FY 2015 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:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
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 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None, 300% non-HIV, 500% HIV meds)
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:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
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 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None, 300% non-HIV, 500% HIV meds)
1.	
2.	
3.	

FY 2015 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 2015 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 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 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None, 300% non-HIV, 500% HIV meds)
1.	
2.	
3.	

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 Current Fiscal Year 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 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None)
1.	
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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 *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 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 500%
1.	
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3.	

Houston EMA/HSDA Ryan White Part A Service Definition **Outreach Services – Primary Care Re-Engagement** Revised June 2017	
HRSA Service Category Title: **RWGA Only**	Outreach Services
Local Service Category Title:	Outreach Services – Primary Care Re-Engagement
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
HRSA Service Category Definition: **RWGA Only**	*Outreach Services* include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Local Service Category Definition:	Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.
Services to be Provided:	Outreach service is field based. Outreach workers are expected to coordinate activities with PLWHA, including locations outside of primary care clinic in order to develop rapport with individuals and

	ensuring intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Outreach patients are those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria. Contractor must document efforts to re-engage Primary Care Re-Engagement Outreach patients prior to closing patients in the CPCDMS.
Service Unit Definition(s): **RWGA Only**	15 Minutes = 1 Unit
Financial Eligibility:	Refer to the RWPC's approved *Current Fiscal Year Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Outreach Services must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1.	
2.	
3.	

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FY 2017 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 2017 Performance Measures

Measures in this report are based on the 2017 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

Local Pharmacy Assistance

- Among LPAP clients with viral load tests, 2,913 (72%) clients were virally suppressed during this time period.

Medical Case Management

- During FY 2017, 5,189 clients utilized Part A medical case management. According to CPCDMS, 2,626 (51%) 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, 699 (14%) clients accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 1,764 (34%) clients had third-party payer coverage after accessing medical case management.

Primary Medical Care

- During FY 2017, 7,512 clients utilized Part A primary medical care. According to CPCDMS, 4,231 (73%) 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, 291 (22%) had an AIDS diagnosis (CD4 < 200) within the first 90 days of initial enrollment in primary medical care.
- Among these clients, 82% had a viral load test performed at least every six months during this time period.
- Among clients with viral load tests, 71% were virally suppressed during this time period.
- During FY 2017, the average wait time for an initial appointment availability to enroll in primary medical care was 13 days, while the average wait time for an appointment availability to receive primary medical care was 12 days.

Non-Medical Case Management / Service Linkage

- During FY 2017, 7,084 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,259 (46%) 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, 372 (43%) clients utilized primary medical care for the first time after accessing service linkage for the first time.
- Among these clients, the median number of days between the first service linkage visit and the first primary medical care visit was 18 days during this time period.

Vision Care

- During FY 2017, 1,584 clients were diagnosed with HIV/AIDS related and general ocular disorders. Among 636 clients with follow-up appointments, 590 (93%) clients had disorders that were either resolved, improved or had remained the same.

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2016	FY 2017	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,839 (72.6%)	2,913 (72.3%)	**-0.3%**

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Medical Case Management
All Providers

For FY 2017 (3/1/2017 to 2/28/2018), 5,189 clients utilized Part A medical case management.

HIV Performance Measures	FY 2016	FY 2017	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	2,553 (50.3%)	2,626 (50.6%)	**0.3%**
Percentage of medical case management clients who utilized mental health services	616 (12.1%)	699 (13.5%)	**1.4%**
Increase in the percentage of clients who have third-party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	1,909 (37.6%)	1,764 (34.0%)	**-3.6%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,032 (67.7%)	2,004 (67.5%)	**-0.2**
Percentage of clients 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	770 (40.3%)		
Percentage of clients who did not have a medical visit in the last six months of the measurement year	591 (23.9%)	660 (25.5%)	**1.6%**
Percentage of clients who were homeless or unstably housed	1,190 (23.5%)	1,001 (19.3%)	**-4.2%**

According to CPCDMS, 112 (2.2%) clients utilized primary care for the first time and 257 (5.0%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	FY 2016
*60% of medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	41%

*For FY 2017, due to limited data, combined clinical/medical case management plans were evaluated.

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Primary Medical Care
All Providers

For FY 2017 (3/1/2017 to 2/28/2018), 7,512 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2016	FY 2017	Change
90% of clients will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,205 (75.3%)	4,231 (73.2%)	**-2.1%**
Less than 20% of clients who have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care	266 (17.9%)	291 (22.2%)	**4.3%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD4 cell counts or percentages performed during the measurement year at least three months apart	3,782 (67.7%)	4,010 (69.4%)	**1.7%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,486 (74.2%)	5,694 (75.8%)	**1.6%**
Percentage of clients who received an oral exam by a dentist at least once during the measurement year	1,837 (24.8%)	1,813 (24.1%)	**-0.7%**
85% of clients will have a test for syphilis performed within the measurement year	5,960 (80.7%)	5,902 (78.7%)	**-2.0%**
95% of clients will be screened for Hepatitis B virus infection status (ever)	5,846 (79.1%)	6,219 (82.8%)	**3.7%**
90% of clients will have a viral load test performed at least every six months during the measurement year	3,584 (79.7%)	3,695 (81.7%)	**2.0%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	7,189 (71.3%)	7,317 (71.4%)	**0.1%**
Percentage of clients 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	2,248 (23%)		
Percentage of clients who did not have a medical visit in the last six months of the measurement year	1,542 (27.6%)	1,716 (29.7%)	**2.1%**
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**		

For FY 2017, 60% 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 = 13 Days

Agency 1: 18
Agency 2: 13
Agency 3: 19
Agency 4: 4
Agency 5: 9

For FY 2017, 60% 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 = 12 Days

Agency 1: N/A
Agency 2: 10
Agency 3: 27
Agency 4: 4
Agency 5: 7

Clinical Chart Review Measures*	FY 2015	FY 2016
100% of clients will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	93.0%	100%
100% of pregnant women will be prescribed antiretroviral therapy	100%	100%
75% of female clients will receive cervical cancer screening in the last three years	68.2%	80.1%
55% of clients will complete the vaccination series for Hepatitis B	59.9%	55.6%
85% of clients will receive HIV risk counseling within the measurement year	71.3%	69.4%
95% of clients will be screened for substance abuse (alcohol and drugs) in the measurement year	98.7%	98.6%
90% of clients who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	88.4%	88.9%
65% of clients at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	69.6%	72.9%
75% of clients 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	67.1%	66.9%
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	56.3%	53.1%
95% of clients will be screened for clinical depression using a standardized tool with follow-up plan documented	92.3%	87.9%
90% of clients will have ever received pneumococcal vaccine	87.8%	86.7%
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	100%	99.4%
95% of clients will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	96.5%	98.6%
85% of clients will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	70.0%	69.2%

* To view the full FY 2016 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Non-Medical Case Management / Service Linkage
All Providers

For FY 2017 (3/1/2017 to 2/28/2018), 7,084 clients utilized Part A non-medical case management.

HIV Performance Measures	FY 2016	FY 2017	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)	3,072 (45.0%)	3,259 (46.0%)	**1.0%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage for the first time	508 (52.5%)	372 (42.9%)	**-9.6%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	36	35	**-2.8%**
Median	21	18	**-14.3%**
Mode	14	1	**-92.9%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	132 (46.3%)	119 (43.1%)	**-3.2%**

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Executive Director

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Building a Healthy Community

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Primary Care Chart Review Report FY 2017

Ryan White Part A Quality Management Program – Houston EMA

October 2018

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

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2017, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to five organizations. Approximately 12,000 unduplicated individuals living with HIV receive Ryan White-funded services at these organizations.

Harris County Public Health (HCPH) must ensure the quality and cost effectiveness of primary medical care. The medical services chart review is performed to ensure that the medical care provided adheres to current evidence-based guidelines and standards of care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

Introduction

On March 26, 2017, 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 people 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 3/1/17 and 2/28/18. 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* 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, 2017* 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. For some data elements, the reviewer looked for documentation that the requisite test/assessment/vaccination was performed, e.g., lipid screening or pneumococcal vaccination. Other data elements required that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was a colposcopy performed? 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 evaluate 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?

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	Viral Load Assays are recommended every 3-6 months. Clients on ART should have a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually for clients at risk
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	Screening is recommended at least once since HIV diagnosis, either PPD, IGRA or chest X-ray.
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the previous three years
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV Risk Counseling	Clients are screened for behaviors associated with HIV transmission and risk reduction discussed
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 7,423 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/17 and 2/28/18. The medical charts of 635 clients were used in this review, representing 8.6% 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 44.6% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes for each site. The demographic

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/17-2/28/18

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	310	48.8%	5,513	74%
Female	283	44.6%	1,821	24.5%
Transgender Male to Female	42	6.6%	112	1.5%
Transgender Female to Male	0	0%	0	0%
TOTAL	**635**		**7,446**	
Race				
Asian	8	1.3%	99	1.3%
African-Amer.	310	48.8%	3,737	50.2%
Pacific Islander	0	0%	4	.1%
Multi-Race	5	.8%	56	.7%
Native Amer.	2	.3%	30	.4%
White	310	48.8%	3,520	47.3%
TOTAL	**635**		**7,446**	
Hispanic				
Non-Hispanic	376	59.2%	4,775	64.1%
Hispanic	259	40.8%	2,671	35.9%
TOTAL	**635**		**7,446**	
Age				
<=24	23	3.6%	455	5.4%
25-34	164	25.8%	2,199	29.3%
35-44	176	27.7%	2,093	28%
45-49	97	15.3%	955	12.8%
50-64	169	26.6%	1,661	22.3%
65 and older	6	.9%	83	1.1%
Total	**635**		**7,446**	

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 two preceding years are provided, as well as comparison to EMA goals. Performance measures are also depicted with results categorized by race/ethnicity.

