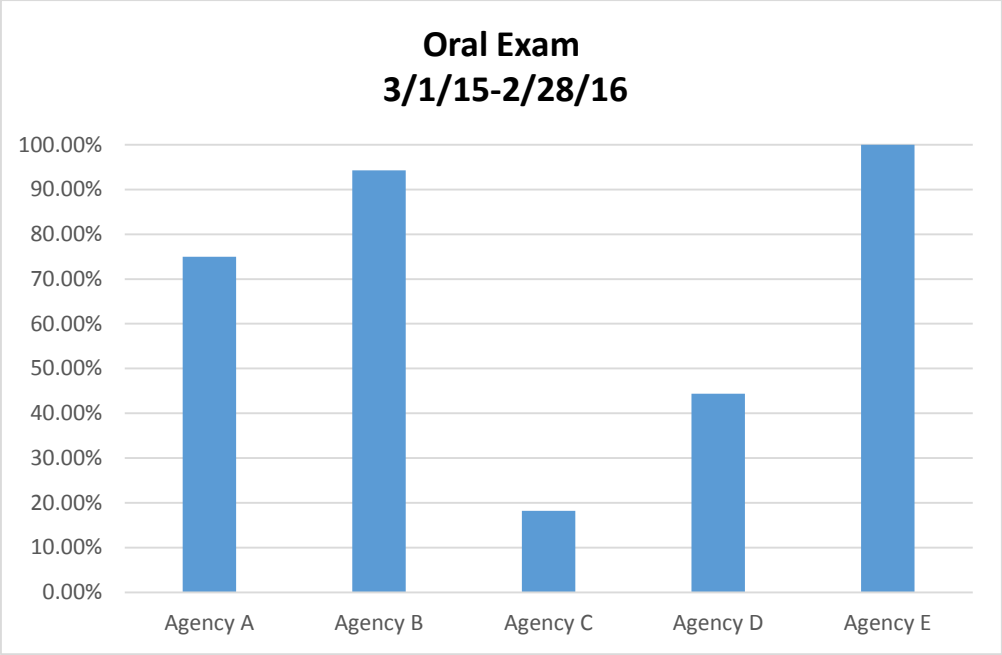


Oral Exam

- Percent of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year

	2013	2014	2015
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	364	356	340
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**57.3%**	**56.1%**	**53.5%**
Change from Previous Years Results	**2.9%**	**-.8%**	**-2.6%**

2015 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	153	125	60
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**55.6%**	**53.2%**	**49.6%**



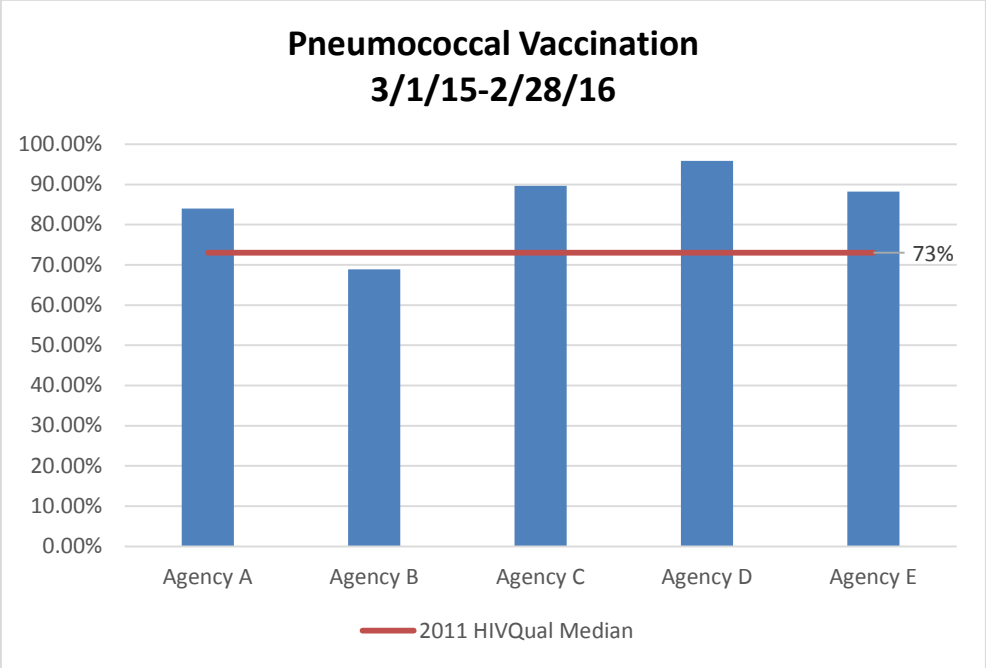
Pneumococcal Vaccination

- Percentage of clients with HIV infection who ever received pneumococcal vaccination

	2013	2014	2015
Number of HIV-infected clients who received pneumococcal vaccination	470	556	546
Number of HIV-infected clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	555	623	622
Rate	**84.7%**	**89.2%**	**87.8%**
Change from Previous Years Results	**1.6%**	**4.5%**	**-1.4%**

- 275/635 clients (43.3%) received both PPV13 and PPV23 (FY14-36.9%,FY13-13.7%)

2015 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who received pneumococcal vaccination	230	213	100
Number of HIV-infected clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	269	231	118
Rate	**85.5%**	**92.2%**	**84.7%**



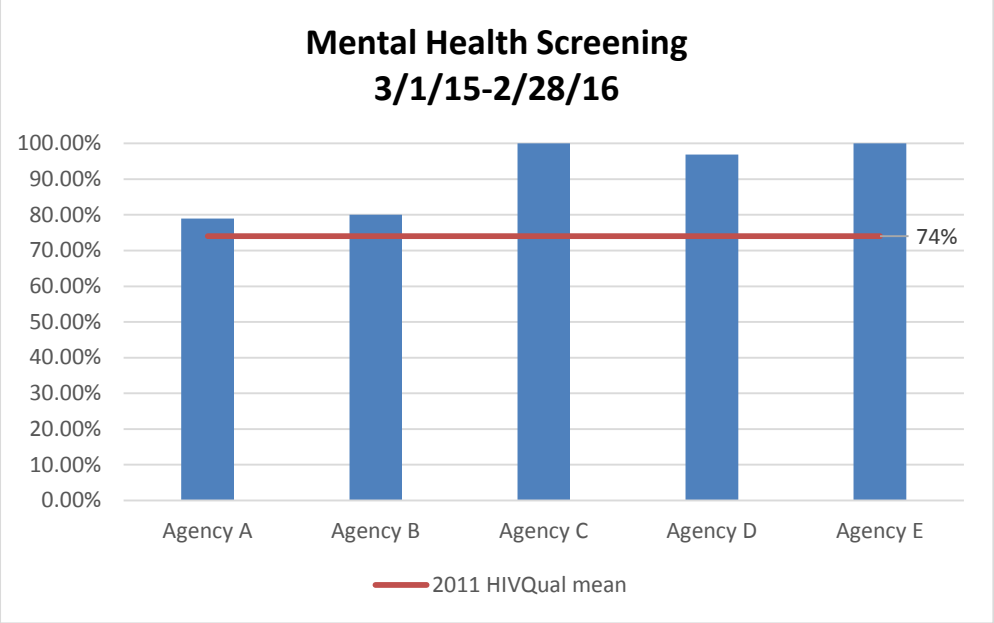
Preventative Care and Screening: Mental Health Screening

- Percentage of clients with HIV infections who have had a mental health screening

	2013	2014	2015
Number of HIV-infected clients who received a mental health screening*	520	567	586
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**81.9%**	**89.3%**	**92.3%**
Change from Previous Years Results	**-5.5%**	**7.4%**	**3%**

*The 2014 & 2015 definition only includes those who had a mental health screening using a standardized tool

- 31% (197/635) had mental health issues. Of the 98 who needed additional care, 75 (76.5%) were either managed by the primary care provider or referred; 12 clients refused a referral.

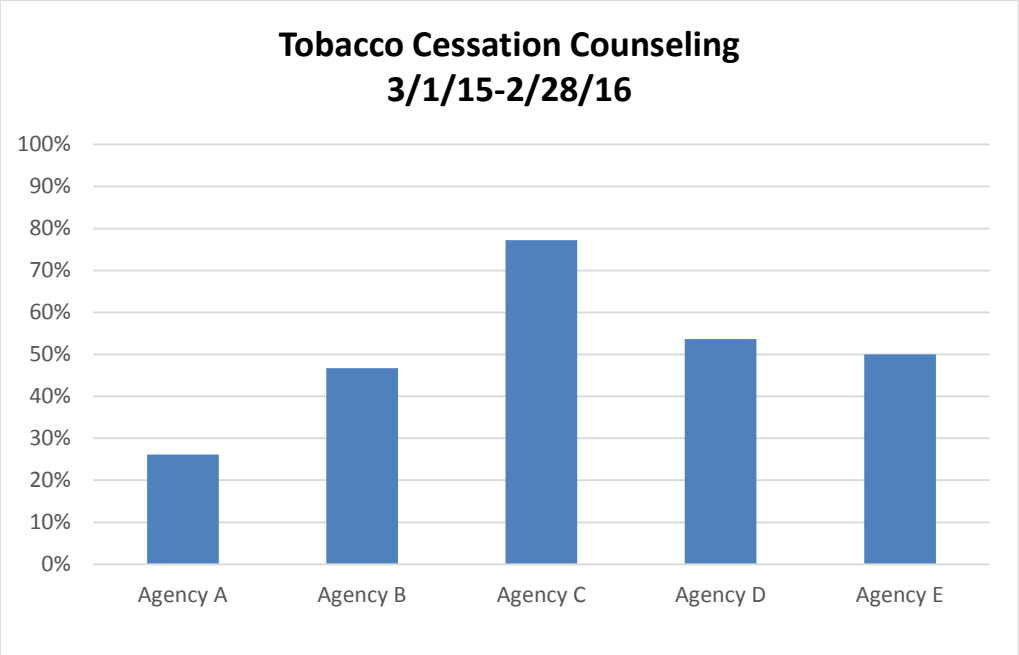


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

- Percentage of clients with HIV infection who were screened for tobacco use one or more times with 24 months and who received cessation counseling if indicated

	2013	2014	2015
Number of HIV-infected clients who were screened for tobacco use in the measurement period	633	631	635
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.7%**	**99.4%**	**100%**
Change from Previous Years Results	**15.1%**	**-.3%**	**6%**

- **HIVQUAL-US Mean 86%**
- Of the 635 clients screened, 185 (29.1%) were current smokers.
- Of the 185 current smokers, 104 (56.2%) received smoking cessation counseling, and 24 (13%) refused smoking cessation counseling



