Houston Area Comprehensive HIV Prevention and Care Services Plan 2017 - 2021

Capturing the community's vision for an ideal system of HIV prevention and care for the Houston Area

HOUSTON EMA HIV CARE CONTINUUM

What is the Care Continuum?

The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum describes a seamless system of HIV prevention and care services, in which people living with HIV (PLWH) receive the full benefit of HIV treatment by being diagnosed, linked to care, retained in care, and taking HIV medications as prescribed to achieve viral suppression.

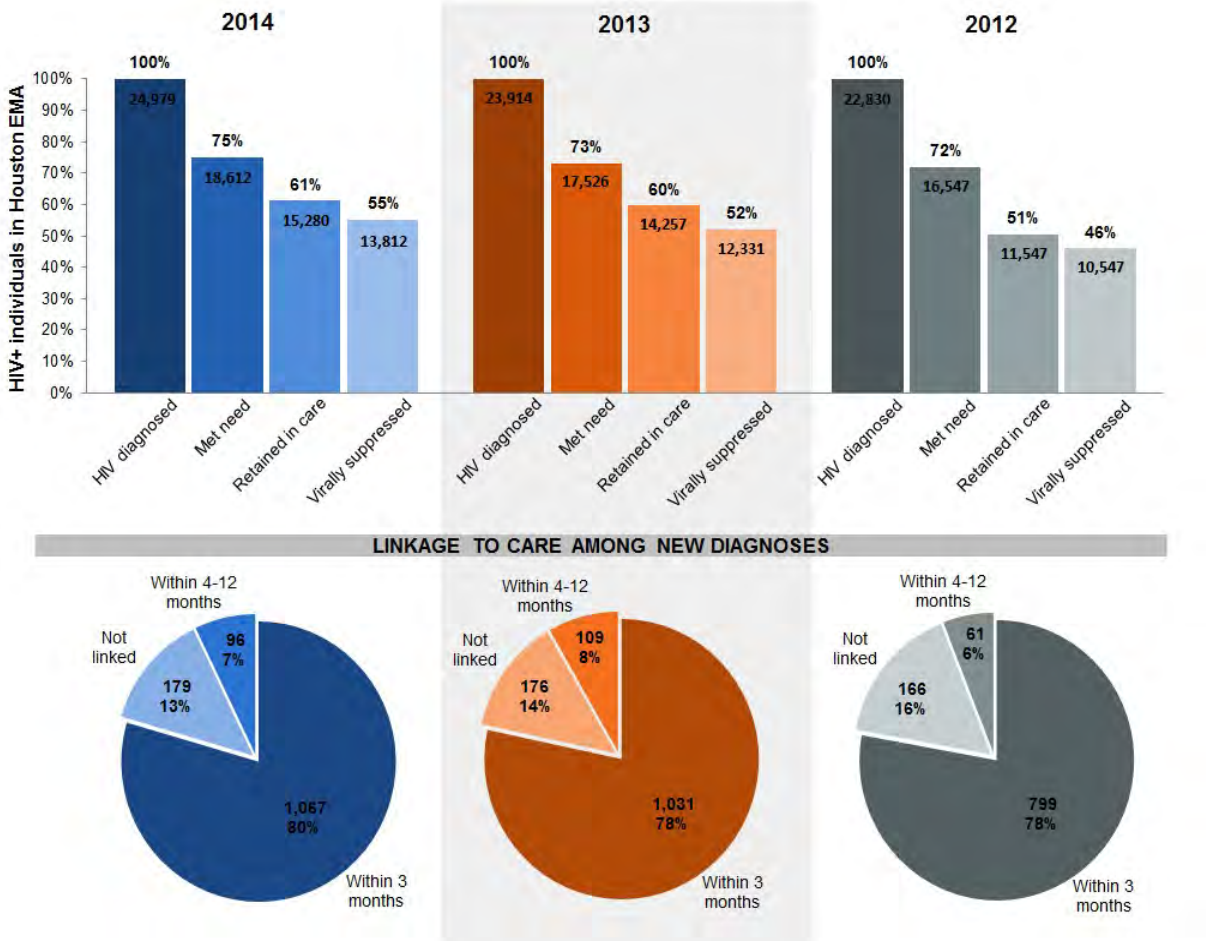
The Houston EMA Care Continuum (HCC)

The HCC is a diagnosis-based continuum. The HCC reflects the number of PLWH who have been diagnosed ("HIV diagnosed"); and among the diagnosed, the numbers and proportions of PLWH with records of engagement in HIV care ("Met need"), retention in care ("Retained in care"), and viral suppression ("Virally suppressed") within a calendar year. Although retention in care is a significant factor for PLWH to achieve viral suppression, 'Virally suppressed' also includes those PLWH in the Houston EMA whose most recent viral load test of the calendar year was <200 copies/mL but who did not have evidence of retention in care.

Linking newly diagnosed individuals into HIV medical care as quickly as possible following initial diagnosis is an essential step to improved health outcomes. In the HCC, initial linkage to HIV medical care ("Linkage to care") is presented separately as the proportion of *newly* diagnosed PLWH in the Houston EMA who were successfully linked to medical care within three months or within one year after diagnosis.

Please see the last page for the Methodology used to develop the Houston EMA HIV Care Continuum.

Figure 1: Houston EMA HIV Care Continuum, 2012-2014



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

From 2012-2014, the total number of HIV diagnosed increased each year, but the percentage of those with met need, retained in care, and virally suppressed also increased.

- There was a 10% increase in the percentage of persons retained in care over the course of three years, with the greatest increase from 2012-2013.
- There was a 9% increase in the percentage of those virally suppressed from 2012 to 2014.
- The percentage of those with met need and those linked within 3 months was relatively stable, with a change of 2% or less between each year.

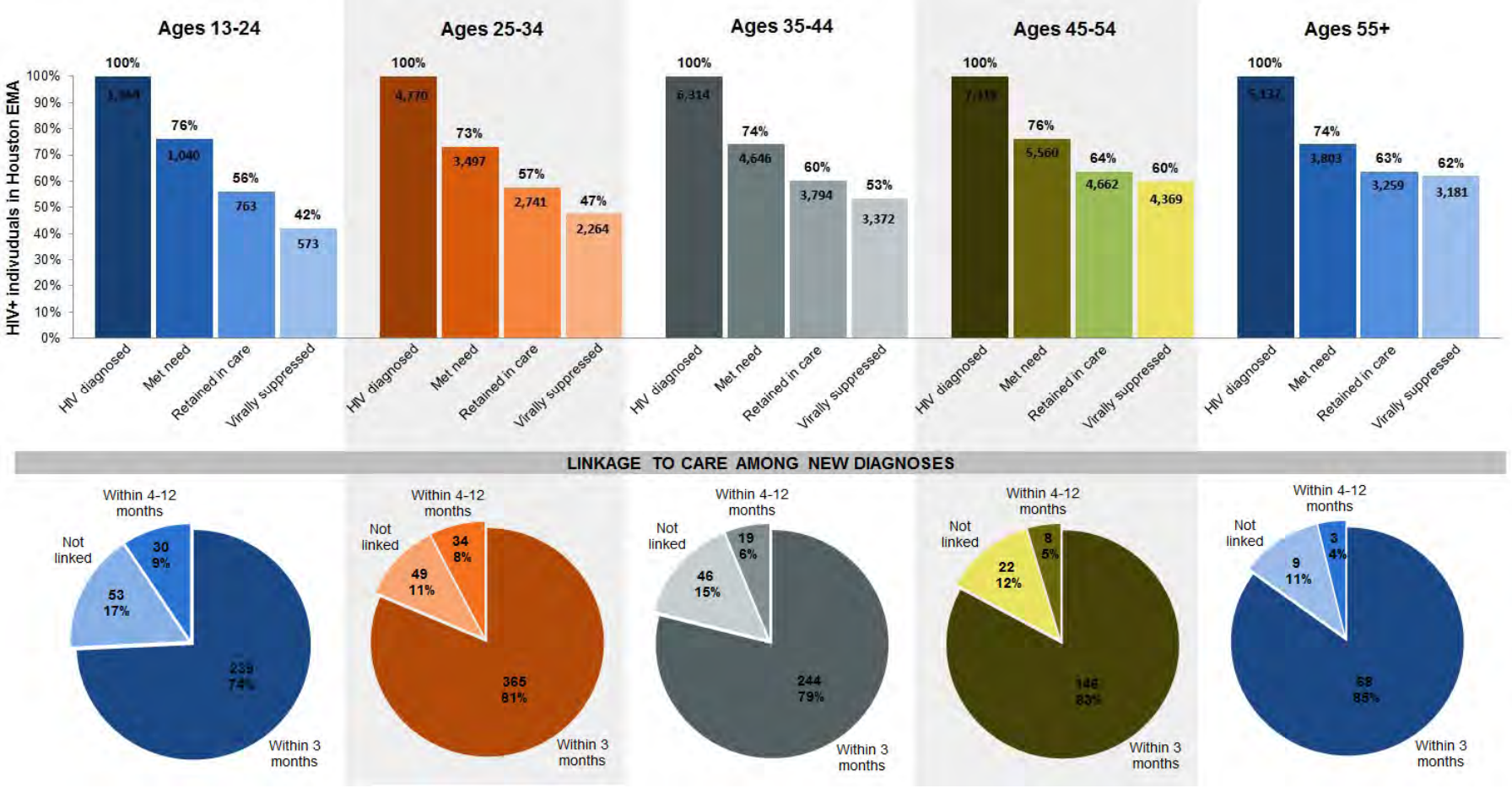
Disparities in Engagement among Key Populations

Multiple versions of the HCC have been created to illustrate engagement disparities and service gaps that key populations encounter in the Houston EMA.

It is important to note that available data used to construct each version of the Houston EMA HCC do not portray the need for activities to increase testing, linkage, retention, ART access, and viral suppression among many other at-risk key populations, such as those who are transgender or gender non-conforming, intersex, experiencing homelessness, or those recently released from incarceration

The Houston EMA Care Continuum, by Age

Figure 2: Houston EMA HIV Care Continuum by Age Groups, 2014



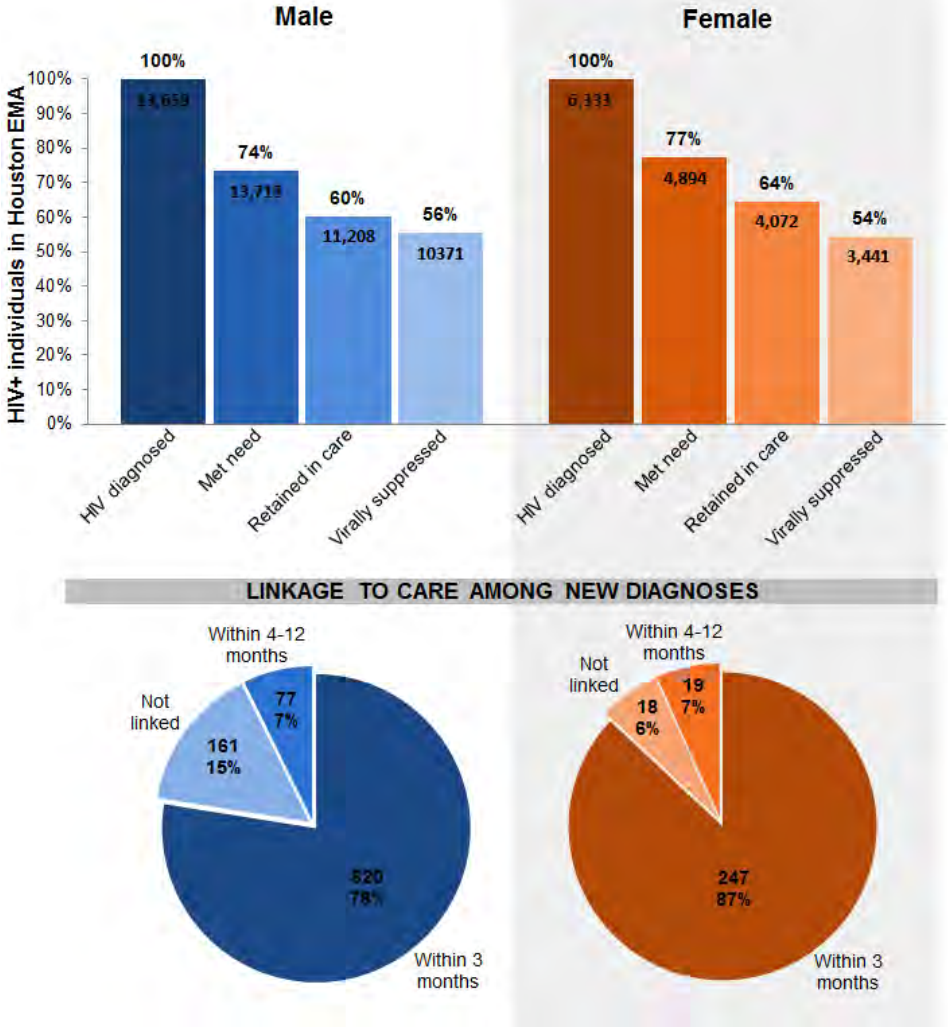
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Younger adults had lower percentages of retention and viral suppression compared to the older adult age groups.

- Youth and young adults (13-24 years old) also had the lowest proportion of newly diagnosed PLWH who were linked within three months of diagnosis when compared to the older adult age groups.

The Houston EMA Care Continuum, by Sex at Birth

Figure 3: Houston EMA HIV Care Continuum by Sex at Birth, 2014

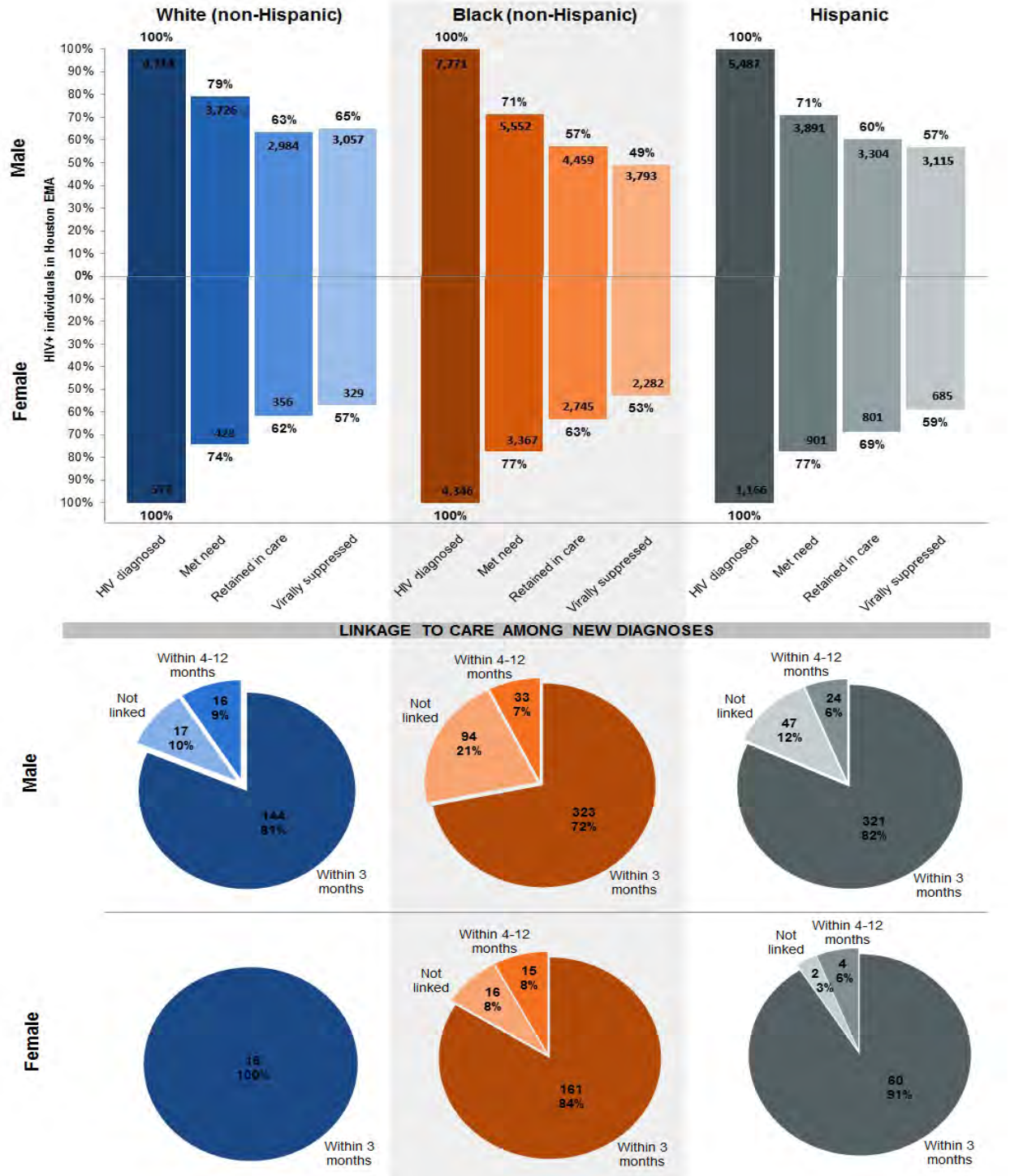


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Females living with HIV in the Houston EMA in 2014 had a higher proportion of individuals with met need and retention in care than males living with HIV, although females had a smaller proportion of viral suppression.
- The proportion of newly diagnosed female PLWH linked to care within the first three months after diagnosis was almost 10% higher among females than males.

The Houston EMA Care Continuum, by Sex at Birth and Race/Ethnicity in 2014

Figure 4: Houston EMA HIV Care Continuum by Sex at Birth and Race/Ethnicity, 2014



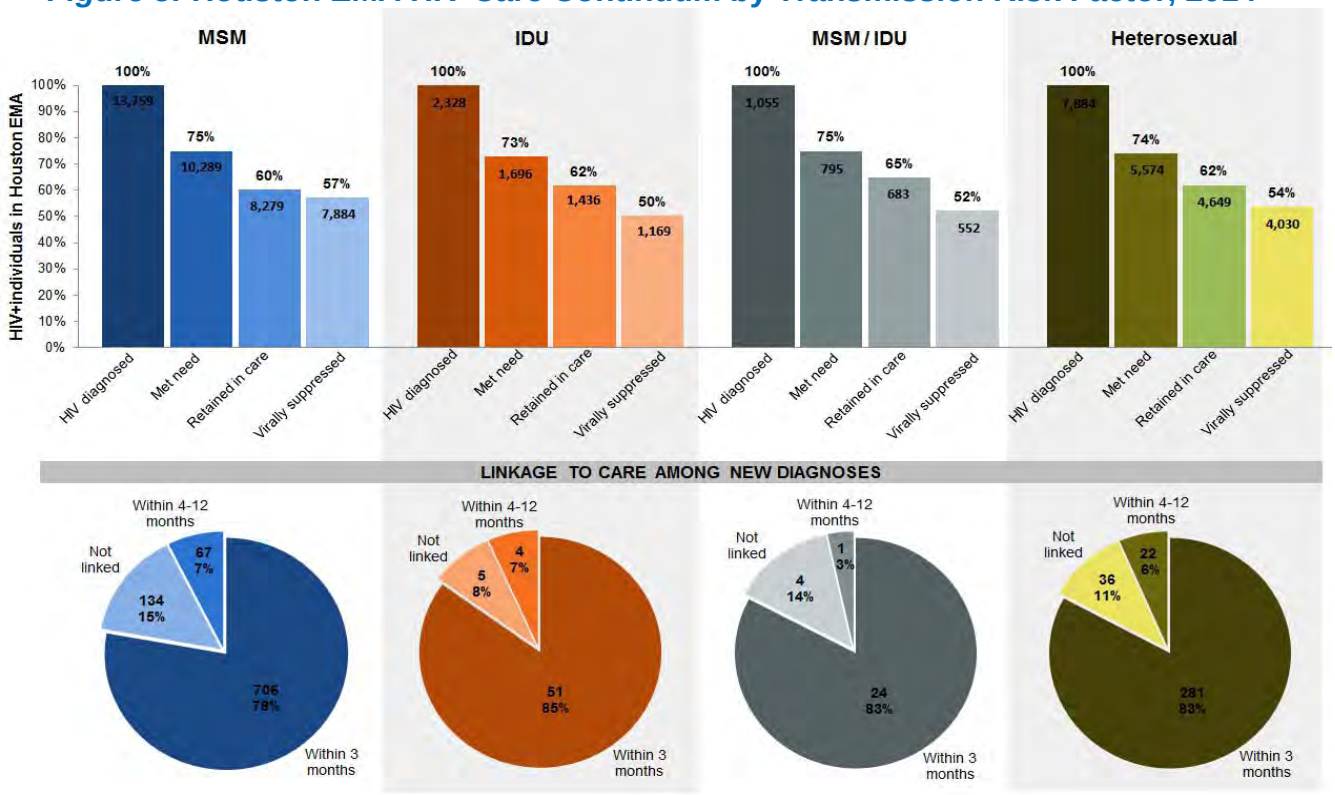
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Hispanic and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need, retention in care, and viral suppression among males in 2014.