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

Findings

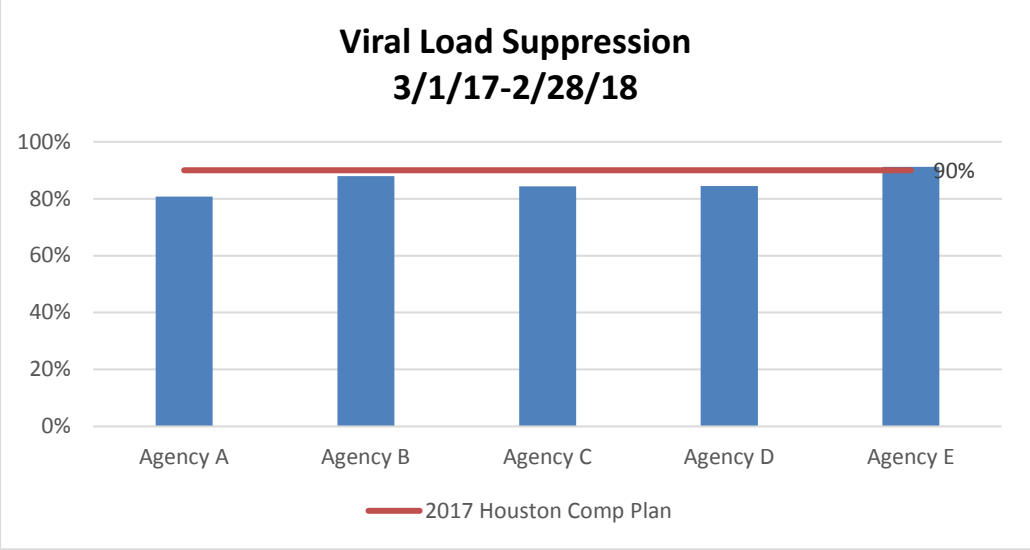
Core Performance Measures

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

	2015	2016	2017
Number of clients with viral load below limits of quantification at last test during the measurement year	519	544	535
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	601	615	626
Rate	**86.4%**	**88.5%**	**85.5%**
	-5.6%	**2.1%**	**-3%**

2017 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	236	225	62
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	283	257	73
Rate	**83.4%**	**87.5%**	**84.9%**



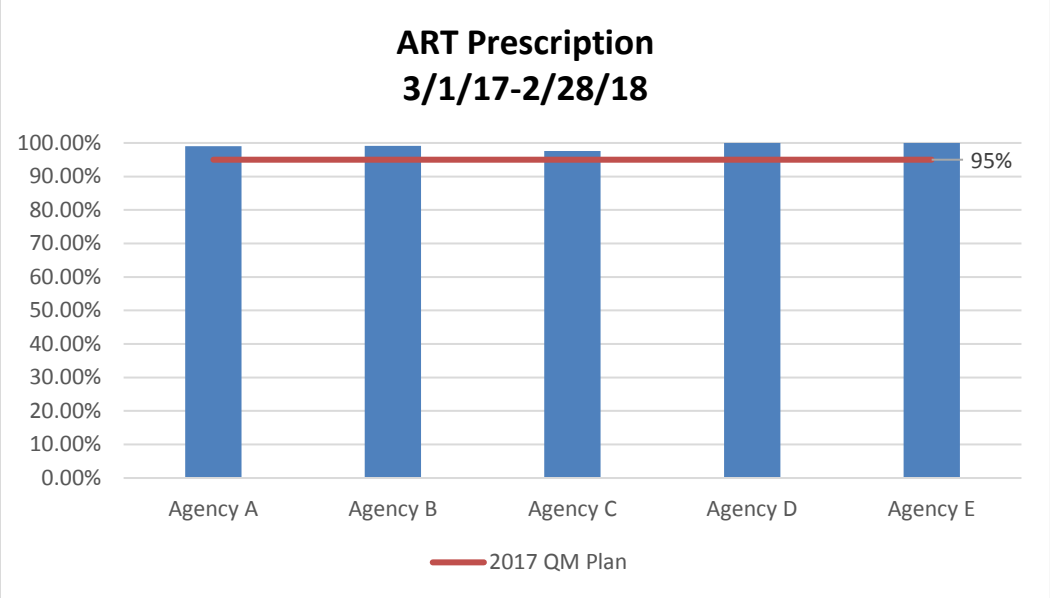
ART Prescription

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

	2015	2016	2017
Number of clients who were prescribed an ART regimen within the measurement year	613	620	627
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	**96.5%**	**97.6%**	**98.7%**
Change from Previous Years Results	**1.2%**	**1.1%**	**1.1%**

- Of the 8 clients not on ART, none had a CD4 <200, 5 were long-term non-progressors, and 3 refused

2017 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	284	257	73
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	290	259	73
Rate	**97.9%**	**99.2%**	**100%**

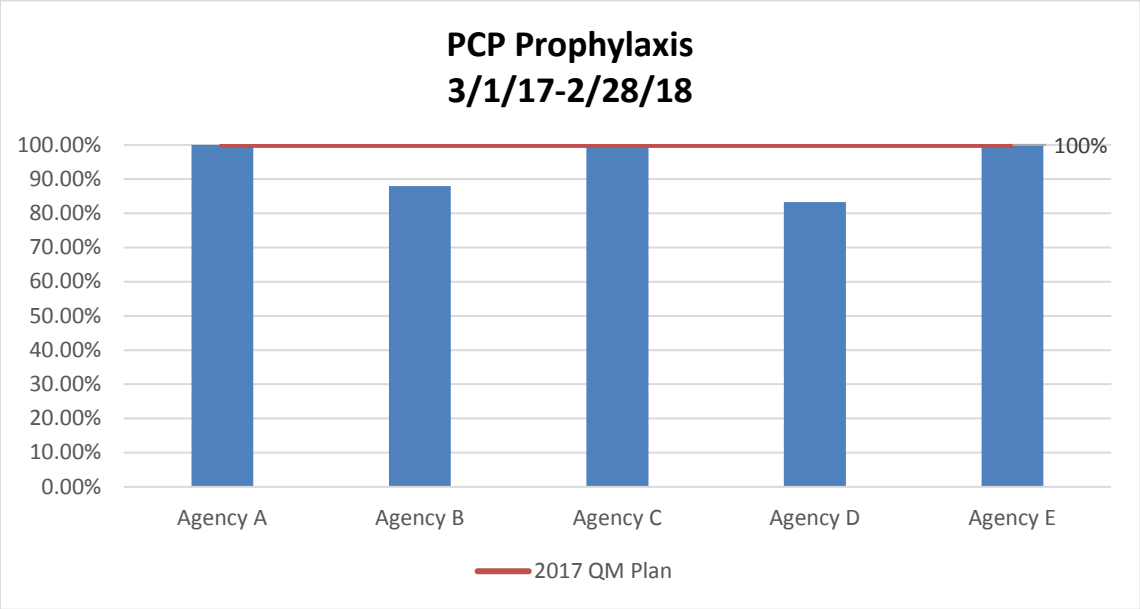


PCP Prophylaxis

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

	2015	2016	2017
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	53	48	53
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	57	48	57
Rate	**93%**	**100%**	**93%**
Change from Previous Years Results	**-7%**	**7%**	**-7%**

2017 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	22	25	5
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	25	25	6
Rate	**88%**	**100%**	**83.3%**



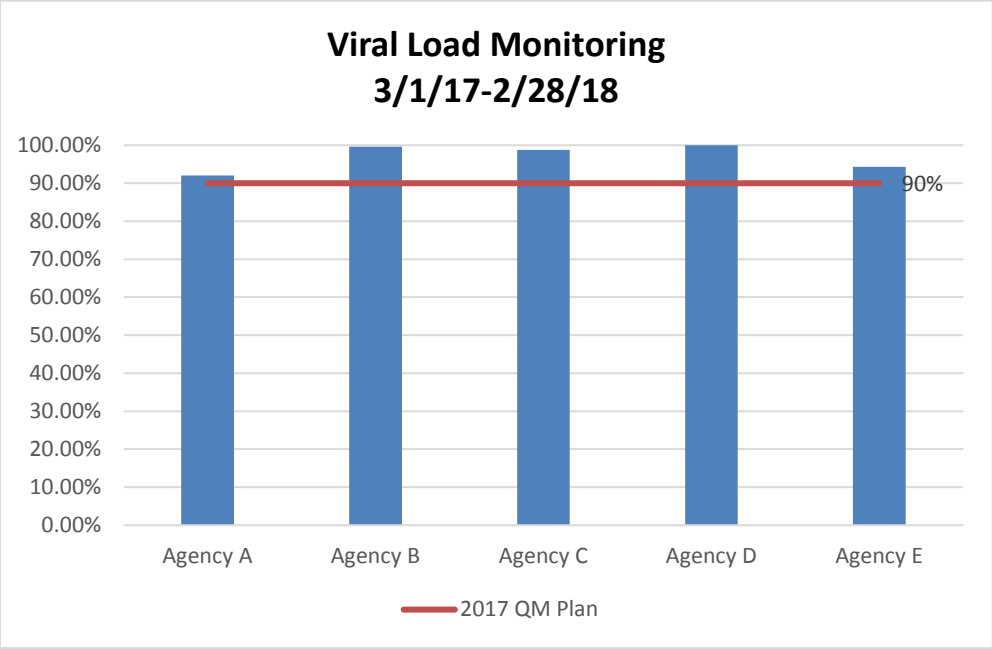
All Ages Performance Measures

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

	2015	2016	2017
Number of clients who had a viral load test performed at least every six months during the measurement year	590	601	622
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	**92.9%**	**94.6%**	**98%**
Change from Previous Years Results	**1.4%**	**1.7%**	**3.4%**

2017 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	285	254	70
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	290	259	73
Rate	**98.3%**	**98.1%**	**95.9%**



