FY 2018 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be

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

	Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The

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

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

	access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.

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

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

	RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication

	refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those**

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

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HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without

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

	Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B

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

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

	• On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Women's Services must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their

	medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth

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

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

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

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

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2018 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the

	subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA

	performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation

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

	• Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements:

	• Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be

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

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

	independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with

	knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.**

	Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for

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

	Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See FY 2018 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1)

	office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex

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

	medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for females of child bearing age must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; Patient Medication Education Services must adhere to the following

	requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Medical Case Management Services:** Services include screening all

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

	medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and

	certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.

Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Pharmacy Assistance** (Revised April 2017)	
HRSA Service Category Title: **RWGA Only**	Emergency Financial Assistance
Local Service Category Title:	Emergency Financial Assistance – Pharmacy Assistance
Budget Type: **RWGA Only**	Hybrid Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
HRSA Service Category Definition: **RWGA Only**	*Emergency Financial Assistance* provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	Emergency Financial Assistance – Pharmacy Assistance provides limited one-time and/or short-term 14-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 14-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed HIV medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA.
Services to be Provided:	Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program

	operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded Emergency Financial Assistance – Pharmacy Assistance or LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.
Service Unit Definition(s): **RWGA Only**	A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
Financial Eligibility:	Refer to the RWPC's approved *FY 2018 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management), Local Pharmacy Assistance Program (LPAP), and Emergency Financial Assistance-Pharmacy services.

Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/24/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

SUMMARY FOR HOW TO BEST MEET THE NEED

Harris County
Public Health
Building a Healthy Community

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

MARCH 2017

CONTACT:
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SERVICE CATEGORIES

OUTPATIENT/AMBULARTORY CARE SERVICES -- PAGE 2

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

DRUG/PHARMACY SERVICES -- PAGE 7

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

CASE MANAGEMENT SERVICES -- PAGE 11

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

CLIENT SATISFACTION SURVEY SERVICE CATEGORY SUMMARY

OUTPATIENT/AMBULARTORY CARE SERVICES

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

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

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

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

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

DRUG/PHARMACY SERVICES

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

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

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

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

CASE MANAGEMENT SERVICES

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

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

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

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Building a Healthy Community

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FY 2016 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

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

Follow HCPH on Twitter @hcphtx and like us on Facebook

Highlights from FY 2016 Performance Measures

Local Pharmacy Assistance

- Among LPAP clients with viral load tests, 2,839 (73%) clients were virally suppressed during this time period.

Medical Case Management

- During FY 2016, 5,073 clients utilized Part A medical case management. According to CPCDMS, 2,553 (50%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these medical case management clients, 616 (12%) accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 1,909 (38%) clients had third-party payer coverage after accessing medical case management.

Primary Medical Care

- During FY 2016, 7,393 clients utilized Part A primary medical care. According to CPCDMS, 4,205 (75%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 266 (18%) had an AIDS diagnosis (CD4 < 200) within the first 90 days of initial enrollment in primary medical care.
- Among clients, 3,584 (80%) had a viral load test performed at least every six months during this time period.
- Among clients with viral load tests, 7,189 (71%) clients were virally suppressed during this time period.
- During FY 2016, the average wait time for an initial appointment availability to enroll in primary medical care was 7 days, while the average wait time for an appointment availability to receive primary medical care was 11 days.

Non-Medical Case Management / Service Linkage

- During FY 2016, 6,824 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,072 (45%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, 508 (53%) clients utilized primary medical care for the first time after accessing service linkage for the first time.
- Among these clients, the average number of days between the first service linkage visit and the first primary medical care visit was 36 days during this time period.

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2015	FY 2016	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,549 (73.9%)	2,839 (72.6%)	**-1.3%**

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Medical Case Management
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 5,073 clients utilized Part A medical case management.

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,484 (49.2%)	2,553 (50.3%)	**1.1%**
Percentage of medical case management clients who utilized mental health services	599 (11.9%)	616 (12.1%)	**0.2%**
Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	2,117 (41.9%)	1,909 (37.6%)	**-4.3%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,110 (70.9%)	2,032 (67.7%)	**-3.2%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	836 (44.8%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	545 (23.3%)	591 (23.9%)	**0.6%**
Percentage of clients who were homeless or unstably housed	1,420 (28.1%)	1,190 (23.5%)	**-4.6%**

According to CPCDMS, 147 (2.9%) clients utilized primary care for the first time and 243 (4.8%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	FY 2015
60% of HIV-infected medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	12%

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Primary Medical Care
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 7,393 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2015	FY 2016	Change
90% of clients with HIV infection will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,019 (76.3%)	4,205 (75.3%)	**-1.0%**
Less than 20% of clients who have a CD-4 < 200 within the first 90 days of initial enrollment in primary medical care	299 (20.6%)	266 (17.9%)	**-2.7%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD-4 cell counts or percentages performed during the measurement year at least three months apart	3,683 (69.9%)	3,782 (67.7%)	**-2.2%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,081 (72.9%)	5,486 (74.2%)	**1.3%**
Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year	1,729 (24.8%)	1,837 (24.8%)	**0.0%**
85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year	5,791 (83.2%)	5,960 (80.7%)	**-2.5%**
95% of clients with HIV infection will be screened for Hepatitis B virus infection status (ever)	5,211 (74.8%)	5,846 (79.1%)	**4.3%**
90% of clients with a diagnosis of HIV/AIDS will have a viral load test performed at least every six months during the measurement year	3,405 (78.0%)	3,584 (79.7%)	**1.7%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	6,962 (73.7%)	7,189 (71.3%)	**-2.4%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,162 (23.0%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	1,394 (26.5%)	1,542 (27.6%)	**1.1%**
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	**Data below**		
Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network who had a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	**Data below**		

From 3/1/2016 through 2/28/2017, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 7 Days

Agency 1: 7
Agency 2: 5
Agency 3: 12
Agency 4: 4
Agency 5: 6

From 3/1/2016 through 2/28/2017, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 11 Days

Agency 1: 5
Agency 2: 2
Agency 3: 10
Agency 4: 4
Agency 5: 5

Clinical Chart Review Measures*	FY 2014	FY 2015
100% of clients with a diagnosis of HIV/AIDS will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	100%	93.0%
100% of pregnant women with HIV infection will be prescribed antiretroviral therapy	100%	100%
Percentage of female clients with a diagnosis of HIV who have a pap screening in the measurement year	63.5%	68.2%
55% of clients with HIV infection will complete the vaccination series for Hepatitis B	55.6%	59.9%
85% of clients with HIV infection will receive HIV risk counseling within the measurement year	77.0%	71.3%
95% of clients with a diagnosis of HIV will be screened for substance abuse (alcohol and drugs) in the measurement year	98.3%	98.7%
90% of clients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	93.1%	88.4%
65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	67.2%	69.6%
75% of clients with a diagnosis of HIV/AIDS, for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	71.1%	67.1%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	66.6%	56.3%
95% of clients will be screened for clinical depression using a standardized tool with follow up plan documented	89.3%	92.3%
90% of clients with HIV infection will have ever received pneumococcal vaccine	89.2%	87.8%
100% of clients will be screened for tobacco use at least one during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user	99.4%	100%
95% of clients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	95.3%	96.5%
85% of clients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	85.0%	70.0%

* To view the full FY 2015 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Non-Medical Case Management / Service Linkage
All Providers

For FY 2016 (3/1/2016 to 2/28/2017), 6,824 clients utilized Part A non-medical case management.

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	2,870 (45.9%)	3,072 (45.0%)	**-0.4%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage for the first time	423 (54.4%)	508 (52.5%)	**-1.9%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean 29		36	**24.1%**
Median 14		21	**50.0%**
Mode 7		14	**100.0%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	105 (49.3%)	132 (46.3%)	**-3.0%**

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Executive Director

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Building a Healthy Community

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Primary Care Chart Review Report FY 2016

Ryan White Part A Quality Management Program – Houston EMA

December 2017

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2016 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Medical Services to five organizations. Approximately 7,800 unduplicated-HIV positive individuals are serviced by these organizations.