- Among females, White (non-Hispanic) and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of retention in care and viral suppression in 2014.
- Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals in each care continuum stage across all birth sex and race/ethnicity groups.

The Houston EMA Care Continuum, by Transmission Risk Factor in 2014

Figure 5: Houston EMA HIV Care Continuum by Transmission Risk Factor, 2014



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

Transmission risk factors that are associated with increased risk of HIV exposure and transmission include Men who have Sex with Men (MSM), injection drug use (IDU), MSM who also practice IDU (MSM/IDU), and heterosexual exposure.

- Although MSM have higher numbers of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV show evidence of met need and retention in care similar to those observed for other risk groups.
- MSM also has a higher proportion of diagnosed PLWH who are virally suppressed, but a lower proportion of newly diagnosed PLWH who were successfully linked to care within three months of initial diagnosis.
- Those with IDU as a primary transmission risk factor exhibited the lowest proportions of both met need and viral suppression.

Questions about the Houston EMA HIV Care Continuum can be directed to: Amber Harbolt, Health Planner in the Office of Support.

The methodology used to develop the Houston EMA Care Continuum:

Measure	Definition	Data Source(s)
HIV diagnosed	No. of persons diagnosed and living with HIV (PLWH) residing in Houston EMA through end of year (alive)	Texas eHARS data
Met need	No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year.	Texas Department of State Health Services HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)*
Linkage to care (pie chart)	No. (%) of **newly diagnosed** PLWH in Houston EMA who were linked to medical care ("Met need") within N months of their HIV diagnosis	
Retained in care	No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart	
Virally suppressed	No. (%) of PLWH in Houston EMA whose last viral load test of the year was <200 copies/mL	Texas ELRs, ARIES labs, ADAP labs

★ ROADMAP ★

TO ENDING THE HIV EPIDEMIC IN HOUSTON

~December 2016~

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Access to Care

ACCESS TO CARE

The vision of the access to care work group is to ensure all residents of the Houston Area receive proactive and timely access to comprehensive and non-discriminatory care to prevent new diagnoses, and for those living with HIV/AIDS to achieve and maintain viral suppression.

Recommendation 1: Enhance the health care system to better respond to the HIV/AIDS epidemic

The ability of the local health care system to appropriately respond to the HIV/AIDS epidemic is a crucial component to ending the epidemic in Houston. FQHCs, in particular, represent a front line for providing comprehensive and appropriate access to care for people living with HIV/AIDS. While we acknowledge the commitment of many medical providers to provide competent care, ending the epidemic will require a more coordinated and focused response.

Ending the epidemic will require a more coordinated and focused response.

Some specific actions include:

- Develop a more coordinated and standard level of HIV prevention services and referrals for treatment, so that patients receive the same type and quality of services no matter where care is accessed.
- Integrate a women-centered care model approach to increase access to sexual and reproductive health services. Women-centered care meets the unique needs of women living with HIV and provides care that is non-stigmatizing, holistic, integrated, and gender-sensitive.
- Train more medical providers on the Ryan White care system.
- Explore feasibility of implementing a pilot rapid test and treat model, in which treatment would start immediately upon receipt of a positive HIV test.
- Better equip medical providers and case managers with training on best practices, latest developments in care and treatment, and opportunities for continuing education credits.
- Increase use of METRO Q® Fare Cards, telemedicine, mobile units, and other solutions to transportation barriers.
- Develop performance measures to improve community viral load as a means to improve health outcomes and decrease HIV transmission.
- Integrate access to support services such as Women, Infants and Children (WIC), food stamps, Children's Health Insurance Program (CHIP), and health literacy resources in medical settings.

Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.

Recommendation 2: Improve cultural competency for better access to care

Lack of understanding of the social and cultural norms of the community is one of the most cited barriers to care. These issues include race, culture, ethnicity, religion, language, poverty, sexual orientation and gender identity. Issues related to the lack of cultural competency are more often experienced by members of the very communities most impacted by HIV. Medical providers must improve their cultural understanding of the communities they serve in order to put the "care" back in health care. Individuals will not seek services in facilities they do not feel are designed for them or where they receive insensitive treatment from staff.

Some specific actions include:

- Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.
- Include training on interventions for trauma-informed care and gender-based violence. This type of care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that contribute to mental health issues including substance abuse, domestic violence, and child abuse.
- Establish measures to evaluate effectiveness of training.
- Revise employment applications to include questions regarding an applicant's familiarity with the community being served. New hires with lack of experience working with certain communities should receive training prior to interacting with the community.

Recommendation 3: Increase access to mental health services and substance abuse treatment

Access to behavioral health and substance abuse treatment are two of the most critical unmet needs in the community. Individuals have difficulty staying in care and adhering to medication without access to mental health and substance abuse treatment. Comprehensive HIV/AIDS care must address the prevalence of these conditions.

Increase the availability of mental health services and substance abuse treatment.

Some specific actions include:

- Perform mental health assessments on newly diagnosed persons to determine readiness for treatment, the existence of an untreated mental health disorders, and need for substance abuse treatment.
- Increase the availability of mental health services and substance abuse treatment, including support groups and peer advocacy programs.
- Implement trauma-informed care in health care settings to respond to depression and post-traumatic stress disorders.

Recommendation 4: Improve health outcomes for people living with HIV/AIDS with co-morbidities

Because of recent scientific advances, people living with HIV/AIDS, who have access to antiretroviral therapy, are living long and healthy lives. HIV/AIDS is now treated as a manageable chronic illness and is no longer considered a death sentence. However, these individuals are developing other serious health conditions that may cause more complications than the virus. Some of these other conditions include Hepatitis C, hypertension, diabetes, and certain types of cancer. When coupled with an HIV diagnosis, these additional conditions are known as co-morbidities. HIV treatment must address the impact of co-morbidities on treatment of HIV/AIDS.

Some specific actions include:

- Utilize a multi-disciplinary approach to ensure that treatment for HIV/AIDS is integrated with treatment for other health conditions.
- Develop treatment literacy programs and medication adherence support programs for people living with HIV/AIDS to address co-morbidities.

Recommendation 5: Develop and publicize complete and accurate data for transgender people and those recently released from incarceration

There is insufficient data to accurately measure the prevalence and incidence of HIV among transgender individuals. In addition, there appears to be a lack of data on those recently released from incarceration. We need to develop data collection protocols to improve our ability to define the impact of the epidemic on these communities.

Recommendation 6: Streamline the Ryan White eligibility process for special circumstances

The Ryan White program is an important mechanism for delivering services to individuals living with HIV/AIDS. In order to increase access to this program, we must remove barriers to enrollment for qualified individuals experiencing special situations. We recommend creating a fast track process for Ryan White eligibility determinations for special circumstances, such as when an individual has recently relocated to Houston and/or has fallen out of care.

Recommendation 7: Increase access to care for diverse populations

According to the 2016 Kinder Houston Area Survey, the Houston metropolitan area has become "the single most ethnically and culturally diverse urban region in the entire country." Between 1990 and 2010, the Hispanic population grew from 23% to 41%, and Asians and others from 4% to 8%. It is imperative that we meet the needs of an increasingly diverse populace.[10]

Some specific actions include:

- Train staff and providers on culturally competent care.
- Hire staff who represent the communities they serve.
- Increase access to interpreter services.
- Develop culturally and linguistically appropriate education materials.
- Market available services directly to immigrant communities.

[10] https://kinder.rice.edu/uploadedFiles/Center_for_the_Study_of_Houston/53067_Rice_HoustonAreaSurvey2016_Lowres.pdf

ROADMAP
TO ENDING THE HIV EPIDEMIC IN HOUSTON

-December 2018-

endhivhouston.org

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2016 Houston HIV Care Services Needs Assessment provides both a "snapshot" of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(**Table 1**) Overall, 93% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (67%), African American/Black (63%), and heterosexual (54%). Greater than half were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $9,380 annually, with the majority living below 100% of federal poverty (**FPL**). Most participants paid for healthcare using Medicaid/Medicare and assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2016

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	464	93.4%	13 to 17	1	0.2%	Male	341	67.3%
Fort Bend	21	4.2%	18 to 24	17	3.4%	Female	166	37.7%
Liberty	1	0.2%	25 to 49	219	43.2%	Intersex	0	-
Montgomery	6	1.2%	50 to 54	123	24.3%	Transgender	20	3.9%
Other	5	1.0%	55 to 64	133	26.2%	Currently pregnant	1	0.2%
			≥65	14	2.8%			
			Seniors (≥50)	270	53.3%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	60	11.8%	Heterosexual	274	54.0%	Private insurance	53	8.6%
African American/Black	318	62.7%	Gay/Lesbian	171	33.7%	Medicaid/Medicare	307	49.8%
Hispanic/Latino	121	23.9%	Bisexual	39	7.7%	Harris Health System	146	23.7%
Asian American	5	1.0%	Other	23	4.5%	Ryan White	105	17.0%
Other/Multiracial	3	0.6%	MSM	216	42.6%	None	6	1.0%
Immigration status			Yearly income (average: $9,380)					
Born in the U.S.	427	84.6%	Federal Poverty Level (FPL)					
Citizen > 5 years	33	6.5%	Below 100%	278	78.8%			
Citizen < 5 years	4	0.8%	100%	45	12.7%			
Undocumented	10	2.0%	150%	13	3.7%			
Prefer not to answer	22	4.4%	200%	10	2.8%			
Other	9	1.8%	250%	2	0.6%			
			≥300%	5	1.4%			

(**Table 2**) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2016 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2016

	No.	%
Unstable Housing	142	28.0%
Injection drug users (IDU)*	8	1.6%
Men who have sex with men (MSM)	216	42.6%
Not retained in care (last 6 months)	4	0.8%
Recently released from incarceration	41	8.1%
Rural (non-Harris County resident)	33	6.4%
Transgender	20	3.9%

*See Limitations section for further explanation of identification of IDU

Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV disease. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department. The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program.

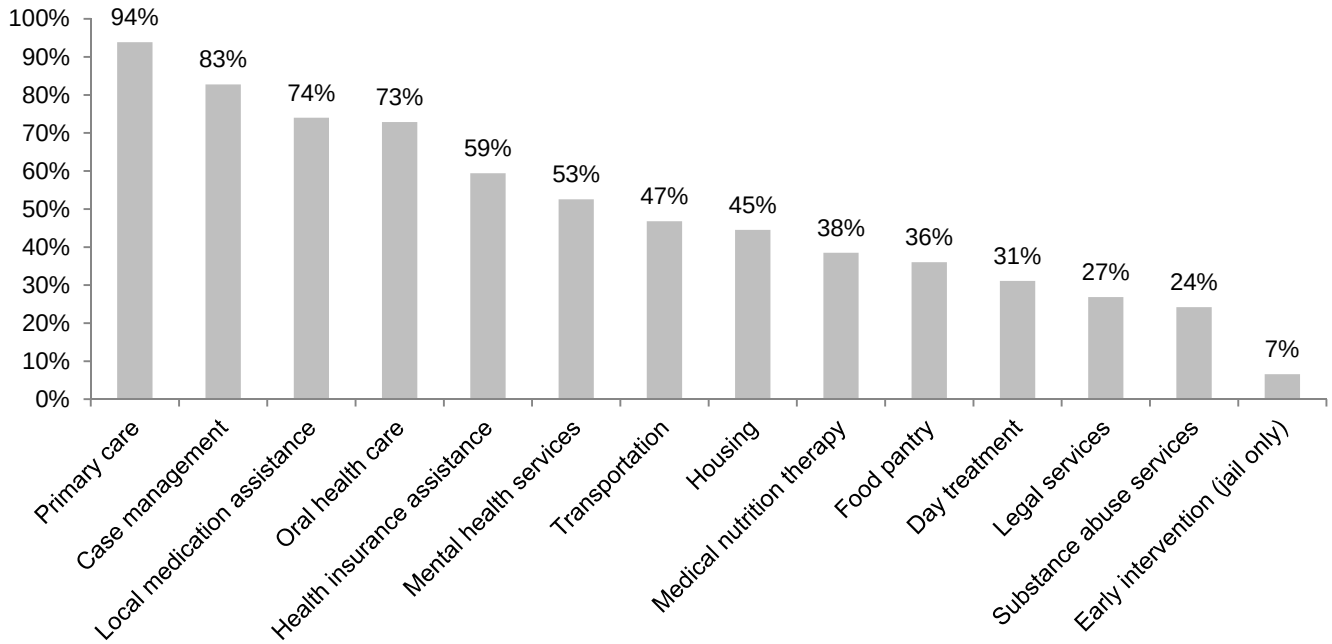
Overall Ranking of Funded Services, by Need

In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed. Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services except hospice and linguistics were analyzed and received a ranking of need. At 94%, primary care was the most needed funded service in the Houston Area, followed by case management at 83%, local medication assistance at 74%, and oral health care at 73%. Primary care had the highest need ranking of any core medical service, while transportation received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2014, need ranking increased for many core medical services, and decreased for most support services. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2016

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator:



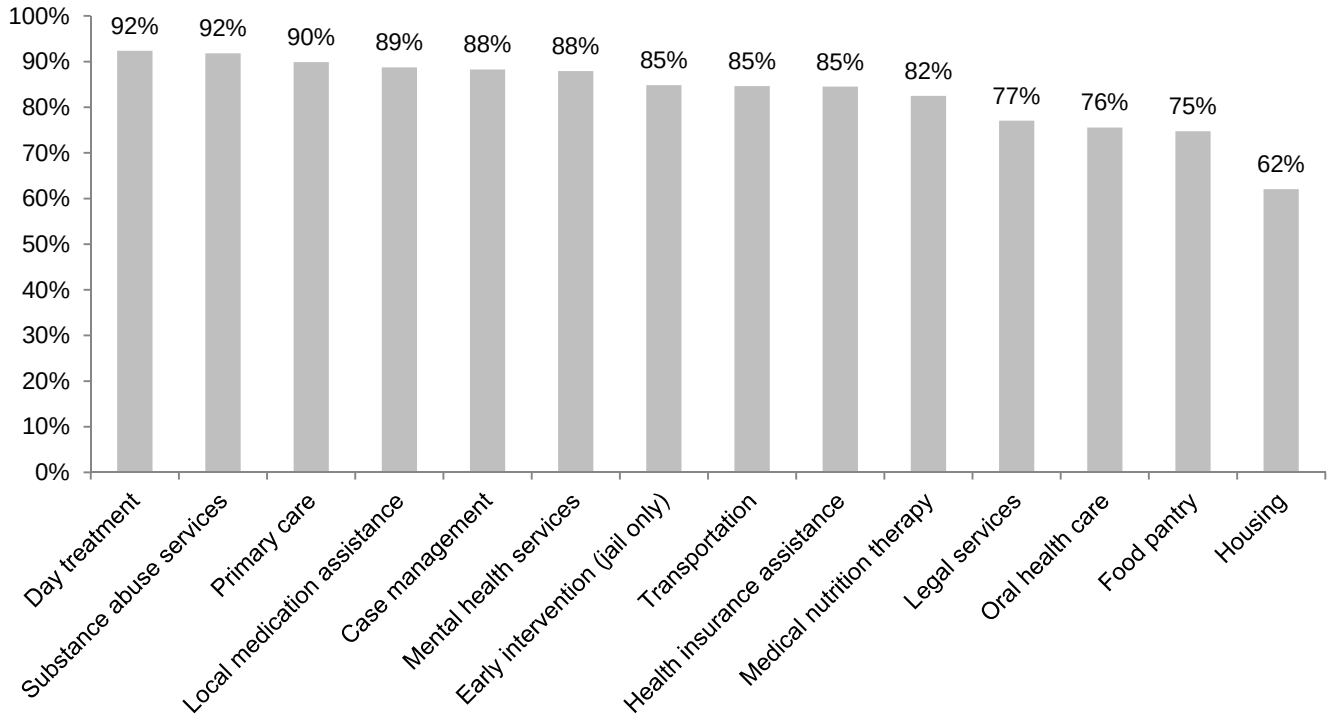
Overall Ranking of Funded Services, by Accessibility

Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The two most accessible services were day treatment and substance abuse services at 92% ease of access, followed by primary care at 90% and local medication assistance at 89%. Day treatment had the highest accessibility ranking of any core medical service, while transportation received the highest accessibility ranking of any support service. Compared 2014 needs assessment, reported accessibility increased for each service category, with an average increase of 9 percentage points. The greatest increase in percent of participants reporting ease of access was observed in early intervention services, while transportation experienced the lowest increase in accessibility.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2016

Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.



Overall Ranking of Barriers Types Experienced by Consumers

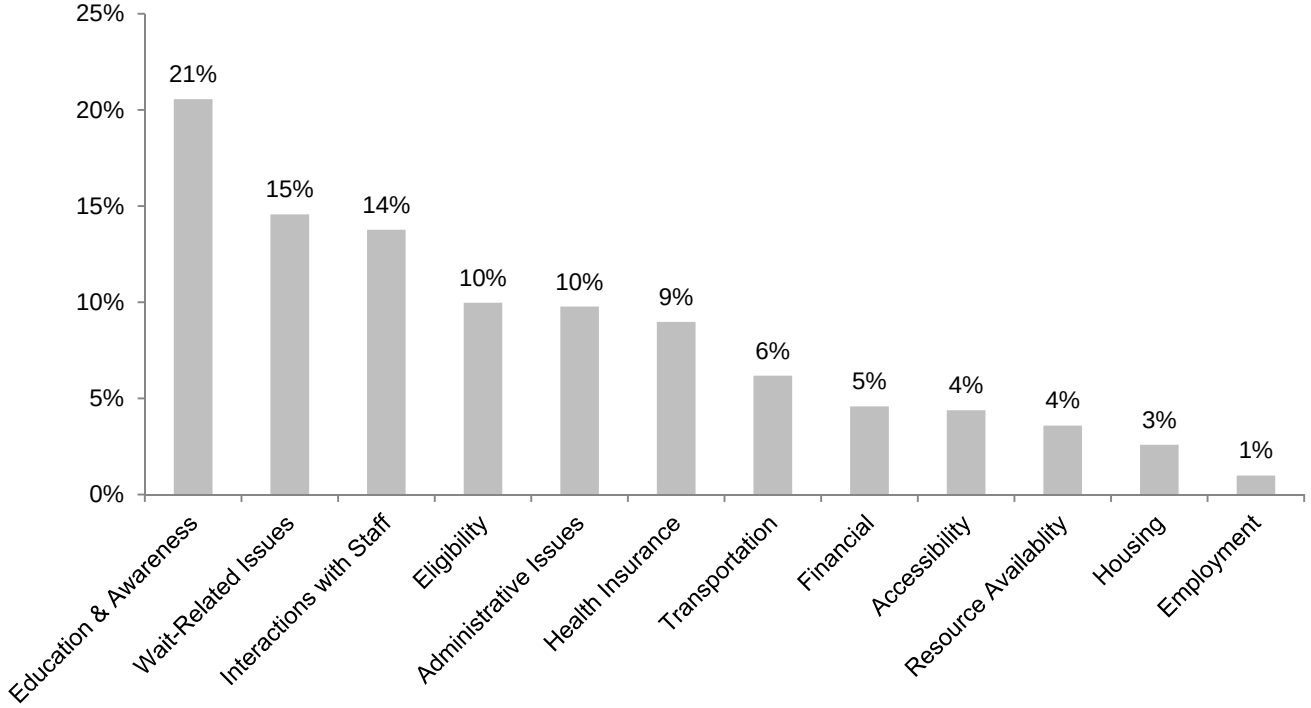
For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 3**) Overall, the barrier types reported most often related to service education and awareness issues (21% of all reported barriers); wait-related issues (15%); interactions with staff (14%); eligibility issues (10%); and administrative issues (10%). Employment concerns were reported least often (1%). Due to the change in methodology for barrier assessment between the 2014 and 2016 HIV needs assessments, a comparison of the change in number of reports of barriers will not be available until the next HIV needs assessment.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2016

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 33 reports of barriers per service. Participants reported the least barriers for Hospice (two barriers) and the most barriers for Oral Health Care (86 barriers). In total, 525 reports of barriers across all services were indicated in the sample.