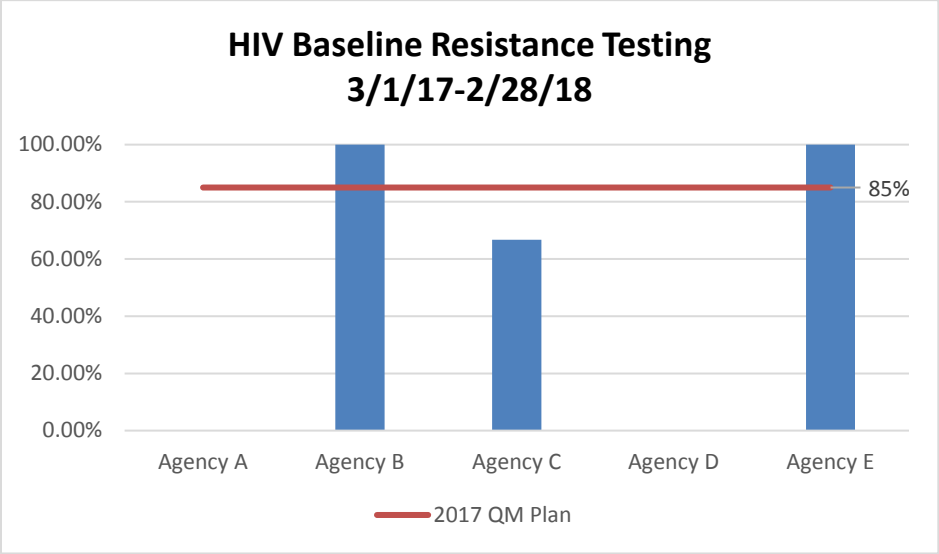
HIV Drug Resistance Testing Before Initiation of Therapy

- 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

	2015	2016	2017
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	7	9	5
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	10	13	7
Rate	**70%**	**69.2%**	**71.4%**
Change from Previous Years Results	**-15%**	**-.8%**	**2.2%**

2017 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	1	1	2
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	2	2	2
Rate	**50%**	**50%**	**100%**

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



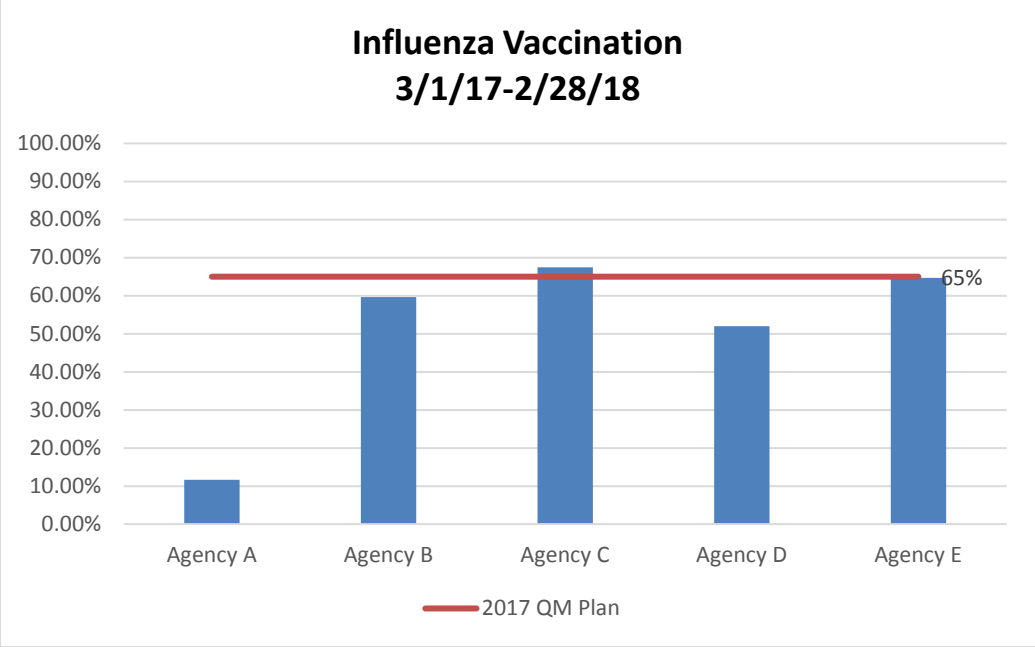
Influenza Vaccination

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

	2015	2016	2017
Number of clients who received influenza vaccination within the measurement year	326	312	310
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	579	588	579
Rate	**56.3%**	**53.1%**	**53.5%**
Change from Previous Years Results	**-10.3%**	**-3.2%**	**.4%**

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

2017 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	129	144	30
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	257	249	62
Rate	**50.2%**	**57.8%**	**48.4%**

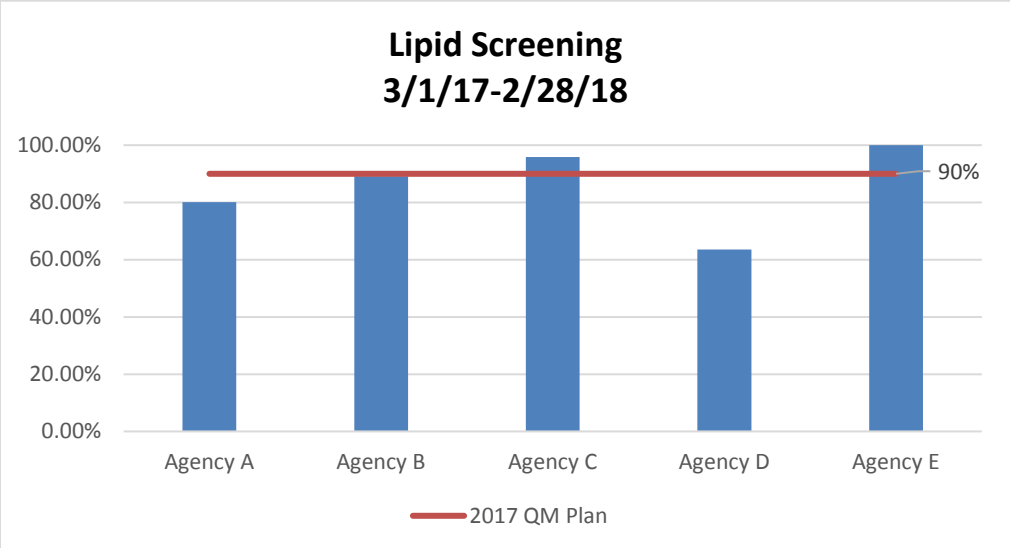


Lipid Screening

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

	2015	2016	2017
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	542	551	557
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	613	620	627
Rate	**88.4%**	**88.9%**	**88.8%**
Change from Previous Years Results	**-4.7%**	**.5%**	**-.1%**

2017 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	247	235	65
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	284	257	73
Rate	**87%**	**91.4%**	**89%**

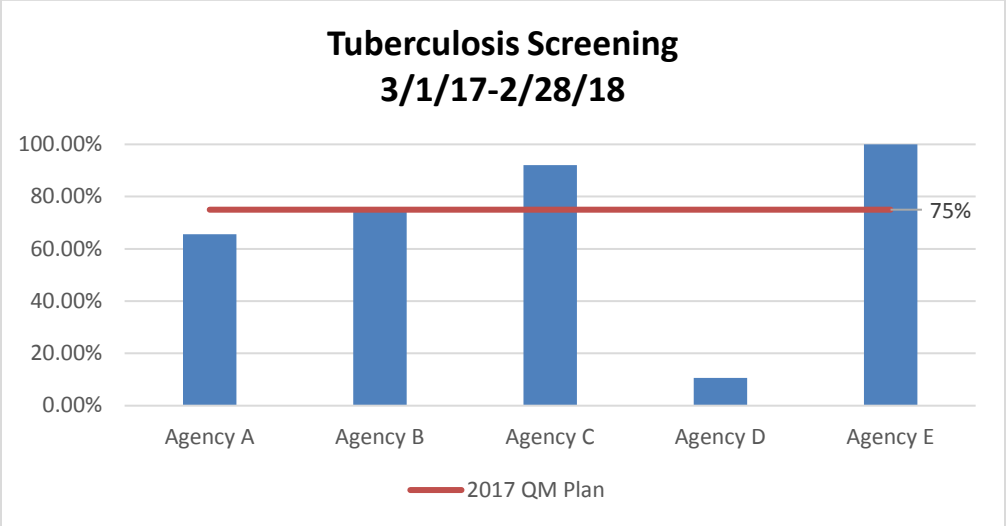


Tuberculosis Screening

- 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

	2015	2016	2017
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	376	382	375
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.	560	571	558
Rate	**67.1%**	**66.9%**	**67.2%**
Change from Previous Years Results	**-4%**	**-.2%**	**.3%**

2017 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	165	154	50
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.	247	228	72
Rate	**66.8%**	**67.5%**	**69.4%**