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

Introduction

On March 27, 2016, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/16 and 2/28/17. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV: January 28, 2016*, were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Improvement (CQI) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, 2016* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

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

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

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

Tale 1. Data Collection Parameters

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

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

The Sample Selection Process

The sample population was selected from a pool of 7,299 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/16 and 2/28/17. The medical charts of 635 clients were used in this review, representing 8.7% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 45.7% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

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

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/16-2/28/17

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	308	48.5%	5,383	73.75%
Female	290	45.7%	1,833	25.11%
Transgender Male to Female	37	5.8%	81	1.11%
Transgender Female to Male	0	0%	2	.03%
TOTAL	**635**		**7,299**	
Race				
Asian	9	1.4%	99	1.36%
African-Amer.	306	48.2%	3,718	50.94%
Pacific Islander	0	0%	5	.07%
Multi-Race	2	.3%	50	.69%
Native Amer.	1	.2%	28	.38%
White	317	49.9%	3,399	46.57%
TOTAL	**635**		**7,299**	
Hispanic				
Non-Hispanic	392	61.7%	4,756	65.16%
Hispanic	243	38.3%	2,543	34.84%
TOTAL	**635**		**7,299**	
Age				
18-24	27	4.3%	469	6.43%
25-34	166	26.1%	2,090	28.63%
35-44	182	28.7%	2,036	27.89%
45-54	169	26.6%	1,815	24.87%
55-64	79	12.4%	775	10.62%
65 and older	12	1.9%	114	1.56%
Total	**635**		**7,299**	

Report Structure

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

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

Findings

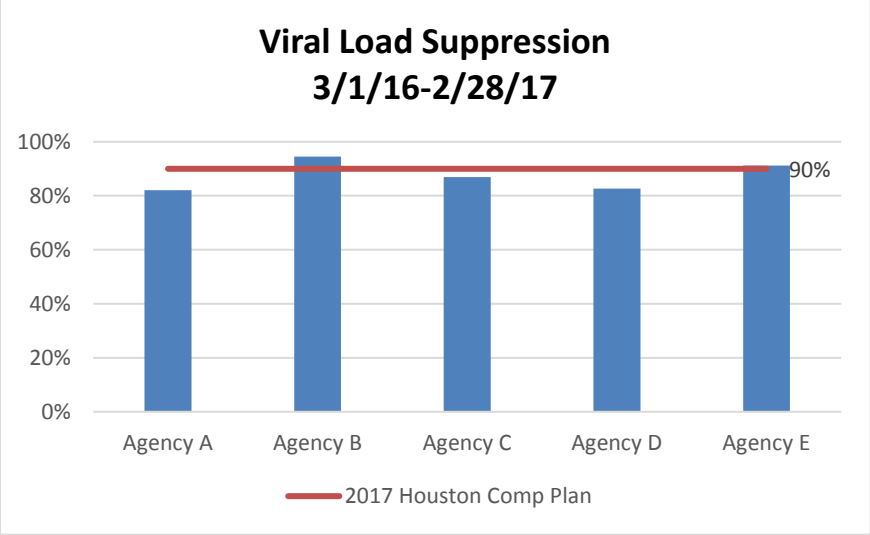
Core Performance Measures

Viral Load Suppression

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

	2014	2015	2016
Number of clients with viral load below limits of quantification at last test during the measurement year	539	519	544
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	586	601	615
Rate	**92%**	**86.4%**	**88.5%**
	4.1%	**-5.6%**	**2.1%**

2016 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	238	216	80
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	277	240	88
Rate	**85.9%**	**90%**	**90.9%**



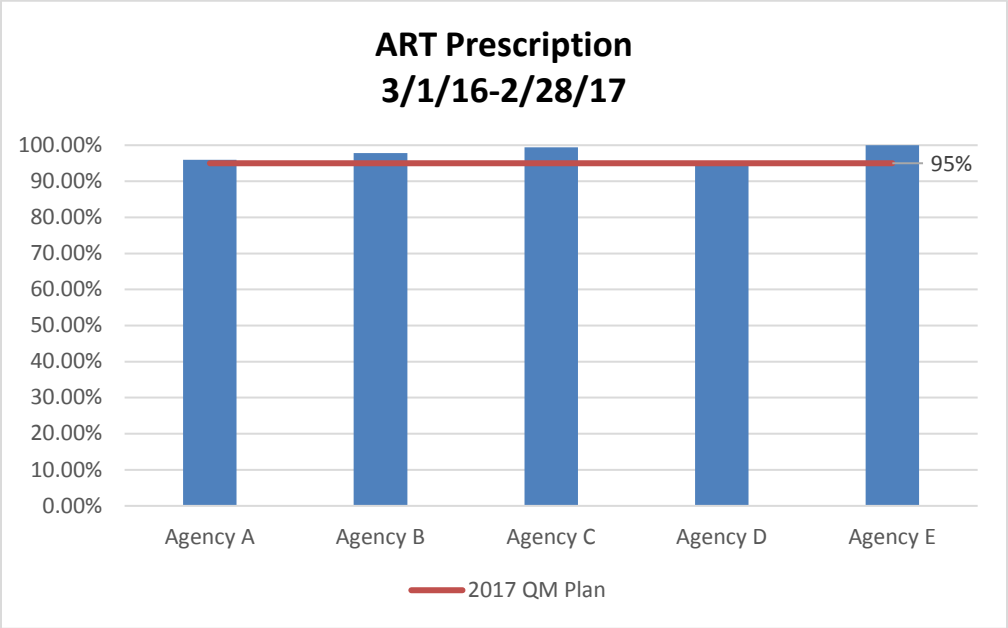
ART Prescription

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

	2014	2015	2016
Number of clients who were prescribed an ART regimen within the measurement year	605	613	620
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**95.3%**	**96.5%**	**98.6%**
Change from Previous Years Results	**-.6%**	**1.2%**	**2.1%**

- Of the 15 clients not on ART, none had a CD4 <200

2016 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	279	241	90
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	291	243	91
Rate	**95.9%**	**99.2%**	**98.9%**

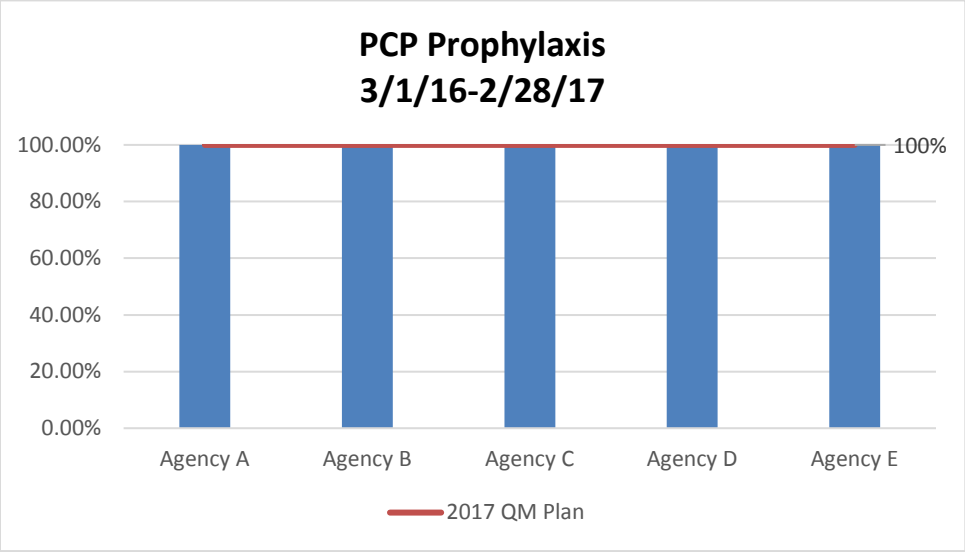


PCP Prophylaxis

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

	2014	2015	2016
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	45	53	48
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	45	57	48
Rate	**100%**	**93%**	**100%**
Change from Previous Years Results	**1.3%**	**-7%**	**7%**

2016 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	19	20	7
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	19	20	7
Rate	**100%**	**100%**	**100%**



All Ages Performance Measures

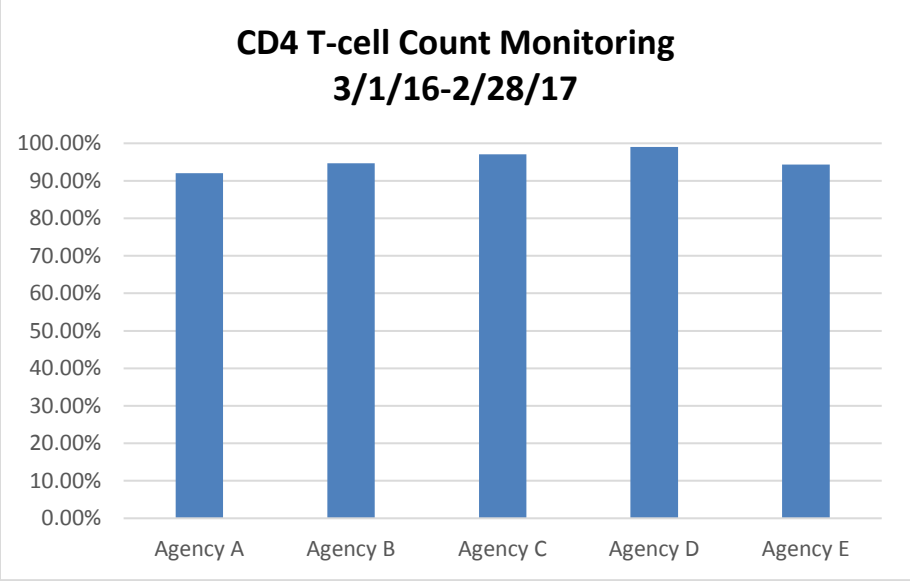
CD4 T-Cell Count

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

	2014	2015	2016
Number of clients who had a CD4 T-cell count performed at least every six months during the measurement year	581	590*	607*
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**91.5%**	**92.9%**	**95.6%**
Change from Previous Years Results	**.9%**	**1.4%**	**2.7%**

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

2016 CD4 by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a CD4 T-cell count performed at least every six months during the measurement year	277	234	86
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	291	243	91
Rate	**95.2%**	**96.3%**	**94.5%**