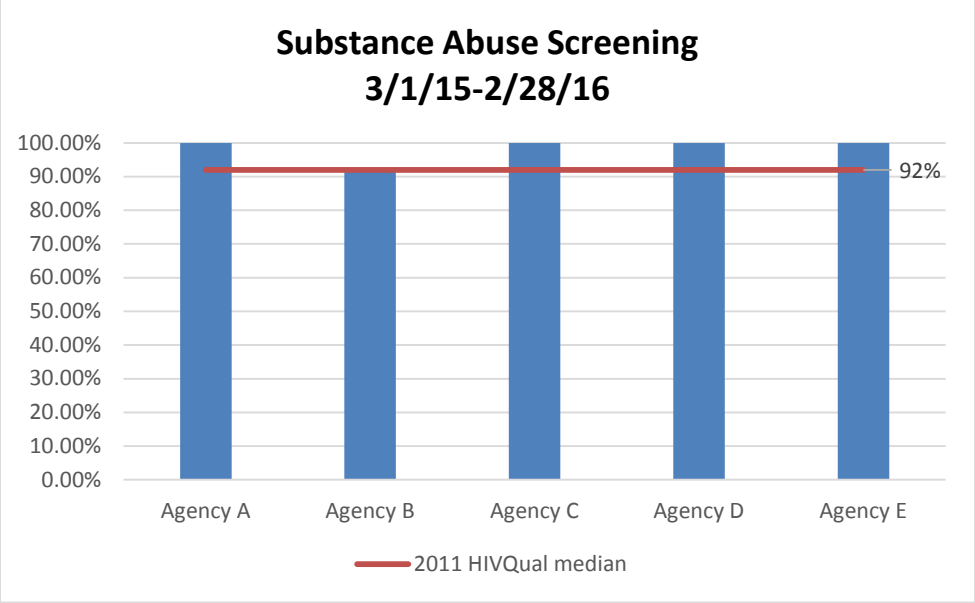
Substance Abuse Screening

- Percentage of clients with HIV infections who have been screened for substance use (alcohol & drugs) in the measurement year*

	2013	2014	2015
Number of new HIV-infected clients who were screened for substance use within the measurement year	620	624	627
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**97.6%**	**98.3%**	**98.7%**
Change from Previous Years Results	**22.6%**	**.7%**	**.4%**

*HAB measure indicates only new clients be screened. However, Houston EMA standards of care require medical providers to screen all clients annually.

- 5% (32/635) had substance abuse issues. Of the 32 clients who needed referral, 17 (53%) received one, and 12 (37.5%) refused.

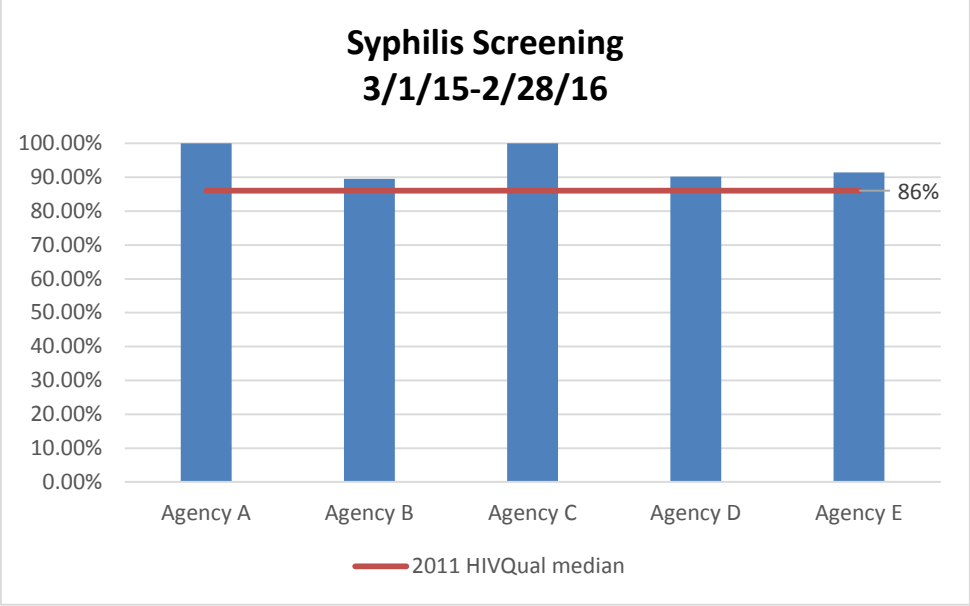


Syphilis Screening

- Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement year

	2013	2014	2015
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	591	594	599
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	632	635	635
Rate	**93.5%**	**93.5%**	**94.3%**
Change from Previous Years Results	**9.9%**	**0%**	**.8%**

- 6.2% (37/599) new cases of syphilis diagnosed

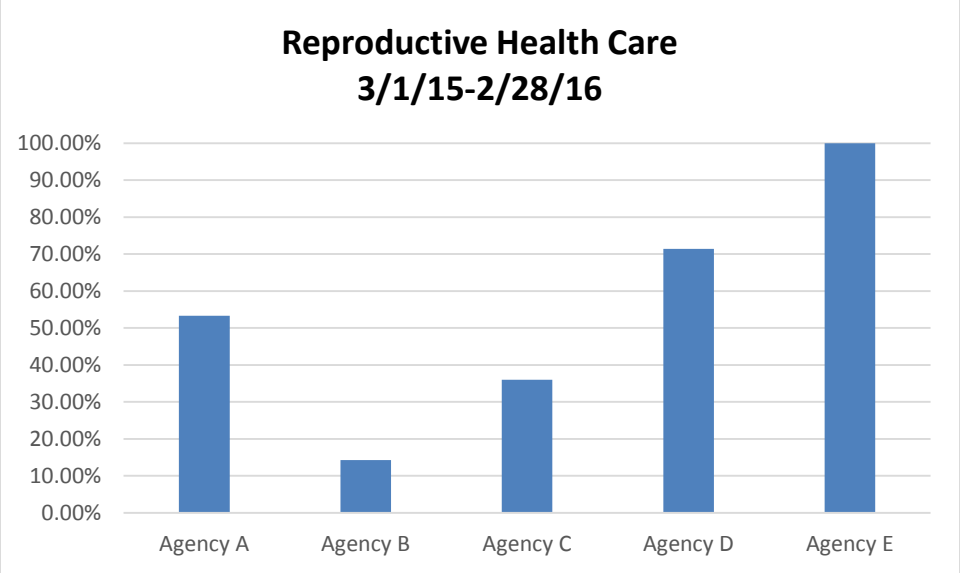


Other Measures

Reproductive Health Care

- Percentage of reproductive-age women with HIV infection who received reproductive health assessment and care (i.e, pregnancy plans and desires assessed and either preconception counseling or contraception offered)

	2013	2014	2015
Number of HIV-infected reproductive-age women who received reproductive health assessment and care	32	30	34
Number of HIV-infected reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	67	73	69
Rate	**47.8%**	**41.7%**	**49.3%**
Change from Previous Years Results	**15.7%**	**-6.1%**	**7.6%**

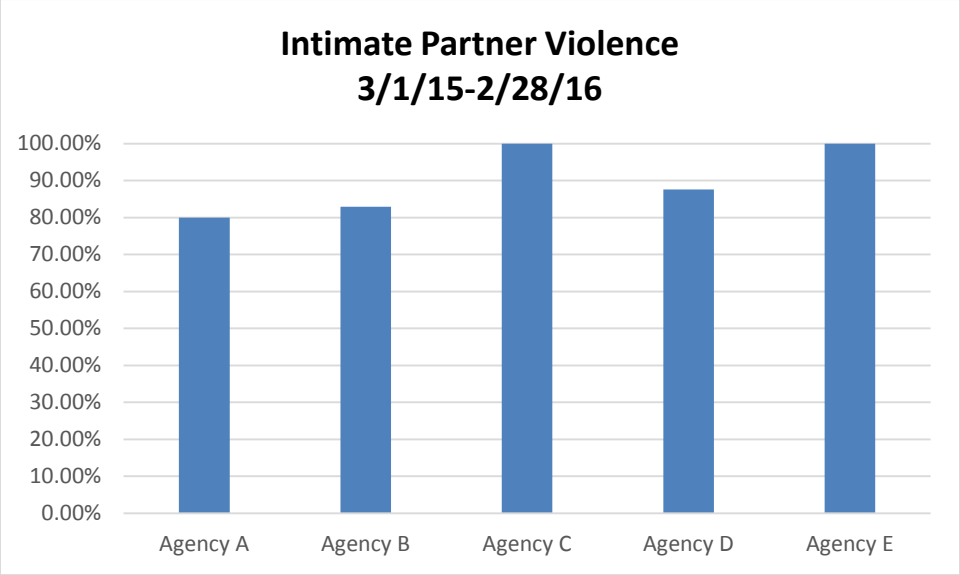


Intimate Partner Violence Screening

- Percentage of clients with HIV infection who received screening for current intimate partner violence

	2013	2014	2015
Number of HIV-infected clients who received screening for current intimate partner violence	462	570	569
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**72.8%**	**89.8%**	**89.6%**
		17%	**-.2%**

*7/635 (1.1%) screened positive



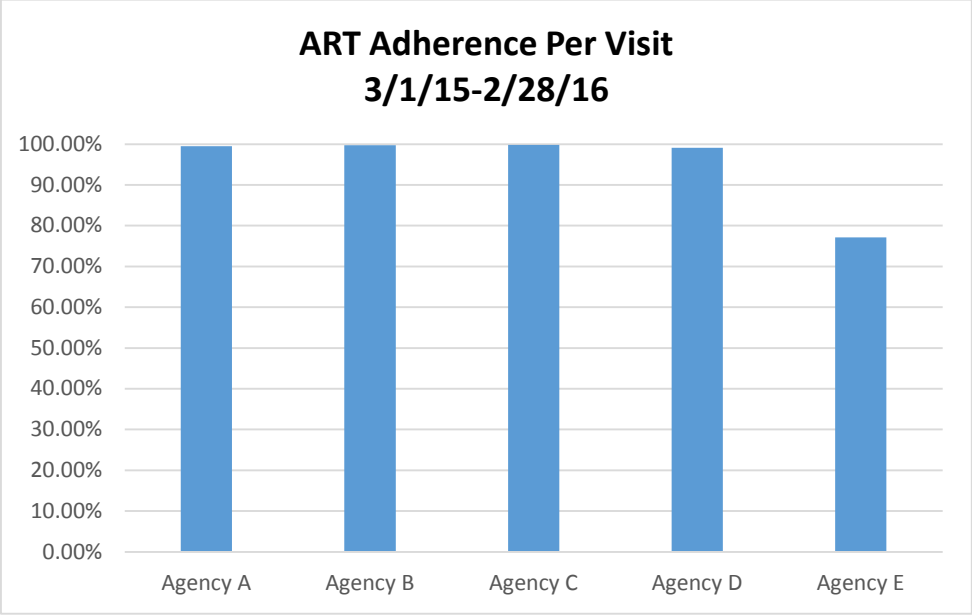
Adherence Assessment & Counseling

- Percentage of clients with HIV infection on ART who were assessed for adherence at least once per year