(**Table 1**) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 82% barriers reported. Being put on a waitlist accounted for a majority (66%) of wait-related issues barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (51%) of barriers related to staff interactions. Almost all (86%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service or difficulty obtaining the required documentation to establish eligibility. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (59%) the barriers reported.

Most (84%) of health insurance-related barriers occurred because the participant was uninsured or underinsured and experiencing coverage gaps for needed services or medications. The largest proportion (81%) of transportation-related barriers occurred when participants had no access to transportation. It is notable that multiple participants reported losing bus cards and the difficulty of replacing the cards presented a barrier to accessing other services. Inability to afford the service accounted for all barriers relating to participant financial resources. The service being offered at a distance that was inaccessible to participants or being recently released from incarceration accounted for most (77%) of accessibility-related barriers, though it is worth note that low or no literacy accounted for 14% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Homelessness accounted for virtually all housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (60%) employment-related barriers.

TABLE 1-Barrier Proportions within Each Barrier Type, 2016					
Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	50%	**Waitlist** (Put on a waitlist)	66%	**Communication** (Poor correspondence/ Follow up from staff)	51%
Definition (Didn't know what service entails)	7%	**Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist)	15%	**Poor Treatment** (Staff insensitive to clients)	17%
Location (Didn't know where to go [location or location w/in agency])	32%	**Wait at Appointment** (Appointment visits take long)	7%	**Resistance** (Staff refusal/ resistance to assist clients)	13%
Contact (Didn't know who to contact for service)	11%	**Approval** (Long durations between application and approval)	12%	**Staff Knowledge** (Staff has no/ limited knowledge of service)	7%
				Referral (Received service referral to provider that did not meet client needs)	17%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	48%	**Staff Changes** (Change in staff w/o notice)	12%	**Uninsured** (Client has no insurance)	53%
Eligibility Process (Redundant process for renewing eligibility)	16%	**Understaffing** (Shortage of staff)	2%	**Coverage Gaps** (Certain services/medications not covered)	31%
Documentation (Problems obtaining documentation needed for eligibility)	38%	**Service Change** (Change in service w/o notice)	10%	**Locating Provider** (Difficulty locating provider that takes insurance)	13%
		Complex Process (Burden of long complex process for accessing services)	59%	**ACA** (Problems with ACA enrollment process)	17%
		Dismissal (Client dismissal from agency)	4%		
		Hours (Problem with agency hours of operation)	16%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	81%	**Financial Resources** (Could not afford service)	100%	**Literacy** (Cannot read/difficulty reading)	14%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	19%			**Spanish Services** (Services not made available in Spanish)	9%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	32%
				Distance (Service not offered within accessible distance)	45%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	56%	**Homeless** (Client is without stable housing)	100%	**Unemployed** (Client is unemployed)	40%
Quality (Resource quality was poor)	44%	**IPV** (Interpersonal domestic issues make housing situation unsafe)	0%	**Leave** (Employer does not provide sick/wellness leave for appointments)	60%

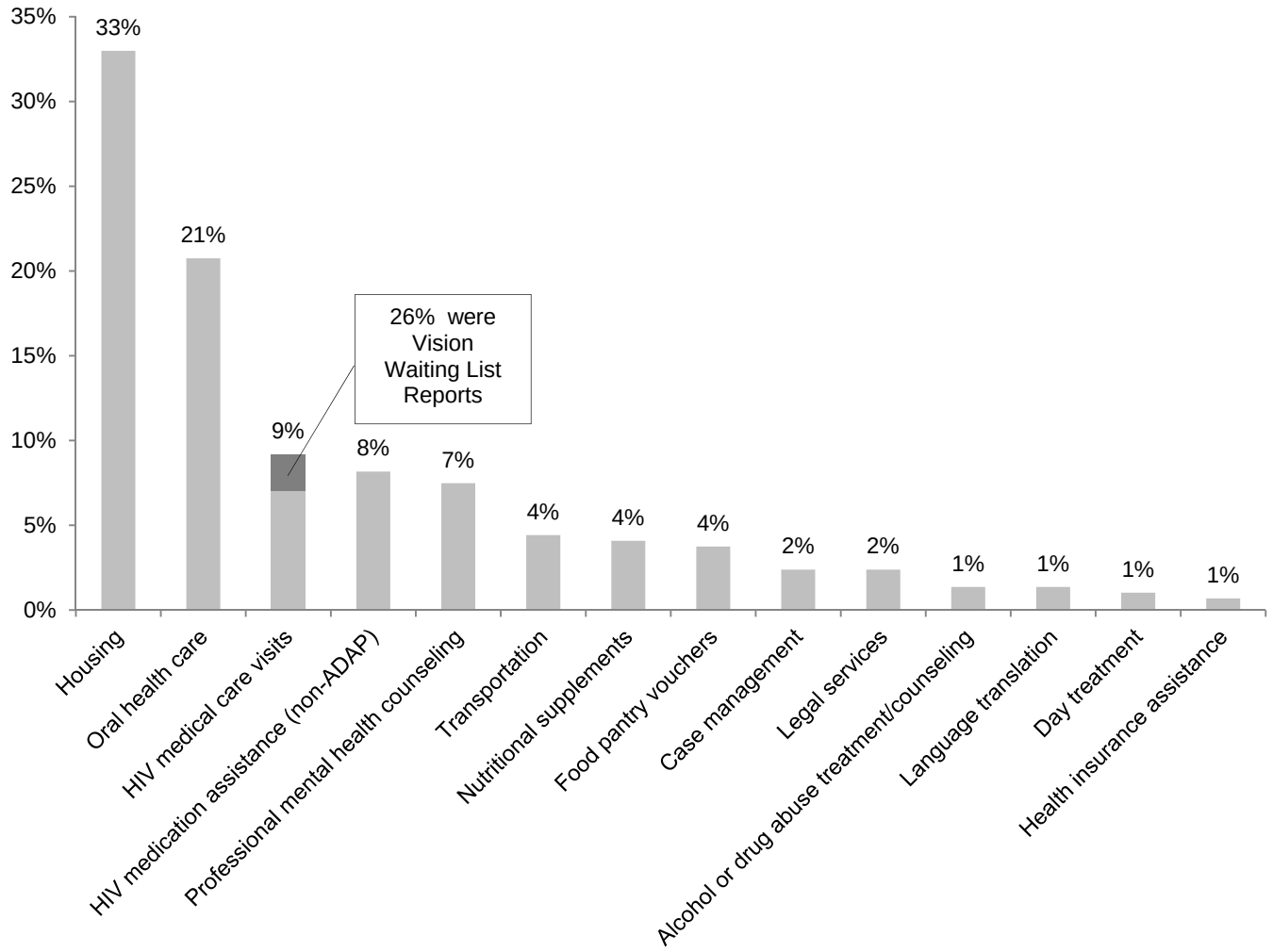
Waiting List Barriers and Experiences

In February 2014, the Ryan White Planning Council formed the ad-hoc Waiting List Workgroup to evaluate the extent to which waiting and waitlists impact the receipt of HIV care and treatment services in the Houston Area, and propose ways to address wait-related issues through changes to the HIV care and treatment system. With input from the Waiting List Workgroup, the 2016 Houston HIV Care Services Needs Assessment included questions specifically designed to elicit information from participants about which services they had been placed on a waiting list for in the past 12 months, the time period between first request for a service and eventual receipt of the service, awareness of other providers of waitlisted services, and services for which clients reported being placed on a waitlist more than once. Thirty-nine percent (39%) of participants indicated that they had been placed on a waiting list for at least one service in the past 12 months.

(**Graph 4**) A third of participant reports of being on a waiting list were for housing services. This was followed by oral health care (21%), HIV medical care (9%), local medication assistance (8%), and professional mental health counseling (7%). Of all participants reporting being on a wait list for HIV medical care visits, 26% indicated being placed on a waiting list specifically for vision services. There were no reports of participants being placed on a wait list for hospice or pre-discharge planning.

GRAPH 4-Percentage of Waiting List Reports by Service, 2016

Definition: Percent of times needs assessment participants reported being on a waiting list for each service.

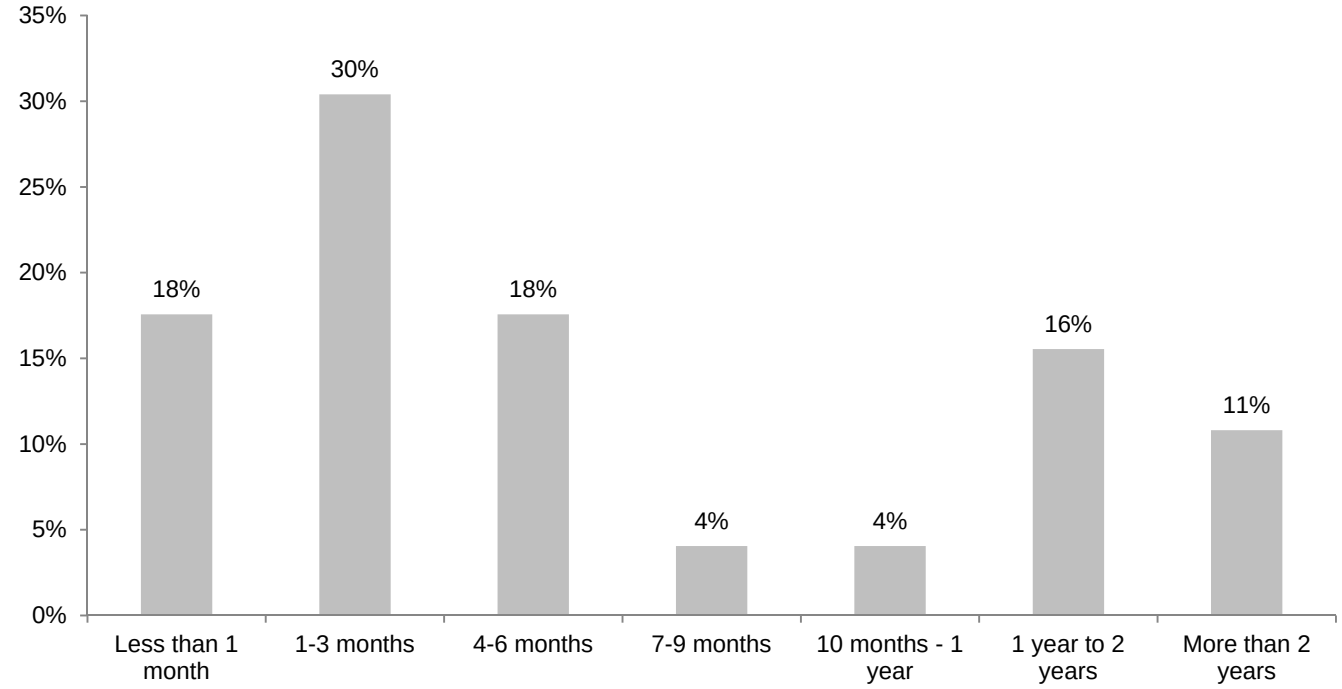


(**Graph 5**) Participant reports of time elapsed from the initial request for a service until receipt of the service vary from 1 day to over 2 years. The greatest number of reports of time elapsed occurred for wait times between one and three months (30%), followed by less than one month (18%) and four to six months 18%).

Most wait times reported for housing services occurred for one to three months (26%), one to two years (26%), or 10 months to one year (18%). It is worth noting that 8% of participants reporting a wait time for housing services had over two years elapse between first request and receipt of service, with several expressing that they were on a housing wait list at the time of survey. Most reports of wait times for oral health care were less than one month (26%) or four to six months (26%). However, 14% of participants indicating a wait time for oral health care services reported wait times of over one year. Finally, most participants (64%) indicating wait times for HIV medical care including vision services reported waiting one to three months.

GRAPH 5-Percentage of Wait Times Reports, 2016

Definition: Percent of times needs assessment participants reported time elapsed from the initial request for a service until receipt of the service each time period.



Awareness of other providers for services operating waiting lists can offer timely service to consumers with acute needs and reduce wait times for those remaining on wait lists. A majority (83%) of participants who reported being on a wait list for at least one in the past 12 months stated that they were not aware of another provider of the service for which they were waiting, or did not remember if they were aware of another provider. Of the remaining 35% of participants who were aware of another provider, over half (59%) reported not seeking service from the alternative provider.

Nearly one-third of participants who reported being placed on a wait list in the past 12 months also reported having been placed on a wait list for the service more than once. This was observed primarily for among participants reporting being placed on a wait list for housing services (34%) and oral health care (29%).

Other Identified Needs

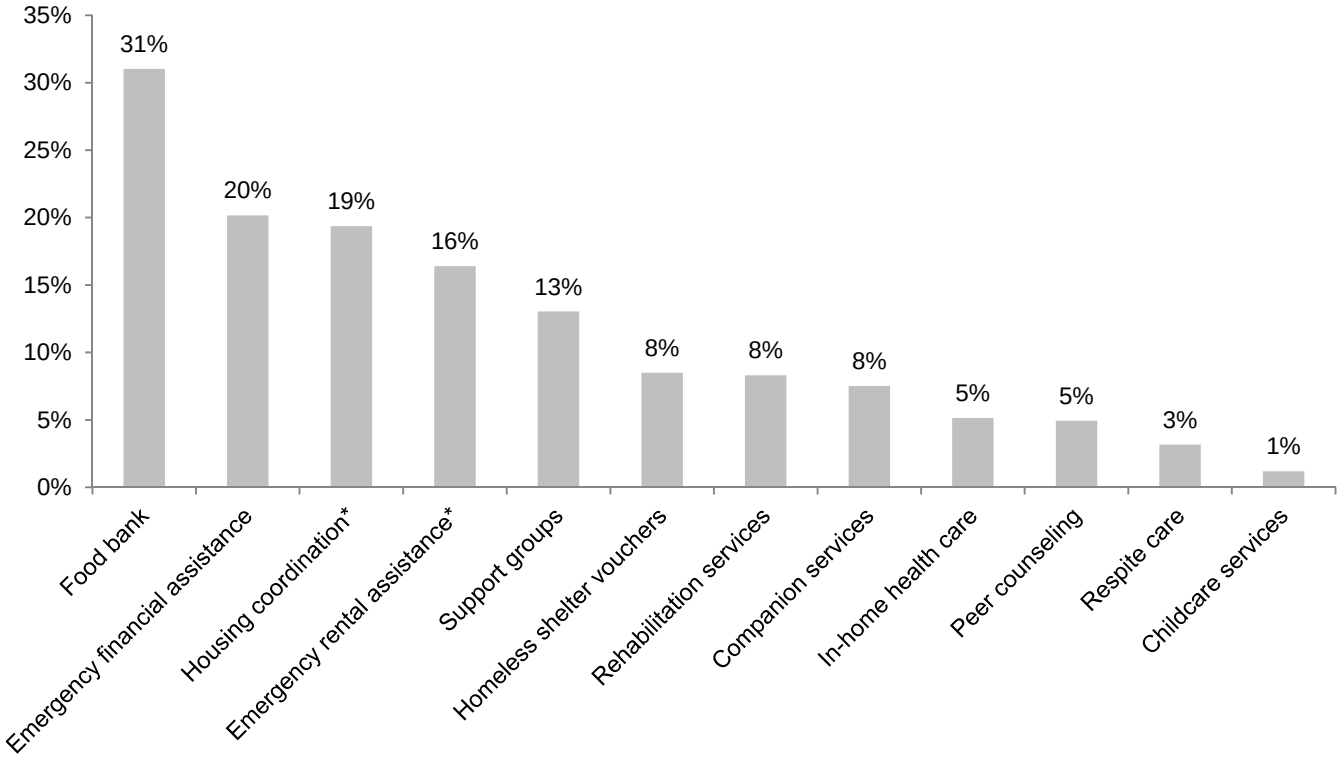
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2016 Houston HIV Care Services Needs Assessment measured the need for these services to order to gauge any new or emerging service needs in the community. In addition, some of these services are currently funded through other HIV-specific non-Ryan White sources, namely housing-related services provided by the Housing Opportunities with People with AIDS (HOPWA) program, as indicated.

(**Graph 6**) Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services. Of the 12 services options provided, 31% of participant selected food bank was needed services, a decrease of 14 percentage points from the 2014 needs assessment. Emergency financial assistance was selected second (20%), followed by housing-related services cited third (20%) and fourth (16%), and support groups cited fifth (13%).

Services that were written-in most often as a need (and that are not currently funded by Ryan White) were (*in order*): employment assistance and job training, vision hardware/glasses, and services for spouses/partners.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2016

Definition: Percent of needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"



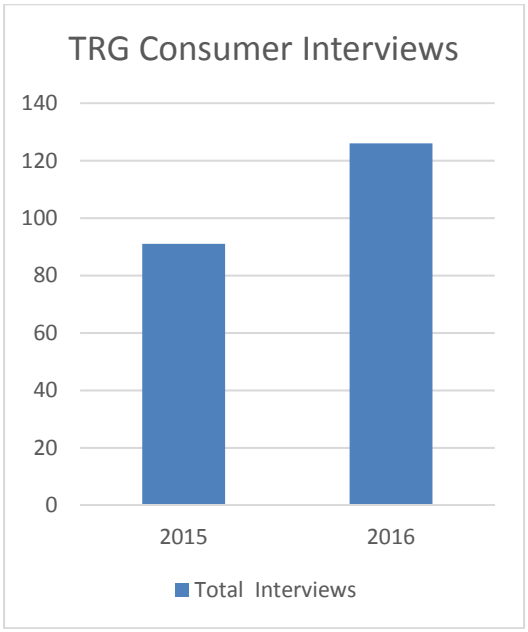
*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.

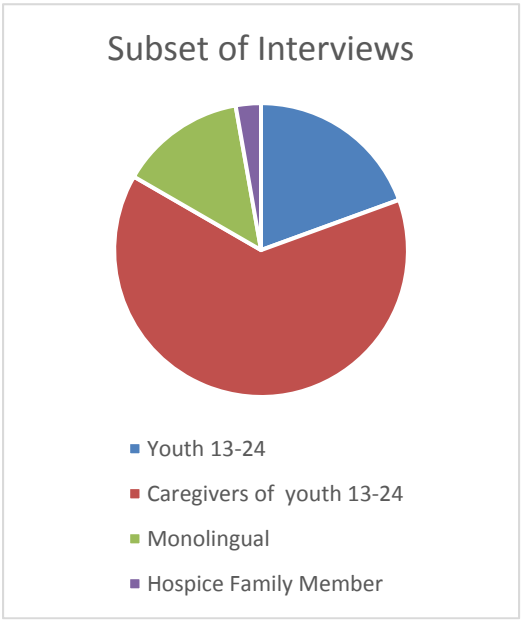
TRG Consumer Interview Results 2016

Interview and feedback Period April-2016-December 2016

OVERVIEW

The Consumer Interview Process is used by The Resource Group (TRG) to determine client satisfaction and collect additional feedback from consumers. Client interviews are required as part of the Quality Compliance Reviews (QCR) at each agency in Houston and the fifty-one county areas of East Texas. During the 2016 QCR season one hundred and twenty-six (126) client participated in the interview process including monolingual Spanish clients, youth as young as 13 with caregivers/guardians. HIV positive clients have been in care ranging from two months though thirty years. The majority of sessions conducted were individual based interviews, while a few were conducted as group interviews. Below is a comparison between the 2015 and 2016 reporting process showing an increase in participation. Four agencies had an increase in the participation of their clients, while three agencies did not reach the requested ten (10) clients for interviews. Youth participation had an increase while, monolingual was the same as the previous year. The total interviews include a new perspective of feedback not collected or documented in this process. The before mentioned perspective was from a hospice client's family member.