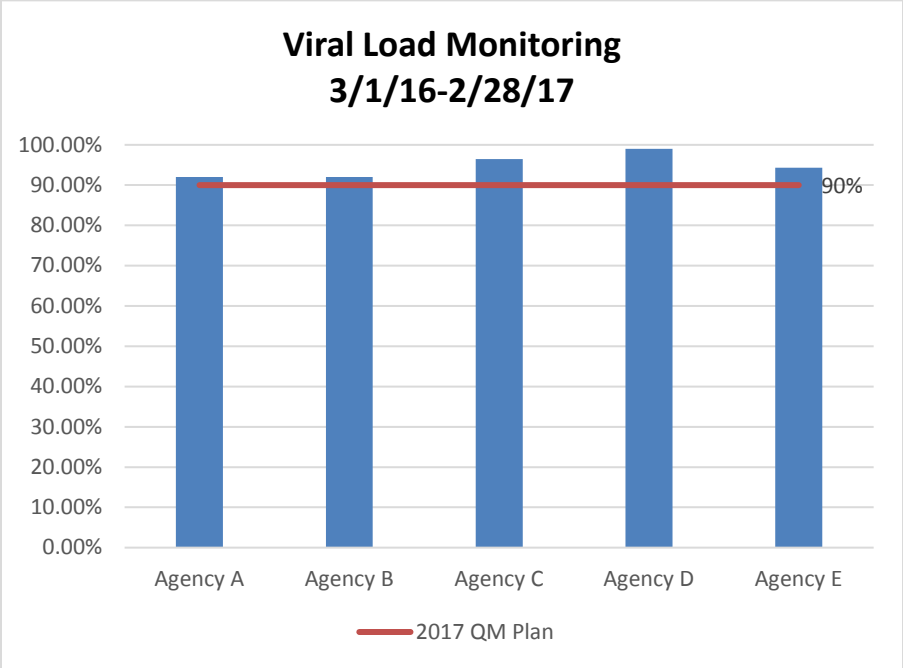


Viral Load Monitoring

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

	2014	2015	2016
Number of clients who had a viral load test performed at least every six months during the measurement year	580	590	601
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**91.3%**	**92.9%**	**94.6%**
Change from Previous Years Results	**1.1%**	**1.4%**	**1.7%**

2016 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	273	233	85
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	291	243	91
Rate	**94.8%**	**95.9%**	**93.4%**



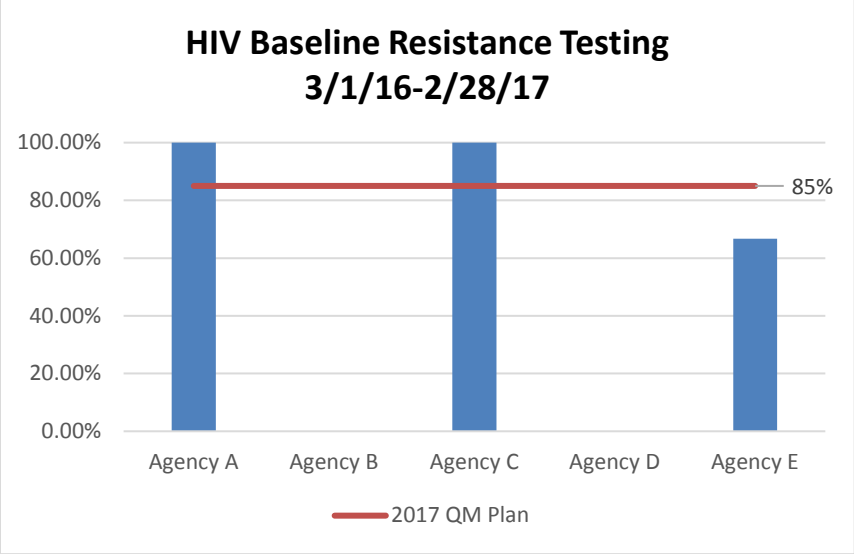
HIV Drug Resistance Testing Before Initiation of Therapy

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

	2014	2015	2016
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	17	7	9
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	20	10	13
Rate	**85%**	**70%**	**69.2%**
Change from Previous Years Results	**18.3%**	**-15%**	**-.8%**

2016 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	5	3	1
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	7	3	3
Rate	**71.4%**	**100%**	**33.3%**

*Agency B did not have any clients that met the denominator



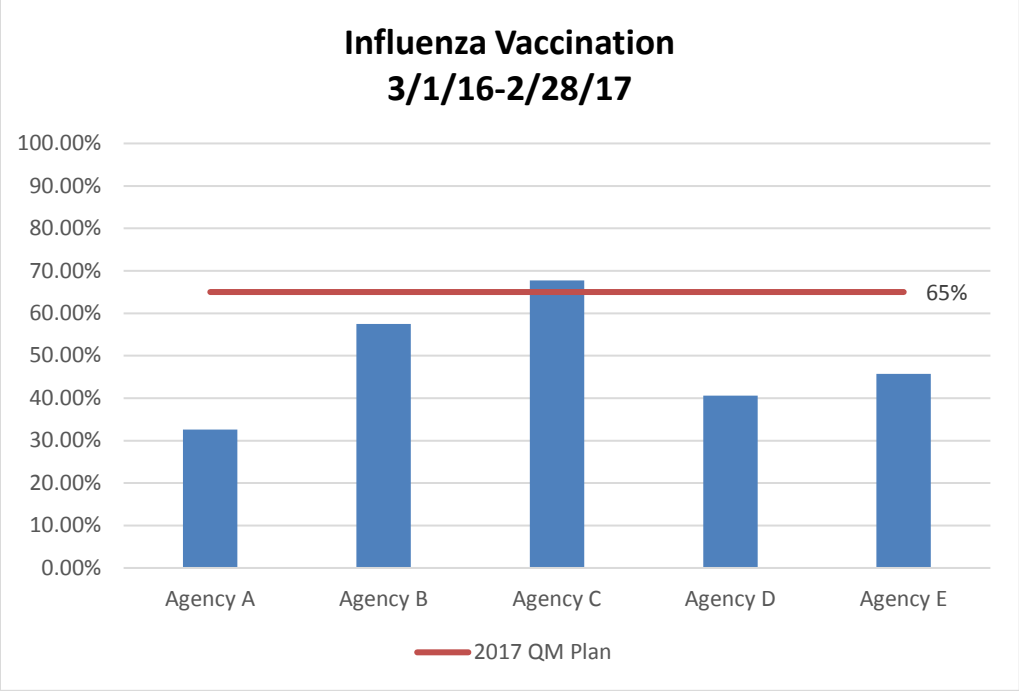
Influenza Vaccination

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

	2014	2015	2016
Number of clients who received influenza vaccination within the measurement year	404	326	312
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	607	579	588
Rate	**66.6%**	**56.3%**	**53.1%**
Change from Previous Years Results	**4.3%**	**-10.3%**	**-3.2%**

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

2016 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	125	131	49
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	262	230	86
Rate	**47.7%**	**57%**	**57%**

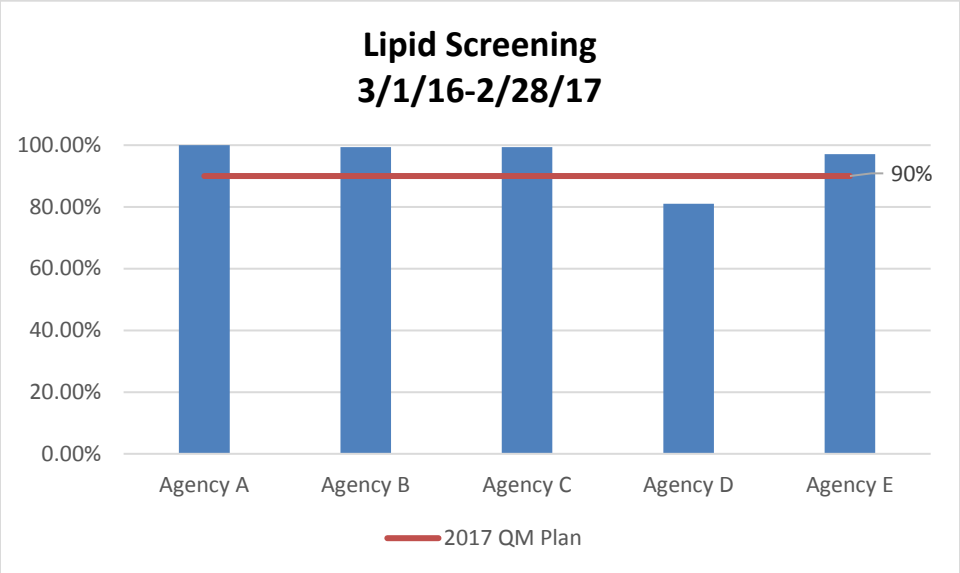


Lipid Screening

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

	2014	2015	2016
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	563	542	551
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	605	613	620
Rate	**93.1%**	**88.4%**	**88.9%**
Change from Previous Years Results	**.8%**	**-4.7%**	**.5%**