	Adherence Assessment		
	2013	2014	2015
Number of HIV-infected clients, as part of their primary care, who were assessed for adherence at least once per year	541	599	607
Number of HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	573	605	613
Rate	**94.4%**	**99%**	**99%**
Change from Previous Years Results	**-4.2%**	**4.6%**	**0%**

- **HIVQUAL-US Mean 96%, 75th percentile 100%**

Adherence Assessment Per Visit	
	2015
Number of primary care visits where ART adherence was assessed	1,940
Number of primary care visits for HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	1,981
Rate	**97.9%**



ART for Pregnant Women

- Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy (ART)

	2013	2014	2015
Number of HIV-infected pregnant women who were prescribed ART during the 2nd and 3rd trimester	4	4	5
Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	4	4	5
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0**

Primary Care: Diabetes Control

- Percentage of clients with HIV infection and diabetes who maintained glucose control during measurement year

	2013	2014	2015
Number of HIV-infected diabetic clients whose last HbA1c in the measurement year was <8%	34	41	27
Number of HIV-infected diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	53	68	47
Rate	**64.2%**	**60.3%**	**57.4%**
Change from Previous Years Results		**-3.9%**	**-2.9%**

- 634/635 (99.8%) of clients where screened for diabetes and 47/634 (7.4%) were diagnosed diabetic

Primary Care: Hypertension Control

- Percentage of clients with HIV infection and hypertension who maintained blood pressure control during measurement year

	2013	2014	2015
Number of HIV-infected hypertensive clients whose last blood pressure of the measurement year was <140/90	123	125	131
Number of HIV-infected hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	172	173
Rate	**68.3%**	**72.7%**	**75.7%**
Change from Previous Years Results		**4.4%**	**3%**

- 173/635 (27.2%) of clients where were diagnosed with hypertension

Primary Care: Breast Cancer Screening

- Percentage of women with HIV infection, over the age of 41, who had a mammogram documented in the previous two years

	2013	2014	2015
Number of HIV-infected women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	136	138	140
Number of HIV-infected women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	163	158	168*
Rate	**83.4%**	**87.3%**	**83.3%**
Change from Previous Years Results		**3.9%**	**-4%**

*The denominator excluded three clients who refused a mammogram

Conclusions

The Houston EMA demonstrates performance rates at or above national averages for nearly all performance measures. Overall, performance rates were comparable to the previous year. There have been several positive trends over the past 2 years: cervical cancer screening, sexually transmitted infection screening, and Hepatitis B vaccination rates have continued to improve. However, viral load suppression has slightly decreased, as well as influenza vaccination, and HIV risk counseling. RWGA will continue to monitor these measures closely and initiate quality improvement initiatives as needed. In addition, racial and ethnic disparities continue to be seen for most measures, with African-Americans having lower rates than White and Hispanic clients. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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FY 2015 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

Highlights from FY 2015 Performance Measures 1

Summary Reports for all Services

- Local Pharmacy Assistance 2
- Medical Case Management 3
- Primary Medical Care 4

HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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Highlights from FY 2015 Performance Measures

Local Pharmacy Assistance

- Among LPAP clients with viral load tests, 2,549 (74%) clients were virally suppressed during this time period.

Medical Case Management

- During FY 2015, 5,047 clients utilized Part A medical case management. According to CPCDMS, 2,484 (49%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these medical case management clients, 599 (12%) accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 2,078 (41%) clients had third-party payer coverage after accessing medical case management.

Primary Medical Care

- During FY 2015, 6,966 clients utilized Part A primary medical care. According to CPCDMS, 4,019 (76%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 299 (21%) had an AIDS diagnosis (CD4 < 200) within the first 90 days of initial enrollment in primary medical care.
- Among clients with viral load tests, 6,962 (74%) clients were virally suppressed during this time period.

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2014	FY 2015	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,631 (74.4%)	2,549 (73.9%)	**-0.5%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Medical Case Management
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 5,047 clients utilized Part A medical case management.

HIV Performance Measures	**FY 2014**	**FY 2015**	**Change**
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,664 (52.7%)	2,484 (49.2%)	**-3.5%**
Percentage of medical case management clients who utilized mental health services	548 (10.8%)	599 (11.9%)	**1.1%**
Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	2,060 (40.8%)	2,078 (41.2%)	**0.4%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,188 (71.8%)	2,110 (70.9%)	**-0.9%**
Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,171 (23.7%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	664 (24.9%)	545 (23.3%)	**-1.6%**
Percentage of clients who were homeless or unstably housed	1,751 (34.7%)	1,879 (37.2%)	**2.5%**

According to CPCDMS, 194 (3.8%) clients utilized primary care for the first time and 241 (4.8%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	**FY 2014**
60% of HIV-infected medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	33%

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Primary Medical Care
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 6,966 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2014	FY 2015	Change
90% of clients with HIV infection will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,106 (74.9%)	4,019 (76.3%)	**1.4%**
Less than 20% of clients who have a CD-4 < 200 within the first 90 days of initial enrollment in primary medical care	272 (20.0%)	299 (20.6%)	**0.6%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD-4 cell counts or percentages performed during the measurement year at least three months apart	4,107 (74.9%)	3,683 (69.9%)	**-5.0%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,154 (73.4%)	5,081 (72.9%)	**-0.5%**
Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year	1,987 (28.3%)	1,729 (24.8%)	**-3.5%**
85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year	6,046 (86.1%)	5,791 (83.2%)	**-2.9%**
95% of clients with HIV infection will be screened for Hepatitis B virus infection status (ever)	5,114 (72.8%)	5,211 (74.8%)	**2.0%**
90% of clients with a diagnosis of HIV/AIDS will have a viral load test performed at least every six months during the measurement year	3,797 (86.6%)	3,405 (78.0%)	**-8.6%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	6,928 (72.9%)	6,962 (73.7%)	**0.8%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,171 (23.7%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	1,566 (28.6%)	1,394 (26.5%)	**-2.1%**

Clinical Chart Review Measures	FY 2014
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	Data below
Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network who had a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	Data below

From 3/1/2014 through 2/29/2015, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 5.7 Days

Agency 1: 5.4
Agency 2: 7.4
Agency 3: 2.7
Agency 4: 8.5
Agency 5: 4.7

From 3/1/2014 through 2/29/2015, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 10.1 Days

Agency 1: 6.6
Agency 2: 10.0
Agency 3: 10.0
Agency 4: 14.0
Agency 5: 10.1

Clinical Chart Review Measures*	**FY 2013**	**FY 2014**
100% of clients with a diagnosis of HIV/AIDS will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	98.7%	100%
100% of pregnant women with HIV infection will be prescribed antiretroviral therapy	100%	100%
Percentage of female clients with a diagnosis of HIV who have a pap screening in the measurement year	61.2%	63.5%
55% of clients with HIV infection will complete the vaccination series for Hepatitis B	50.3%	55.6%
85% of clients with HIV infection will receive HIV risk counseling within the measurement year	82.8%	77.0%
95% of clients with a diagnosis of HIV will be screened for substance abuse (alcohol and drugs) in the measurement year	97.6%	98.3%
90% of clients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	92.3%	93.1%
65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	62.4%	67.2%
75% of clients with a diagnosis of HIV/AIDS, for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	62.0%	71.1%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	62.3%	66.6%
95% of clients will be screened for clinical depression using a standardized tool with follow up plan documented	81.9%	89.3%
90% of clients with HIV infection will have ever received pneumococcal vaccine	84.7%	89.2%
100% of clients will be screened for tobacco use at least one during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user	99.7%	99.4%
95% of clients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	95.9%	95.3%
85% of clients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	66.7%	85.0%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/Services-Programs/Programs/RyanWhite/Quality

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 66 / No. 4
February 3, 2017

National Black HIV/AIDS Awareness Day — February 7, 2017

February 7 is National Black HIV/AIDS Awareness Day, an observance intended to raise awareness of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS), and encourage action to reduce the disproportionate impact of HIV on blacks/African Americans (blacks) in the United States. From 2010 to 2014, the annual HIV diagnosis rate decreased for blacks by 16.2% (*1*); however, in 2015, blacks accounted for approximately half (45%) of all new HIV diagnoses (17,670), 74% of which were in men (*1*). The majority of these diagnoses were among gay and bisexual men.

The annual rate of HIV diagnosis among black women (26.2 per 100,000) was approximately 16 times the rate among white women (1.6) and approximately five times the rate among Hispanic women (5.3). Among blacks living with diagnosed HIV infection in 2013, 54% were receiving continuous HIV medical care (two or more CD4 or viral load tests ≥3 months apart) and 49% had a suppressed viral load (<200 copies/mL at most recent test) (*2*).

Additional information regarding National Black HIV/AIDS Awareness Day is available at https://www.cdc.gov/features/blackhivaidsawareness. Additional information about blacks and HIV is available at https://www.cdc.gov/hiv/group/racialethnic/africanamericans.

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HIV Care Outcomes Among Blacks with Diagnosed HIV — United States, 2014

Andre F. Dailey, MSPH[1]; Anna Satcher Johnson, MPH[1]; Baohua Wu, MS[1]

Since the release of the National HIV/AIDS Strategy (NHAS) (*1*) and the establishment of the federal Human Immunodeficiency Virus (HIV) Care Continuum Initiative (*2*), federal efforts have accelerated to improve and increase HIV testing, care, and treatment and to reduce HIV-related disparities in the United States. National HIV Surveillance System (NHSS)* data are used to monitor progress toward reaching NHAS goals,† and recent data indicate that blacks have lower levels of care and viral suppression than do persons of other racial and ethnic groups (*3*). Among persons with HIV infection diagnosed through 2012 who were alive at

* NHSS is the primary source for monitoring HIV trends in the United States. The system collects, analyzes, and disseminates information about new and existing cases of HIV infection.
† NHAS was updated in July 2015 to look forward to 2020. The NHAS goals to be accomplished by 2020 are as follows: 1) 85% of all persons with newly diagnosed HIV infection to be linked to care, 2) 90% of persons living with diagnosed HIV to be retained in care, and 3) 80% of persons living with diagnosed HIV to have a suppressed viral load.