CROSS-SERVICE TRENDS

Overall, Clients reported satisfaction with the services they are receiving. Clients, who are in care, feel comfortable and satisfied with their medical team and care process. A high percentage of clients felt they were leaders on their health care team or an important team member of their team. Clients continue to become more descriptive in their roles with their medical team. Clients stated the medical staff answer questions and explain the things the client does not understand. Case managers were described as "good at helping and explaining things".
Statements included;

- One client's statement would like to addressed "the decision makers related to funding" is as follows "You will never know how much the funding helps people out and access to the services provides hope to us"
- "A list of private doctors who accept insured HIV + patients would be helpful as a reasonable clinic alternative."

Clients in Houston and throughout East Texas mentioned general communication between staff and consumers at most service agencies needs improvement. Clients continue to become more open about discussing concerns and reporting dissatisfaction for improvement purposes. There is an ongoing disconnection between clients and the agency complaint process or how concerns are resolve at some agencies. Some clients continue to report they were not aware of the complaint process for problems with services. Some clients were familiar with the agency process and complaint forms. In general, the clients' responses included;

- "The medical staff has an expertise in my ID (infectious disease) needs."
- The compassion and willingness to listen is bigger than anything medically that they could have to offer. I struggle with HIV stigma. The compassion helps me know that HIV did not define me as a person."
- "I needed help and it was made available to me. The staff treats everyone the same."
- "The medical staff keeps their word and they explain everything to me."
- "I like that the medical staff here slows down to talk to me. I would be concerned if they rushed me. My questions could be missed if they did that.
- "Once the nurse helped get my prescriptions filled when I had trouble getting them."
- "The services are convenient and affordable"

Services which received the most detailed comments were Mental Health Services, Oral Health Care, Home and Community-Based Health Care Services and Ryan White Part D services. There was an increase in statements and conversations related to services each year in the TRG Client Interview Process. Most clients were comfortable offering suggestions and recommendation as to how more clients can be reached. In previous years, having online surveys available for clients who may not have the time during their day to complete a survey has been suggested.

Clients who had complaints expressed their complaints have been addressed and resolved. While a few clients worried that if they complained, it may affect their service or that it may take them longer to get an appointment. Clients expressed an explanation of "why they are waiting" was a good way to communicate. In instances, such as the doctor is running late or when calling letting clients know if some is out for the day or for a week. One client stated "I don't mind the waiting, but communication would be helpful so I can decide if I am willing to wait or if I need to reschedule

and appointment. I would like my time respected." Phone system problems such as getting a live person and getting medication refills were discussed as problems. One client suggests an exit survey to ask about any complaints or comments at the end of a visit.

The lessons learned and questions which will be added to the questionnaire for 2017 include:

- "What topics or service would you like to learn more about?"

The client satisfaction questions are reviewed by TRG consumers and feedback is utilized to improve the evaluation process. The Client Interview Process has identified the need for Ryan White agencies to create and facilitate agency specific/ customized trainings for their consumers which may include but are not limited to:

- Consumers reviewing and providing feedback on agency policies and procedures
- Consumer trainings on each service which the agency provides and details to help clients understand the length of processes for specific procedures or service.

SERVICE-SPECIFIC TRENDS

Part D Specific

Individual/ family Interviews clients ranged 1 year to 8 years of receiving services (specific comments are listed below) Statements used to describe what keeps them coming back to the service and what is important about the services included;

- The service & personal relationship and being treated with dignity
- The care is top of the line.
- The phone calls and the return calls are great feels like someone is always there for us.
- The staff does a good job helping the family. I like having a case manager and how the staff handles HIV.
- The staff and medical team keeps up with my child's needs and health.

Group Interviews -The participants ranged from eight (8) to twenty- two (22) years of service with this agency.

- Thirteen caregiver/parents and children/ youth were present during the discussion. Participants represented the youth Consumer Advisory Board (CAB), have been associated with clinical trials, and care or treatment.
- The participants identified that the group serves as a extended family for them when it comes to support for living with HIV.
- Statements used to describe what keeps them coming back to the service and what is important about the services included;
  - The love and care given by the staff
  - The resources
  - The information,
  - "They make me feel human"
  - The staff is very responsive to concerns, needs, and helpful with problems.
- Participants expressed high levels of comfort addressing problems. Participants gave specific examples where problems had been encountered within hospital system and the Ryan White program staff addressed and resolved the problem.

Mental Health Services

Clients were satisfied with this service. Many clients expressed satisfaction with the selection process of pairing a client with an appropriate therapist through this service.

Individual Interviews- clients ranged in years receiving services from 2 weeks to 26 years (specific comments are listed below) Statements included:

- "The staff is really good at matching clients and therapist." One client stated "a staff member called me and said there was someone she thought could better fit my needs. I had not met or talked to the therapist yet. Whatever their process is it is great because I have the best therapist for me. My therapist helps me grow."
- Mental health services clients commented on wanting to have longer sessions to vent their frustration because having a therapist challenged and empowered them. "My therapist is thorough and helps me face my past"
- Clients commented on the ease of changing therapist when needed.
- One client mentioned a desire to have more communication between the therapist and case management staff.

Group Interviews - The members of ranged from six (6) months to ten (10) or more years since diagnosis.

- Consumers were interviewed during a therapeutic session for a peer support group. Once a month, the support group has a licensed therapist attend the group.
- The members identified that the group serves as a surrogate family for them when it comes to support for living with HIV.

Oral Health Care

Clients continued to be concerned with multiple appointments to receive dental care. While some clients did not think, multiple visits were an issue, an equal amount had concerns for their jobs, time and transportation to return and complete necessary dental work. Some described appointments quick and easy to get. Others expressed difficulties or being asked to call back for appointments.

Individual Interviews clients ranged 10 year to 15 years of receiving services (specific comments are listed below) Statements used to describe what keeps them coming back to the service and what is important about the services included;

- "The staff is thorough and polite. I like the atmosphere."
- "I trust the doctors because they are familiar with HIV care. They explain what they are doing. It's important."
- "I am a former dental patient here. I had dental insurance for 5 years. After the loss of my insurance, I had to stabilize my health and return to dental care here. I would not be able to afford dental care without this service."
- "The time to complete some of the procedures or process can take long. One process took 6 months."
- "They ask me my opinion and they explain things to me if I have questions."
- "Have been on the waiting list for three years for a porcelain crown"
- "the dentist here are very warm and friendly. Traditional dentist are not very friendly."
- As a recommendation one client commented "I miss distractions in the lobby like TV. Lobby conversations can be heard too clearly."

Home and Community-Based Health Care Services

Clients were satisfied with this service. Clients expressed satisfaction with the socialization and activities available through this service. Day treatment clients understanding of the service they are receiving has continued to improve from the previous years. The TRG recommends service education is continually administered to day treatment consumers.

Individual Interviews clients ranged 1 year to 8 years of receiving services (specific comments are listed below) Statements used to describe what keeps them coming back to the service and what is important about the services included;

- "Outreach came and told me about the program and provided transportation. I was a volunteer before but I like getting out and meeting new people."
- "The merger was a big change but things are moving forward. There was no program for about two weeks but they worked it out."
- "I like that someone checks on me on a regular basis about my health. They try to keep my mind active. I enjoy it and I feel useful."
- "The front desk is helpful and treats me like family. I have a drug history and the y keep my mind focused on the positive parts of life. They help me with life skill of the things I didn't know and have prior to getting help here."
- "I'm learning about boosting my immune system. The program is helping me grow and develop with taking my meds, going to the doctor, take care of my health and see more clearly the value of it."
- "I like the socialization and meeting people. There are no buses where I live to get around. I felt isolated. The nurse encourages me and that helps me want to do better."
- "the nurse is the best and good at encouraging to everyone. The nurse has no favorites"
- "It use to be wonderful. With staff changes, some new people did not have experience"
- "I get bored and my mind does not feel stimulated. I like movies but I can do that at home. Use our mind and hands to create things. We need more mind stimulating activities. I miss art therapy"
- "I like to feel useful. Sometimes I bring thing to the table for people who can't walk or do the things I still can."
- As a recommendation one client commented "I am diabetic. They should take my blood sugar 1x per week"

Group Interviews -The participants ranged from Three (3) to twenty –two (22) years of service in this program.

- The participants in the group have been living with HIV between four (4) to twenty- six (26) years with service.
- The participants identified that the group serves as a extended family for them when it comes to support for living with HIV.
- Statements used to describe what keeps them coming back to the service and what is important about the services included;
  - The staff works as a team
  - They help with personal hygiene items which is very helpful.
  - Eric is easy to talk to. He is professional and listens and he does what he says he will. He cares and goes the extra mile. He will stop what he is doing and you see results."

- "It feels like family hear and we worry about each other. It is a healthy support away from home."
- "The activity director is good she is new from January but she has grown a lot."
- Recommendations for improvements included; remodeling the space- new paint for the walls, new furniture.
- Recommendations for trip ideas include; fishing, going to Galveston, Kemah
- Other recommendations included more educational and professional speakers and bible study.

Early Intervention Services – Incarcerated (EIS)

EIS clients seem to be very knowledgeable and appreciative of access to service. Statements used to describe what keeps them coming back to the service and what is important about the services included;

- One statement from an incarcerated client said "The staff is nice and discreet. They remember me and that makes it easier for me".
- "I was seen within three days of getting here (referring to being incarcerated)".
- " The doctor takes his time and seems like he cares."

Linguistic Services

There were no issues related to this service and due to the nature of the service delivered, there are no consumer interviews conducted for this service.

Hospice Care Services

There were no issues of note related to this service and due to the nature of the service delivered; consumer interviews were not conducted for this service. 2016 was the first time a family member has given feedback in the client interview process for hospice care. The family is satisfied and grateful for the hospice service.

Health Insurance Premium (HIP)

HIP clients were satisfied and appreciative for the availability of the service. Clients stated that HIP was simple to get and easy to use.

2017-2018 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A/B

STANDARDS OF CARE FOR HIV SERVICES

RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES (HCPHES)

TABLE OF CONTENTS

Introduction

According to the Joint Commission on Accreditation of Healthcare Organization (JCAHO) 2008)[1], a standard is a "statement that defines performance expectations, structures, or processes that must be in place for an organization to provide safe, high-quality care, treatment, and services". Standards are developed by subject experts and are usually the minimal acceptable level of quality in service delivery. The Houston EMA Ryan White Grant Administration (RWGA) Standards of Care (SOCs) are based on multiple sources including RWGA on-site program monitoring results, consumer input, the US Public Health Services guidelines, Centers for Medicare and Medicaid Conditions of Participation (COP) for health care facilities, JCAHO accreditation standards, the Texas Administrative Code, Center for Substance Abuse and Treatment (CSAT) guidelines and other federal, state and local regulations.

Purpose

The purpose of the Ryan White Part A/B SOCs is to determine the minimal acceptable levels of quality in service delivery and to provide a measurement of the effectiveness of services.

Scope

The Houston EMA SOCs apply to Part A, Part B and State Services, funded HRSA defined core and support services including the following services in FY 2015-2016:

- *Primary Medical Care*
- *Vision Care*
- *Medical Case Management*
- *Clinical Case Management*
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Oral Health*
- ***Health Insurance Assistance***
- Hospice Care
- Mental Health Services
- *Substance Abuse services*
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- *Legal Services*
- *Medical Nutrition Supplement*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services

Part A funded services
Combination of Parts A, B, and/or Services funding

Standards Development

The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

[1] The Joint Commission on Accreditation of Healthcare Organization (2008). Comprehensive accreditation manual for ambulatory care; Glossary

Organization of the SOCs
The standards cover all aspect of service delivery for all funded service categories. Some standards are consistent across all service categories and therefore are classified under general standards.
These include:

- Staff requirements, training and supervision
- Client rights and confidentiality
- Agency and staff licensure
- Emergency Management

The RWGA funds three case management models. Unique requirements for all three case management service categories have been classified under Service Specific SOCs “Case Management (All Service Categories)”. Specific service requirements have been discussed under each service category.
All new and/or revised standards are effective at the beginning of the fiscal year.

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://tx.train.org/DesktopShell.aspx	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 year with their current employer must receive four (4) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire.	• Documentation of training is maintained by the agency in the personnel file

	All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
1.5	Staff education on eligibility determination and fee schedule Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	Documentation of training in employee's record
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, job descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights. Reviewed Annually	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures

2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply • Staff interviews indicate compliance
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of Agency's Policies and Procedures Manual indicates compliance
2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel files indicates compliance • Review of agency's complaint and grievance files
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of regular staff meetings • Staff interviews indicate compliance
2.8	Accountability There is a system in place to document staff work time.	• Staff time sheets or other documentation indicate compliance
2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours • Staff time sheets or other documentation indicate compliance
3.0	**Clients Rights and Responsibilities**	

3.1	Clients Rights and Responsibilities Agency has a Client Rights and Responsibilities Statement that is reviewed with each client in a language and format the client can understand. Agency will provide client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors • Scope of service • Criteria for end of services	• Documentation in client's record
3.2	Confidentiality Agency has Policy and Procedure regarding client confidentiality in accordance with RWGA /TRG site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance • Agency's structural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record
3.4	Up to date Release of Information Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain: • Name of the person or entity permitted to make the disclosure	• Current Release of Information form with all the required elements signed by client or authorized person in client's record

	• Name of the client • The purpose of the disclosure • The types of information to be disclosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	
3.5	<u>Grievance Procedure</u> Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • time lines and steps taken by the agency to resolve the grievance • documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form • resolution of each grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources	• Signed receipt of agency Grievance Procedure, filed in client chart • Review of Agency's Policies and Procedures Manual indicates compliance • Review of Agency's Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

3.6	<u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the client's or legal guardian request • Changes in client's need which indicates services from another agency • Fraudulent claims or documentation about HIV diagnosis by the client • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g. phone, mail, email, text message, in person via home visit). • Client service plan is completed and no additional needs are identified. Client must be provided a written notice prior to involuntary termination of services (e.g. due to dangerous behavior, fraudulent claims or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System • A copy of written notice and a certified mail receipt for involuntary termination
3.7	<u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure • Summary of all services received by the client and the client's response to services • Referrals made and/or • Instructions given to the individual at discharge (when applicable)	• Documentation in client record and in the Centralized Patient Care Data Management System
3.8	<u>Client Feedback</u> In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at	• Documentation of clients' evaluation of services is maintained • Documentation of CAB and public meeting minutes

	least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of existence and appropriateness of a suggestion box or other client input mechanism • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance
4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals.	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance

		• Policies and procedures demonstrate commitment to the community and culture of the clients • Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03

	An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that HIV+ clients are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with TRG Policy SG-06 Documentation of Third Party Payer Eligibility or RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Agency conducts six (6) month re-certification of eligibility for all clients. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. At one of the two required re-certifications during a year, agency may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the RWGA eligibility requirements. Appropriate documentation is required for changes in	• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every six (6) months • Review of Policies and Procedures indicates compliance • Information in client's files that includes proof of screening for insurance

	status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent)	coverage (i.e. hard/scanned copy of results) • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02
4.9	<u>Charges for Services</u> Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • <u>Documentation of fees</u>	• Review of Policies and Procedures indicates compliance • Review of system for tracking patient charges and payments indicate compliance • Review of charges and payments in client records indicate compliance with annual cap • Sliding fee application forms on client record is consistent with Federal guidelines
4.10	<u>Information on Program and Eligibility/Sliding Fee Schedule</u> Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service

	Agency should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	Linkage Into Core Services Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record • Review of agency's policies & procedures' manual indicates compliance
4.12	Wait Lists It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of compliance with TRG's Policy SG-19 Client Wait Lists • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted

	The Agency will notify The Resource Group (TRG) or RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to TRG or RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	
4.13	<u>Intake</u> The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indicates compliance
5.0	**Quality Management**	
5.1	<u>Continuous Quality Improvement (CQI)</u> Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

	• Work products • QM program evaluation • Materials necessary for QM activities	
5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Supervisors log on record reviews signed and dated • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of formal agreements with appropriate Points of Entry • Documentation of referrals and their follow-up
7.0	**Emergency Management**	
7.1	Emergency Preparedness Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance

	response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: • IS -100.HC – Introduction to the Incident command system for healthcare/hospitals • IS-200.HC- Applying ICS to Healthcare organization • IS-700.A-National Incident Management System (NIMS) Introduction • IS-800.B National Response Framework (management) The above courses may be accessed at:www.training.fema.gov. Agencies providing support services only may complete alternate courses listed for the above areas All applicable new employees are required to complete the courses within 90 days of hire.	• Documentation of all training including certificate of completion in personnel file
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity • Patient clinical and support activities during emergency situations. (www.jointcommission.org)	• Emergency Preparedness Plan
7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file

Health Insurance Assistance

The Health Insurance Premium and Cost Sharing Assistance service category is intended to help HIV positive individuals continue medical care without gaps in health insurance coverage or discretion of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Agency may provide help with client co-payments, co-insurance, deductibles, and Medicare Part D premiums in amounts up to $650.00 per month.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy.