Adolescent/Adult Performance Measures

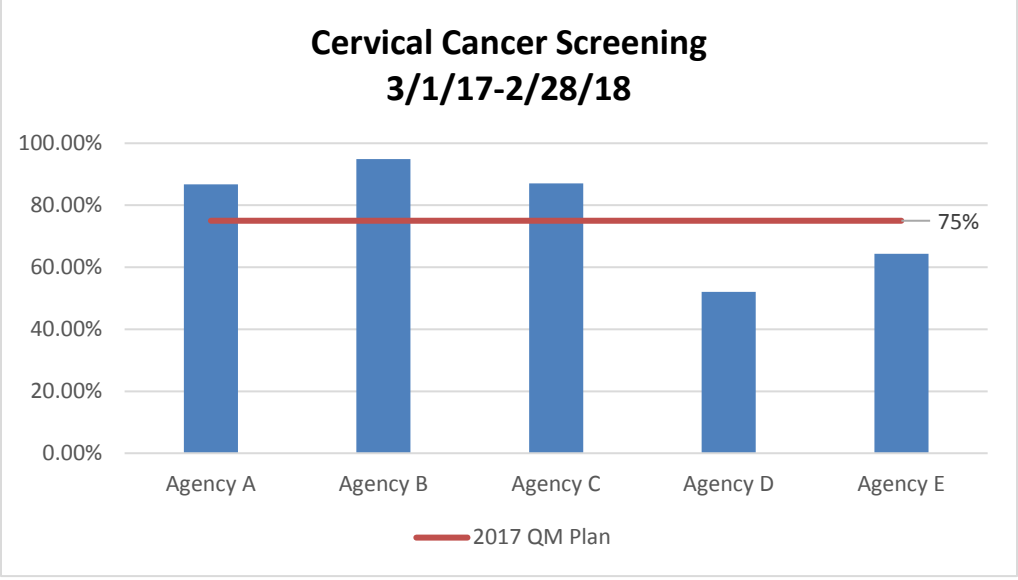
Cervical Cancer Screening

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

	2015	2016	2017
Number of female clients who had Pap screen results documented in the previous three years	197	229	226
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*	289	286	274
Rate	**68.2%**	**80.1%**	**82.5%**
Change from Previous Years Results	**5.3%**	**11.9%**	**2.4%**

- 17.7% (40/226) of pap smears were abnormal

2017 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	103	108	13
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	127	126	18
Rate	**81.1%**	**85.7%**	**72.2%**



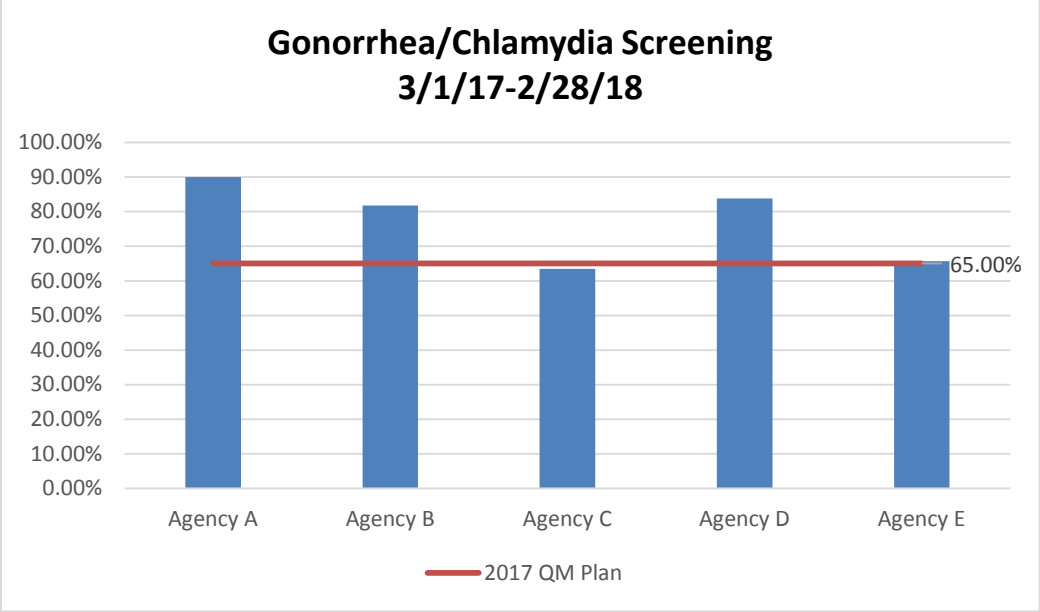
Gonorrhea/Chlamydia Screening

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

	2015	2016	2017
Number of clients who had a test for Gonorrhea/Chlamydia	442	463	493
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	**69.6%**	**72.9%**	**77.6%**
Change from Previous Years Results	**2.4%**	**3.3%**	**4.7%**

- 17 cases of chlamydia and 15 cases of gonorrhea were identified

2017 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	232	200	54
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**80%**	**77.2%**	**74%**



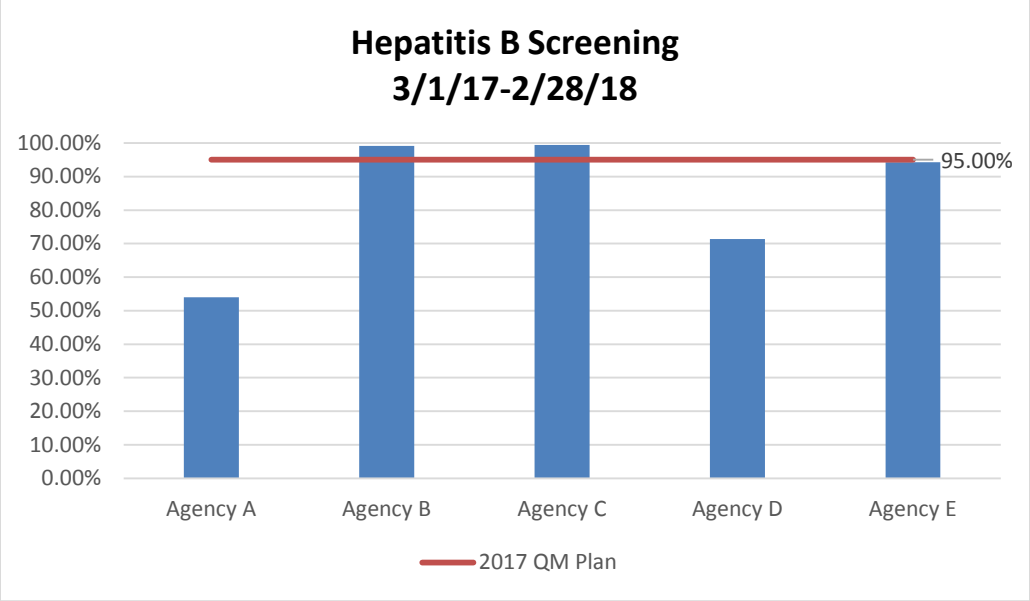
Hepatitis B Screening

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

	2015	2016	2017
Number of clients who have documented Hepatitis B infection status in the health record	634	610	553
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	**99.8%**	**96.1%**	**87.1%**
Change from Previous Years Results	**1.1%**	**-3.7%**	**-9%**

- 2% (13/635) were Hepatitis B positive

2017 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	255	224	63
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**87.9%**	**86.5%**	**86.3%**

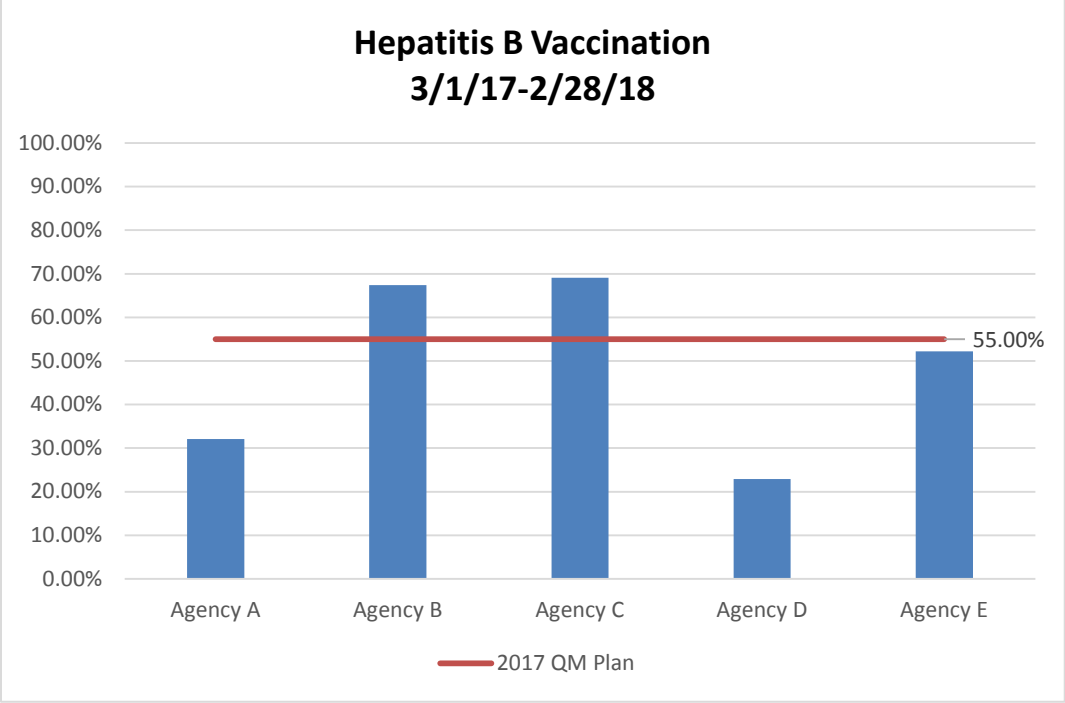


Hepatitis B Vaccination

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

	2015	2016	2017
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	184	179	196
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	307	322	381
Rate	**59.9%**	**55.6%**	**51.4%**
Change from Previous Years Results	**4.3%**	**-4.3%**	**-4.2%**

2017 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	69	107	18
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	153	184	38
Rate	**45.1%**	**58.2%**	**47.4%**