2016 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	238	225	79
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	279	241	90
Rate	**85.3%**	**93.4%**	**87.8%**

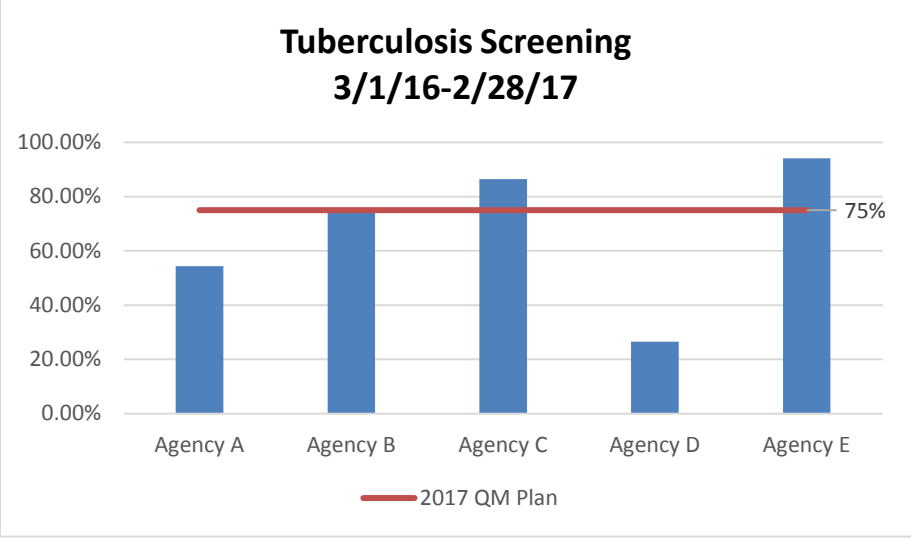


Tuberculosis Screening

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

	2014	2015	2016
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	404	376	382
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	568	560	571
Rate	**71.1%**	**67.1%**	**66.9%**
Change from Previous Years Results	**9.1%**	**-4%**	**-.2%**

2016 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	168	162	45
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	262	219	81
Rate	**64.1%**	**74%**	**55.6%**



Adolescent/Adult Performance Measures

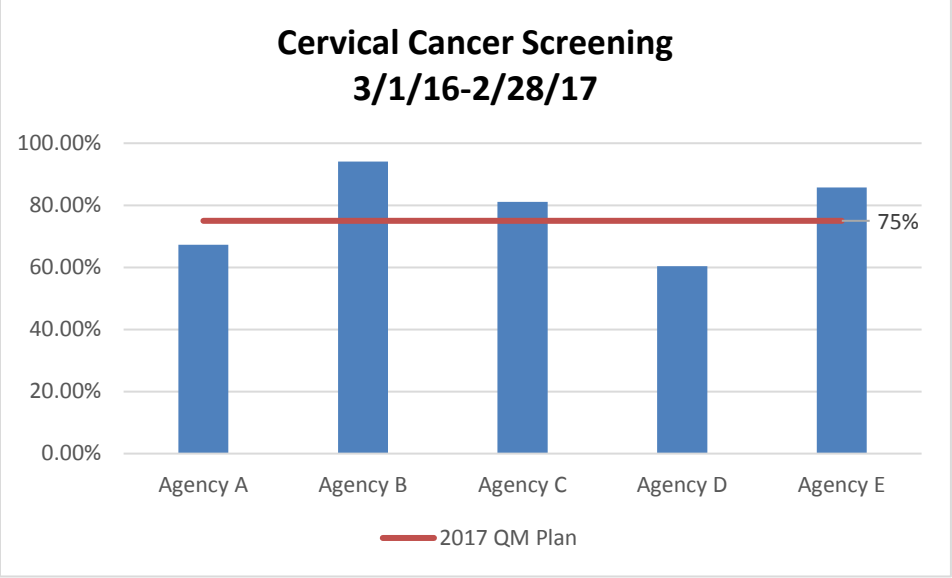
Cervical Cancer Screening

- Percentage of women living with HIV who have Pap screening results documented in the previous three years

	2014	2015	2016
Number of female clients who had Pap screen results documented in the previous three years	183*	197	229
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	288	289	286
Rate	**63.5%**	**68.2%**	**80.1%**
Change from Previous Years Results	**2.3%**	**5.3%**	**11.9%**

- 18.8% (43/229) of pap smears were abnormal
- *Includes women who had screening in the previous year only

2016 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	127	81	20
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	160	94	29
Rate	**79.4%**	**86.2%**	**69%**



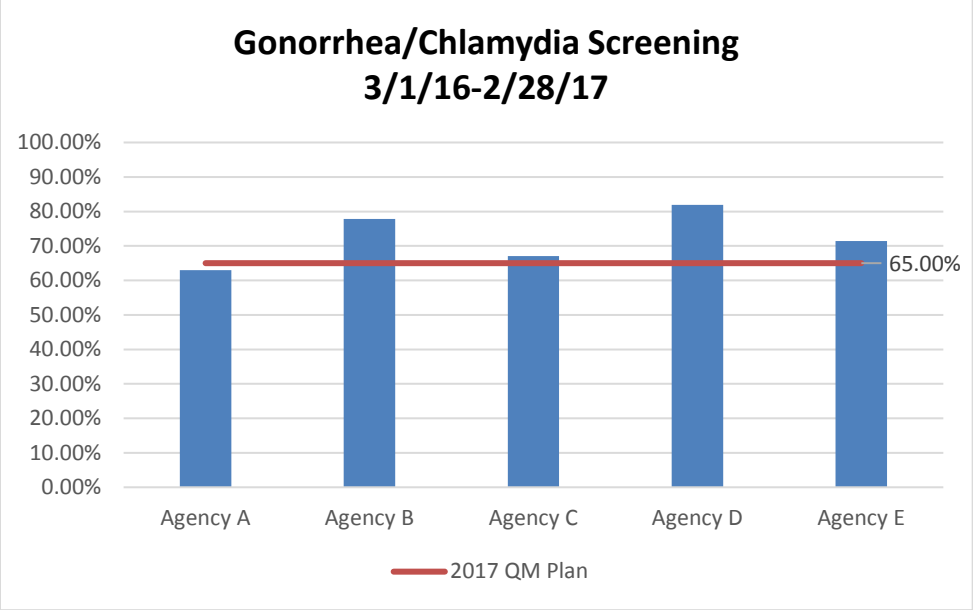
Gonorrhea/Chlamydia Screening

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

	2014	2015	2016
Number of clients who had a test for Gonorrhea/Chlamydia	424	442	463
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	631	635	635
Rate	**67.2%**	**69.6%**	**72.9%**
Change from Previous Years Results	**4.8%**	**2.4%**	**3.3%**

- 13 cases of CT and15 cases of GC were identified

2016 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	220	178	59
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**75.6%**	**73.3%**	**64.8%**



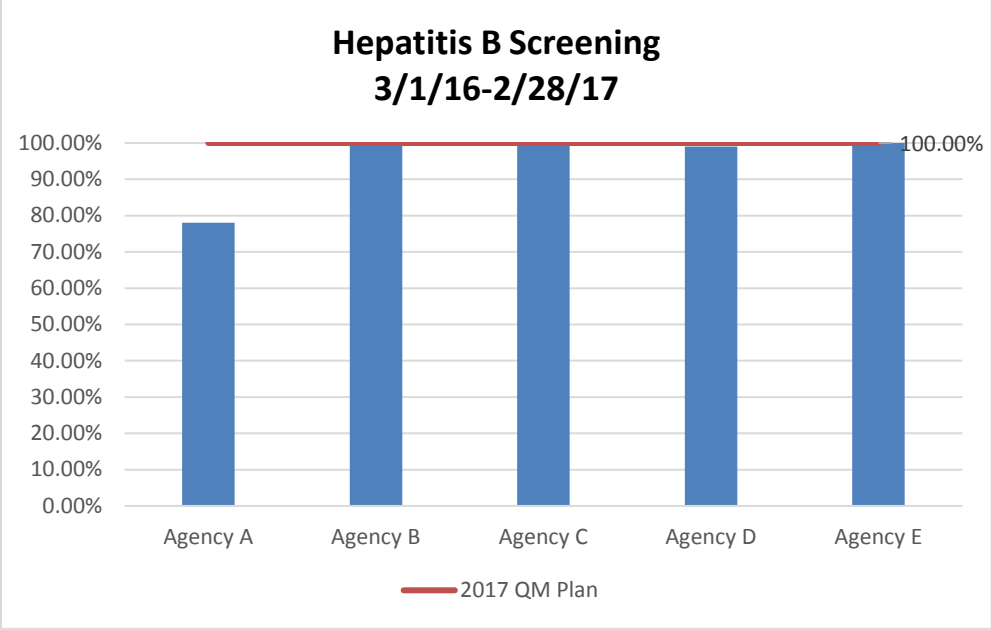
Hepatitis B Screening

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

	2014	2015	2016
Number of clients who have documented Hepatitis B infection status in the health record	627	634	610
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**98.7%**	**99.8%**	**96.1%**
Change from Previous Years Results	**1.1%**	**1.1%**	**-3.7%**