1.0	**Staff/Training**	
1.1	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.2	Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
2.0	**Client Eligibility**	
2.1	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health insurance marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance
2.2	Advance Premium Tax Credit Reconciliation Agency will ensure all clients receiving assistance for Marketplace QHP premiums:	• Review of client record

	• Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment • Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods • Submit prior year tax information no later than May 31st. Tax information must include: o Federal Marketplace Form 1095-A o IRS Form 8962 o IRS Form 1040 (excludes 1040EZ) • Reconciliation of APTC credits or liabilities	
3.0	**Client Access.**	
3.1	<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
3.2	<u>Prioritization of Service</u> Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	<u>Decreasing Barriers to Service</u> Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and	• Review of agency's Policies & Procedures Manual indicates compliance.

	substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.)	• Review of client intake/assessment for service indicates compliance

Medical Nutritional Therapy/Supplements

HRSA defines core Medical Nutrition Therapy as the provision of food, nutritional services and nutritional supplements provided outside of a primary care visit by a licensed registered dietician based on physician's recommendation and a nutritional plan developed by a licensed registered dietician. The Houston EMA Part A/B Medical Nutrition Therapy includes nutritional counseling, provision nutritional supplements (of up to 90 day supply) for eligible HIV/AIDS infected persons living within the Houston EMA. Clients must have a written referral or prescription from a physician or physician extender and a written nutritional plan prepared by a licensed, registered dietician

1.0	**Services are individualized and tailored to client needs.**	
1.1	Education/Counseling – Clients Receiving New Supplements All clients receiving a supplement for the first time will receive appropriate education/counseling. This must include written information regarding supplement benefits, side effects and recommended dosage in client's primary language.	• Client record indicates compliance
1.2	Education/Counseling – Follow-Up Clients receive education/counseling regarding supplement(s) again at: • follow-up • when there is a change in supplements • at the discretion of the registered dietician if clinically indicated	• Client record indicates compliance
2.0	**Services adhere to professional standards and regulations.**	
2.1	Nutritional Supplement Formulary RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Providers wishing to prescribe/order other supplements not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Department of Health	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record

	and Human Services guidelines for ART and treatment of opportunistic infections.	
2.2	Inventory Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.	• Review of agency's Policies & Procedures Manual indicates compliance • Staff interviews
2.3	Licensure Providers/vendors maintain proper licensure. A physician or physician extender (PE) with prescribing privileges at a Part A/B/C and/or MAI-funded agency or qualified primary care provider must write an order for Part A-funded nutritional supplements. A licensed registered dietician must provide an individualized nutritional plan including education/counseling based on a nutritional assessment	• Documentation of current licensure • Nutritional plan in client's record
2.4	Protocols Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV/AIDS including the *American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care.*	• Chart Review shows compliance • Review of agency's Policies & Procedures Manual indicates compliance

Oral Health

Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, diagnosis and treatment of HIV-related oral pathology, restorative dental services, oral surgery, root canal therapy and oral medication (including pain control) for HIV patients 15 years old or older based on a comprehensive individual treatment plan. Additionally, the category includes prosthodontics services (Part B) to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

1.0	**Staff HIV/AIDS knowledge is based on documented training.**	
1.1	Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV/AIDS is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
1.2	Experience – HIV/AIDS A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
2.2	Consultation for Treatment	• Documentation of communication in the client record

	Agency consults with client's medical care providers when indicated.	
2.3	<u>Health History Information</u> Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline (current within the last 12 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems	• Documentation of health history information in the client record. Reasons for missing health history information are documented
2.4	<u>Client Health History Update</u> An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
2.5	<u>Comprehensive Periodontal Examination (Part B Only)</u> Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance

2.6	<u>Treatment Plan</u> • A comprehensive, multi disciplinary Oral Health treatment plan will be developed in conjunction with the patient. • Patient's primary reason for dental visit should be addressed in treatment plan • Patient strengths and limitations will be considered in development of treatment plan • Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions • Treatment plan will be updated as deemed necessary	• Treatment plan dated and signed by both the provider and patient in patient file • Updated treatment plan dated and signed by both the provider and patient in patient file
2.7	<u>Annual Hard/Soft Tissue Examination</u> The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
2.8	<u>Oral Hygiene Instructions</u> Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record

Substance Abuse Services

The Houston EMA Substance Abuse Treatment/Counseling service is an outpatient service providing treatment and/or counseling to HIV-infected individuals with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse and must be coordinated with local TDSHS/SAS HIV Early Intervention funded programs. All services must be provided in accordance with the Texas Department of State Health Services/Substance Abuse services (TDSHS/SAS) Chemical Dependency Treatment Facility Standards as well as current treatment guidelines.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV/AIDS.**	
1.1	Comprehensive Assessment A comprehensive assessment including the following will be completed within ten (10 days) of intake or no later than and prior to the third therapy session. • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance abuse history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) Specific assessment tools such as the Addiction Severity Index(ASI) could be used for substance abuse and sexual history and the Mini Mental State Examination (MMSE) for cognitive assessment.	• Completed assessment in client's record
1.2	Psychosocial History A psychosocial history will be completed and must include: • Education and training • Employment • Military service	• Completed assessment in client's record

	• Legal history • Family history and constellation • Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	
1.3	<u>Treatment Plan</u> Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in the Texas Department of State Health Services Administrative code for substance abuse including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address full range of substances the patient is abusing Treatment plans must be completed no later than five working days of admission. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse as clinically indicated.	• Completed treatment plan in client's record • Treatment Plan review documented in client's records
1.4	<u>Treatment Plan Review</u> In accordance with the Texas Department of State Health Services Administrative code on Substance Abuse, the treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	• Review of agency's Policy and Procedure Manual indicates compliance • Updated treatment plan in client's record
2.0	**Services are part of the coordinated continuum of HIV/AIDS services.**	

2.1	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agency must have collaboration agreements with mental health and primary care providers or demonstrate that they offer these services on-site.	• Documentation of referrals received • Documentation of referrals out • Staff interviews indicate compliance • Collaborative agreements demonstrate that these services are offered on an off-site
2.2	Facility License Agency is appropriately licensed by the Texas Department of State Health Services – Substance Abuse Services (TDSHS/SAS) with outpatient treatment designations.	• Documentation of current agency licensure
2.3	Minimum Qualifications All agency staff that provides direct client services must be properly licensed per current TDSHS/SAS requirements. Non-licensed staff must meet current TDSHS/SAS requirements.	• Documentation of current licensure in personnel files
3.0	**Staff HIV/AIDS knowledge is based on documented training and experience.**	
3.1	Staff Training All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance to the Texas Administrative Code, rule §448.603 (a), (c) & (d).	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines • Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b)
3.2	Experience – HIV/AIDS A minimum of one (1) year documented HIV/AIDS work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV/AIDS work experience.	• Documentation of work experience in personnel file
4.0	**Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV/AIDS. Staff efforts are compassionate and sensitive to client needs.**	

4.1	<u>Staff Supervision</u> The agency shall ensure that each substance abuse Supervisor shall, at a minimal, be a Masters level professional (e.g. LPC, LCSW, LMSW, LMFT, Licensed Clinical Psychologist, LCDC if applicable) and licensed by the State of Texas and qualified to provide supervision per applicable TDSHS/SAS licensure requirements. Professional staff must be knowledgeable of the interaction of drug/alcohol use and HIV transmission and the interaction of prescribed medication with other drug/alcohol use.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service **Health Insurance Assistance:** The Health Insurance Assistance (HIP) service category is intended to help HIV positive individuals maintain a continuity of medical benefits without gaps in health insurance coverage or discretion of treatment. This financial assistance program enables eligible individuals who are HIV positive to utilize their existing third party or public assistance (e.g. Medicare) medical insurance, not to exceed the cost of care delivery. Under this provision an agency can provide assistance with health insurance premiums, co-payments, co-insurance, deductibles, Medicare Part D premiums, and tax reconciliation. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Tax Reconciliation: A refundable credit will be given on an individual's federal income tax return if the amount of advance-credit payments is *less* than the tax credit they should have received. Conversely, individuals will have to repay any excess advance payments with their tax returns if the advance payments for the year are *more* than the credit amount. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500. Revised Income Guidelines: Marketplace Plans: 100-400% of Federal Poverty Level All other plans: 0-400% of Federal Poverty Level Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Compliance with Regional Health Insurance Assistance Policy The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1601).	• Annual Review of agency shows compliance with established policy.
9.3	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary. Agencies must maintain referral relationships with organizations or individuals who can provide income tax preparation assistance.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
9.4	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required. Minimum of two (2) hours training for all relevant staff on how to indentify advance premium tax credits and liabilities.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.5	Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
9.6	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.7	Program Policies Agency will develop policies and procedures regarding HIP assistance, cost-effectiveness and expenditure policy, and client contributions. Agencies must maintain policies on the assistance that can be offered for clients who are covered under a group policy. Agency must have P&P in place detailing the required process for reconciliation and documentation requirements. Agencies must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual clients, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of personnel files indicates training on the policies.
9.8	Prioritization of Cost-Sharing Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agencies use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles 3. Co-payments for provider visits (e.g. physician visit and/or lab copayments) 4. Medicare Part D (Rx) premiums 5. APTC Tax Liability 6. Out of Network out-of-pocket expenses	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)* 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. Only Medical, Dental and Vision plans are covered. Life insurance and other elective policies are not covered	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIC funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a clients failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIP funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Health Insurance Premium Assistance The following criteria must be met for a health plan to be eligible for HIP assistance: 1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 1. Health Insurance coverage must be evaluated for cost effectiveness 2. Health insurance plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 3. COBRA plans must be evaluated based on cost effectiveness and client benefit. Additional Requirements for ACA plans: 1. If a clients between 100%-250% FPL, only SILVER level plans are eligible for HIP payment assistance (unless client enroll prior to November 1, 2015). 2. Clients under 100% FPL, who present with an ACA plan, are NOT eligible for HIP payment assistance (unless enroll prior to November 1, 2015). 3. All clients who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL). All clients receiving HIP assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client records indicates compliance.
9.12	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.
9.13	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.14	Waiver Process In order to ensure proper program delivery, a waiver from the AA is required for the following circumstances: 1. HIC payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers, 3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary, 4. Discontinuing HIC payment assistance due to client conduct or fraud, 5. Refusing HIC assistance for a client who is eligible and whom HIC provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted and; 7. Assisting an eligible client with the entire cost of a group policy that includes coverage for persons not eligible for HIC payment assistance.	•
9.15	Payer of Last Resort Agencies must assure that all clients are screened for potential third party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist clients in enrollment.	•
9.16	Vigorous Pursuit All contracted agencies must vigorously pursue any excess premium tax credit received by the client from the IRS upon submission of the client's tax return. To meet the standard of "*vigorously pursue*", all clients receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must: 1. Designate premium tax credit be taken in advance during enrollment 2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal 3. Submit prior year tax information no later than May 31st. 4. Reconciliation of advance premium tax credits or liabilities.	•

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
COMMUNITY-BASED HEALTH SERVICES

Definition:
Home and Community-Based Health Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Services Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of clients through the provision of treatment and activities of daily living. Services must include: **Skilled Nursing** including medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physician(s), personal care, and diagnostics testing; **Other Therapeutic Services** including recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation; **Nutrition** including evaluation and counseling, supplemental nutrition, and daily nutritious meals; and **Education** including instructional workshops of HIV related topics and life skills. Services will be available at least Monday through Friday for a minimum of 10 hours/day.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	Licensure Agency must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider. Agency maintains other certification for facilities and personnel, if applicable. Services are provided in accordance with Texas State regulations.	• Documentation of license and/or certification posted in a highly-visible place at the site where services are provided to clients.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.3	Services Requiring Licensed Personnel All services requiring licensed personnel shall be provided by Registered Nurses/Licensed Vocational Nurses or appropriate licensed personnel in accordance with State of Texas regulations. Other Therapeutic Services are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, LMFTA). Nutritional Services are provided by a Registered Dietician and food managers. Education Services are provided by a health educator.	• Documentation of qualification in personnel file
9.4	Staff Qualifications All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working knowledge of: ➢ HIV and its diverse manifestations ➢ HIV transmission and effective methods of reducing transmission ➢ current treatment modalities for HIV and co-morbidities ➢ HIV/AIDS continuum of care ➢ diverse learning and teaching styles ➢ the impacts of mental illness and substance use on behaviors and adherence to treatment ➢ crisis intervention skills ➢ the use of individualized plans of care in the provision of services and achievement of goals • Effective crisis management skills • Effective assessment skills	• Personnel Qualification on file • Documentation of orientation of file
9.5	Doctor's Order Community-based Health Services must be provided in accordance with doctor's orders. As part of the intake process, doctor's orders must be obtained to guide service provision to the client.	• Review of client files indicates compliance.
9.6	Billing Requirement Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third party payers.	• Provider will provide evidence of third-party billing.

#	STANDARD	MEASURE
9.7	Comprehensive Client Assessment A comprehensive client assessment, including nursing, therapeutic, and educational is completed for each client within seven (7) days of intake and every six (6) months thereafter. A measure of client acuity will be incorporated into the assessment tool to track client's increased functioning. A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of client's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine client's ability to perform activities of daily living and the level of attendant care assistance the client needs to maintain living independently.	• Review of client files indicates compliance. • Acuity levels documented as part of assessment.
9.8	Nutritional Evaluation Each client shall receive a nutritional evaluation within 15 days of initiation of care.	• Documentation is on file.
9.9	Meal Plan Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
9.10	Plan of Care A written plan of care is completed for each client within seven (7) days of intake and updated every six (6) months thereafter. Development of plan of care incorporates a multidisciplinary team approach. Care plan is signed by both case manager and clinical health care professional.	• Review of client files indicates compliance
9.11	Implementation of Care Plan In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation. • Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services). • Monitor changes in client's physical and mental health, and level of functionality. • Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service related needs, challenges and barriers.	• Documentation in the client chart indicates services provided were consistent with the treatment plan.

#	STANDARD	MEASURE
9.11	Implementation of Care Plan (Cont'd • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with client's self administration of medication. • Promptly report any problems or questions regarding the client's adherence to medication. • Report any changes in the client's condition and needs.	• Documentation in the client chart indicates services provided were consistent with the treatment plan.
9.12	Refusal of referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home/community setting. The agency must document the situation in writing and immediately contact the client's primary medical care provider.	• Documentation in the client chart will indicate the reason for refusal
9.13	Completion of Services/Discharge Services will end when one or more of the following takes place: • Client acuity indicates self-sufficiency and care plan goals completed; • Client expresses desire to discontinue services; • Client is not seen for ninety (90) days or more; and • Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility) • Client is unable or unwilling to adhere to agency policies.	• Documentation in client chart of specific criteria indicating appropriateness of discharge

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HOSPICE SERVICES

Definition: Provision of Hospice Care provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Scope of Service (Cont'd) Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the client. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services.	
9.3	Client Eligibility In addition to general eligibility criteria, individuals must meet the following criteria in order to be eligible for services. The client's eligibility must be recertified for the program every six (6) months. • Referred by a licensed physician • Certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course • Must be reassessed by a physician every six (6) months. • Must first seek care from other facilities and denial must be documented in the resident's chart.	• Documentation of HIV+ status, residence, identification and income in the client record. • Documentation in client's chart that an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
9.4	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received. • Documentation of referrals out • Staff reports indicate compliance
9.5	Staff Education Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV/AIDS. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of persons living with HIV/AIDS.	• Staff will attend and has continued access to training activities: • Staff has access to updated HIV/AIDS information • Agency maintains system for dissemination of HIV/AIDS information relevant to the needs of PLWHA to paid staff and volunteers. • Agency will document provision of in-service education to staff regarding current treatment methodologies and promising practices.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Ongoing Staff Training • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff (in addition to training required in General Standards). • One (1) hour of training in HIV/AIDS is required annually for all other staff (in addition to training required in General Standards).	• Materials for staff training and continuing education are on file • Documentation of training in personnel file
9.7	Staff Credentials & Experience All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas. A minimum of one year documented hospice and/or HIV/AIDS work experience is preferred.	• Personnel files reflect requisite licensure or certification. • Documentation of work experience in personnel file
9.8	Staff Requirements Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• Review of personnel file indicates compliance • Staff interviews indicate compliance.
9.9	Volunteer Assistance Volunteers cannot be used to substitute for required personnel. They may however provide companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation of all training in volunteer files • Signed compliance by volunteer
9.10	Volunteer Training Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV/AIDS. For volunteers who are licensed practitioners, training addresses documentation practices.	• Review of training curriculum indicates compliance • Documentation of all training in volunteer files
9.11	Staff Supervision Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years experience in hospice care of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas licensure requirements. Supervisory, provider or advanced practice registered nurses will document supervision over other staff members	• Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance. • Review of documentation that supervisory provider or advanced practice registered nurse provided supervision over other staff members

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Facility Licensure Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation.	• License and/or certification will be posted in a conspicuous place at the site where services are provided to patients. • Documentation of license and/or certification is available at the site where services are provided to clients
9.13	Denial of Service The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following: • There are no beds available • Level of patient's acuity and staffing limitations • Patient is aggressive and a danger to the staff • Patient is a "no show" Agency must develop and maintain s system to inform Administrative Agency regarding issue of long term care facilities denying admission for HIV positive clients based on inability to provide appropriate level of skilled nursing care.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation of notification is available for review.
9.14	Multidisciplinary Team Care Agency must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's records

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Medication Administration Record Agency documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	• Documentation in client's record
9.16	PRN Medication Record Agency documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.	• Documentation in client's record
9.17	Physician Orders The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse.	• Documentation in client's record
9.18	Intake and Service Eligibility Agency will receive referrals from a broad range of HIV/AIDS service providers. Information will be obtained from the referral source and will include: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (client self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information • Documentation of insurance status • Documentation of income (including a "zero income" statement) • Documentation of state residency • Documentation of proof of HIV positivity • Photo ID or two other forms of identification • Acknowledgement of client's rights	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's records

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.19	Comprehensive Health Assessment A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Documentation in client's record
9.20	Plan of Care Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. A written Plan of Care is completed for each patient within 48 hours of admission and reviewed monthly. Care Plans will be updated once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV/AIDS (http://hab.hrsa.gov/tools/palliative/contents.html) and professional guidelines Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Documentation in client's record

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.21	Counseling Services The need for counseling services for family members must be assessed and a referral made if requested. The need for bereavement and counseling services for family members must be consistent with definition of mental health counseling.	• Documentation in client's record
9.22	Bereavement Counseling Bereavement counseling must bwe provided. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery; • make bereavement services available to a patient's family and other persons in the bereavement plan of care for up to one year following the death of the patient; • extend bereavement counseling to residents of a skilled nursing facility, a nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions when appropriate and as identified in the bereavement plan of care; • ensure that bereavement services reflect the needs of the bereaved.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.23	Dietary Counseling Dietary counseling must be provided. Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a hospice patient's condition progresses. Dietary counseling, when identified in the plan of care, must be performed by a qualified person. • A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a client are met.	• Assessment present in the client's record. • Referral and/or service provision documented.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.24	Mental Health Counseling Mental health counseling must be provided. Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.25	Spiritual Counseling A hospice must provide spiritual counseling that meets the patient's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the client's and family's spiritual needs; • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a client's spiritual needs; and • Advise the client and family of the availability of spiritual counseling services.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.26	Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.	• Assessment present in the client's record. • Documentation in client's records.
9.27	Medical Social Services Medical social services must be provided by a qualified social worker. and is based on: • The patient's and family's needs as identified in the patient's psychosocial assessment • The patient's and family's acceptance of these services.	• Assessment present in the client's record. • Documentation in client's records.
9.28	Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves and hospice care is no longer necessary. • Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's records.

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 201, p. 15-17.
Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services
Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

Definition:

Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services.

#	STANDARD	MEASURE
9.0	**Services are part of the coordinated continuum of HIV/AIDS and social services**	
9.1	Scope of Service The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual HIV positive clients. Services exclude Spanish Translation Services.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	Staff Qualifications and Training • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI). Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), or the National Interpreter Certification (NIC) at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting	• Program Policies and Procedures will ensure the contracted agency is in compliance with legislation/regulations • Legislation and Regulations • (Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act
9.3	Program Policies Agency will develop policies and procedures regarding the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and procedures to providers seeking to utilize the service.	• Review of Program Policies.

#	STANDARD	MEASURE
9.0	**Services are part of the coordinated continuum of HIV/AIDS and social services**	

9.4	Provision of Services
	• Agency/providers will offer services to the client only in connection with other HRSA approved services (such as clinic visits).
	• Providers will deliver services to the client only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the client
	• Based on provider need, agency shall provide the following types of linguistic services in the client's preferred language:
	  • Oral interpretation
	  • Written translation
	  • Sign language
	• Agency/providers should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the client seeking assistance
	• Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area
		• Review of Program's Policies and Procedures indicate compliance.
		• Documentation of provision of services present in client files indicates compliance.

9.5	Timeliness of Scheduling Agency will schedule service within one (1) business day of the request.	• Review of client files indicates compliance.
9.6	Interpreter Certifications All American Sign Language interpreters will be certified in the State of Texas. Level II and III interpreters are recommended for medical interpretation.	• Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency requests denote appropriate levels of interpreters are requested.
9.7	Subcontractor Exclusion: Due to the nature of subcontracts under this service category, the staff training outlined in the General Standards are excluded from being required for interpreters.	• No Measure

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Definition:
Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Work Agency will provide the following services: **Individual Therapy/counseling** is defined as 1-on-1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person. Mental health services include Mental Health Assessment, Treatment Planning, Treatment Provision, Individual psychotherapy, Family psychotherapy, Conjoint psychotherapy, and Group psychotherapy, Drop-In Psychotherapy Groups, and Emergency/Crisis Intervention. Also included are Psychiatric medication assessment, prescription and monitoring and Psychotropic medication management. General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for non-HIV infected family members or significant others.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Licensure Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking clients.	• A file will be maintained on each professional counselor. Supportive documentation of credentials is maintained by the agency in each counselor's personnel file. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.3	Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	• Personnel record will reflect all orientation and required continuing education training. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.4	Family Counseling Experience Professional counselors must have two years experience in family counseling if providing services to families.	• Experience is documented via resume or other method. Exceptions noted in personnel files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.5	Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Documentation of liability insurance coverage is maintained by the agency.
9.6	Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Documentation of training is maintained by the agency in each counselor's personnel file.
9.7	Crisis Situations and Behavioral Emergencies Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the client during the orientation process. In emergency circumstances, an appointment will be scheduled within twenty four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the client to another organization that can provide the requested services.	• Review of Agency Policies and Procedures Manual indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	Other Policies and Procedures The agency must develop and implement Policies and Procedures that include but are not limited to the following: • Client neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, time line for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months.	• Review of Agency Policies and Procedures Manual indicates compliance.
9.9	In-Home Services Therapy/counseling and/or bereavement counseling may be conducted in the client's home.	• Program Policies and Procedures address the provision of home visits.
9.10	Client Orientation Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will be provided to all clients and include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	• Documentation in client record indicates compliance. • Annual Client Interviews indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self Assessment/Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation.	• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment.
9.12	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: • Statement of the goal(s) of counseling and description of the mental health issue • Goals and objectives • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review	• Documentation in client record. • Exceptions noted in client file.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Treatment Plan (Cont'd) Initial treatment plans must be completed no later than the third counseling session. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals as clinically indicated. The treatment plan will be signed by the mental health professional rendering service.	
9.13	Treatment Plan Review Treatment plans shall be reviewed and modified at least every 90 days or more frequently as clinically indicated. -The plan must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures.	• Review of Agency Policies and Procedures Manual indicates compliance. • Client's records • Exceptions noted in client files.
9.14	Progress Notes Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	• Legible, signed and dated documentation in client record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Discharge Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death	• Agency will develop discharge criteria and procedures.
9.16	Discharge Summary Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, • Date	• Documentation in client record.
9.17	Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Documentation of supervisor credentials is maintained by the agency.
9.18	Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Documentation in supervision notes. • Each mental health service agency must have and implement a written policy for regular supervision of all licensed staff.