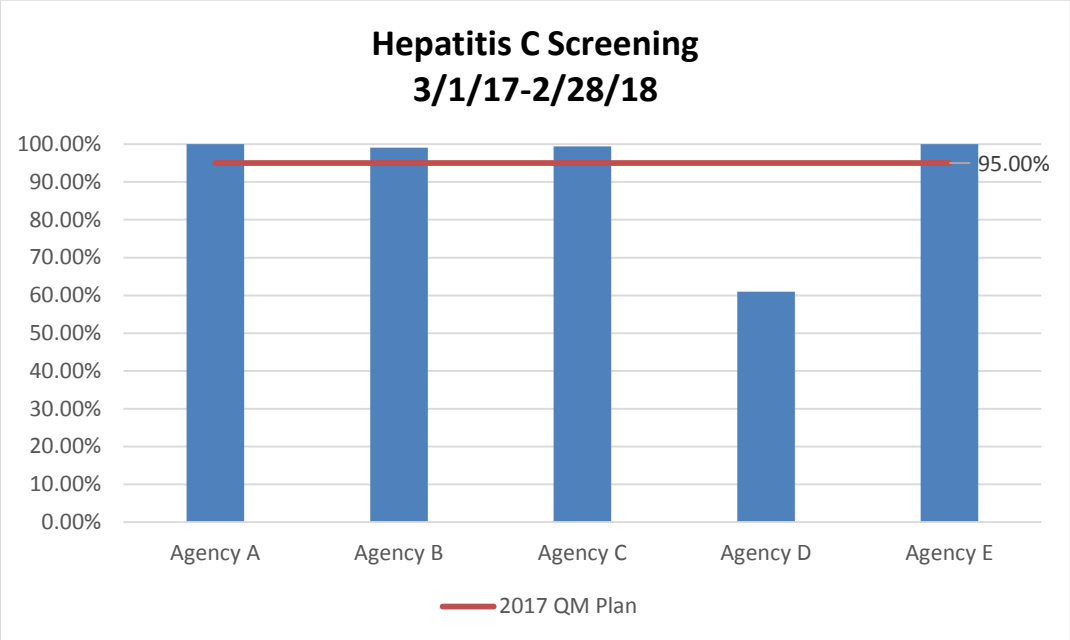
Hepatitis C Screening

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

	2015	2016	2017
Number of clients who have documented HCV status in chart	633	629	589
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	**99.7%**	**99.1%**	**92.8%**
Change from Previous Years Results	**1.1%**	**-.6%**	**-6.3%**

- 8% (52/635) were Hepatitis C positive, including 14 acute infections only and 21 cures

2017 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	266	244	69
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**91.7%**	**94.2%**	**94.5%**

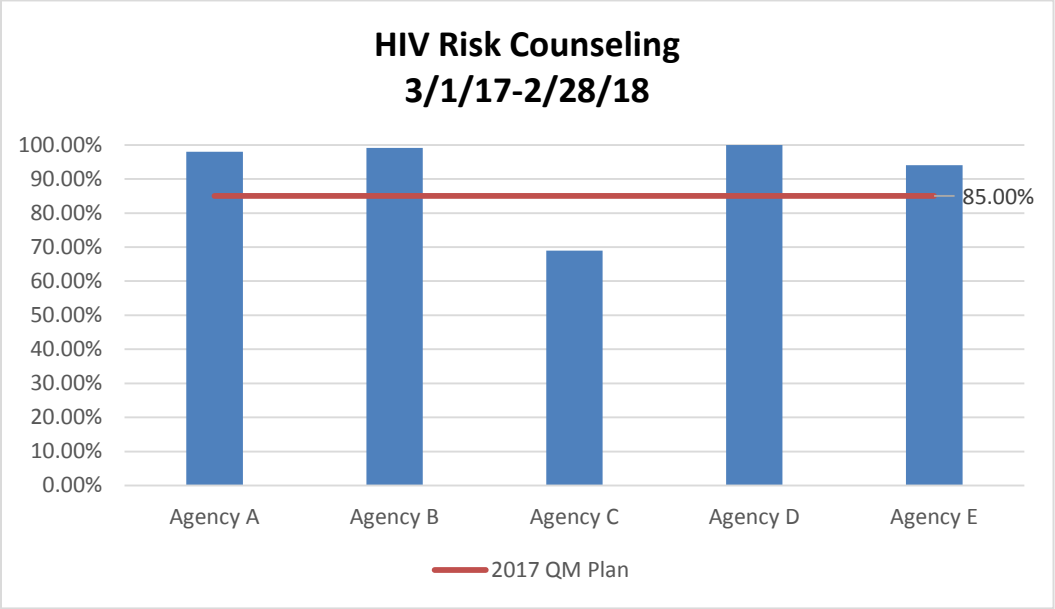


HIV Risk Counseling

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

	2015	2016	2017
Number of clients, as part of their primary care, who received HIV risk counseling	453	441	576
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	**71.3%**	**69.4%**	**90.7%**
Change from Previous Years Results	**-5.7%**	**-1.9%**	**21.3%**

2017 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	265	233	67
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**91.4%**	**90%**	**91.8%**

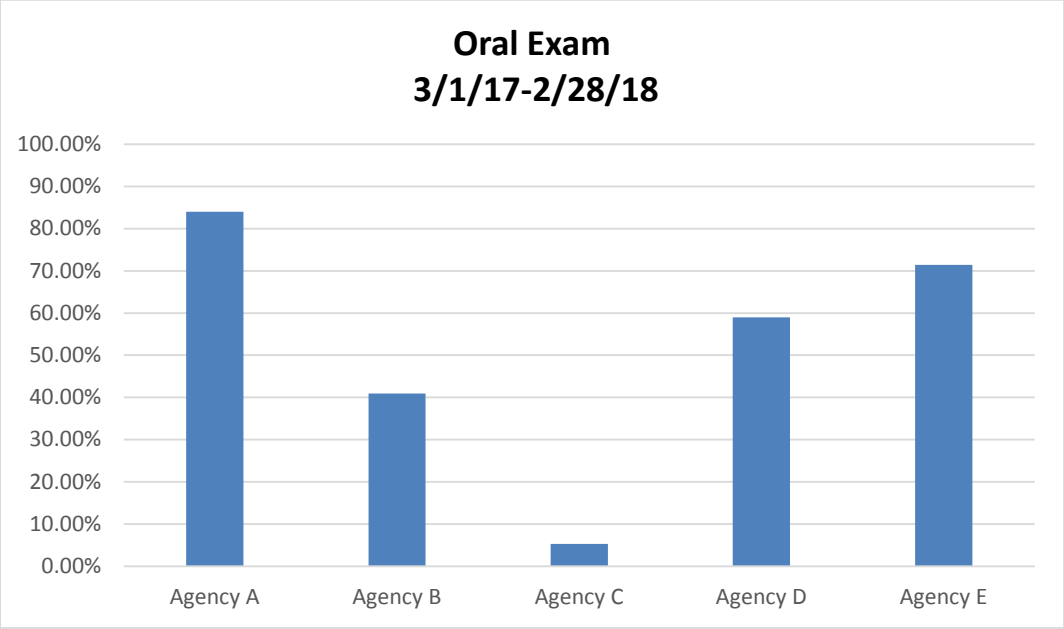


Oral Exam

- 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

	2015	2016	2017
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	340	327	272
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	**53.5%**	**51.5%**	**42.8%**
Change from Previous Years Results	**-2.6%**	**-2%**	**-8.7%**

2017 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	113	114	39
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**39%**	**44%**	**53.4%**



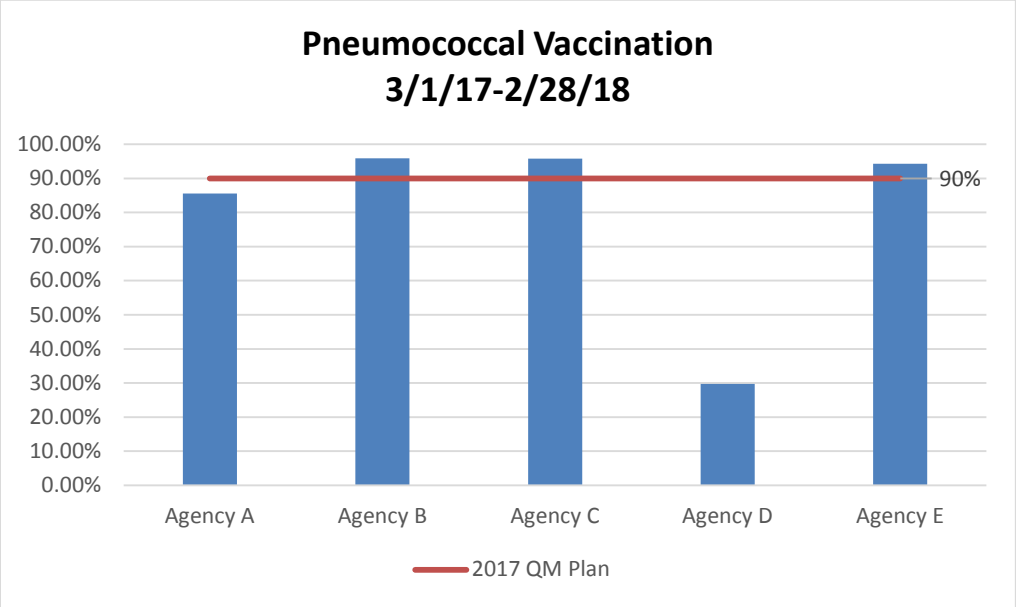
Pneumococcal Vaccination

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

	2015	2016	2017
Number of clients who received pneumococcal vaccination	546	534	514
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	622	616	616
Rate	**87.8%**	**86.7%**	**83.4%**
Change from Previous Years Results	**-1.4%**	**-1.1%**	**-3.3%**

- 311 clients (60.5%) received both PPV13 and PPV23 (FY16- 49.4%,FY15- 43.3%)

2017 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	234	219	51
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	281	252	70
Rate	**83.3%**	**86.9%**	**72.9%**