INSIDE

104 Changes in the Disparity of HIV Diagnosis Rates Among Black Women — United States, 2010–2014
107 Multiple Fentanyl Overdoses — New Haven, Connecticut, June 23, 2016
112 Trends in Beverage Consumption Among High School Students — United States, 2007–2015
117 Notes from the Field: Knowledge, Attitudes, and Practices Regarding Yellow Fever Vaccination Among Men During an Outbreak — Luanda, Angola, 2016
119 Announcement
121 QuickStats

Continuing Education examination available at https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

year-end 2013, 68.1% of blacks received any HIV medical care compared with 74.4% of whites (*3*). CDC used NHSS data to describe HIV care outcomes among blacks who received a diagnosis of HIV. Among blacks with HIV infection diagnosed in 2014, 21.9% had infection classified as HIV stage 3 (acquired immunodeficiency syndrome [AIDS]) at the time of diagnosis compared with 22.5% of whites; 71.6% of blacks were linked to care within 1 month after diagnosis compared with 79.0% of whites. Among blacks with HIV infection diagnosed through 2012 who were alive on December 31, 2013, 53.5% were receiving continuous HIV medical care compared with 58.2% of whites; 48.5% of blacks achieved viral suppression compared with 62.0% of whites. Intensified efforts and implementation of effective interventions and public health strategies that increase engagement in care and viral suppression among blacks (*1*,*4*) are needed to achieve NHAS goals.

All states, the District of Columbia, and U.S. territories report cases of HIV infection and associated demographic and clinical information to NHSS. CDC analyzed data for persons aged ≥13 years reported through December 2015 from 33 jurisdictions[§] with complete laboratory reporting.[¶] These jurisdictions accounted for 65.3% of blacks living with diagnosed HIV infection at year-end 2013 in the United States. Stage 3 classification and linkage to care were assessed among blacks living in any of the 33 jurisdictions at the time of HIV diagnosis in 2014. A stage 3 classification was defined as having a CD4 count of <200/μL, CD4 percentage of total lymphocytes of <14, or documentation of an AIDS-defining condition ≤3 months after a diagnosis of HIV infection. Linkage to care was defined as having documentation of ≥1 CD4 count or percentage or viral load (VL) tests ≤1 month after HIV diagnosis. Retention in care and viral suppression were assessed among blacks with HIV diagnosed by December 31, 2012, and who were alive and resided (based on the most recent known address) in any of the 33 jurisdictions as of December 31, 2013 (i.e., persons living with diagnosed HIV). Retention in HIV care, defined as having two or more CD4 or VL tests ≥3 months apart, and viral suppression, defined as a VL of <200 copies/mL at most recent test, were assessed for 2013. Data were statistically adjusted by using multiple imputation techniques to account for missing HIV transmission categories (*5*).

[§] The 33 jurisdictions were Alabama, Alaska, California, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

[¶] The criteria for complete reporting were the following: 1) the jurisdiction's laws or regulations required reporting of all CD4 and viral load (VL) test results to the state or local health department, 2) ≥95% of all laboratory test results were reported by laboratories that conduct HIV-related testing for each jurisdiction, and 3) the jurisdiction reported to CDC ≥95% of CD4 and VL results received since at least January 2013.

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Suggested citation: [Author names; first three, then et al., if more than six.] [Report title]. MMWR Morb Mortal Wkly Rep 2017;66:[inclusive page numbers].

Summary

What is already known about this topic?

Blacks living with diagnosed human immunodeficiency virus (HIV) infection have lower levels of care and viral suppression than do persons of other racial groups. National HIV/Acquired immunodeficiency syndrome (AIDS) Strategy goals include 85% linkage to care, 90% retention in care, and 80% viral load suppression by 2020.

What is added by this report?

In 2014, 21.9% of infections diagnosed among blacks were classified as stage 3 (AIDS) at the time of diagnosis and 71.6% of blacks with HIV diagnoses were linked to care within 1 month. Among blacks living with diagnosed HIV at year-end 2013, 53.5% were retained in care and 48.5% achieved viral suppression. The lowest levels of care and viral suppression were among persons with infection attributed to injection drug use and males with infection attributed to heterosexual contact; linkage to care and viral load suppression were lower among persons aged <35 years than persons aged ≥35 years.

What are the implications for public health practice?

Increasing the proportion of black persons living with HIV who are receiving care is critical for achieving the National HIV/AIDS Strategy 2020 goals to reduce new infections, improve health outcomes, and decrease health disparities. Tailored strategies for black subpopulations, including persons who inject drugs and young males with infection attributed to heterosexual contact, might be needed to achieve improvements in linkage and retention in care.

In the 33 jurisdictions, 12,269 blacks received a diagnosis of HIV infection in 2014. Among these, 21.9% had infections classified as stage 3 at diagnosis (Table 1). Among males, 20.9% had a stage 3 classification, compared with 24.8% of females. The highest percentage of infections classified as stage 3 among different age groups were reported in persons aged ≥55 years (38.2%); stage 3 classifications increased with age group. By transmission category, males with infection attributed to injection drug use (IDU) had the highest percentage (32.5%) of infections classified as stage 3, followed by males with infection attributed to heterosexual contact (32.2%).

Overall, 8,780 (71.6%) of the 12,269 blacks with HIV infection diagnosed during 2014 were linked to care ≤1 month after HIV diagnosis; the percentage of persons linked to care increased with increasing age group (Table 2). Overall, 70.0% of males and 76.2% of females were linked to care. By transmission category and age group, males aged 13–24 years with infection attributed to male-to-male sexual contact and IDU accounted for the lowest percentage of persons linked to care (54.9%), followed by males aged 25–34 years with infection attributed to heterosexual contact (63.0%).

Among 257,316 blacks aged ≥13 years living with diagnosed HIV in 33 jurisdictions on December 31, 2013, approximately half (53.5%) were retained in care (Table 3), including 52.4% of males and 55.6% of females. A lower percentage of persons aged 13–34 years were retained in care (50.3%) than were persons aged ≥35 years (54.4%). By transmission category and age group, males aged 25–34 years with infection attributed to IDU accounted for the lowest percentage retained in care (38.1%), followed by males aged 13–24 years with infection attributed to heterosexual contact (39.4%). VL suppression at the most recent test was achieved by 48.5% of persons (Table 3); a higher percentage of females had suppressed VL (49.8%) than did males (47.9%). Among all age groups, the lowest level of VL suppression was among persons aged 13–24 years (39.7%); VL suppression increased with increasing age group. Females aged 13–24 years with infection attributed

TABLE 1. Number and percentage of HIV infection diagnoses among blacks aged ≥13 years who were stage 3 (AIDS) at the time of diagnosis — National HIV Surveillance System, 33 jurisdictions,* United States, 2014

Characteristic	No. HIV diagnoses	Stage 3 (AIDS) at diagnosis† no. (%)
Sex		
Male	9,121	1,908 (20.9)
Female	3,148	780 (24.8)
Age group at diagnosis (yrs)		
13–24	3,539	362 (10.2)
25–34	3,832	700 (18.3)
35–44	2,106	630 (29.9)
45–54	1,642	557 (33.9)
≥55	1,150	439 (38.2)
Transmission category§		
Male-to-male sexual contact	7,393	1,374 (18.6)
Injection drug use		
Male	378	123 (32.5)
Female	276	74 (26.9)
Male-to-male sexual contact and injection drug use	187	37 (19.6)
Heterosexual contact¶		
Male	1,144	369 (32.2)
Female	2,859	700 (24.5)
Other**		
Male	19	6 (31.6)
Female	14	6 (41.2)
Total	**12,269**	**2,688 (21.9)**

Abbreviations: AIDS = acquired immunodeficiency syndrome; HIV = human immunodeficiency virus.

* The 33 jurisdictions were Alabama, Alaska, California, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

† Stage of disease at diagnosis of HIV infection based on first CD4 test performed or documentation of an AIDS-defining condition ≤3 months after a diagnosis of HIV infection.

§ Data statistically adjusted to account for missing transmission categories.

¶ Heterosexual contact with a person known to have or to be at high risk for HIV infection.

** Includes persons with diagnosed infection attributed to hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or not identified.

TABLE 2. Linkage to HIV medical care within 1 month after HIV diagnosis,* among blacks aged ≥13 years, by age group and selected characteristics — National HIV Surveillance System, 33 jurisdictions,† United States, 2014

Characteristic	Age group (yrs)										Total	
	13–24		25–34		35–44		45–54		≥55			
	No. HIV diagnoses	No. linked§ (%)	No. HIV diagnoses	No. linked§ (%)	No. HIV diagnoses	No. linked§ (%)	No. HIV diagnoses	No. linked§ (%)	No. HIV diagnoses	No. linked§ (%)	No. HIV diagnoses	No. linked§ (%)
Sex												
Male	3,044	1,945 (63.9)	3,009	2,111 (70.2)	1,338	999 (74.7)	1,036	779 (75.2)	694	548 (79.0)	**9,121**	**6,382 (70.0)**
Female	495	353 (71.3)	823	624 (75.8)	768	584 (76.0)	606	465 (76.7)	456	372 (81.6)	**3,148**	**2,398 (76.2)**
Transmission category¶												
Male-to-male sexual contact	2,847	1,821 (64.0)	2,650	1,873 (70.7)	954	714 (74.8)	638	483 (75.7)	303	234 (77.2)	**7,393**	**5,124 (69.3)**
Injection drug use												
Male	30	21 (70.0)	69	51 (73.9)	67	53 (79.1)	93	66 (71.0)	119	88 (73.9)	**378**	**278 (73.6)**
Female	31	22 (71.0)	57	38 (66.7)	62	45 (72.6)	71	52 (73.2)	55	45 (81.8)	**276**	**203 (73.5)**
Male-to-male sexual contact and injection drug use	51	28 (54.9)	62	43 (69.4)	33	22 (66.7)	22	16 (72.7)	19	16 (84.2)	**187**	**125 (66.7)**
Heterosexual contact**												
Male	106	67 (63.2)	227	143 (63.0)	282	209 (74.1)	281	213 (75.8)	249	208 (83.5)	**1,144**	**841 (73.5)**
Female	455	323 (71.0)	764	584 (76.4)	705	539 (76.5)	534	412 (77.2)	400	326 (81.5)	**2,859**	**2,185 (76.4)**
Other††												
Male	9	8 (88.9)	2	1 (50.0)	2	1 (50.0)	2	1 (50.0)	4	3 (75.0)	**19**	**14 (73.2)**
Female	10	7 (70.0)	2	2 (100.0)	0	0 (0.0)	0	0 (0.0)	1	1 (100.0)	**14**	**10 (76.5)**
Total	**3,539**	**2,298 (64.9)**	**3,832**	**2,735 (71.4)**	**2,106**	**1,583 (75.2)**	**1,642**	**1,244 (75.8)**	**1,150**	**920 (80.0)**	**12,269**	**8,780 (71.6)**

Abbreviation: HIV = human immunodeficiency virus.