- 1.9% (12/635) were Hepatitis B positive

2016 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	286	226	88
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**98.3%**	**93%**	**96.7%**

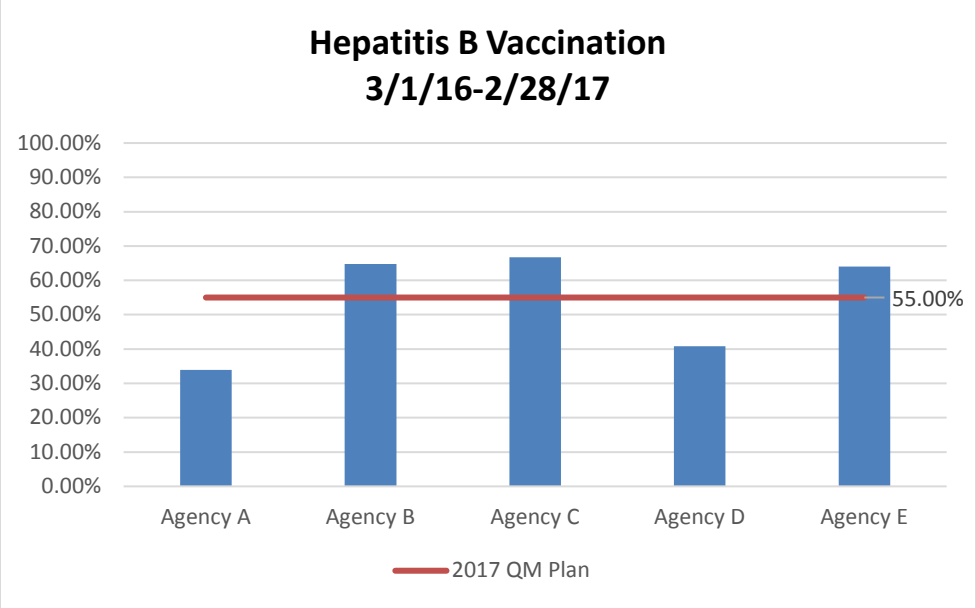


Hepatitis B Vaccination

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

	2014	2015	2016
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	179	184	179
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	322	307	322
Rate	**55.6%**	**59.9%**	**55.6%**
Change from Previous Years Results	**5.3%**	**4.3%**	**-4.3%**

2016 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	67	92	16
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	131	147	38
Rate	**51.1%**	**62.6%**	**42.1%**



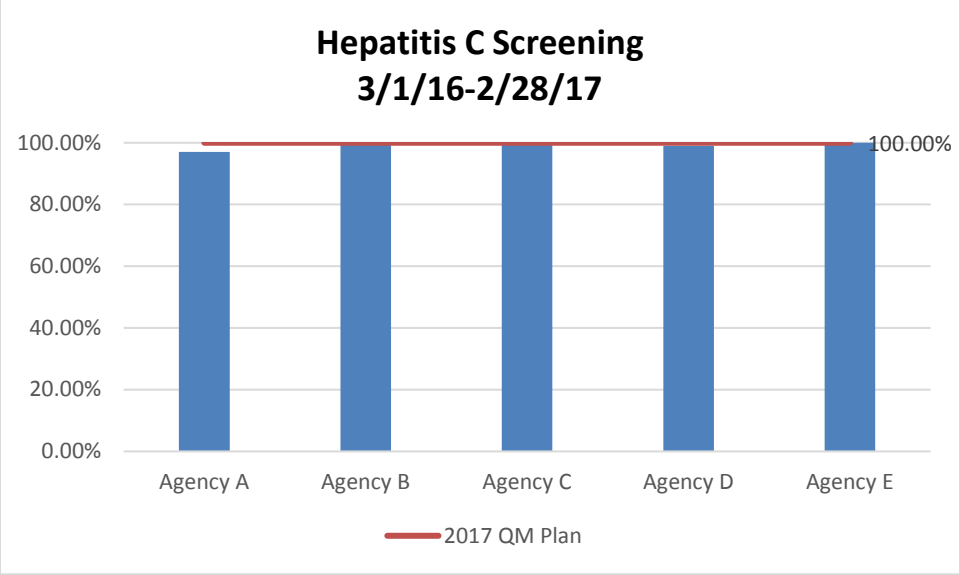
Hepatitis C Screening

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

	2014	2015	2016
Number of clients who have documented HCV status in chart	626	633	629
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**98.6%**	**99.7%**	**99.1%**
Change from Previous Years Results	**3%**	**1.1%**	**-.6%**

- 8% (51/635) were Hepatitis C positive, including 14 acute infections only and 21 cures

2016 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	287	241	91
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**98.6%**	**99.2%**	**100%**

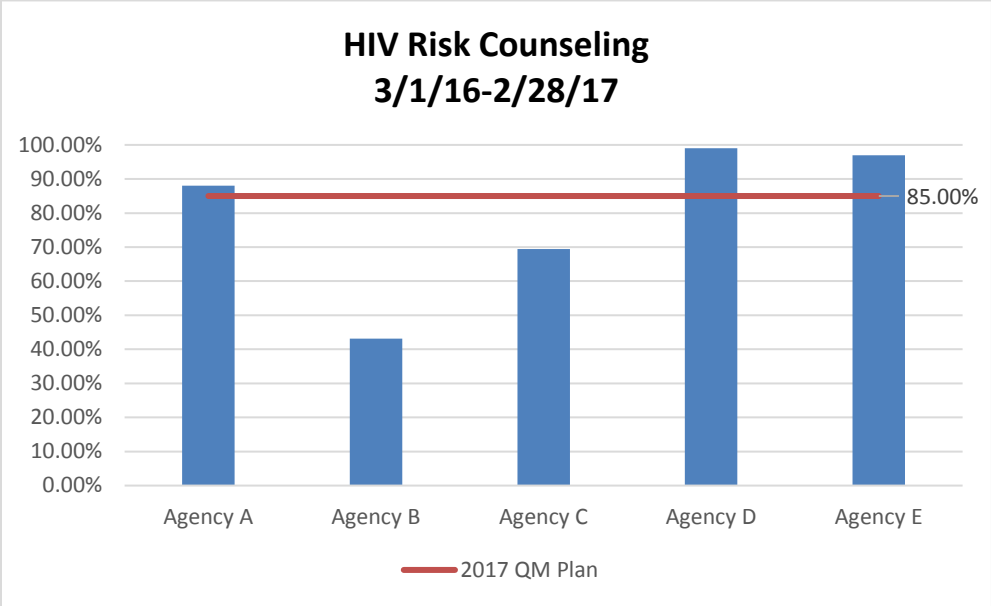


HIV Risk Counseling

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

	2014	2015	2016
Number of clients, as part of their primary care, who received HIV risk counseling	489	453	441
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**77%**	**71.3%**	**69.4%**
Change from Previous Years Results	**-5.8%**	**-5.7%**	**-1.9%**

2016 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	197	171	68
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**67.7%**	**70.4%**	**74.7%**

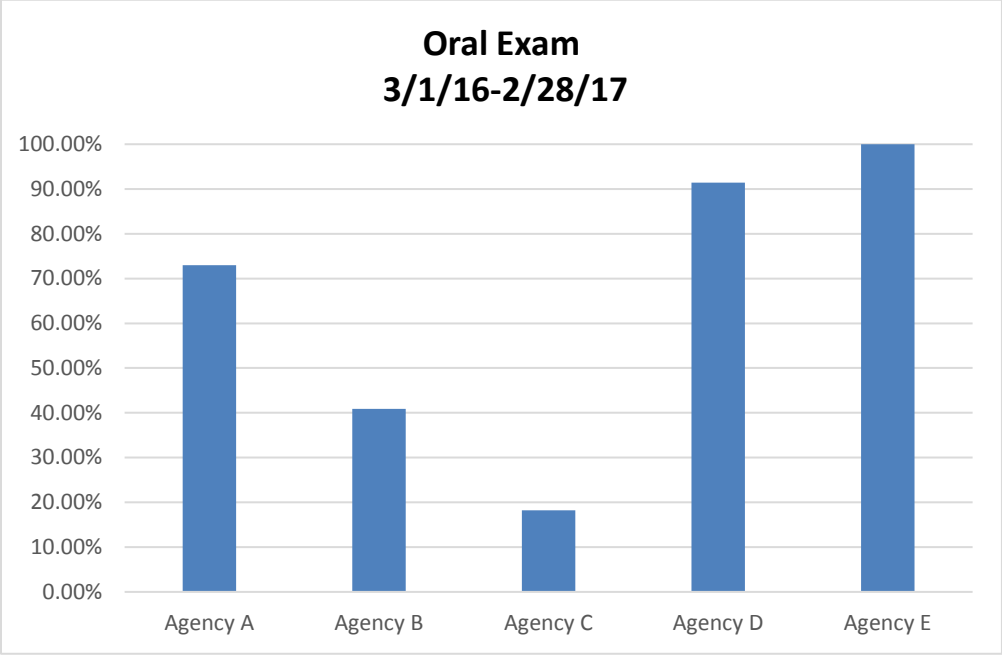


Oral Exam

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

	2014	2015	2016
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	356	340	327
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**56.1%**	**53.5%**	**51.5%**
Change from Previous Years Results	**-.8%**	**-2.6%**	**-2%**