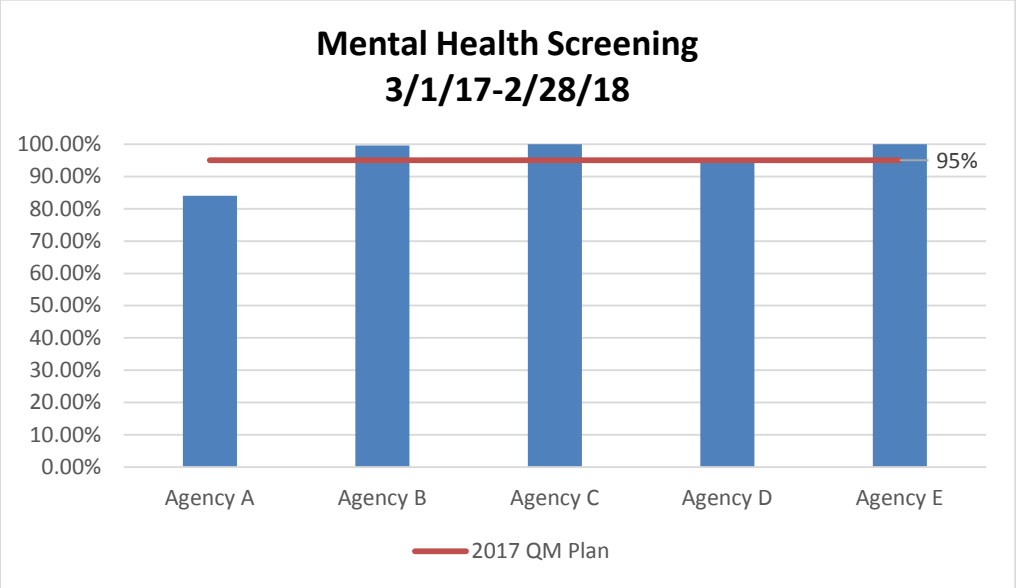


Preventative Care and Screening: Mental Health Screening

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

	2015	2016	2017
Number of clients who received a mental health screening	586	558	612
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	**92.3%**	**87.9%**	**96.4%**
Change from Previous Years Results	**3%**	**-4.4%**	**8.5%**

- 25.4% (161/635) had mental health issues. Of the 58 who needed additional care, 49 (84.5%) were either managed by the primary care provider or referred; 6 clients refused a referral.

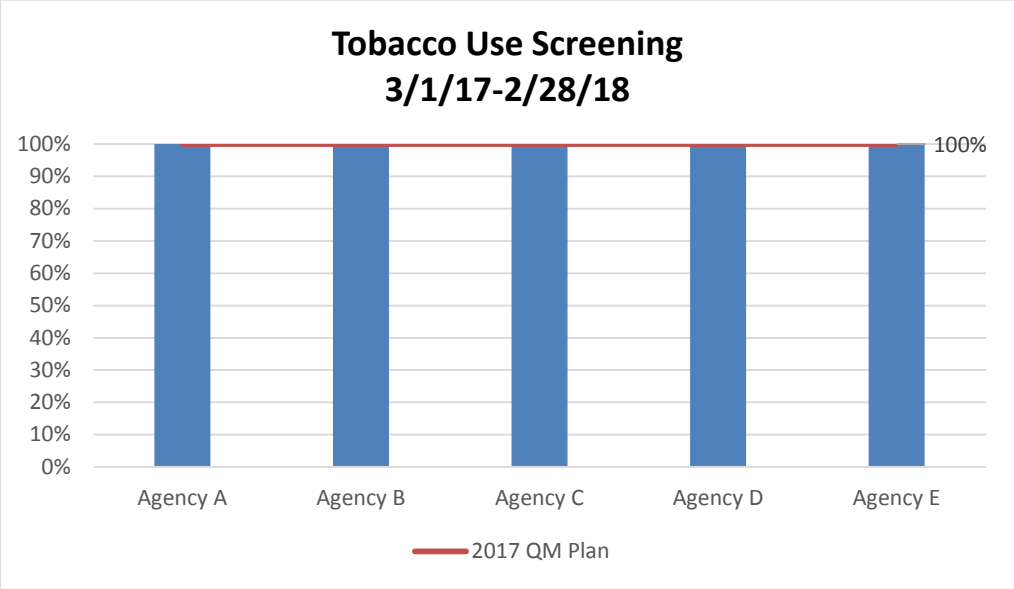


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

- 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

	2015	2016	2017
Number of clients who were screened for tobacco use in the measurement period	635	631	635
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	**100%**	**99.4%**	**100%**
Change from Previous Years Results	**.6%**	**-.6%**	**.6%**

- Of the 635 clients screened, 174 (27.4%) were current smokers.
- Of the 174 current smokers, 97 (55.7%) received smoking cessation counseling, and 11 (6.3%) refused smoking cessation counseling



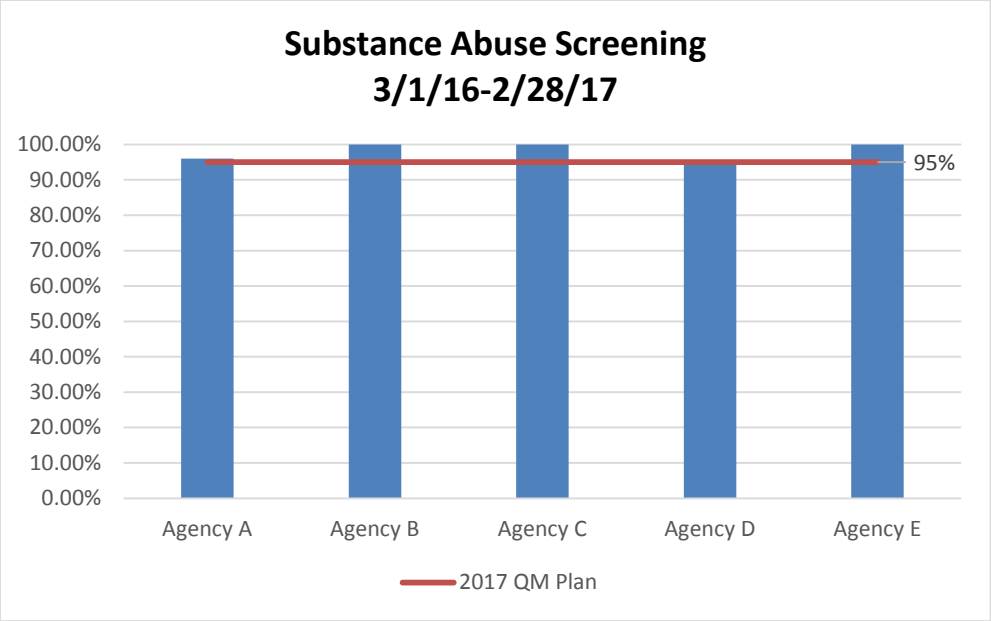
Substance Use Screening

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

	2015	2016	2017
Number of new clients who were screened for substance use within the measurement year	627	626	629
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	**98.7%**	**98.6%**	**99.1%**
Change from Previous Years Results	**.4%**	**-.1%**	**.5%**

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

- 6.9% (44/635) had a substance use disorder. Of the 44 clients who needed referral, 27 (61.4%) received one, and 11 (25%) refused.

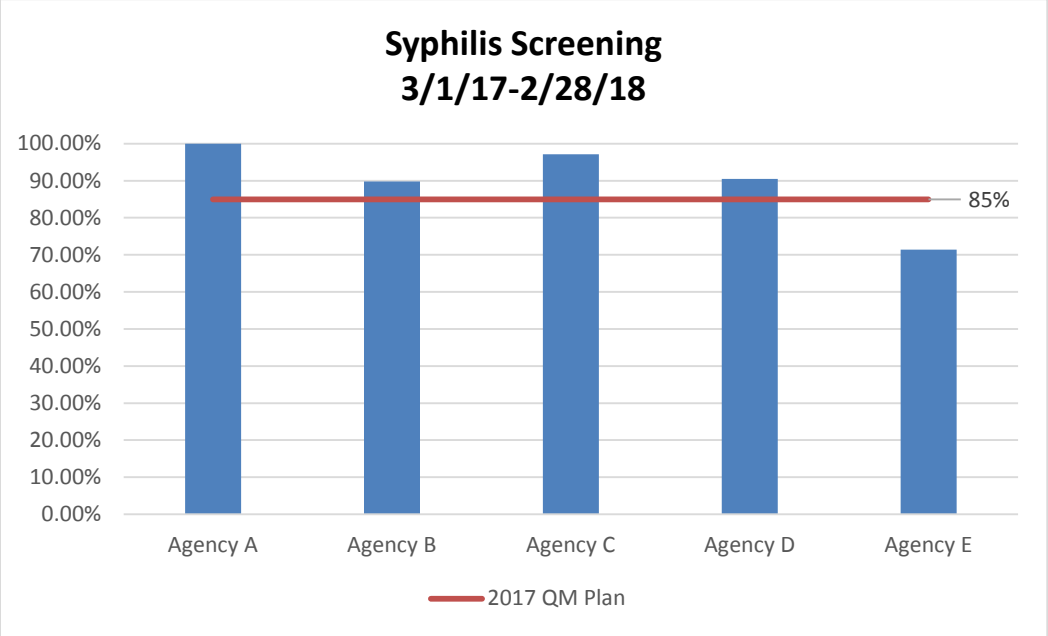


Syphilis Screening

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

	2015	2016	2017
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	599	597	587
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	**94.3%**	**94%**	**92.4%**
Change from Previous Years Results	**.8%**	**-.3%**	**-1.6%**