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

Definition:
Support for Oral Health Services including diagnostic, preventive, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Work Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, routine dental examinations, diagnosis and treatment of HIV-related oral pathology, restorative dental services, root canal therapy, prophylaxis, x-rays, fillings, and basic oral surgery (simple extractions), endodontistry and oral medication (including pain control) for HIV patients 15 years old or older based on a comprehensive individual treatment plan. Referral for specialized care should be completed if clinically indicated. Additionally, the category includes prosthodontics services to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room. Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
	Staff Qualifications All oral health care professionals, such as general dental practitioners, dental specialists, and dental hygienists shall be properly licensed by the State of Texas Board of Dental Examiners while performing tasks that are legal within the provisions of the Texas Dental Practice including satisfactory arrangements for malpractice insurance. Dental Assistants who make x-rays in Texas must register with the State Board of Dental Examiners. Dental hygienists and assistants will be supervised by a licensed dentist. Students enrolled in a College of Dentistry may perform tasks under the supervision	• Documentation of qualifications for each dental provider present in personnel file.
9.2	Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV/AIDS is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
9.3	Experience – HIV/AIDS Service provider should employ individuals experienced in dental care and knowledgeable in the area of HIV/AIDS dental practice. A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Documentation of work experience in personnel file
9.4	Confidentiality Confidentiality statement signed by dental employees.	• Signed statement in personnel file.
9.5	Universal Precautions All health care workers should adhere to universal precautions as defined by Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. It is strongly recommended that staff are aware of the following to ensure that all vaccinations are obtained and precautions are met: • Health care workers who perform exposure-prone procedures should know their HIV antibody status • Health care workers who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status. • Tuberculosis tests at least every 12 months for all staff. • OSHA guidelines must be met to ensure staff and patient safety.	• Documentation of review in personnel file.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
9.7	Annual Cap On Services Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year. • In cases of emergency, the maximum amount may exceed the above cap • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap. Dental providers must document ***via approved waiver*** the reason for exceeding the yearly maximum amount.	• Annual review of reimbursements indicates compliance • Signed waiver present in patient record for each patient.
9.8	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
9.9	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record
9.10	Dental and Medical History Information To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the patient's health and medication status Provider obtains and documents HIV primary care provider contact information for each patient. Provider obtains from the primary care provider or obtains from the patient health history information with updates as medically appropriate prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within in last 12 months) CBC laboratory test • Current (within the last 12 months) CD4 and Viral Load laboratory test results or more frequent when clinically indicated • Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level (e.g., Factor VIII activity) and inhibitor titer (e.g., BIA) • Tuberculosis screening result • Patient's chief complaint, where applicable • Current Medications	• Documentation of health history information in the client record. Reasons for missing health history information are documented

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
	Dental and Medical History Information (Cont'd) This information should include, but not be limited to, the following: • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis A, B, C status • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems Any predisposing conditions that may affect the prognosis, progression and management of oral health condition	•
9.11	Client Health History Update An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
9.12	Limited Physical Examination Initial limited physical examination should include, but shall not necessarily be limited to, blood pressure, and pulse/heart rate as may be indicated for each patient according to the Texas Board of Dental Examiners. Dental provider will obtain an initial baseline blood pressure/pulse reading during the initial limited physical examination of a dental patient. Dental practitioner should also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a patient's vital signs, the dental practitioner must document in the patient's oral health care record an acceptable reason why the attempt to obtain vital signs was unsuccessful.	• Review of client records indicate compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	Oral Examination Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established patient • D0120-Periodic Oral Evaluation to include bitewing x-rays, established patient, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established patient; not post-operative visit)	• Review of client records indicate compliance
9.14	Comprehensive Periodontal Examination Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines. Patient must have a periodontal screening once per year. A periodontal screen should include: • Assessment of medical and dental histories • Quantity and quality of attached gingival • Bleeding • Tooth mobility • Radiological review of the status of the periodontium and dental implants. Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the patient's dental and medical history and general health assessment. • It may include the evaluation and recording or dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Treatment Plan A dental treatment plan should be developed appropriate for the patient's health status, financial status, and individual preference should be chosen. A comprehensive, multi disciplinary Oral Health treatment plan will be developed and updated in conjunction with the patient. Patient's primary reason for dental visit should be addressed in treatment plan. Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. A comprehensive dental treatment plan that includes preventive care, maintenance and elimination of oral pathology will be developed and updated annually. Various treatment options should be discussed and developed in collaboration with the patient. Treatment plan should include as clinically indicated: • Provision for the relief of pain • Elimination of infection • Preventive plan component • Periodontal treatment plan if necessary • Elimination of caries • Replacement or maintenance of tooth space or function • Consultation or referral for conditions where treatment is beyond the scope of services offered • Determination of adequate recall interval.	• Treatment plan dated and signed by both the provider and patient in patient file • Annually updated treatment plan dated and signed by both the provider and patient in patient file
9.16	Phase 1 Treatment Plan In accordance with the National Monitoring Standards a Phase 1 treatment plan includes prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. Phase 1 treatment plan will be established and updated annually to include what diagnostic, preventative, and therapeutic services will be provided. Phase 1 treatment plan will be established within 12 months of initial assessment. Treatment plan should include as clinically indicated: • Restorative treatment • Basic periodontal therapy (non-surgical) • Basic oral surgery (simple extractions and biopsy) • Non-surgical endodontic therapy • Maintenance of tooth space • Tooth eruption guidance for transitional dentition	• Phase 1 Treatment plan dated and signed by both the provider and patient in patient file • Annually updated Phase 1 treatment plan dated and signed by both the provider and patient in patient file

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.17	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
9.18	**Oral Health Education** Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager. Provider must provide patient oral health education once each year which includes but is not limited to the following: • D1330 Oral hygiene instructions • D1320 Smoking/tobacco cessation counseling as indicated • Additional areas for instruction may include Nutrition (D1310). • For pediatric patients, oral health education should be provided to parents and caregivers and be age appropriate for pediatric patients.	•
9.19	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record
9.20	Referrals Referrals for other services must be documented in the patient's oral health care chart. Outcome of the referral will be documented in the patient's oral health care record.	• Documentation in the client record

References

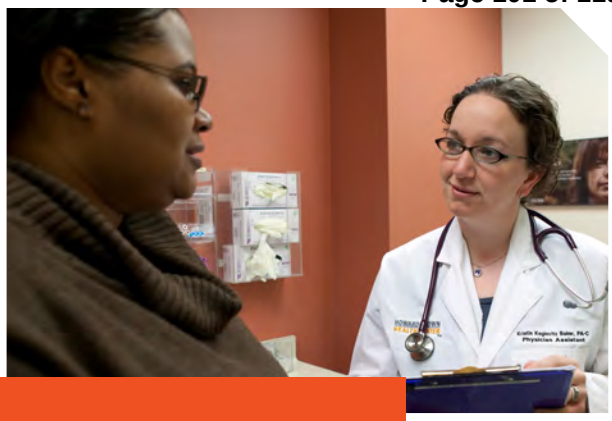
- American Dental Association. Dental Practice Parameters. Patients requiring a comprehensive oral evaluation. Available at: http://www.ada.org/prof/prac/tools/parameters/eval_comprehensive.asp. Accessed on May 8, 2009.
- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2011, page 9-10.
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 9-10.

- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Rule 7.Minimal Standards of Care. located at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm

HRSA Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

March 2016



Black/African American Clients, 2014

Ryan White HIV/AIDS Program Black/African American Client Fast Facts

47.2% OF ALL RWHAP CLIENTS.

79.8% ARE RETAINED IN HIV MEDICAL CARE.

69.2% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

77.1% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant proportion of black/African American clients living with HIV. In 2014, 73 percent of the more than half a million clients served by the Program were from racial or ethnic minority populations, with approximately 47 percent of all RWHAP clients identifying as black/African American. Below are more details about this RWHAP client population:

- **The majority of black/African American clients served by RWHAP are low income.** More than 69 percent of black/African American clients are living at or below 100 percent of the federal poverty level, which is slightly higher than the national RWHAP average (64 percent at or below 100 percent of the federal poverty level).
- **The majority of black/African American clients are male.** More than 62 percent of clients are male, nearly 37 percent are female, and just over 1 percent of clients are transgender. The proportion of black/African American males to females is slightly less than the national RWHAP average (nearly 71 percent males and 28 percent females).
- **One in six black/African American clients have temporary or unstable housing.** More than 11 percent of black/African American clients served by RWHAP have temporary housing and more than 5 percent have unstable housing.
- **Lack of health care coverage continues to impact black/African American clients served by RWHAP.** Nearly 27 percent of black/African American clients have no health care coverage, which is slightly higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. Nearly 80 percent of black/African American clients receiving HIV medical care are retained in HIV medical care. About 77 percent of black/African American clients receiving HIV medical care are virally suppressed, which is slightly lower than the national RWHAP average (more than 80 percent retained in care and more than 81 percent virally suppressed).[1]

- More than 78 percent of black/African American males receiving HIV medical care are retained in care and more than 76 percent are virally suppressed.
- Approximately 82 percent of black/African American females receiving HIV medical care are retained in care and 78 percent are virally suppressed.

[1]Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

HRSA Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

May 2016

Gay, Bisexual, and Other Men Who Have Sex with Men (MSM), 2014

Ryan White HIV/AIDS Program Gay, Bisexual, and Other MSM Fast Facts

44.9% OF ALL RWHAP CLIENTS.

79.4% ARE RETAINED IN HIV MEDICAL CARE.

25.4% HAVE NO HEALTH CARE COVERAGE.

82.8% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are men who have sex with men (MSM). In 2014, nearly 45 percent of the more than 461,000 clients with transmission risk information served by RWHAP were MSM. Below are more details about this RWHAP client population:

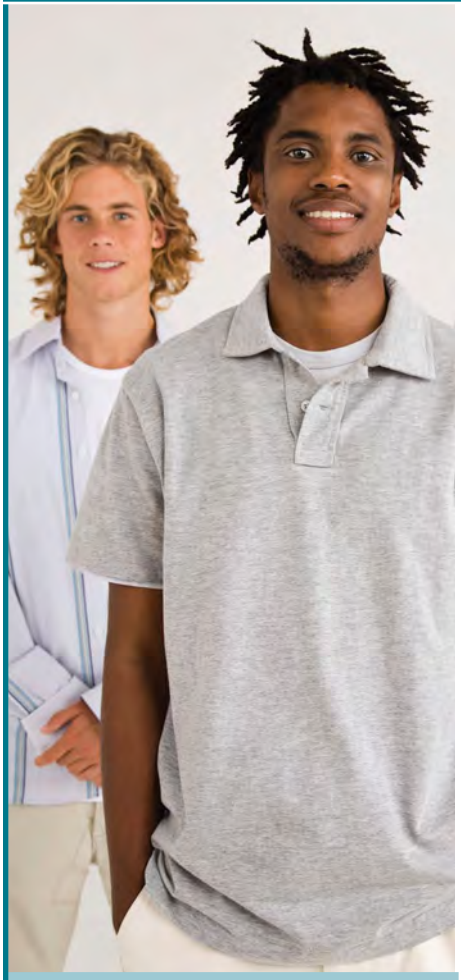
- **61 percent of MSM served by RWHAP are racial and ethnic minorities.** Approximately 34 percent of MSM identify as black/African American, which is less than the national RWHAP average (approximately 47 percent). Approximately 22 percent of men identify as Hispanic/Latino, which is equal to the national RWHAP average (22 percent). Approximately 39 percent of MSM identify as white, which is significantly greater than the national RWHAP average (about 27 percent).
- **The RWHAP MSM client population continues to increase in age.** Half of MSM are aged 45 years and older.
- **More than half (55 percent) of clients aged 13 to 24 years are MSM.** These youth and young adults represent about 7 percent of all MSM served by RWHAP.
- **About 4 percent of MSM have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- **Lack of health care coverage continues to affect MSM served by RWHAP.** Approximately 28 percent of MSM have no health care coverage, which is slightly greater than the national RWHAP average (25 percent).

Medical care and treatment improves health and decreases transmission of HIV. About 79 percent of MSM receiving RWHAP HIV medical care are retained in care, which is slightly less than the national RWHAP average (approximately 80 percent). Nearly 83 percent of MSM receiving RWHAP HIV medical care are virally suppressed, which is slightly greater than the national RWHAP average (81 percent).[1]

- Approximately 72 percent of young MSM (aged 13–24) receiving HIV medical care are retained in care, and more than 65 percent are virally suppressed.
- Approximately 72 percent of young, black/African American MSM (aged 13–24) receiving HIV medical care are retained in care, and 62 percent are virally suppressed.

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

HIV and Young Men Who Have Sex with Men



Many young people in the United States remain at risk for HIV infection. An estimated 47,500 Americans were newly infected with HIV[1] in 2010. Of these, 26%—about 12,200—were adolescents or young adults aged 13–24 years.[1] Young men who have sex with men (YMSM),[a] especially black/African American[b] YMSM, are at highest risk. The ongoing risk for HIV infection among YMSM underscores the need to reach each new generation with effective HIV prevention messages and services. Schools and education agencies are important partners in this effort.

Fast Facts

HIV disproportionately affects young men who have sex with men (YMSM).

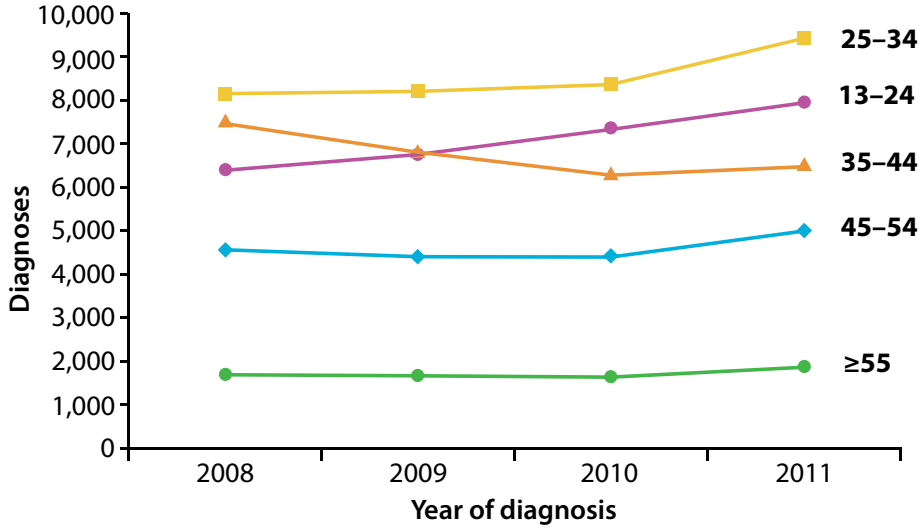
YMSM:

- In 2011, among adolescent males aged 13–19 years, approximately 93% of all diagnosed HIV infections were from male-to-male sexual contact.[2]
- From 2008–2011, YMSM aged 13–24 years had the greatest percentage increase (26%) in diagnosed HIV infections.[3] (Figure 1)

Black and Hispanic/Latino[c] YMSM:

- In 2011, among all YMSM aged 13–24 years with HIV infection, an estimated 58% were black; 20% were Hispanic/Latino.[3]
- Black YMSM also experienced the largest increase of all racial/ethnic groups in diagnosed HIV infections—from 3,762 diagnoses in 2008 to 4,619 diagnoses in 2011.[3] (Figure 2)

Figure 1. Diagnoses of HIV Infection among Men Who Have Sex with Men, by Age Group, 2008–2011—United States and 6 Dependent Areas

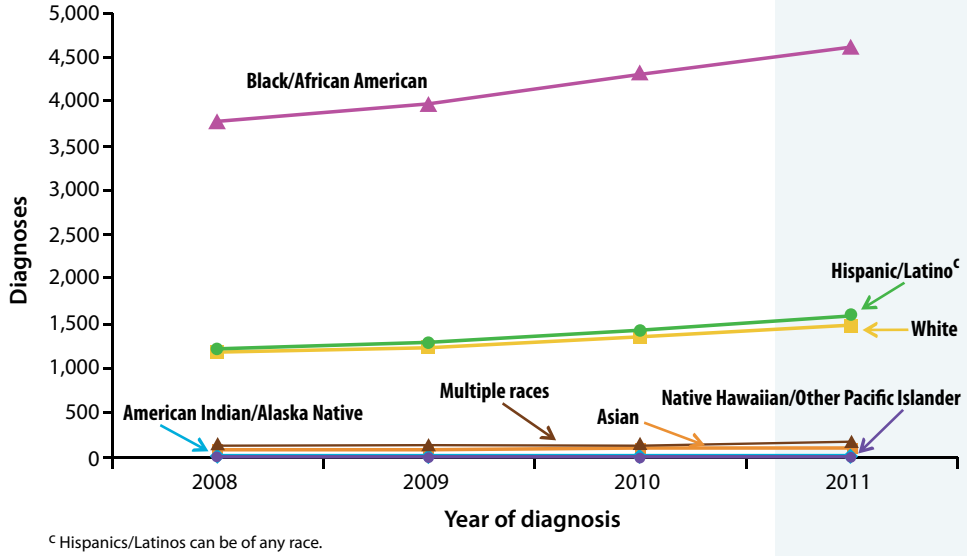


[a] CDC uses the term men who have sex with men (MSM) in its surveillance systems. MSM indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.

[b] Black/African American: Referred to as black in this fact sheet.

[c] Hispanics/Latinos can be of any race.

Figure 2. Diagnoses of HIV Infection Among Men Who Have Sex with Men Aged 13–24 Years, by Race/Ethnicity, 2008–2011—United States and 6 Dependent Areas

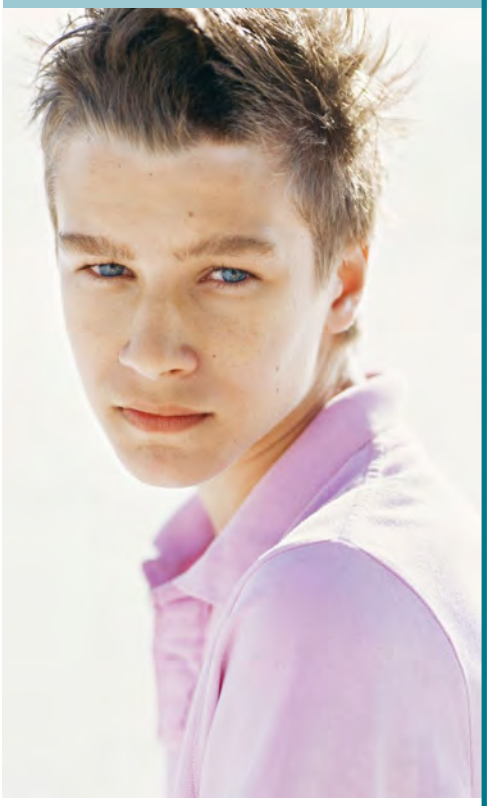


[c] Hispanics/Latinos can be of any race.