* Data include persons with a diagnosis of HIV infection, regardless of stage of disease at diagnosis.

† The 33 jurisdictions were Alabama, Alaska, California, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

§ One or more CD4 or viral load tests performed within 1 month after HIV diagnosis during 2014.

¶ Data statistically adjusted to account for missing transmission categories.

** Heterosexual contact with a person known to have or to be at high risk for HIV infection.

†† Includes persons with diagnosed infection attributed to hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or not identified.

to IDU had the lowest level of viral suppression (29.7%), followed by males aged 13–24 years with infection attributed to heterosexual contact (31.2%).

Discussion

In 2014, among blacks aged ≥13 years with diagnosed HIV, approximately one in five (21.9%) infections were classified as stage 3 (AIDS) at the time of diagnosis and 71.6% were linked to care within 1 month of diagnosis. Among all blacks living with diagnosed HIV at year-end 2013 in the 33 jurisdictions with complete laboratory reporting, 53.5% were retained in care and 48.5% had achieved viral suppression. These percentages are far below the NHAS 2020 goals of 85% linkage to care, 90% retention in care, and 80% VL suppression, and are also below the percentages of whites who were linked to care, retained in care and with VL suppression (79.0%, 58.2%, and 62.0%, respectively). Improving health outcomes for blacks living with HIV infection is necessary to reduce HIV in the United States. Prompt linkage to care after diagnosis allows early initiation of HIV treatment, which is associated with reduced morbidity, mortality, and transmission of HIV (*6*). Findings from CDC's report on monitoring selected HIV prevention and care objectives indicate blacks have lower HIV linkage (71.6%) and viral suppression (48.5%) percentages than do whites (79.0% and 62.0%, respectively) (*1*).

Consistent with findings from a previous report on the continuum of HIV care among blacks with diagnosed HIV based on data from 19 jurisdictions, males had lower levels of care and viral suppression than did females, and persons aged <35 years had lower levels of viral suppression than did persons aged ≥35 years (*7*). The lowest levels of care and viral suppression among blacks with HIV in these 33 jurisdictions were among persons with infection attributed to IDU and males with infection attributed to heterosexual contact. Results of analyses by sex, and transmission category and age group should be interpreted with caution because some subpopulations have small numbers. In addition to routine testing for HIV to identify persons with unrecognized infection, interventions are needed to ensure that all persons with HIV receive optimal care; tailored strategies for black persons

TABLE 3. Retention in HIV medical care and viral suppression among blacks aged ≥13 years with HIV infection diagnosed by December 31, 2012,* who were alive on December 31, 2013, by age group and selected characteristics — National HIV Surveillance System, 33 jurisdictions,† United States, 2014

Characteristic	Total no.	Retained in care in 2013§ No. (%)	Viral suppression¶ No. (%)
Age ≥13 yrs**			
Sex			
Male	**170,740**	89,475 (52.4)	81,816 (47.9)
Female	**86,576**	48,149 (55.6)	43,095 (49.8)
Transmission category††			
Male-to-male sexual contact	**103,681**	55,110 (53.2)	50,927 (49.1)
Injection drug use			
Male	**27,507**	13,187 (47.9)	11,914 (43.3)
Female	**18,806**	10,315 (54.8)	8,931 (47.5)
Male-to-male sexual contact and injection drug use	**11,691**	6,697 (57.3)	5,779 (49.4)
Heterosexual contact§§			
Male	**25,700**	13,333 (51.9)	12,359 (48.1)
Female	**65,385**	36,408 (55.7)	33,199 (50.8)
Other¶¶	**4,546**	2,576 (56.7)	1,803 (39.7)
Total	**257,316**	**137,624 (53.5)**	**124,911 (48.5)**
Age 13–24 yrs**			
Transmission category††			
Male-to-male sexual contact	**10,001**	5,059 (50.6)	4,102 (41.0)
Injection drug use			
Male	**127**	51 (40.2)	42 (33.1)
Female	**219**	102 (46.6)	65 (29.7)
Male-to-male sexual contact and injection drug use	**246**	120 (48.8)	96 (39.0)
Heterosexual contact§§			
Male	**378**	149 (39.4)	118 (31.2)
Female	**2,454**	1,319 (53.7)	953 (38.8)
Other¶¶	**3,222**	1,884 (58.5)	1,238 (38.4)
Total	**16,646**	**8,684 (52.2)**	**6,614 (39.7)**
Age 25–34 yrs**			
Transmission category††			
Male-to-male sexual contact	**25,031**	12,638 (50.5)	11,110 (44.4)
Injection drug use			
Male	**996**	379 (38.1)	326 (32.7)
Female	**1,381**	637 (46.1)	506 (36.6)
Male-to-male sexual contact and injection drug use	**1,178**	605 (51.4)	493 (41.9)
Heterosexual contact§§			
Male	**2,337**	1,006 (43.0)	895 (38.3)
Female	**11,754**	5,907 (50.3)	4,964 (42.2)
Other¶¶	**588**	299 (50.9)	218 (37.1)
Total	**43,265**	**21,471 (49.6)**	**18,512 (42.8)**
Age 35–44 yrs**			
Transmission category††			
Male-to-male sexual contact	**23,987**	12,680 (52.9)	11,909 (49.6)
Injection drug use			
Male	**3,204**	1,441 (45.0)	1,311 (40.9)
Female	**3,936**	2,016 (51.2)	1,679 (42.7)
Male-to-male sexual contact and injection drug use	**2,226**	1,220 (54.8)	1,028 (46.2)
Heterosexual contact§§			
Male	**5,835**	2,860 (49.0)	2,637 (45.2)
Female	**20,017**	10,482 (52.4)	9,549 (47.7)
Other¶¶	**132**	64 (48.5)	50 (37.9)
Total	**59,337**	**30,763 (51.8)**	**28,162 (47.5)**

See table footnotes on page 102.

TABLE 3. (*Continued*) Retention in HIV medical care and viral suppression among blacks aged ≥13 years with HIV infection diagnosed by December 31, 2012,* who were alive on December 31, 2013, by age group and selected characteristics — National HIV Surveillance System, 33 jurisdictions,† United States, 2014

Characteristic	Total no.	Retained in care in 2013§ No. (%)	Viral suppression¶ No. (%)
Age 45–54 yrs**			
Transmission category††			
Male-to-male sexual contact	**30,176**	16,801 (55.7)	15,967 (52.9)
Injection drug use			
Male	**10,168**	5,098 (50.1)	4,477 (44.0)
Female	**7,644**	4,370 (57.2)	3,720 (48.7)
Male-to-male sexual contact and injection drug use	**4,956**	3,003 (60.6)	2,584 (52.1)
Heterosexual contact§§			
Male	**9,815**	5,361 (54.6)	4,997 (50.9)
Female	**19,644**	11,535 (58.7)	10,802 (55.0)
Other¶¶	**287**	157 (54.7)	139 (48.4)
Total	**82,688**	**46,324 (56.0)**	**42,686 (51.6)**
Age ≥55 yrs**			
Transmission category††			
Male-to-male sexual contact	**14,486**	7,933 (54.8)	7,838 (54.1)
Injection drug use			
Male	**13,012**	6,219 (47.8)	5,758 (44.3)
Female	**5,626**	3,190 (56.7)	2,961 (52.6)
Male-to-male sexual contact and injection drug use	**3,086**	1,749 (56.7)	1,577 (51.1)
Heterosexual contact§§			
Male	**7,335**	3,956 (53.9)	3,713 (50.6)
Female	**11,517**	7,164 (62.2)	6,931 (60.2)
Other¶¶	**318**	171 (53.8)	159 (50.0)
Total	**55,380**	**30,382 (54.9)**	**28,937 (52.3)**

Abbreviation: HIV = human immunodeficiency virus.

* Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Data are based on address of residence as of December 31, 2013 (i.e., most recent known address).

† The 33 jurisdictions were Alabama, Alaska, California, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

§ Defined as having two or more CD4 or viral load tests performed ≥3 months apart during 2013, among persons diagnosed through December 31, 2012, and alive on December 31, 2013.

¶ Defined as having a viral load result of ≤200 copies/mL at the most recent viral load test during 2013. The cutoff value of ≤200 copies/mL was based on the U.S. Department of Health and Human Services recommended definition of virologic failure.

** Age at year-end 2013.

†† Data statistically adjusted to account for missing transmission categories.

§§ Heterosexual contact with a person known to have or to be at high risk for HIV infection.

¶¶ Includes persons with diagnosed infection attributed to hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or not identified.

who inject drugs, black youths, and black males who engage in heterosexual contact might be needed to achieve improvements in care outcomes. U.S. Department of Health and Human Services treatment guidelines recommend that all adults and adolescents living with HIV in the United States be offered treatment (*2*).

The findings in this report are subject to at least two limitations. First, analyses were limited to 33 jurisdictions with complete laboratory reporting of all levels of CD4 and VL test results; these 33 jurisdictions might not be representative of all blacks living with diagnosed HIV infection in the United States. Second, comparisons of numbers and percentages by sex, and transmission category and age group should be made cautiously because subpopulations vary in size and some have small numbers.

Because blacks account for a large percentage of persons living with HIV in the United States, and to address racial/ethnic disparities in HIV care outcomes, increasing the proportion of blacks living with HIV who receive optimal HIV care is critical for achieving the goals of NHAS. Through partnerships with federal, state, and local health agencies, CDC is pursuing a high-impact prevention approach to maximize the effectiveness of current HIV prevention and care methods (*8*). CDC supports projects focused on blacks to optimize outcomes along the HIV care continuum, such as HIV testing (the first essential step for entry into the continuum of care)

and projects that support linkage to, retention in, and return to care for all persons infected with HIV (*9*). Among blacks, tailored strategies for subpopulations, including persons who inject drugs and young males with infection attributed to heterosexual contact, might be needed to achieve the NHAS goal of 80% of persons living with diagnosed HIV having a suppressed viral load for all population segments.

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Trauma Informed Care for HIV+ homeless patients

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Abstract

Problem: Problem: Many homeless HIV-positive patients struggle with HIV management because of substance use, untreated mental health disorders, and unmet needs for food, shelter, and other services. These challenges present barriers to engagement in HIV care and improvement of HIV viral load (VL).