- 6.6% (42/635) new cases of syphilis diagnosed

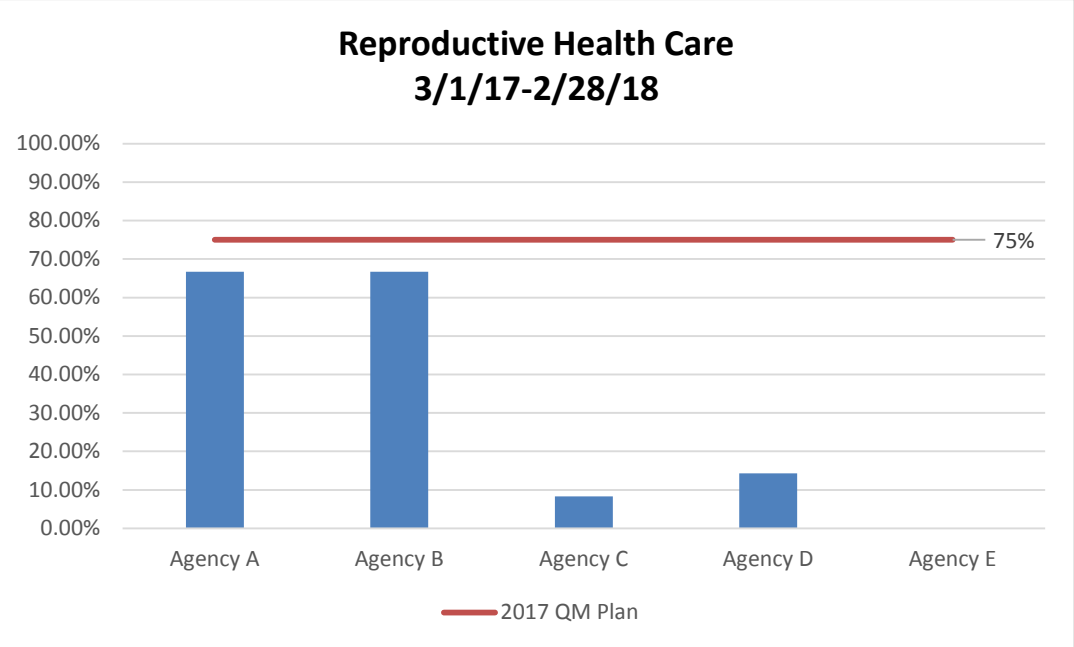


Other Measures

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)

	2015	2016	2017
Number of reproductive-age women who received reproductive health assessment and care	34	34	22
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	69	63	63
Rate	**49.3%**	**54%**	**34.9%**
Change from Previous Years Results	**7.6%**	**4.7%**	**-19.1%**

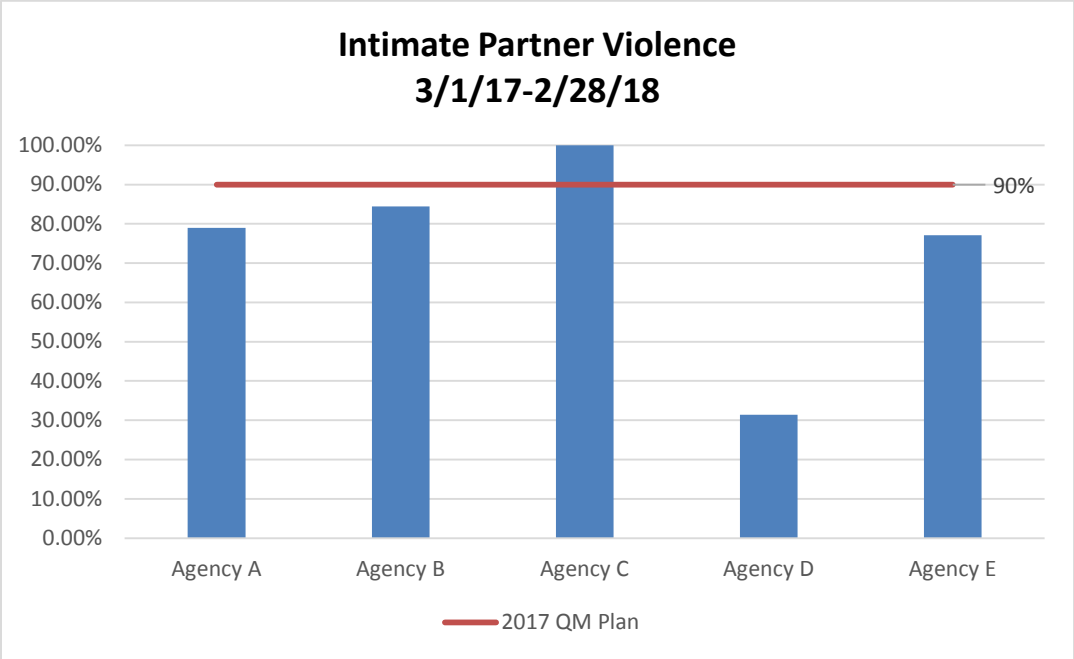


Intimate Partner Violence Screening

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

	2015	2016	2017
Number of clients who received screening for current intimate partner violence	569	520	499
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	**89.6%**	**81.9%**	**78.6%**
	-.2%	**-7.7%**	**-3.3%**

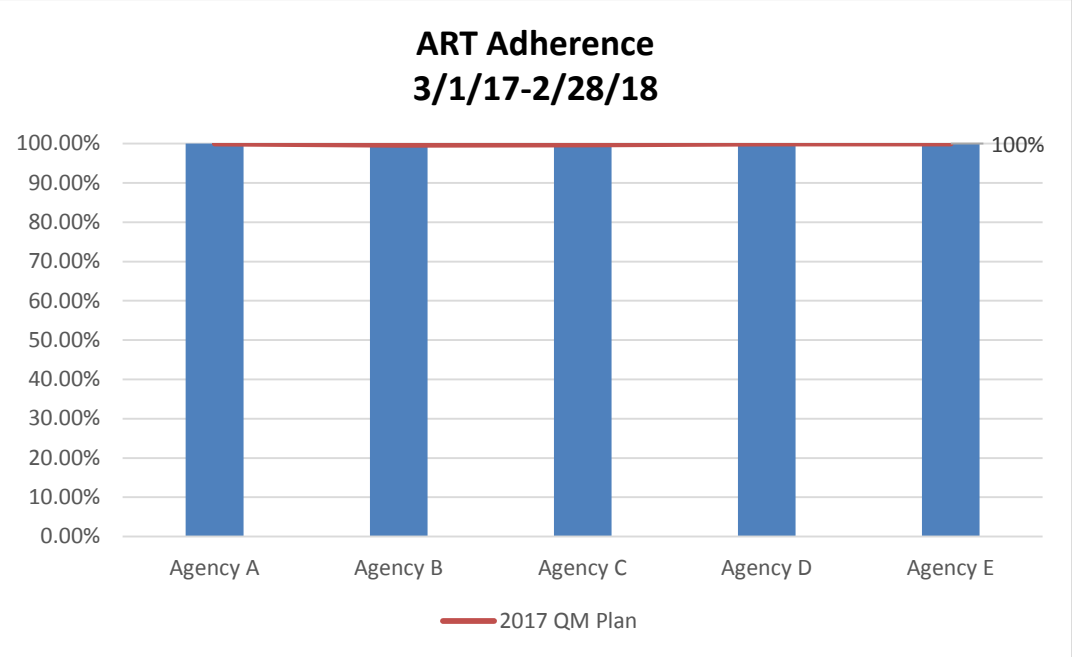
* 4/635 screened positive



Adherence Assessment & Counseling

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

	Adherence Assessment		
	2015	2016	2017
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	607	617	627
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	613	620	627
Rate	**99%**	**99.5%**	**100%**
Change from Previous Years Results	**0%**	**.5%**	**.5%**



ART for Pregnant Women

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

	2015	2016	2017
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	5	3	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	5	3	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

	2015	2016	2017
Number of diabetic clients whose last HbA1c in the measurement year was <8%	27	51	48
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	47	70	74
Rate	**57.4%**	**72.9%**	**64.9%**
Change from Previous Years Results	**-2.9%**	**15.5%**	**-8%**

- 635/635 (100%) of clients where screened for diabetes and 74/635 (11.7%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2015	2016	2017
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	131	133	166
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	173	180	206
Rate	**75.7%**	**73.9%**	**80.6%**
Change from Previous Years Results	**3%**	**-1.8%**	**6.7%**

- 206/635 (32.4%) 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 or a referral for a mammogram, in the previous two years

	2015	2016	2017
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	131	133	150
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	173	180	171
Rate	**75.7%**	**73.9%**	**87.7%**
Change from Previous Years Results	**3%**	**-1.8%**	**13.8%**

Primary Care: Colon Cancer Screening

- Percentage of clients living with HIV, over the age of 50, who received colon cancer screening (colonoscopy, sigmoidoscopy, or fecal occult blood test) or a referral for colon cancer screening

	2015	2016	2017
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	72	82	93
Number of clients over age 50 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	142	152	151
Rate	**50.7%**	**53.9%**	**61.6%**
Change from Previous Years Results		**3.2%**	**7.7%**

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 decreases in Hepatitis B and C screening, IPV screening and Reproductive Health Care. Performance Measures that rely on data beyond the measurement year may have been affected by new Electronic Medical Record data systems that had not yet imported historic data. RWGA will monitor these measures closely and initiate quality improvement initiatives as needed. In addition, racial and ethnic disparities continue to be seen for most measures. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

RYAN WHITE GRAND ADMINSITRATION - HARRIS COUNTY, TX

Case Management Chart Review Cumulative De-identified Report

2017-2018

Anne Russey, MEd, LPC-Supervisor

Independent Contractor

This reports summarizes the data collected from the 2017-2018 chart review of non-medical and medical case management services. Site visits and remote reviews occurred during October and November of 2018.

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Overview

A total of 312 medical case management and non-medical case management (or service linkage) client charts were reviewed. The dates of service included in the review period were March 1, 2017 - February 28, 2018, with the exception of AIDS Healthcare Foundation, the newest addition to Harris County Ryan White Part A services, whose dates of service under review were May 1, 2018-October 29, 2018. Progress notes, brief assessments, comprehensive assessments, supporting documents in any format available (electronic, hard copy, scanned documents) were reviewed as provided by each site. The sample selection was provided to this contractor by RWGA staff and included clients whom received services under each of the service category types identified above.