2016 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	146	128	47
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**50.2%**	**52.7%**	**51.6%**



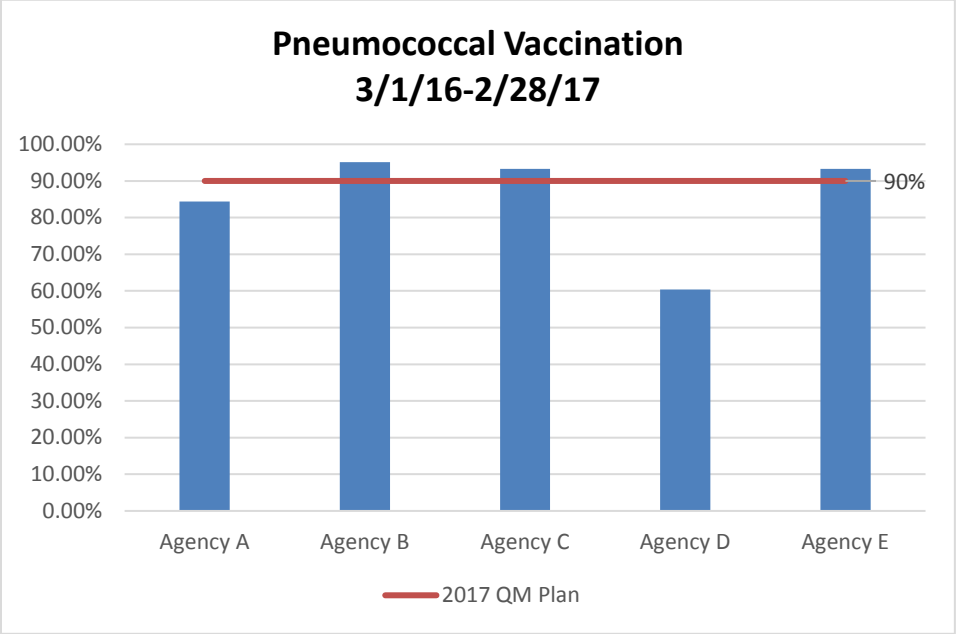
Pneumococcal Vaccination

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

	2014	2015	2016
Number of clients who received pneumococcal vaccination	556	546	534
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	623	622	616
Rate	**89.2%**	**87.8%**	**86.7%**
Change from Previous Years Results	**4.5%**	**-1.4%**	**-1.1%**

- 304 clients (49.4%) received both PPV13 and PPV23 (FY15- 43.3%,FY14- 36.9%)

2016 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	230	213	65
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	291	243	91
Rate	**79%**	**87.7%**	**71.4%**

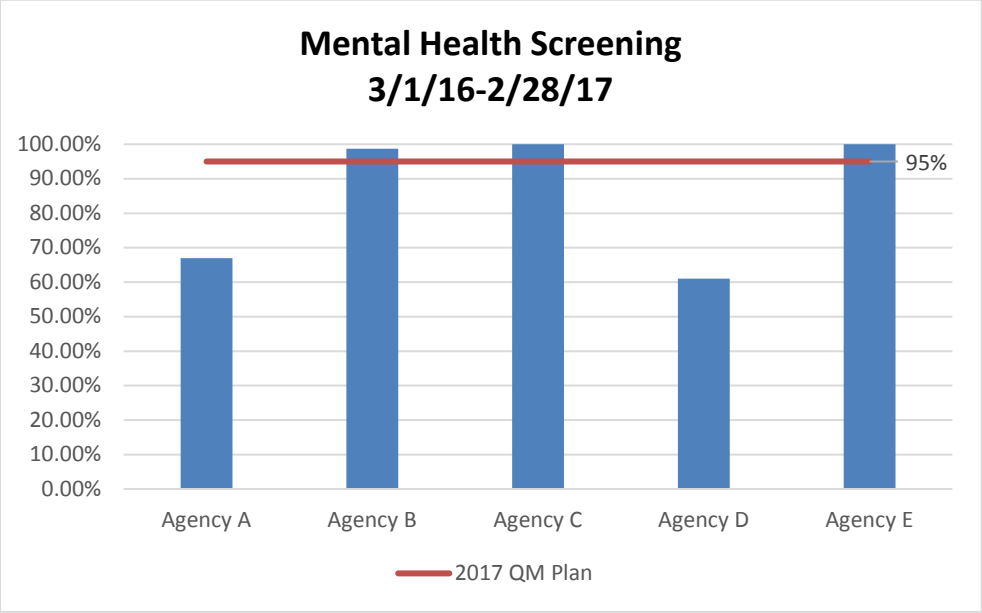


Preventative Care and Screening: Mental Health Screening

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

	2014	2015	2016
Number of clients who received a mental health screening	567	586	558
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**89.3%**	**92.3%**	**87.9%**
Change from Previous Years Results	**7.4%**	**3%**	**-4.4%**

- 28.3% (180/635) had mental health issues. Of the 69 who needed additional care, 62 (90%) were either managed by the primary care provider or referred; 4 clients refused a referral.

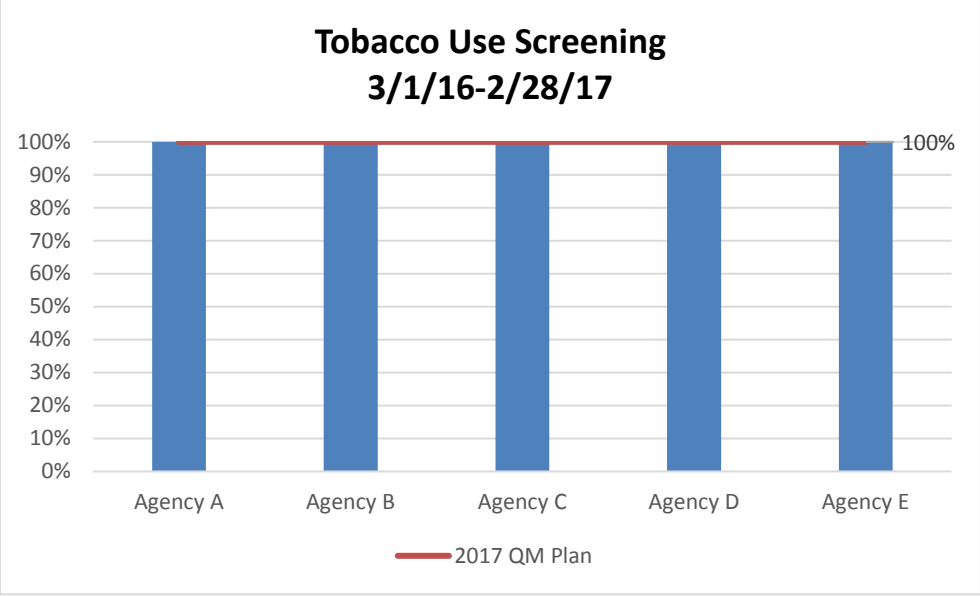


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

	2014	2015	2016
Number of clients who were screened for tobacco use in the measurement period	631	635	631
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.4%**	**100%**	**99.4%**
Change from Previous Years Results	**-.3%**	**.6%**	**-.6%**

- **HIVQUAL-US Mean 86%**
- Of the 631 clients screened, 175 (27.7%) were current smokers.
- Of the 175 current smokers, 101 (57.7%) received smoking cessation counseling, and 9 (5.1%) refused smoking cessation counseling



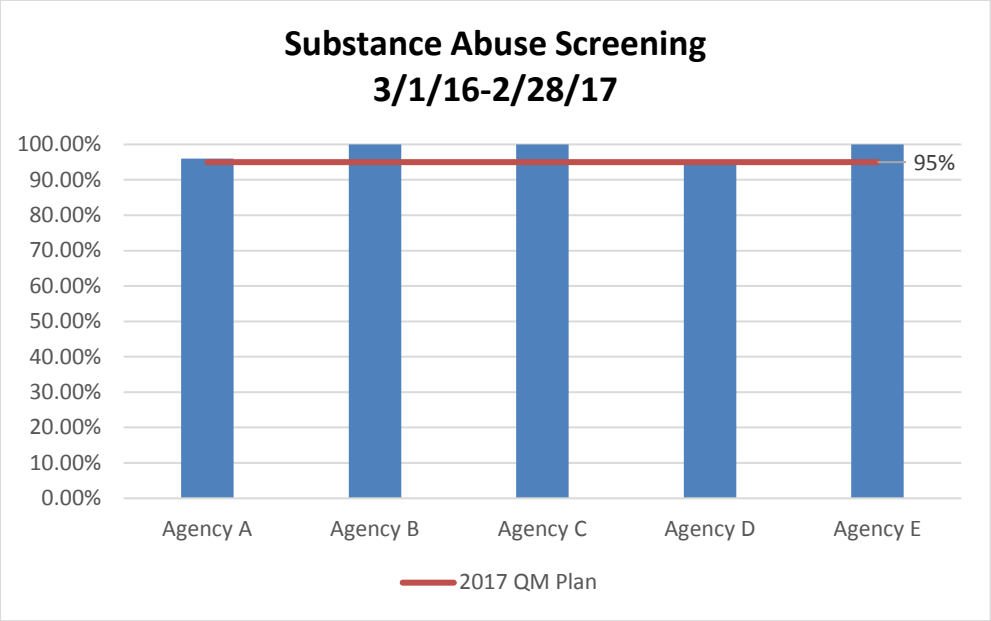
Substance Abuse Screening

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

	2014	2015	2016
Number of new clients who were screened for substance use within the measurement year	624	627	626
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.3%**	**98.7%**	**98.6%**
Change from Previous Years Results	**.7%**	**.4%**	**-.1%**

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

- 4.3% (27/635) had substance abuse issues. Of the 27 clients who needed referral, 22 (81.5%) received one, and 4 (1.5%) refused.