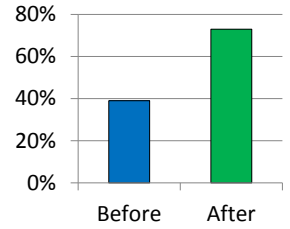
Methodology: Using data from a cohort of homeless HIV-positive patients, we examined whether Trauma-Informed-Care-based case management could improve outcomes. This ongoing, single-arm study included out-of-care HIV-infected homeless patients in Houston, TX who were enrolled in a HRSA-funded Special Projects of National Significance demonstration project between September 2013 and February 2015. At enrollment, patients were assessed for housing, substance use, mental health, and unmet needs. A housing score was assigned to each patient at baseline using a 6-point scale (6 = Street Homeless, 0 = Permanent Housing). An updated housing score was assigned during subsequent encounters. Outcomes measured included changes in the housing score from baseline, engagement in care (HIV visit within 6 months compared to pre-enrollment) and suppression of VL (< 200 copies/mL) within 12 months of enrollment compared to pre-enrollment.

Intervention: Trauma-Informed-Care-based case management and system navigation focused efforts on obtaining improved housing for patients, accompanying them to providing agencies, and providing services using our in-house resources, which represented expansion of the scope of case management typically provided to our patients living with HIV.

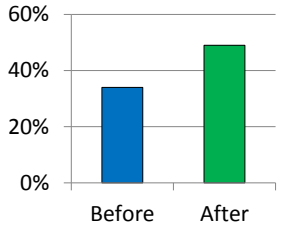
Outcomes: A total of 157 patients were enrolled.
- ✓ Engagement in care rate improved by 87% (from 39% to 73%)
- ✓ VL suppression rate improved by 44% (from 34% to 49%)
- ✓ 95% of patients needed housing assistance; 88% received it
- ✓ 87% of patients needed mental health referral; 93% received it
- ✓ 88% of patients needed substance abuse referral; 94% received it
- ✓ Housing score improved by 37% (from 4.1 to 2.6) however for many patient the housing status showed large fluctuations over time

Our study suggests trauma-informed-care-based case management may yield positive results in improving management of HIV disease among homeless patients.

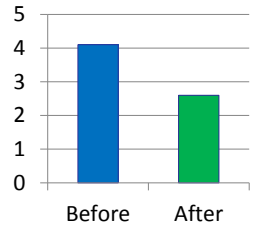
Engagement In Care



Viral Suppression

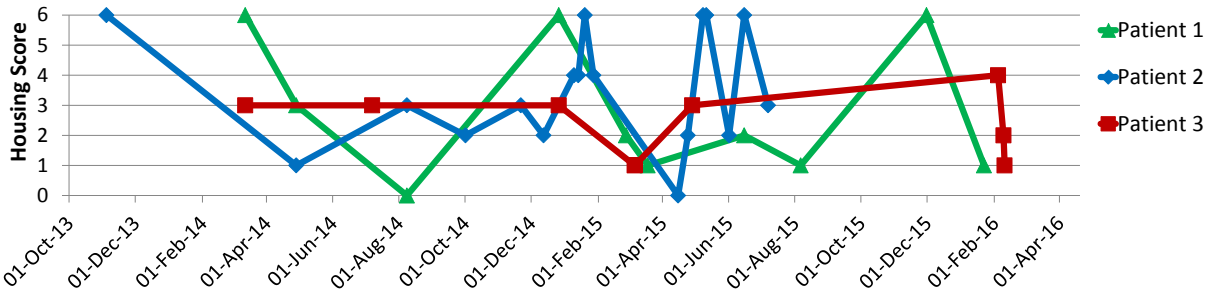


Housing Score*



* A lower housing score is better

Sample Housing Score Fluctuations



Demographics of enrolled patients

		#	%
Gender	Female	37	24%
	Male	118	75%
	Transgender	2	1%
Race	Black /African-American	106	68%
	Hispanic/Latino	17	11%
	White	32	20%
	Other	2	1%
Housing	Street Homeless	109	69%
	Unstably Housed	47	30%
	Fleeing Domestic Violence	1	1%

Services provided to enrolled patients

Service	#	Denominator**	%
Housing Referral	131	149	88%
Cell Phone Assistance	21	73	29%
Peer Mentoring	48	101	48%
Medication Delivery	15	86	17%
Mental Health Referral	128	137	93%
Substance Abuse Referral	130	138	94%
HIV Care at Shelter	23	62	37%
ANY of the above services	147	151	97%

** Those enrolled patients who needed each service and were neither receiving it already nor refused receiving it

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Routledge
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Health-related quality of life among people living with HIV/AIDS receiving case management

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ABSTRACT

Using a cross-sectional descriptive survey, we assessed the health-related quality of life (HRQOL) of 97 people living with HIV/AIDS receiving case management services in the Big Bend area of northern Florida. There is only one AIDS service organization and only one Ryan White Program–supported HIV/AIDS medical care provider in the region. Improvement in HRQOL is a treatment goal set by the Ryan White Program and is a common goal of HIV case management. Results indicate mild symptom burden, mild functional impairment, and poor HRQOL. Implications for HIV case management and social work and practice are discussed.

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case management; health-related quality of life; HIV/AIDS

We sought to assess the health-related quality of life (HRQOL) of people living with HIV/AIDS (PLHA) who receive HIV/AIDS case management services in the Big Bend area of northern Florida. More than 11% of those infected with HIV in the United States are living in Florida (Florida Department of Health, Division of Disease Control, 2014). This exploratory study addresses several gaps in the literature. First, we identify the HRQOL of a sample of PLHA living in the Big Bend Region of northern Florida; this information is not known and can assist the limited number of HIV care providers in the area. Second, we apply a model of HRQOL (Vidrine, Amick, Gritz, & Arduino, 2005) to a sample of PLHA receiving case management services in this predominantly rural area of the southeastern United States. This model has not been tested previously in a nonurban setting.

The big bend

Despite being one of the most populous states in the country, almost half of the counties in Florida are rural (Florida Department of Health, n.d.). The Big Bend Area is composed of seven predominantly rural counties, and Leon County, which includes the county seat and the state capitol of

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Florida, Tallahassee. More than two-thirds of the residents of Leon County live in Tallahassee (U.S. Census Bureau, 2011). The Florida Department of Health, Division of Disease Control (2013) estimates that there are 98,530 PLHA in Florida, of whom more than 1% ($n = 1{,}048$) live in the Big Bend region. When relatively few numbers of PLHA reside in a large geographic region, a lack of available resources contributes to difficulties in accessing affordable and appropriate medical care and social support. This is the case in the Big Bend region as there is only one AIDS service organization (ASO) providing case management support to the entire region and only one Ryan White Program–supported HIV/AIDS medical care provider. Because of the dearth of available services, we were interested in assessing the HRQOL of this hard-to-reach population to better understand their needs.

Health-related quality of life

HRQOL is a multidimensional concept of an individual's well-being, which includes physical and psychological health, as well as one's social well-being (The WHOQOL Group, 1995). Measures of HRQOL can provide insight into the health of PLHA, provide prognostic information that may be more informative than standard biological markers of CD4 count and viral load, and may serve as a predictor of long-term survival (Cunningham, Crystal, Bozzette, & Hays, 2005).

The majority of studies concerning HRQOL as an outcome measure for PLHA pertain to clinical trials of antiretroviral medications (Pugh, 2009), although other studies have focused on predictors of quality of life, including age, sex, ethnicity, injecting drug use, income, employment status, educational attainment, health insurance status, and CD4 cell count (Campsmith, Nakashima, & Davidson, 2003; Eller, 2001). For instance, a longitudinal study surveying a probability sample of PLHA in the United States found that nonwhite individuals report lower levels of HRQOL (Cunningham, Bozzette, Hays, Kanouse, & Shapiro, 1995; Cunningham, Wong, & Hays, 2008), while other studies show older individuals often report lower levels of HRQOL (Wachtel et al., 1992) than their younger counterparts.

Vidrine et al. (2005) proposed and evaluated a model of HRQOL of PLHA that considers the natural progression of HIV disease (see Figure 1). Their framework is an adaptation of models by Wilson and Cleary (1995) and Brenner, Curbow, and Legro (1995) and posits that HRQOL outcomes exist on a continuum and is proximal-distal in nature. As an individual begins to experience increasing symptom frequency or severity, his or her role-specific functional status is altered, which then influences the individual's assessment of his or her overall HRQOL. In addition, Vidrine et al.

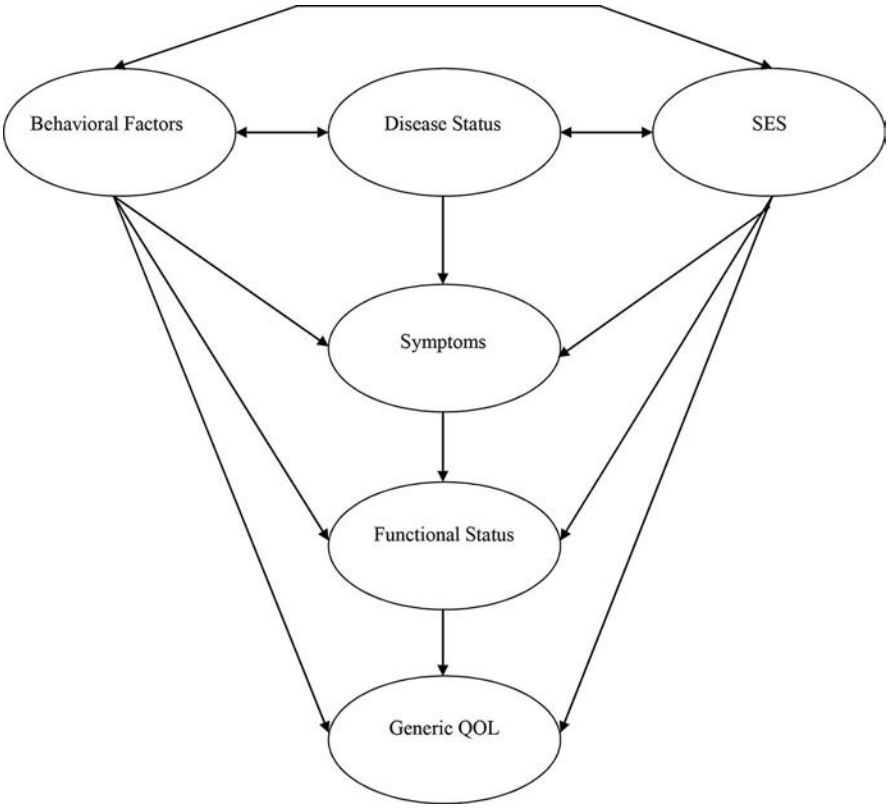

Figure 1. A conceptual framework of health-related quality of life. Adapted from Vidrine, D. J., Amick, B. C., Gritz, E. R., & Arduino, R. C. (2005). Assessing a conceptual framework of health-related quality of life in a HIV/AIDS population. *Quality of Life Research, 14*, 929–933.

theorized that behavioral factors and socioeconomic status directly impact disease status, symptom status, functional status, and HRQOL. Each is briefly explored next.