HIV Prevention Challenges

The reasons for disparities in HIV infection are varied and not well understood. These disparities do not appear to reflect individual racial or ethnic differences in risk behaviors.[4] Possible factors to explain these disparities may include the following:

- **Inadequate HIV prevention education and interventions.** Sex education programs that are not sensitive and appropriate to the needs of YMSM might not be effective in reducing sexual risk behaviors among those students.[5]
- **Limited awareness of infection.** Some HIV-infected men who have sex with men (MSM) may not know they are infected, especially MSM of color and YMSM.[6] Those who do not know they are infected might be less likely to take measures to keep from spreading the virus to others. Getting tested for HIV is an important part of prevention.
- **Low perception of risk.** Improved treatment for HIV has helped many people with HIV infection live longer and healthier lives. YMSM, who did not witness the toll of AIDS in the early years of the epidemic, might view HIV as less dangerous and disregard risks and important prevention practices.[7]
- **Alcohol and illegal drug use.** Alcohol, methamphetamine (commonly known as "meth" or "crystal meth"), and other "party drug" use is common among some YMSM. Alcohol and drug use can lead to risky sexual behavior.[7]
- **Feelings of rejection and isolation.** Bullying, harassment, family disapproval, social isolation, and sexual violence are experienced frequently by YMSM and other sexual minority youth.[d] These experiences can cause poor self-esteem and feelings of shame and can lead to more emotional distress, suicide attempts, substance use, and risky sexual behavior.[8-10]



[d] Those who identify as gay, lesbian, or bisexual or who have sexual contact with persons of the same or both sexes.

School-Based Strategies for Addressing HIV Among YMSM

CDC funds state and local education and health agencies to help schools implement policies and practices to reduce health risks among sexual minority youth, including YMSM. Because black and Hispanic/Latino YMSM are at especially high risk of HIV infection, CDC collaborates with local education agencies and national nongovernmental organizations to reduce HIV and other sexually transmitted diseases (STDs) among this population. These partners are collaborating with local community-based organizations, health departments, and other health care organizations to collect data, promote safe and supportive environments, increase HIV/STD testing and treatment in schools and school-based health centers, refer students to youth-friendly health services, and implement evidence-based HIV/STD education and prevention activities.

Collect and use health risk behavior data.

Many states and large urban school districts use CDC's Youth Risk Behavior Survey (YRBS) data to monitor health risk behaviors and selected health outcomes among sexual minority students. In addition, starting in 2015, the national YRBS questionnaire and the state/local standard questionnaire will include questions about sexual identity and sex of sexual contacts. By documenting that some youth do engage in same-sex sexual activity and various health risk behaviors, YRBS data can help confirm the value of addressing the health needs of sexual minority youth in schools, adjust intervention priorities, and monitor health outcomes.

More information is available at www.cdc.gov/yrbs.

Establish safe and supportive school environments.

HIV prevention activities are more likely to have an impact if they address the challenges YMSM face at school, especially verbal harassment related to their sexual orientation.[11] For lesbian, gay, bisexual, or transgender students, having a safe and supportive school environment has been associated with decreases in depression, suicidal feelings, substance use, and unexcused school absences.[12,13] To help establish supportive school environments for YMSM, schools can address bullying and sexual harassment, help students feel cared for and valued, and foster parent engagement.

Provide key sexual health services.

Linking YMSM to HIV testing and treatment is key to preventing the spread of HIV and AIDS. Confidential clinical services can help prevent new cases of HIV by increasing testing and treating HIV and other STDs. Schools can help youth access key preventive sexual health services such as HIV and STD testing, counseling, and referral, either by providing these services at schools or connecting students with community providers.[14]

Implement exemplary sexual health education.[e]

Because sexual health education programs that ignore issues in the lives of YMSM might not work effectively, schools and education agencies should ensure that health education curricula include evidence-based prevention information relevant to this population. Professional development training can help school staff understand the health needs of YMSM and shape health messages accordingly.

[e] Sexual health education programs that are medically accurate, consistent with scientific evidence, and tailored to students' contexts; and that use effective classroom instructional methods.

HIV and YMSM Resources

- Evidence-based HIV prevention interventions:
  www.cdc.gov/healthyyouth/adolescenthealth/registries.htm
- Specific CDC-funded YMSM program activities:
  www.cdc.gov/healthyyouth/disparities/ymsm/
- CDC resources on school connectedness and parent engagement in school health:
  www.cdc.gov/healthyyouth/adolescenthealth/protective.htm
- Parental influence on sexual minority youth:
  www.cdc.gov/healthyyouth/protective/positiveparenting/parents_influence.htm

Getting tested for HIV is a critical part of prevention.

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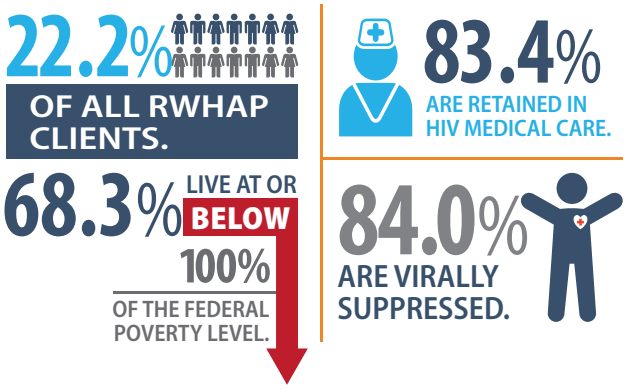
Ryan White HIV/AIDS Program

May 2016

Hispanic/Latino Clients, 2014

Ryan White HIV/AIDS Program Hispanic/Latino Client Fast Facts



The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant population of Hispanic/Latino clients living with HIV. In 2014, 73 percent of the more than half a million clients served by the Program were from racial or ethnic minority populations, and approximately 22 percent of all RWHAP clients identified as Hispanic/Latino. Below are more details about this RWHAP client population:

- **The majority of Hispanic/Latino clients are low-income.** More than 68 percent of Hispanic/Latino clients served by RWHAP live at or below 100 percent of the federal poverty level. This is greater than the national RWHAP average (64 percent).
- **The majority of Hispanic/Latino clients are male.** About 74 percent of Hispanic/Latino clients are male, about 25 percent are female, and slightly more than 1 percent of Hispanic/Latino clients are transgender. The proportion of Hispanic/Latino males compared to females is slightly higher than the national RWHAP average (about 71 percent males and 28 percent females).
- **The RWHAP Hispanic/Latino client population continues to increase in age.** About 36 percent of Hispanic/Latino clients are aged 50 years and older. An additional 16 percent are aged 40 to 49 years old.
- **About 4 percent of Hispanic/Latino clients have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- **Approximately 45 percent of all Hispanic/Latino clients are men who have sex with men (MSM).** This is the national RWHAP average of MSM clients (about 45 percent).
- **Lack of health care coverage continues to affect Hispanic/Latino clients served by RWHAP.** More than 31 percent of Hispanic/Latino clients have no health care coverage, which is higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. More than 83 percent of Hispanic/Latino clients receiving HIV medical care are retained in care, which is higher than the national RWHAP average (approximately 80 percent). About 84 percent of Hispanic/Latino clients receiving HIV medical care are virally suppressed, which also is higher than the national RWHAP average (81 percent).[1]

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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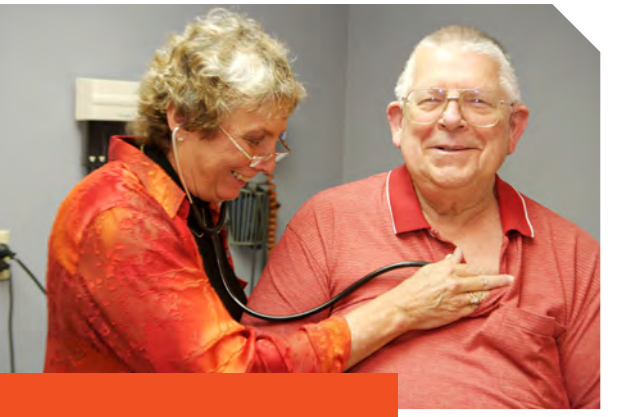
May 2016



Older Adults, 2014

Ryan White HIV/AIDS Program Clients Aged 50 Years and Older—Fast Facts

40.4% OF ALL RWHAP CLIENTS.

83.7% ARE RETAINED IN HIV MEDICAL CARE.

60.6% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

87.6% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are aged 50 years and older. In 2014, more than 40 percent of the more than half a million clients served by the Program were aged 50 and older. Below are more details about this RWHAP client population:

- **The majority of RWHAP clients aged 50 and older are racial and ethnic minorities.** About 68 percent of clients aged 50 and older are from racial and ethnic minority populations. More than 45 percent of clients in this age group identify as black/African American, which is less than the national RWHAP average (approximately 47 percent). More than 19 percent identify as Hispanic/Latino, which is less than the national RWHAP average (22 percent).
- **The majority of clients aged 50 and older are low-income.** Nearly 61 percent of people aged 50 and older served by RWHAP live at or below 100 percent of the federal poverty level. This is less than the national RWHAP average (64 percent).
- **The majority of RWHAP clients aged 50 and older are male.** Nearly 72 percent of clients aged 50 and older are male, more than 27 percent are female, and 0.5 percent of clients aged 50 and older are transgender. The ratio of males to females in the older population is comparable to the national RWHAP average (71 percent males, 28 percent females, and 1 percent transgender).
- **About 4 percent of clients aged 50 and older have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- **Lack of health care coverage continues to affect older clients served by RWHAP.** More than 16 percent of clients aged 50 and older have no health care coverage, which is significantly less than the national RWHAP average (about 25 percent), likely because they are eligible for Medicare.

Medical care and treatment improves health and decreases transmission of HIV. Nearly 84 percent of clients aged 50 and older receiving HIV medical care are retained in care, which is greater than the national RWHAP average (approximately 80 percent). More than 87 percent of clients aged 50 and older receiving HIV medical care are virally suppressed, which is also greater than the national RWHAP average (81 percent).[1]

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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Youth and Young Adults, 2014

Ryan White HIV/AIDS Program Youth and Young Adults Fast Facts

5.8% OF ALL RWHAP CLIENTS.

75.1% ARE RETAINED IN HIV MEDICAL CARE.

76.0% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

64.6% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are youth and young adults. In 2014, more than 29,500 (nearly 6 percent) of the more than half a million clients served by the Program were between the ages of 13 and 24 years old. Below are more details about this RWHAP client population:

- **The majority of RWHAP clients between the ages of 13 and 24 are racial and ethnic minorities.** Approximately 63 percent of these clients identify as black/African American, which is more than the national RWHAP average (approximately 47 percent). About 19 percent of clients in this age group identify as Hispanic/Latino, which is lower than the national RWHAP average (22 percent).
- **The majority of RWHAP clients between the ages of 13 and 24 are low-income.** Seventy-six percent of these clients live at or below 100 percent of the federal poverty level. This is significantly greater than the national RWHAP average (64 percent).
- **The majority of RWHAP clients between the ages of 13 and 24 are male.** About 70 percent of clients in this age group are male, 29 percent are female, and about 1.5 percent are transgender. The proportions of male, female, and transgender clients in the youth and young adult population are similar to the national RWHAP averages (71 percent male, 28 percent female, and 1 percent transgender).
- **About 5 percent of RWHAP clients between the ages of 13 and 24 have unstable housing situations.** This is comparable to the national RWHAP average (about 5 percent).
- **Lack of health care coverage continues to affect youth and young adult clients served by RWHAP.** Approximately 33 percent of these clients have no health care coverage, which is significantly higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. Approximately 75 percent of RWHAP clients between the ages of 13 and 24 who receive HIV medical care are retained in care, which is less than the national RWHAP average (approximately 80 percent). About 64 percent of RWHAP clients in this age group who receive HIV medical care are virally suppressed, which is significantly less than the national RWHAP average (81 percent).[1]

- Seventy-two percent of young men having sex with men (MSM) receiving HIV medical care are retained in care, and 65 percent receiving HIV medical care are virally suppressed.
- Seventy-two percent of young black MSM receiving HIV medical care are retained in care, and approximately 62 percent receiving HIV medical care are virally suppressed.
- Seventy-nine percent of young black women receiving HIV medical care are retained in care, and 60 percent receiving HIV medical care are virally suppressed.

[1]Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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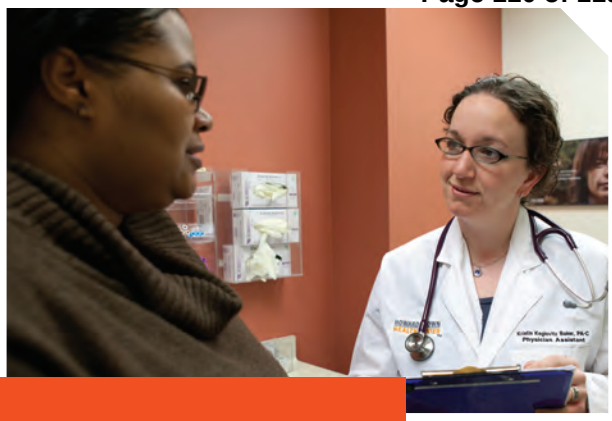
Ryan White HIV/AIDS Program

April 2016



Female Clients, 2014

Ryan White HIV/AIDS Program Female Clients Fast Facts

28.2% OF ALL RWHAP CLIENTS.

82.4% ARE RETAINED IN HIV MEDICAL CARE.

72.5% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

80.1% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller, but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant proportion of female clients living with HIV. In 2014, more than 28 percent of the more than half a million clients served by the Program were female. Below are more details about this RWHAP client population:

- **The majority of female clients served by RWHAP are racial and ethnic minorities.** About 84 percent of female clients are from racial and ethnic minority populations. Approximately 61 percent of female clients identify as black/African American, which is higher than the national RWHAP average (approximately 47 percent). Approximately 19 percent identify as Hispanic/Latina, which is slightly lower than the national RWHAP average (22 percent identify as Hispanic/Latino).
- **The majority of female clients are age 45 and above.** Nearly 39 percent of female clients served by RWHAP are 50 and older. Approximately 14 percent of clients are age 29 or younger.
- **The majority of female clients are low income.** 72 percent of female clients served by RWHAP live at or below 100 percent of the federal poverty level (FPL). This is above the national RWHAP average (64 percent).
- **Lack of health care coverage continues to impact female clients served by RWHAP.** Approximately 23 percent of female clients have no health care coverage, which is slightly lower than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. About 82 percent of female clients receiving HIV medical care are retained in care, which is slightly higher than the national RWHAP average (approximately 80 percent retained in care). Approximately 80 percent of female clients receiving HIV medical care are virally suppressed, which is slightly lower than the national RWHAP average (81 percent virally suppressed).[1]

- Approximately 82 percent of black/African American females receiving HIV medical care are retained in care, and 78 percent are virally suppressed.
- Approximately 86 percent of Hispanic/Latina females receiving HIV medical care are retained in care, and 82 percent are virally suppressed.

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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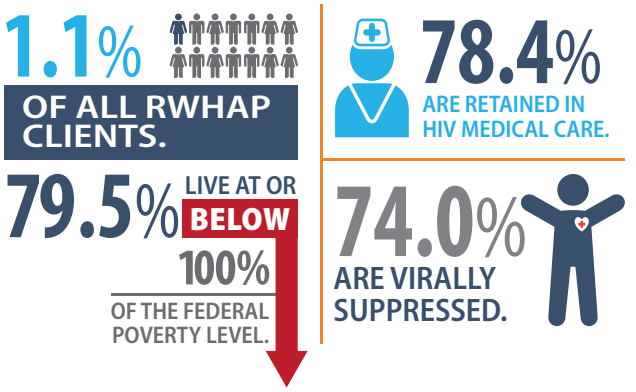
Ryan White HIV/AIDS Program

May 2016

Transgender Clients, 2014

Ryan White HIV/AIDS Program Transgender Client Fast Facts



The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A critical population served by RWHAP is transgender individuals. In 2014, approximately 1.1 percent of the more than half a million clients served by the Program were transgender. Below are more details about this RWHAP client population:

- **The majority of transgender clients served by RWHAP are racial and ethnic minorities.** Approximately 88 percent of transgender clients are from racial and ethnic minority populations. About 53 percent of transgender clients identify as black/African American, which is greater than the national RWHAP average (47 percent). About 30 percent identify as Hispanic/Latino, which is also greater than the national RWHAP average (approximately 22 percent).
- **The RWHAP transgender client population continues to increase in age.** One in five RWHAP transgender clients is aged 50 and older. An additional 28 percent are aged 40 to 49 years old.
- **About 10 percent of transgender clients have unstable housing situations.** This is greater than the national RWHAP average (about 5 percent).
- **The majority of transgender clients are low income.** More than 79 percent of transgender clients served by RWHAP live at or below 100 percent of the federal poverty level. This is significantly greater than the national RWHAP average (64 percent).
- **Lack of health care coverage affects transgender clients served by RWHAP.** Approximately 27 percent of transgender clients have no health care coverage, which is greater than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. 78 percent of transgender clients receiving HIV medical care are retained in care, which is slightly less than the national RWHAP average (approximately 80 percent). 74 percent of transgender clients receiving HIV medical care are virally suppressed, which is significantly less than the national RWHAP average (81 percent).[1]

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

HIV Among Incarcerated Populations

July 2015

Fast Facts

- HIV is a serious health issue for correctional facilities and their incarcerated populations.
- Most incarcerated people with HIV got the virus before entering a correctional facility.
- HIV testing at a correctional facility may be the first time incarcerated people are tested and diagnosed with HIV.

More than 2 million people in the United States are incarcerated in federal, state, and local correctional facilities on any given day. In 2010, the rate of diagnosed HIV infection among inmates in state and federal prisons was more than five times greater than the rate among people who were not incarcerated. Most inmates with HIV acquire it in their communities, before they are incarcerated.

The Numbers

- In 2012, 1.57 million people were incarcerated in state and federal prisons and at midyear 2013 there were 731,208 people detained in local jails.[1]
- In 2010, there were 20,093 inmates with HIV/AIDS in state and federal prisons with 91% being men.
- Among state and federal jurisdictions reporting in 2010[2] there were 3,913 inmates living with an AIDS diagnosis.
- Rates of AIDS-related deaths among state and federal prisoners declined an average of 16% per year between 2001 and 2010, from 24 deaths/100,000 in 2001 to 5/100,000 in 2010.
- Among jail populations, African American men are 5 times as likely as white men, and twice as likely as Hispanic/Latino men, to be diagnosed with HIV.
- Among jail populations, African American women are more than twice as likely to be diagnosed with HIV as white or Hispanic/Latino women.

Prevention Challenges

- Lack of awareness about HIV and lack of resources for HIV testing and treatment in inmates' home communities. Most inmates with HIV become infected in their communities, where they may engage in high-risk behaviors or be unaware of available prevention and treatment resources.
- Lack of resources for HIV testing and treatment in correctional facilities. Prison and jail administrators must weigh the costs of HIV testing and treatment against other needs, and some correctional systems may not provide such services. HIV testing can identify inmates with HIV before they are released. Early diagnosis and treatment can potentially reduce the level of HIV in communities to which inmates return.
- Rapid turnover among jail populations. While most HIV programs in correctional facilities are in prisons, most incarcerated people are detained in jails. Nine out of ten jail inmates are released in under 72 hours, which makes it hard to test them for HIV and help them find treatment.
- Inmate concerns about privacy and fear of stigma. Many inmates do not disclose their high-risk behaviors, such as anal sex or injection drug use, because they fear being stigmatized. Health care providers should keep inmate's health care information confidential, know the public health confidentiality and reporting laws, and inform inmates about them.

What CDC Is Doing

Funding state, local, and territorial health departments. This is CDC's largest investment in HIV prevention. CDC funds health departments and community-based organizations (CBOs) to provide HIV prevention services in many settings, including prisons and jails.