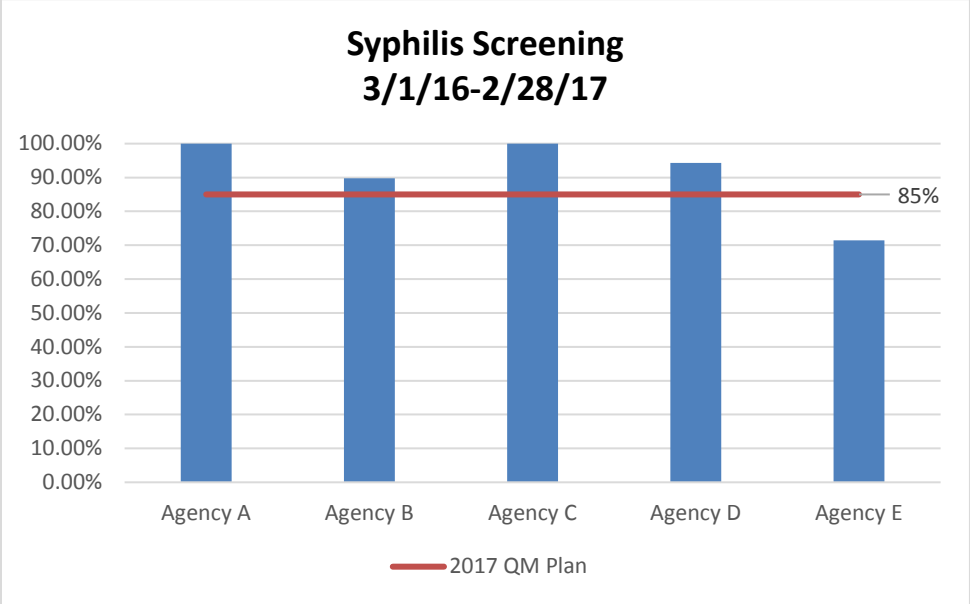


Syphilis Screening

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

	2014	2015	2016
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	594	599	597
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**93.5%**	**94.3%**	**94%**
Change from Previous Years Results	**0%**	**.8%**	**-.3%**

- 6% (38/635) new cases of syphilis diagnosed

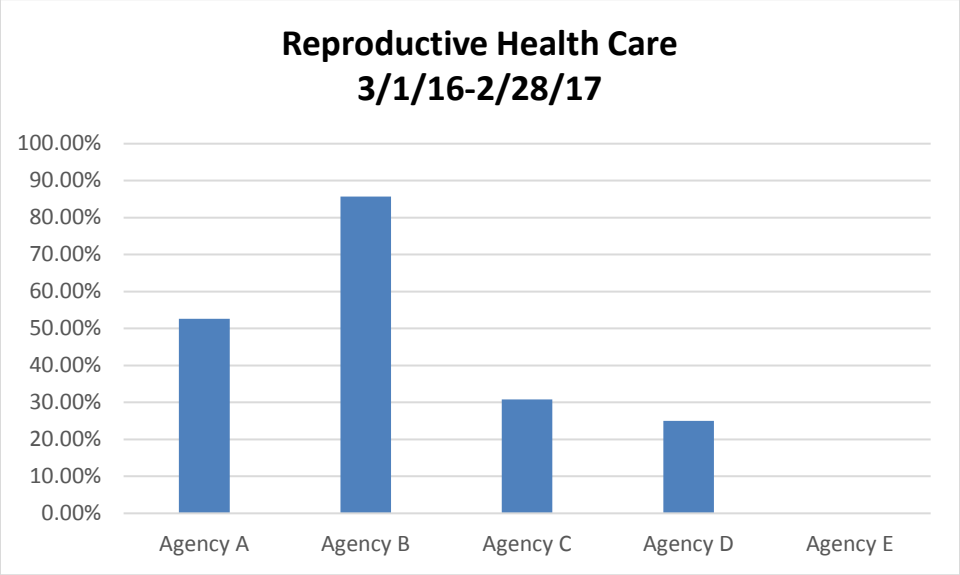


Other Measures

Reproductive Health Care

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

	2014	2015	2016
Number of reproductive-age women who received reproductive health assessment and care	30	34	34
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	73	69	63
Rate	**41.7%**	**49.3%**	**54%**
Change from Previous Years Results	**-6.1%**	**7.6%**	**4.7%**

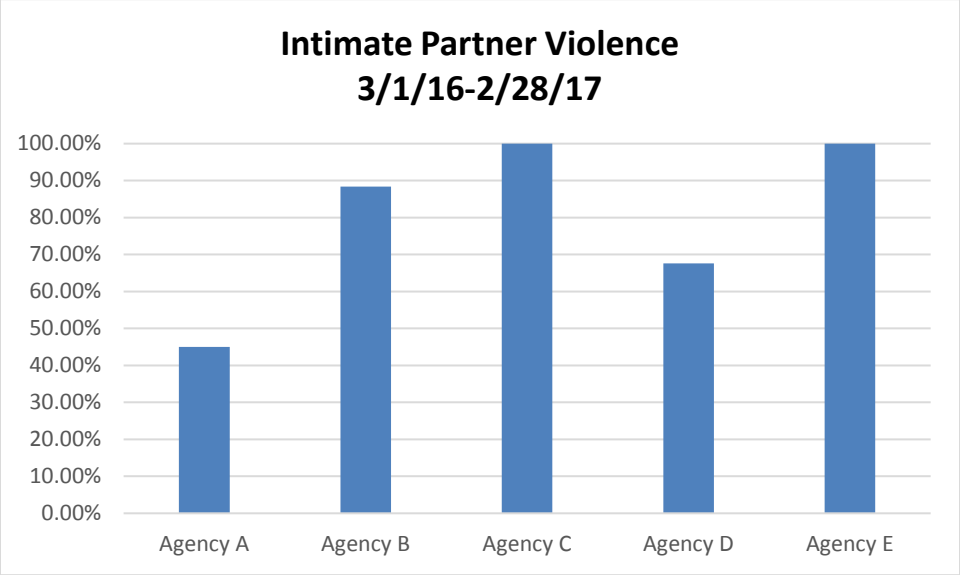


Intimate Partner Violence Screening

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

	2014	2015	2016
Number of clients who received screening for current intimate partner violence	570	569	520
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**89.8%**	**89.6%**	**81.9%**
	17%	**-.2%**	**-7.7%**

* 3/635 screened positive

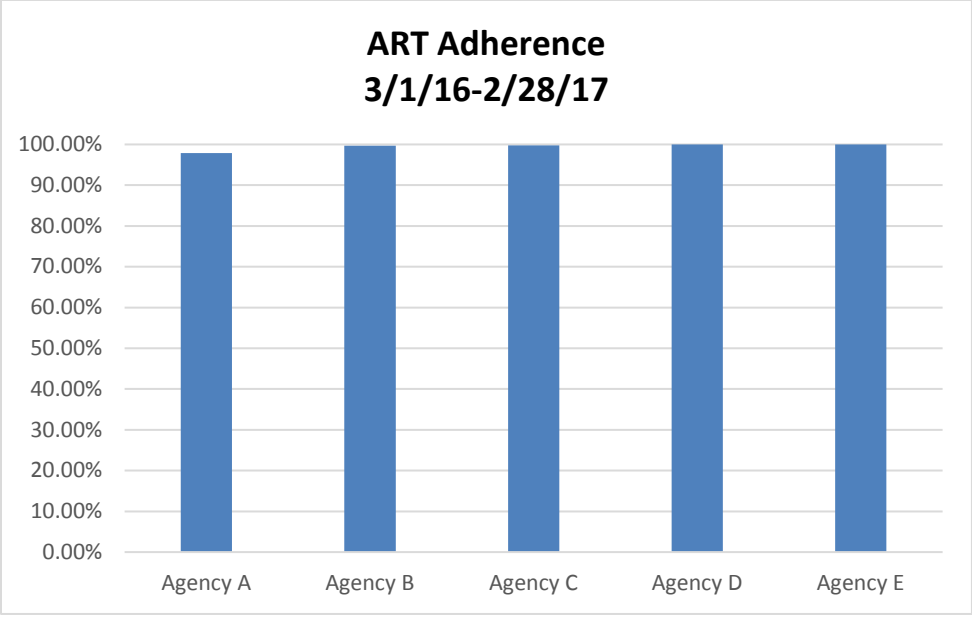


Adherence Assessment & Counseling

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

	Adherence Assessment		
	2014	2015	2016
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	599	607	617
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	605	613	620
Rate	**99%**	**99%**	**99.5%**
Change from Previous Years Results	**4.6%**	**0%**	**.5%**