Socioeconomic status

Lower education and income, in addition to not having private health insurance, are factors associated with lower levels of HRQOL among PLHA (Campsmith et al., 2003; Cunningham et al., 2005, 2008; Eller, 2001). Given that as many as 22% of the residents of Leon county were living in poverty at the time of our study (U.S. Census Bureau, 2009) and 59% of Floridians receiving Ryan White Program services live below the federal poverty level (HRSA, 2010), we were interested in examining if socioeconomic status (SES) impacts the HRQOL of PLHA living in the Big Bend region. When these relationships were tested by Vidrine et al. (2005), findings showed that the direct effects of SES on role-specific functional status and HRQOL were present but were related to symptom status.

Behavioral factors

The effects of substance use and abuse on HRQOL among PLHA are well documented (Cunningham et al., 1995, 2008; Turner et al., 2001). Smoking status, alcohol use, and illicit drug use were evaluated by Vidrine et al. (2005) to assess the impact of these behavioral variables on symptom status, functional status, and HRQOL. These behavioral variables were found to increase symptoms, impair individual's functional status, and decrease an individual's HRQOL.

Disease status

Clinical factors also impact HRQOL. Generally speaking, PLHA with lower levels of CD4 cell counts and higher viral loads will report lower levels of HRQOL (Cunningham et al., 1995, 2008; Ganz, Coscarelli Schag, Kahn, Petersen, & Hirji, 1993). However, when tested by Vidrine et al. (2005), there was no statistically significant relationship between disease status and role-specific functional status and HRQOL.

Symptoms status

As proposed by Brenner et al. (1995), disease signs and symptoms manifest on a continuum of HRQOL as HIV disease advances. HRQOL is "less sensitive to immunologic/virologic changes compared with responsiveness to symptom changes" (Burgoyne, Rourke, Behrens, & Salit, 2004, p. 151), although the impact of symptoms on HRQOL is dependent on severity and type of symptoms. A national study of PLHA revealed that experiencing symptoms such as "pain in the mouth, lips, or gums; trouble with eyes; pain, numbness, or tingling of hands or feet; and diarrhea or loose or watery stools were associated with worse perceived quality of life" (Lorenz, Shapiro, Asch, Bozzette, & Hays, 2001, p. 854).

Functional status

Disease status has a direct impact on symptoms; symptoms then directly impact functional status, which is an individual's ability to perform specific tasks (e.g., work, self-care, child-care, activities of daily living). Ryu, West, and Sousa (2009) adapted the model proposed by Wilson and Cleary (1995) and found that "symptom status was found to be negatively related to the quality of life (QOL) of HIV patients. This relationship is partially mediated by functional health (disability) in that having more symptoms increased the levels of disability, which, in turn, lowered QOL" (p. 226).

It should be noted that many of these studies were conducted before the availability of highly active antiretroviral treatment and the recent bifurcation of case management services for PLHA. While the Ryan White Program has now distinguished between medical and nonmedical case management, these services continue to vary greatly across patient populations, practice settings, and geographic locations. Additionally, there has been a trend to study this phenomenon in rural areas of Africa, India, and Southeast Asia, yet the literature on the topic of HRQOL in PLHA living in rural areas of the United States has not been updated in the past 5 years. To address these gaps, we accessed a sample of PLHA receiving nonmedical HIV case management in a region with scarce HIV resources.

Because the HRQOL of PLHA in the Big Bend area is not known, our primary objective was to test a model of HRQOL among PLHA while assisting the local ASO, medical providers, and HIV planning body in identifying client needs, areas for improvement, and potential areas for case management interventions. Two research questions were addressed: What is the HRQOL status for PLHA, residing in the Big Bend area, who are receiving case management services? How much variance in HRQOL is accounted for by disease status, symptom status, functional status, socioeconomic status, and behavioral factors among PLHA residing in the Big Bend area?

Method

Using a cross-sectional survey design, we assessed the HRQOL of PLHA receiving federally supported HIV nonmedical case management in the Big Bend area of northern Florida. This study was approved by the Florida State University Institutional Review Board to ensure human subject protection. No personally identifying information was collected as a part of this study, to protect participants' anonymity. Completing the survey implied consent. To be eligible for participation, individuals were required to be HIV positive, receive case management at the agency, be at least 18 years of age, and be able to speak English.

Sampling procedures

The sample for this study included clients receiving case management at Big Bend Cares, a nonprofit, Ryan White Program–funded ASO located in Tallahassee, Florida. The agency provides case management for residents of the eight counties of the Big Bend area with six case managers providing services to more than 950 HIV-positive clients. This is the only ASO in the eight-county region and the only source of federally supported HIV case management services for PLHA living in the area. Due to confidentiality concerns, we were unable to access the full client database of the ASO, and there is no

database of contact information for any other PLHA living in the region receiving case management services through other agencies. Therefore, there is no reasonable method for obtaining a true probability sample for this study. Instead, a convenience sampling strategy was used to obtain our participants.

Several recruitment methods were used, including posting flyers throughout the agency and informing agency staff about the study so that they could refer clients, and for 1 week, the Principal Investigator approached clients as they came to the agency for services. To boost response rates, the final recruitment method used direct mailing to clients. The agency maintains a mailing list of clients who have consented to receive mail from the agency. Using a systematic random sample, a total of 100 flyers were mailed to clients. There were roughly 450 clients on the mailing list; the random start began at the 143rd client, with every 10th client on the list being selected.

Participants could complete the survey in one of three ways: in person, over the phone, or online. All participants were given a $10.00 gift card to a local dollar store in return for their participation.

Data collection instrument

Demographic and SES variables

To determine the sample characteristics, participants were asked to provide their age, sex, race, ethnicity, length of time since CD4 cell count, and HIV risk factor.

Behavioral factors

A modified version of the National Institute on Drug Abuse–Modified Alcohol, Smoking, and Substance Involvement Screening Test (National Institute on Drug Abuse, 2012) was used to assess behavioral factors of participants. This instrument is a checklist of use of numerous substances, including alcohol, tobacco, prescription opioids, and eight illicit substances (e.g., cannabis, cocaine, prescription stimulants, methamphetamine, inhalants, sedatives, hallucinogens, and street and prescription opioids). Participants are asked to recall frequency of substance use in the previous 3 months. Response options include "daily," "monthly," "weekly," or "once or twice." The behavioral variables of tobacco use, alcohol use, and use of any illicit substance were all collapsed into dichotomous variables: "any reported use" and "no reported use" for analyses.

Disease status

Disease status was captured using the dichotomous variable self-reported use of antiretroviral medication (HAART) and self-report of most recent CD4 count.

Symptom status

The Sign and Symptom Check-List for Persons with HIV Disease (SSC-HIV) was used to assess symptom burden in this study. Previous studies using this instrument produced Cronbach α reliability estimates ranging from .72 to .90 (Holzemer et al., 1999). This six-factor instrument is composed of 26 items that assess the intensity of symptoms experienced by PLHA (Holzemer et al., 1999). Initial validation of the SSC-HIV included exploration of construct validity through principal components factor analysis with varimax rotation and ultimately indicated the six symptom cluster factors, along with Cronbach α reliability estimates, as follows: malaise/weakness/fatigue ($\alpha = .90$), confusion/distress ($\alpha = .90$), fever/chills ($\alpha = .85$), gastrointestinal discomfort ($\alpha = .81$), shortness of breath ($\alpha = .79$), and nausea/vomiting ($\alpha = .77$) (Holzemer et al., 1999). A subsequent study conducted by Sousa, Tann, and Kwok (2006) using confirmatory factor analysis provides further evidence of the validity of the SSC-HIV, including its utility as an adequate conceptual model for assessing symptom status. For our sample of PLHA, the overall Cronbach α of the SSC-HIV was .95. Reliabilities for each factor were not calculated as these scales were not examined independently. Concurrent validity was established through stepwise multiple regressions of the SSC-HIV with two other HRQOL measures, the Health Status Questionnaire and the Quality Audit Marker. The original validation of the SSC-HIV asked participants to rate the symptoms as they are experiencing them "today," with no symptom that day left blank and scored as 0, mild scored as 1, moderate scored as 2, and severe scored as 3. Symptoms assessed with the SSC-HIV include malaise, weakness, fatigue, confusion, distress, fever, chills, gastrointestinal discomfort, nausea, vomiting, and shortness of breath. A later version of this instrument, the SSC-HIVrev, includes 45 items but was not used in this study as the researchers were concerned about response burden.

Functional status

The Health Assessment Questionnaire (HAQ-DI) is most widely used self-report questionnaire to assess functional status of patients with certain physical conditions such as arthritis and has been suggested for use as a generic instrument (Kose et al., 2010). Eight domains and twenty questions capture a set of daily activities such as dressing, rising, eating, walking, hygiene, reach, and grip, with respondent scores ranging from 0 (no disability) to 3 (completely disabled) (Bruce & Fries, 2003). A previous study conducted in Turkey by Kose et al. (2010) found good reliability of the HAQ-DI, with a Cronbach α of .95. The HAQ-DI in our study produced a Cronbach α of .96.

HRQOL

For this analysis, we measured HRQOL using the Overall Functioning domain of the HIV/AIDS Targeted-Quality of Life scale (HAT-QOL, Holmes & Shea, 1997). This domain produced a Cronbach α of .89 in previous studies and is measured with a total of six items that assess the PLHA's physical, role, and social functioning (Holmes & Shea, 1997) including the ability to engage in work and social activities. Using a 5-point, Likert-type scale with response options of 1 (All of the time), 2 (A lot of the time), 3 (Some of the time), 4 (A little of the time), and 5 (None of the time), dimensions are scored so that the final score is transformed to a linear 0-to-100 scale, where 0 is the worst score possible and 100 is the best score possible.

Data analysis

Descriptive analyses were used to answer the question, "What is the HRQOL status for PLHA, residing in the Big Bend area?" Multiple regression modeling was applied to answer the question, "How much variance in HRQOL is accounted for by disease status, symptom status, functional status, socioeconomic status, and behavioral factors among PLHA residing in the Big Bend area?" Listwise deletion was used to address missing data.