- CDC funded selected state health departments to conduct voluntary rapid HIV testing in jails, identify previously undiagnosed cases, and refer inmates to medical care. Of the 33,211 inmates tested, 409 (1.2%) tested positive, and 269 (0.8%) undiagnosed cases of HIV were detected, many among people who had not disclosed their risk behaviors.

[1] Jails are short-term facilities that are usually run by a local law enforcement agency. Jail sentences may range from a few hours up to one year. Compared with jail facilities, prisons are longer-term facilities owned by a state or by the federal government that typically hold people sentenced to more than one year.

[2] State and federal jurisdictions reporting in 2010 included 37 states and the Bureau of Federal Prisons.

Funding community-based pilot projects. CDC has joined with universities, CBOs, and other partners to find out which HIV prevention interventions are most effective among incarcerated populations and how they can be applied to other settings.

- CDC supported Project START (https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions/ProjectSTART.aspx), a pre-release HIV intervention for young men. Project participants reduced their HIV risk behaviors after their release back into the community.
- CDC funded the University of North Carolina to evaluate Project POWER (http://www.ncbi.nlm.nih.gov/pubmed/23631715), an HIV intervention among women in state correctional facilities. Six months after release, participants reported significantly greater condom use than nonparticipants. Participants also reported greater HIV knowledge, and more social support.
- CDC partnered with Emory University to adapt and evaluate an HIV intervention program for African American girls aged 13-17 in a juvenile detention center. Three months after the intervention, participants reported greater condom use, HIV/STD prevention knowledge, and condom use skills.
- CDC joined with Morehouse Medical School to counsel African American male jail inmates about high-risk sexual behaviors and ways to reduce them. After six months, participants reported significantly more condom use during vaginal or anal sex than nonparticipants. Participants 14-18 years old reported significantly more condom use at last sex with a non-main female sex partner than nonparticipants.

Voluntary rapid HIV testing. CDC partnered with Emory University to support voluntary rapid HIV testing at a large county jail located in a community with a high prevalence of HIV. The jail's nursing staff provided more than 12,000 tests, and 52 cases of HIV infection were newly diagnosed.

CDC has published HIV testing guidance for correctional facilities (https://www.cdc.gov/hiv/pdf/group/cdc-hiv-correctional-settings-guidelines.pdf) which recommends testing inmates when they enter correctional facilities, during incarceration, and just prior to release. CDC also recommends medical treatment and counseling to educate inmates about HIV risk behaviors. HIV prevention education should address male to male sex, tattooing, injection drug use, and other high risk behaviors that occur during and after incarceration.

CDC recommends that condom distribution programs be evaluated for use in prisons and jails in the United States. The World Health Organization recommends such programs (http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf?ua=1) as an effective way to reduce HIV among incarcerated populations.

The National Center for HIV/AIDS, Hepatitis, STD and TB Prevention, (NCHHSTP) Corrections Workgroup addresses the prevention and control of HIV, STDs, Viral hepatitis, and TB among incarcerated people. The workgroup includes experts in epidemiology, criminology, and corrections issues, and works to reduce health disparities among incarcerated populations.

CDC scientists edited a special issue of the journal Women & Health, "Infectious and Other Disease Morbidity and Health Equity among Incarcerated Adolescent and Adult Women," in November 2014, which focused on the health challenges, including HIV, faced by incarcerated women.

For more information on this topic visit www.cdc.gov/hiv/group/correctional.html.

Additional Resources

CDC-INFO
1-800-CDC-INFO (232-4636)
www.cdc.gov/info

CDC HIV Website
www.cdc.gov/hiv

CDC Act Against AIDS Campaign
www.cdc.gov/actagainstaids

Sociocultural dimensions of HIV/AIDS among Middle Eastern immigrants in the US: bridging culture with HIV/AIDS programmes

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Key words

HIV risk factors; sociocultural factors; immigrants; Middle Easterners; health disparity

Abstract

The population of Middle Eastern immigrants in the US has been increasing dramatically over the past 30 years, growing from 200,000 in 1970 to 1.5 million in 2000. These immigrants and their descendants constitute an important new population of interest for public health and other social programmes. With this addition to the cultural diversity of American society, it is important for healthcare programmes to be responsive to the unique cultural needs of those of Middle Eastern origin and to include them in healthcare curricula. This need is particularly imperative for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) intervention programmes, where the reduction of risky behaviours is essential to controlling the epidemic. When Middle Easterners emigrate to the US they must adjust to the American culture, which leads to preservation of some aspects of their culture and adjustment of behaviors to match American customs. This article aims to present sociocultural factors of HIV risk behaviours that are specific to Middle Eastern culture. The article also provides recommendations for HIV/AIDS-culturally appropriate intervention programmes.

INTRODUCTION

Middle Eastern and HIV/AIDS epidemics

One of the fastest growing populations in the US is the Middle Eastern immigrant population, having increased from 200,000 in 1970 to 1.5 million in the 2000 census.[1] Recent statistics show that 40% of the Middle Eastern immigrant population in the US comes from Arab countries.[1] In addition, a sizable portion of Middle Easterners come from non-Arab countries, including Iran, Israel, Turkey and Pakistan.[1] For the purposes of this paper, the Middle East is defined as a region including Afghanistan, Bahrain, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen (Figure 1), with a population of about 460 million.[2,3] While immigrants from this region are quite diverse in their heritage, history and languages, most Middle Easterners share a set of beliefs that are rooted in Islam.

This is an important group to investigate with regard to HIV/AIDS because, according to one study of foreign and US-born populations in Los Angeles, HIV prevalence was highest among North African/Middle Easterners compared to other immigrant populations (3.3%), with North Africa/Middle Eastern males having a prevalence of 4.1%. The same study concluded that there is a need to develop HIV-prevention materials and treatment programmes that are sensitive to the needs of Middle Eastern immigrants, since the disease affects their communities so strongly.[4]

BACKGROUND

Middle Eastern immigrants: preservation or disintegration of cultural identities?

An individual's cultural beliefs and sexual behaviours are important risk factors for HIV-acquisition.[5,6,7] Like other immigrants, Middle Easterners find it necessary to adjust to Western

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Figure 1

Middle East

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culture over time, leading to their traditional values being challenged by new cultural norms.[7,8,9,10] The degree of adaptation and change varies within various cultural groups.[11,12] For example, among Middle Eastern immigrants in the US, social attitudes of Arab immigrants have been found to be less Americanized than their Iranian counterparts who come from a non-Arab culture.[11] In addition, the degree to which previous generations of Middle Eastern immigrants acculturated in the past may be very different from newer generations.[8,13] New generations may not preserve the customs and traditions of their forefathers while they are living in the US or travelling back to their home countries.

Furthermore, the mobility and growth of a population impacts on the overall spread of HIV among both immigrants and non-immigrants. It has also been shown that immigrants are more likely to engage in risky sexual behaviour than non-immigrants.[14,15] Studies of some immigrant groups have suggested that the majority of the foreign-born HIV-infected patients were infected after immigration to the US.[15,16] This aspect of behaviour among immigrants has not been studied in the Middle Eastern immigrant population. Therefore it is important to examine the behaviours and beliefs that might facilitate or retard risky behaviours in Middle Eastern immigrants.

Middle Eastern immigrants, particularly Arabs, usually tend to maintain their traditional customs as they explore new opportunities and take pride in their cultural heritage and identity.[8,13,17] National origin, *per se*, does not automatically make someone more or less at risk of HIV infection. Behaviours associated with certain cultural beliefs or values may make a person more or less likely to be at risk of infection. Several features of the immigration process can affect HIV risk behaviours in this population. Immigration tends to be dominated by males and often leaves the migrant with poor prospects for marriage within his cultural group. Also the control of behaviour that is often exercised in tight-knit communities where individuals are monitored by family and neighbours is lost when one is submerged in a large foreign culture.

There is no published study on risky behaviours with regard to HIV/AIDS among Middle Eastern immigrants in the US. In addition, no culturally appropriate HIV/AIDS educational programmes for this population were found to have been developed. This may be due to the fact that most HIV educators are not familiar with the sociocultural norms, beliefs and stigmas that may increase the risk of HIV transmission in this population. Therefore this paper has been prepared to review sociocultural factors and their potential impact on risky behaviours. These include norms with regard to sexual intercourse, drug use and perinatal behaviours that might result in HIV transmission, and attitudes towards health. Understanding these cultural beliefs is crucial in order for healthcare providers to design culturally appropriate programmes for these clients.

SEXUAL TRANSMISSION

Religious culture

Islam is the fastest growing faith worldwide and in the US. It is also the second largest religion worldwide and

the dominant religion in the Middle East.[18,19] According to the US Census Bureau, in the year 2000, 73% of Middle Eastern immigrants to the US were Muslims, with a faster population growth rate than non-Muslim Middle Easterners.[1] Decades of Islamic domination and culture have influenced the Middle Eastern way of life.[20] HIV/AIDS challenges the religious beliefs of Middle Easterners due to the nature of the leading mode of transmission, which is sexual intercourse. Islam commands that followers practice a sexually healthy lifestyle, male circumcision and purification rituals.[18] Furthermore, Islam orders that believers avoid alcohol consumption, extra- and premarital sex, anal sex, homosexuality and vaginal sex during menses.[18] Adherence to these religious constraints constitutes behaviours consistent with reducing the incidence of HIV. As a result, it has been hypothesized that Islamic religious adherence is negatively related to HIV infection.[21] Conversely, polygamy and an attitude opposed to condom use appear to increase the risks of HIV.[20] In addition, some sects of the Muslim faith allow the practice of 'Nikah mut'ah', which allows temporary marriage and sexual intercourse with the temporary spouse.[20] This marriage has a preset duration, which may be as little as one hour. After the preset time period has ended, the marriage is automatically dissolved. Multiple, sequential, temporary marriages are allowed.[22]

Condom use

Condom use is seen as a sign of embarrassment, immorality and corruption in Middle Eastern culture. Embarrassment with regard to condoms in particular is a barrier to condom use.[23,24] Condoms are allowed only within legal marriages[18,25] and are intended for family planning.[20] The importance of fertility, particularly the importance of having male children,[20,26] is deeply ingrained in Middle Eastern culture, which hinders condom use even among married people. Hence, AIDS education programmes must be sensitive to these beliefs. Therefore when educating this population, safe sex with condom use as an HIV prevention message – particularly for singles – must be done within this cultural context.

Homosexuality

The practice of homosexuality is culturally and religiously prohibited, and if discovered may lead to community chastisement, rejection or a death sentence.[18,27] Despite the strong prohibition and social stigma, there is an increasingly visible presence of homosexuality among Middle Easterners around the world.[28,29] Unfortunately the fear of the disease along with societal rejection, denial and lack of education makes Middle Easterners who engage in male-to-male sex a particularly vulnerable population.

Sex industry

Approximately 50,000 people a year, most of them women and children, are trafficked to the US for illegitimate purposes including commercial sex work.[30] Although commercial sex is not culturally condoned, the sex industry has established itself as a mainstream business among Middle Easterners.[31,32] The practice of Islamic religious customs of polygamy and temporary marriages can result in promiscuity, especially among immigrants who are living far from their families. Some immigrants develop 'parallel lives' when they move out of their home country. Being away from their families, friends and communities allows them a certain degree of freedom which, if taken advantage of, can lead to promiscuity.[20] These are populations that need to be targeted with prevention programmes. However, it must be recognized that to be seen listening to these messages is stigmatizing; it may be seen as a violation of religious and cultural norms. Even where AIDS prevention programmes and care services exist, individuals whose culture condemns those practices (in the US or their home countries) may be reluctant to participate in programmes.

Cultural beliefs and taboos on sexuality

Sexual issues and sex education are considered shameful and therefore are not discussed in families or between sexual partners.[7, 33,34] Cultural taboos and shame of talking openly about sex inhibit conservative families from seeking information concerning safe sex.[7,35] Despite the important role of family communication, Middle Easterners seem less likely to supply their children with critical sexual information and HIV/AIDS education, and parents may themselves be uninformed or misinformed. School-based, in-depth, culturally sensitive programmes on sexual education and HIV/AIDS (preferably in the presence of parents or guardians) could be used to accurately and appropriately address sexuality and HIV-related risks.

Female virginity is a social value. However, the tradition surrounding it is a taboo discussion topic among Middle Easterners.[20] Because the bride-price for virgins is higher than for non-virgins, the social authorities or family members may impose a virginity examination.[20,36] The prominent sign of virginity is the release of blood due to the breaking of the hymen; this evidence on a white sheet may be used later for further investigation. The absence of bleeding is considered a sign of disgrace for the bride's family and may result in shame, and in some sub-cultures, the bride's suicide or murder.[36,37,38] To avoid the stigma attached to losing her virginity, a woman can try alternative sex like oral or anal sex. She may also attempt to 'restore' her virginity through hymenoplasty, which if performed using non-sterile techniques can lead to increased HIV risk and significant risk of other infections like hepatitis B.[20]

Sexual subordination

The culture of patriarchy is not limited to Middle Easterners, but is highly visible and valued among them.[39,40] Strong male authority forces women to be dependent upon the men.[34,41] Women should be obedient to husbands and if a woman suspects that her husband has been unfaithful, she may be in danger of divorce if she voices her suspicions, initiates safe-sex practices or discusses HIV/AIDS.[34,41,42,43] In Middle Eastern culture, sexual satisfaction is considered a priority for men, although this is largely unrecognized and even considered

inappropriate for women.[35,44] Divorce is taboo, especially for women. If a divorced woman wishes to remarry, many sub-cultures will limit remarriage to an older man or a married man as his second wife.[45,46]

Although increasingly common, sexual activity outside of marriage is decisively negative and stigmatizes a female's reputation.[20,34,47] The fear of being judged or discriminated against due to immoral behaviour adds another level of distress. Additionally, a mother and her child without a legally recognized father would face shame, social neglect and ridicule. Sexual liaisons resulting in unwanted pregnancies therefore contribute to illegal abortions.[20] Women's risk of HIV infection is affected by sociocultural values, economic need and poor access to HIV/AIDS education.[35,44,48] Even where sex education exists, Arab Americans tend to preserve cultural taboos on female sexuality and HIV/AIDS, which makes it more difficult for HIV/AIDS educational programmes to reach these women.[49] Most Middle Eastern Muslim women prefer or expect to have minimal casual contact with the opposite sex.[13,50,51] The conservative culture of the Middle East can either increase women's vulnerabilities to HIV/AIDS by deterring them from seeking safe sex, or it may protect them from unsafe sex due to its conservative nature.

BLOOD-BORNE TRANSMISSION

Information on Middle Eastern immigrants' drug use and HIV transmission through injection drug users (IDUs) in the US is unavailable.[20] The Joint United Nations Programme on HIV/AIDS (UNAIDS) has reported that sexual intercourse is the main transmission route of HIV infection in the Middle East, followed by IDUs.[52] There is also a high rate of drug trafficking from heroin-producing countries to Middle Eastern countries. There are approximately 400,000 IDUs in Arab countries and about 200,000 of these in Iran.[52] According to Islam, mind-altering substances including alcohol and injection drugs are prohibited.[18] Therefore information regarding needle-replacement or needle-cleaning practices needs to be transmitted in a fashion that avoids stigmatization.

Cutting one's skin is another traditional rite that is believed to improve one's health,[53] cure diseases and/or furnish heavenly rewards.[20] This is akin to bleeding practices that were practiced in Western countries in the early 20th century. These traditional practices are possible routes of HIV transmission when conducted with non-sterile or shared devices.

ABORTION AND PERINATAL TRANSMISSION

Islam like all of the major world religions forbids abortion. Therapeutic abortion is allowed under certain conditions such as AIDS but only if carried out before four months of gestation and only after that to save the life of the mother.[54] This in turn means that Islam does not permit abortion under normal health conditions, and considers it an elaborate act of killing an innocent human being, which is a crime under any law. Those who seek illegal abortions for unwanted pregnancies are highly stigmatized.[20] As a result, unsafe abortions performed by untrained persons and/or in improperly equipped institutions occur. These carry a high risk of death or disability for the woman and may increase the risk of HIV infection due to the unsterile circumstances of the procedure.

Anti-retroviral therapy for an HIV-positive mother and baby before, during and after delivery can drastically reduce the risk of HIV transmission to the neonate. Fortunately, Islam does not forbid taking medication to treat life-threatening diseases. So health professionals can explain the advantages and disadvantages of anti-retroviral treatments to their Middle Eastern patients in a manner that is similar to non-Muslims. However, while avoidance of breastfeeding can reduce mother-to-child transmission, there are strong Middle Eastern cultural and Islamic commands for breastfeeding that may make this preventive practice difficult.[18] Healthcare providers need to provide their patients with alternative explanations for not breastfeeding.

HEALTH AND DISEASE BELIEFS

Expression of health, diseases and death are influenced by cultural norms.[11,55,56] Commonly, Arabs tend to underutilize health services.[57,58] Muslims may believe that disease is a punishment from God due to sin and this is particularly true of AIDS.[18] This punitive belief may prevent Muslims from seeking HIV-related services including testing, treatment and counselling. This failure to seek care and health information may even carry over to more acculturated Arabs.

Middle Easterners generally value family ties and hold family institutions in high regard; the protection of and support for families is a matter of civil, moral and spiritual value.[59,60,61] In the Middle East, people who are ill habitually turn to their family members first for comfort, prayer and advice. Families are expected to help each other[41] and be engaged in the patient's treatment and support.[62] At least one family member usually accompanies the patient to a medical centre. It is common for a family member to stay with the patient when they are being seen by a physician to help answer questions. In Middle Eastern healthcare situations patients are only told the good news about their ailment. Physicians would normally report the significance of illnesses and consequences to a chosen family member. In the event of death or the immediate prospect of death, a guardian is designated to take care of the will and religious customs associated with burial. In the US, however, medical professionals are trained to talk frankly and directly with patients. This may have to be done more discreetly with Muslim patients and particular care must be exercised in stigmatized conditions such as HIV/AIDS. Clinicians should also be aware that if using an interpreter, their direct discussions of illnesses and their prognoses might not be accurately translated. For one thing, Middle Eastern cultural norms – particularly Islam – do not allow the discussion of certain fastidious sexual matters.[63] In addition, specific cultural concepts are not easily translated from one language to another.[64]

In Middle Eastern culture, prayer and spirituality are believed to enhance recovery and give comfort to patients and their families.[59] When patients are admitted to hospital, there is a social obligation for friends and family to visit them. This custom may be in conflict with hospital rules about number of visitors, hours of visiting, etc. Immigrants who have lived in the US for an extended time may understand these rules, reflecting the role of acculturation. However, new immigrants or the poorly acculturated may find this difficult. As a result, Middle Eastern people may postpone seeking professional treatment because they perceive that traditional methods bring psychological relief for patients and that their families may be denied to them. Therefore training and linking community leaders and traditional healers to modern health facilities is essential.[55,60,65]

CONCLUSION

Middle Easterners are one of the fastest growing immigrant populations in the US. Lack of valid, reliable information is a major barrier to providing effective HIV/AIDS prevention and treatment for this growing population, both in their homeland and in the US. Sex and IDU are the main HIV transmission routes, yet these are culturally and religiously stigmatized. Due to language and cultural barriers, immigrant populations may be less able to seek HIV educational information and access proper care.

It is important to highlight to Western hosts that the main HIV/AIDS risk factors (non-marital sex and IDU) are sins or against the law in most of the Middle Eastern countries. Consequently, Middle Easterners may be unwilling to disclose HIV risk behaviours. Finally, existing American HIV/AIDS intervention programmes and sexual orientation messages may not be culturally and religiously appropriate for Middle Easterners. It is strongly recommended that Middle Easterners be involved in the preparation of culturally sensitive curricula for these populations. It is particularly important to encourage religious and community leaders to take part in the development of such programmes. These individuals will differ from community to community among immigrants of various different countries of origin (e.g. Iranians versus Saudi Arabians).

The population of Middle Easterners in the US is rapidly growing. Lack of knowledge and an unwillingness to confront detested truths are harming people by perpetuating the stigma attached to HIV/AIDS. In order to combat the HIV/AIDS epidemic effectively, it is important to understand the sociocultural risk predictors of HIV/AIDS and address them through culturally competent programmes.

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