Adherence Assessment Per Visit	
	2016
Number of primary care visits where ART adherence was assessed	2,016
Number of primary care visits for clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	2,041
Rate	**98.8%**



ART for Pregnant Women

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

	2014	2015	2016
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	4	5	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	4	5	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

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

	2014	2015	2016
Number of diabetic clients whose last HbA1c in the measurement year was <8%	41	27	51
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	68	47	70
Rate	**60.3%**	**57.4%**	**72.9%**
Change from Previous Years Results	**-3.9%**	**-2.9%**	**15.5%**

- 635/635 (100%) of clients where screened for diabetes and 70/635 (11%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2014	2015	2016
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	125	131	133
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	172	173	180
Rate	**72.7%**	**75.7%**	**73.9%**
Change from Previous Years Results	**4.4%**	**3%**	**-1.8%**

- 180/635 (28.3%) of clients where were diagnosed with hypertension

Primary Care: Breast Cancer Screening

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

	2014	2015	2016
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	138	140	146
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	158	168	184
Rate	**87.3%**	**83.3%**	**79.3%**
Change from Previous Years Results	**3.9%**	**-4%**	**-4%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year. There have been several positive trends over the past few years: cervical cancer screening, sexually transmitted infection screening, and ART prescription rates have continued to improve. However, there have been slight decreases in influenza vaccination, IPV screening and HIV risk counseling. RWGA will continue to monitor these measures closely and initiate quality improvement initiatives as needed. In addition, racial and ethnic disparities continue to be seen for most measures, with African-Americans having lower rates than White and Hispanic clients. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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

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

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

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

References

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2. CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. HIV surveillance supplemental report 2016; vol. 21(no. 4). Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf

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

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

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

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

INSIDE

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

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

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

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

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

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

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Summary

What is already known about this topic?

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

What is added by this report?

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

What are the implications for public health practice?

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

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

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

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

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

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

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

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

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

§ Data statistically adjusted to account for missing transmission categories.

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

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

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

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

Abbreviation: HIV = human immunodeficiency virus.

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

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

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

¶ Data statistically adjusted to account for missing transmission categories.

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

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

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

Discussion

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

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

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

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

See table footnotes on page 102.

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

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

Abbreviation: HIV = human immunodeficiency virus.

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

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

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

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

** Age at year-end 2013.

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

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

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

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

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

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

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

[1]Division of HIV/AIDS Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, CDC.

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LEARNING MORE ABOUT HIV

Trauma-Informed Care and HIV

FOR HIV EDUCATORS

Some key points about trauma, trauma-informed care, and HIV

- Trauma refers to negative events, circumstances, or experiences that are a threat to one's physical and emotional well-being and that elicit intense feelings of helplessness, terror, and lack of control[1,2]
- In one study, 91% of people with HIV reported at least 1 traumatic event in their lifetime, with 54% reporting a history of physical and/or sexual abuse[3]
- People with HIV and a history of trauma are more likely to:
  - Experience disrupted or negative interactions with medical personnel[4]
  - Engage in increased risk-taking behaviors, such as using drugs or alcohol and having sex without condoms[4]
  - Transmit HIV to others because of their increased risk-taking behaviors[5]
  - Have a poor quality of life[6]
- The adverse impact of trauma on people living with HIV can be devastating, resulting in[7,8]:
  - Poor linkage to HIV care
  - Poor retention in HIV care
  - Poor adherence to HIV treatment
  - HIV treatment failure and disease progression
- It is important that healthcare providers recognize and address the negative effects of trauma by adopting trauma-informed care practices in their interactions with clients[6]
- Better understanding of the complex association between trauma and health can help enhance the ability of healthcare providers to provide effective, compassionate, and comprehensive care for people living with HIV[6]

What is trauma-informed care?

- Trauma-informed care is a comprehensive, systematic, patient-centered approach to engaging people with histories of trauma that recognizes the symptoms of trauma and acknowledges the impact that trauma has had on their lives[2,9,10]
- Trauma-informed care:
  - Seeks to do no further harm to people with histories of trauma and to avoid retraumatizing them[11]
  - Creates opportunities for trauma survivors to rebuild a sense of control and empowerment[11]
  - Can help improve client engagement in care and health outcomes[12]

The 4 R's of trauma-informed care

Trauma-informed care[13]:

Realizes the prevalence of trauma and understands potential paths for recovery

Recognizes the signs and symptoms of trauma in clients and their families

Responds appropriately by incorporating knowledge about trauma in medical procedures and practices

Resists retraumatization by working to minimize its potential

NOTES

Talking With Healthcare Providers and Their Staff About Trauma-Informed Care and HIV

Steps for providing trauma-informed care[14]

1. Train staff about trauma, trauma-informed care, and the importance of sharing critical information.
2. Screen and assess clients for trauma.
3. Communicate sensitivity to trauma issues.
4. Create a safe and secure environment.
5. Provide services in a trauma-informed manner.

Some practical tips for implementing trauma-informed care[14]

- Engage clients, develop rapport with them, and build trust over time
- Talk about any worries or concerns your client may have (for example, disrobing) and how you can help
- Give clients as much control and choice as possible
- Validate clients' concerns as understandable
- Explain each procedure thoroughly and get client consent
- Ask clients if they are ready to begin, and tell them that they can pause or stop the procedure at any time
- Talk with your clients during procedures to let them know what you are doing and why
- Allow a support person to be present in the exam room
- Provide a calm and soothing office environment
- Give relaxed, unhurried attention
- Be personable, respectful, kind, and honest with your clients
- Encourage clients to do what feels most comfortable (for example, keeping their clothes on)
- Place a high priority on showing awareness of and respect toward the culture of your clients, including their ethnicity, race, religion, sexual orientation, and any history of social trauma, such as homelessness and poverty

NOTES

Encourage clients to talk with their healthcare provider about any past or ongoing traumas that might impact their HIV care.

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GILEAD

Trauma Informed Care for HIV+ homeless patients

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Abstract

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

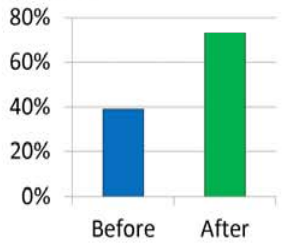
Methodology: Using data from a cohort of homeless HIV-positive patients, we examined whether Trauma-Informed-Care-based case management could improve outcomes. This ongoing, single-arm study included out-of-care HIV-infected homeless patients in Houston, TX who were enrolled in a HRSA-funded Special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

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

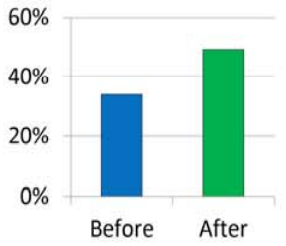
Outcomes: A total of 157 patients were enrolled.
- ✓ Engagement in care rate improved by 87% (from 39% to 73%)
- ✓ VL suppression rate improved by 44% (from 34% to 49%)
- ✓ 95% of patients needed housing assistance; 88% received it
- ✓ 87% of patients needed mental health referral; 93% received it
-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

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

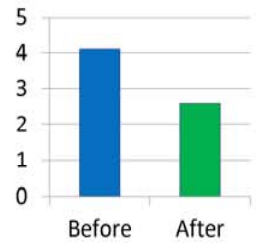
Engagement In Care



Viral Suppression

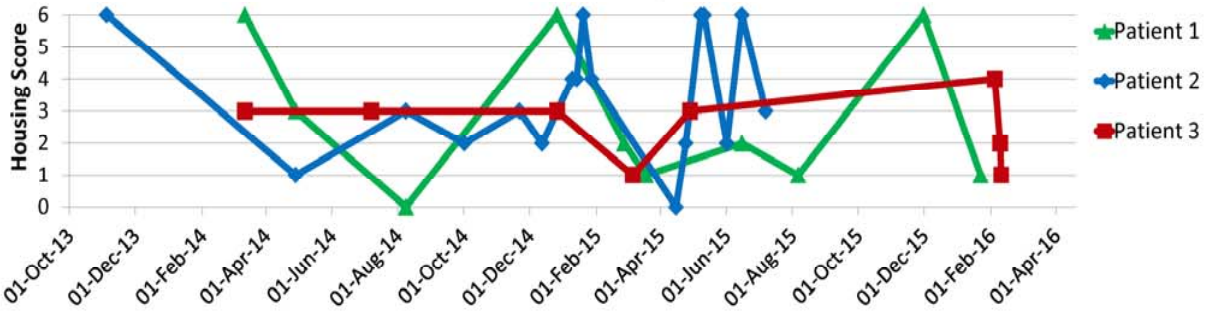


Housing Score*



* A lower housing score is better

Sample Housing Score Fluctuations



Demographics of enrolled patients

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

Services provided to enrolled patients

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

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

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