Results

One hundred individuals began the survey, and 97 finished, yielding a very high completion rate of 97%. This represents more than 10% of the clients receiving services at Big Bend Cares. The majority of participants completed the survey in person ($n = 68$). Fewer completed the survey over the telephone ($n = 22$). Only seven individuals selected to complete the survey via the Internet. There was no statistically significant correlation between response mode and the dependent variables. Table 1 presents the demographic characteristics of this sample. These results are similar to the demographic characteristics of PLHA living in this geographic area (Florida Department of Health, 2015).

Of the respondents, 61.9% taking antiretroviral medications at the time of the survey. There was a statistically significant difference in ability to recall a most recent CD4 cell count between individuals who reported taking HAART and those not currently taking HAART [$\chi^2(1,\ N = 93) = 4.56,\ p = .049,\ \varphi = .22$]. Specifically, individuals who report taking medications were more likely to recall a recent CD4 cell count ($n = 32$, 53.3%) than were those who report no current use of HAART ($n = 10$, 30.3%).

Half of this sample reported using tobacco products in the past 3 months, of whom 36.1% used daily. More than two-thirds of this sample reported drinking, of whom 10.3% indicated that they drink alcoholic beverages daily.

Table 1. Participant demographics.

Variable	*N*	%
Sex		
Male	56	57.70
Female	39	40.20
Missing	2	2.06
Race		
White	13	13.40
Black	81	83.50
More than one	1	1.03
Missing	2	2.06
Ethnicity		
Hispanic	4	4.12
Non-Hispanic	88	90.72
Missing	5	5.15
Education		
Less than high school diploma	34	35.05
High school diploma, no college	31	31.95
Some college, no degree	16	16.49
Associate's degree	10	10.30
Bachelor's degree	3	3.09
Master's degree	1	1.03
Missing	2	2.06
Income		
<$10,000	75	77.31
$10,001–$20,000	13	13.40
$20,001–$30,000	5	5.15
$30,001–$40,000	1	1.03
Missing	3	3.09
Risk factor		
Men who have sex with men	32	33.00
Intravenous drug users	2	2.10
Heterosexuals	30	30.90
Other	26	26.80
Missing	7	7.20

A total of 62.9% of the sample reported any drug use in the past 3 months. While one-third of the sample reports using cannabis in the past 3 months, the majority (15.5%) of these individuals report using only once or twice in the past 3 months. Roughly one-quarter of this sample reported using cocaine, more than half of whom used it only once or twice in the past 3 months or monthly over the same period of time. Interestingly, 8.2% of respondents reported sedative use, and 11.3% of those reporting using prescription opioids also reported using these substances on a daily basis. Table 2 presents the descriptive statistics for Overall Functioning, Symptom Status, Functional Status, and self-reported CD4 cell count.

We conducted a multiple regression analysis to assess the predictive ability of Vidrine and colleagues' model of HRQOL for this sample of PLHA. Bivariate correlations were reviewed (see Table 3). This sample reported low Overall Functioning ($M = 58.69$, $SD = 23.22$). The following variables were regressed on Overall Functioning: income, education, HAART use,

Table 2. Descriptive statistics for overall functioning, symptom status, functional status, and self-reported CD4 cell count.

Dimension	Mean	SD	*n*	Skewness	Kurtosis	K-S
Overall Functioning	58.69	23.22	93	0.12	−0.78	1.35
Symptom Status	6.17	4.25	94	0.60	−0.47	1.02
Functional Status	.75	1.04	95	0.82	−1.04	3.87*
Self-report CD4	448.71	283.80	42	0.57	−0.68	.77

Notes. *p < .01; K-S Test = Kolmogorov–Smirnov test.

tobacco use, alcohol use, drug use, symptoms status, and functional status. The results suggested that the model could explain 45.0% of the variance in Overall Functioning [Adj. $R^2 = 0.450$, $F(8,78) = 9.79$, $p = .000$, $n = 87$]; however, only Symptom Status and Functional Status significantly predicted Overall Functioning in this sample (see Table 4). To test for an indirect effect of tobacco use on Overall Functioning, we removed the functional status and symptom status variables. Without these variables, the analysis was not significant and the tobacco use variable did not regain significance, indicating that, for this sample, there is not an indirect effect of tobacco use on Overall Functioning.

We then proceeded to check for collinearity between tobacco use and drug use. First, we reran the regression with symptom status and functional status but dropped the drug use variable. Here, the analysis was significant [Adj. $R^2 = 0.454$, $F(7,79) = 11.21$, $p = .000$, $n = 86$], but tobacco use did not regain significance and only functional status and symptom status were significant predictors of Overall Functioning. When we removed drug use, functional status, and symptom status, the analysis was not significant.

Discussion

Results from this study show that the HRQOL of our sample is low, with mild symptom burden and functional impairment. It is not surprising that previous

Table 3. Bivariate correlations.

	Overall functioning	Income	Education	HAART	CD4	Tobacco use	Alcohol use	Drug use	Symptom status
Income	0.04								
Education	0.02	0.47**							
HAART	−0.08	0.21*	0.18						
CD4	−0.05	0.07	0.11	−0.17					
Tobacco Use	−0.21*	−0.12	−0.15	−0.07	0.05				
Alcohol Use	−0.08	0.08	0.18	−0.05	−0.28	0.36**			
Drug Use	−0.10	−0.01	0.09	−0.19	−0.12	0.35**	0.41**		
Symptom Status	−0.64**	−0.09	−0.06	−0.08	−0.10	0.20*	0.14	0.26*	
Functional Status	−0.48**	−0.12	−0.14	0.05	−0.00	0.133	−0.03	−0.10	0.44**

Note. *p < .05, **p < .01.

Table 4. Multiple regression analysis of variables predicting overall functioning.

Variable	*B*	SE B	*β*	*t*	*p*	95% CI for *B* Lower	Upper
Constant	89.93	7.76		11.57	.000	74.46	105.39
Income	.79	5.29	.01	0.14	.882	−9.76	11.34
Education	−2.64	2.72	−.09	−0.97	.335	−8.07	2.78
Current HAART use	−4.34	4.17	−.08	−1.04	.301	−12.65	3.96
Any drug use	3.15	4.68	.06	0.67	.503	−6.18	12.49
Any alcohol use	−1.29	4.59	−.02	−0.28	.778	−10.44	7.84
Any tobacco use	−5.64	4.40	−.12	−1.28	.204	−14.41	3.11
Symptom Status*	−3.10	0.52	−.55	−5.97	.000	−4.14	−2.07
Functional Status**	−4.80	2.07	−.21	−2.31	.023	−8.93	−0.67

Note. Adj. $R^2 = 0.450$. $^{**}p < .001$, $^{*}p < .05$.

studies (Holmes & Shea, 1997) of asymptomatic PLHA produced higher levels of Overall Functioning ($M = 69.00$, $SD = 23.4$). However, a study of HIV-positive individuals in Brazil also produced higher scores of Overall Functioning, even among respondents with severe depressive symptoms (Reis et al., 2011). While improvement in HRQOL is an essential HIV/AIDS treatment goal, Vidrine et al.'s (2005) model of HRQOL has not been used to inform social work practice related to HIV care. Our results show only partial support for Vidrine et al.'s model of HRQOL for PLHA. Specifically, only Symptom Status and Functional Status remain significant predictors of Overall Functioning. The variables assessing SES, income and education, did not predict Overall Functioning. While the behavioral variables of tobacco, alcohol, and drug use also did not predict HRQOL in our study, previous studies found strong evidence that tobacco use predicts HRQOL in this population (see Turner et al., 2001) and may be the product of chronic obstructive pulmonary disease (Drummond et al., 2010).

Additional research is needed to further explore these relationships given the limitations of our study. The cross-sectional design of this study does not allow for a complete analysis of Vidrine et al.'s (2005) model of HRQOL. Future research endeavors should incorporate a longitudinal design so that the relationships between the variables can be observed over time. Furthermore, our sample was severely underpowered and was not large enough to detect medium and small effect sizes, which may contribute to Type II error. Our use of listwise deletion to handle missing data may have also resulted in biased estimates. One of the challenges with the current analysis is that it is likely that there is error of the measurement in the mediator, which will result in biased estimates of the regression coefficients. Had the sample been larger, we would have preferred to conduct path analysis or SEM. Despite that the results of this study involving a convenience sample cannot be generalized to all PLHA living in the rural south, it does provide some insight into the HRQOL status of PLHA receiving case management in the Big Bend area.

Finally, there may be considerable limitations in the operationalization of the domains in Vidrine et al.'s model. For example, measuring alcohol, tobacco, and illicit drug use may not be a sufficient measure of behavioral variables that impact HRQOL. Future research should incorporate measures of diet, exercise, and adherence to treatment regiments. The use of self-reported disease status variables of CD4 count and HAART use also may not accurately measure the current disease status of the PLHA. Only 43% of this sample was able to recall their most recent CD4 count. This, in and of itself, should be very concerning to HIV case managers. Future research should seek to collect blood samples to measure this and other essential biomarkers. Case managers should be made aware of this deficiency as a key function of social work—related care providers and case managers should encourage adherence to medical appointments and treatment regimens. It is essential that case managers work to educate PLHA on the importance of knowledge of disease status to accurately engage in self-management. Another plausible explanation for respondent inability to recall this crucial lab value is that the respondent may not have been engaged in medical care despite CDC-established guidelines recommending that PLHA see a medical provider every 3 months. While this study did not assess adherence to treatment guidelines, this is a potential area for social workers and case managers to intervene. Case managers should work with clients to ensure that PLHA are obtaining appropriate medical care every 3 months.

Despite these limitations, results from this study provide partial support for a model of HRQOL among PLHA. Translating these findings to inform practice, HIV case managers need to remain cognizant of the roles that symptom burden and functional impairment have on the lives of PLHA. Improvement in HRQOL is a common goal of HIV case management. This study demonstrates that case managers should be concerned with symptom burden and functional impairment, in addition to HRQOL, working to reduce symptoms and alleviate impairment as a means to help improve the quality of life of clients. There is an extensive body of literature on HIV symptom management, primarily focusing on medical and nursing care, though "much of the existing evidence in symptom management is currently based on small studies, weak study designs, or no evidence at all" (Voss, 2013, p. S2). Even as many in the field are calling for updated empirical evidence in the area of symptom management for this population, there has not been as strong of a push for social workers and nonmedical case managers to develop interventions in this area. Case managers and social workers provide access to appropriate interventions to reduce or alleviate symptoms (e.g., access to health insurance, prescription drug coverage, and assistive devices); these professionals can also pioneer the movement by creating and evaluating novel interventions, which can help reduce symptom burden for PLHA.

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