This contractor proposed changes to the Chart Review Tool following the 2016-2017 review, but the proposed changes were not considered by the required parties in time to implement any significant changes for this 2017-2018 review. Carin Martin of RWGA did however, approve use of an addendum page that was added to this year's review. This writer also utilized the notes section of the tool to track a number of co-occurring medical conditions to begin to gather data on other conditions that may influence or impact health outcomes of people living with HIV in the Harris County EMA.

Case management is defined by the Harris County RWGA Standards of Care as "services in HIV care [that] facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of People Living with HIV (PLWH)." Case managers serving in the agency and clinic settings are helping clients navigate very complex and fragmented systems at agency, local, state and federal levels that sometimes feel like they’re working against the very clients they were designed to serve, treat and protect.

If we consider conditions outside of an HIV+ diagnosis, such as active mental health and substance use disorders, unstable or insufficient housing, employment, income or transportation, poor support networks, lack of health insurance, barriers to medication among many other psychical and psychosocial factors contribute to lower retention in care and viral load suppression rates and increased risk and rates of new HIV transmissions, it is clear that case management has the potential to affect and in many cases improve health outcomes for the clients it serves. Licensed case managers are uniquely positioned by their education and training to assist clients struggling with complex mental health and substance use issues.

One can see threads of the old models of case management running through the 312 charts reviewed, with a very small handful of examples of a client quickly completing an assessment and service plan followed by intensive and frequent contact from a non-medical or medical case manager who documents in progress notes as obstacles and barriers are overcome, goals are accomplished and needs are met in their and 6 months later in their re-assessment and service plan review before eventually being discharged. This contractor wants to be clear that those appear to be the exception and not the norm. The majority of charts reviewed (44%) did not have a brief or comprehensive assessment completed at all. Only 152 clients (48%) had 3 or more phone or in person encounters with a case manager during the review year. This The Ryan White Standards of Care seem to presume much more intense and frequent contact between case manager and client than is actually happening in practice. Due presumably to increased demand for services and volume of clients served by each site, case management services seem to be delivered mostly on demand based on the needs of the individual clients in front of the case manager at the moment in which the provider, client or someone else requests help. Gone are the days of a case manager having a small manageable case load that allows for

close monitoring, following up on service plan goals and referrals, and regular discharges from services when goals are met and services are "complete"- unless the system somehow evolves and changes too.

Cumulative Data Summaries

Brief Assessments

# clients with brief assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	7	0	15	56	34	13	125
	39%	0%	31%	55%	42%	25%	40%
1	4	0	24	41	25	10	104
	22%	0%	50%	40%	31%	20%	33%
2	0	0	1	3	1	0	5
	0%	0%	2%	3%	1%	0%	2%
Not applicable	7	12	8	2	21	28	78
	39%	100%	17%	2%	26%	55%	25%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

40% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a brief assessment completed. 25% of the 312 charts reviewed were not required to have a brief assessment completed due to no contact with a non-medical case manager. When there was contact with a non-medical case manager noted, reasons for lack of brief assessments varied but often included client showing up unannounced and/or having a very short period of time to spend with SLW or sometimes frequent phone call contacts rather than in office visits and thus time and attention was spent on meeting client's immediate need and helping overcome a specific barrier rather than on completion of the brief assessment. Client crises especially around medication access clearly take priority (as they should) over completion of the brief assessment. 33% of the 312 charts reviewed had one brief assessment completed and 2% had two completed. The majority of the brief assessments reviewed identified only one or two needs such as transportation, vision, dental and/or other specialty care or supportive service need and noted appropriate referrals were made. In the rare cases more complicated needs were identified there was generally documentation of referral to medical case management noted.

Comprehensive Assessments

# clients with comprehensive assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	8	0	28	15	21	23	95
	44%	0%	58%	15%	26%	45%	30%
1	10	12	5	7	21	13	68
	56%	100%	10%	7%	26%	25%	22%
2	0	0	0	3	1	1	5
	0%	0%	0%	3%	1%	2%	2%
Not applicable	0	0	15	77	38	14	144
	0%	0%	31%	75%	47%	27%	46%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

30% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a comprehensive assessment completed. 46% of the 312 charts reviewed were not required to have a comprehensive assessment completed due to no contact with a medical case manager. When there was contact with a medical case manager, reasons for lack of comprehensive assessments varied but often included client showing up unannounced and/or having a very short period of time to spend with MCM or sometimes frequent phone call contacts rather than in office visits and thus time and attention was spent on meeting client's immediate need and helping overcome a specific barrier rather than on completion of the comprehensive assessment. Client crises especially around medication access clearly take priority (as they should) over completion of the comprehensive assessment. In some cases there was documentation of justification for delay of completion of comprehensive assessment noted in the progress notes of the client's chart. 22% of the 312 charts reviewed had one comprehensive assessment completed and 2% had two completed.

Assessment Needs

Need identified on assessment	Total	
Transportation	74	43%
Mental Health	62	36%
OAMC	55	32%
Insurance	51	29%
Dental	49	28%
Treatment Adherence	42	24%
Vision	42	24%
Housing	33	19%
HIV Education	29	17%
Self Efficacy	29	17%
Substance Abuse	25	14%
Income	24	14%
Basic	23	13%
Support	23	13%
HIV Related Legal	19	11%
Cultural	17	10%
Food	10	6%
General Education	9	5%
Emergency Financial	6	3%
Translation	3	2%
Kids/Child Care	1	1%
Benefits	0	0%

Of the 175 comprehensive, brief and brief-transportation assessments reviewed in detail, the most common need identified in 43% of the charts was transportation. The following came in as the four next most commonly identified needs: mental health (36%), outpatient ambulatory medical care (32%), insurance (29%) and dental (28%). At sites where dental and vision services were readily available, it seemed those needs almost always made it to the service plan. Needs besides transportation may be under represented due to the standard of care requirement of an assessment being on file in order to provide a bus pass. In the cases where an assessment is needed to provide a bus pass, transportation is the focus of the time and the encounter and other needs may be deferred or ignored until subsequent or return encounters. Other needs such as barriers to medication or primary care were addressed in progress notes rather than on the service plan(s). It seemed that more important than the identified need making it to the service plan, was whether or not a client received information, referral or assistance accessing services or support to help them meet their need. Information, referrals and assistance to overcome obstacles or barriers and the outcomes of those efforts was typically documented in detail in progress note encounters or consultation/coordination encounters with other providers rather than in the assessment or service plan.

Service Plans

# clients with service plan in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	10	5	28	14	23	23	103
	56%	42%	58%	14%	28%	45%	33%
1	7	7	5	4	19	13	55
	39%	58%	10%	4%	23%	25%	18%
2	1	0	0	6	1	1	9
	6%	0%	0%	6%	1%	2%	3%
Not applicable	0	0	15	78	38	14	145
	0%	0%	31%	76%	47%	27%	46%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

33% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a service plan completed. 46% of the 312 charts reviewed were not required to have a comprehensive assessment completed due to no contact with a medical case manager. When there was contact with a medical case manager, reasons for lack of service plans varied but as service plans are generally completed following a comprehensive assessment it makes sense that the number of clients missing both an assessment and a service plan would be similar and due to similar obstacles. In follow up to the 2016-2017 review where Agency A and Agency C had some issues with incomplete scanned documents/missing service plans where one was noted, this was not a problem in this year's review. In almost every case if there was a note indicating a service plan was completed, it was readily available in the chart for all sites.

Encounters

# of progress notes during review period	Site						
	A	B	C	D	E	F	Total
1 or more	18	12	48	102	80	51	311
2 or more	18	5	31	69	56	36	215
3 or more	18	2	25	48	36	23	152
4 or more	16	1	15	34	26	15	107
5 or more	14	0	11	19	21	11	76

It seems worth noting that less than half of the clients receiving services during the review period had 3 or more contacts with a case manager during the one year review period. The Ryan White Standards of Care requirements seem to presume much more frequent contacts between case manager and client during a one year period that would allow for more intense case management and follow up. It should come as no surprise that if contact is limited to 1, 2 or 3 instances that opportunities to complete assessments and service plans and subsequent reviews and follow ups are extremely limited if not non-existent.

Assessment Summary

# clients with brief, comprehensive, both or no assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
Brief	0	0	24	35	25	10	94
	0%	0%	50%	34%	31%	20%	30%
Comprehensive	6	12	4	9	23	14	68
	33%	100%	8%	9%	28%	27%	22%
Both	4	0	1	8	0	0	13
	22%	0%	2%	8%	0%	0%	4%
None	8	0	19	50	33	27	137
	44%	0%	40%	49%	41%	53%	44%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

#** and Type of Assessment Reviewed	Site						
	A	B	C	D	E	F	Total
Brief	0	0	25	2	26	10	63
Brief-Transportation	0	0	0	40	0	0	40
Comprehensive	10	12	4	10	22	13	71
Total	10	12	29	52	48	23	174

** Tool did not allow for review of more than one assessment per chart

In summary, 44% of the 312 charts reviewed did not have any assessment completed. 22% had only comprehensive plan completed, 30% had only a brief assessment completed and only 4% had both a comprehensive and brief assessment completed. It should be noted that according to the standards of care, a brief assessment is not required in the event a non-medical case manager provides only basic referral or assistance, thus in cases where there was only contact from a non-medical case manager it may be appropriate that no assessment was completed.

174 assessments (brief, brief-transportation and comprehensive) were reviewed. Brief assessments were not required to have a service plan, and the service plans accompanying comprehensive assessments were often incongruent with the needs identified in the assessment. There were several instances where a need was identified but a note was added to indicate the client was declining to address the need as part of their service plan. Agency D was the only site who documented a separate type of brief assessment being used for clients in need of a Ryan White funded Metro bus pass. Agency B did not have a non-medical case manager on staff during the review period, thus all encounters reviewed were MCM encounters.

Lost to Care Status

Lost to Care Status	Site						
	A	B	C	D	E	F	Total
LTC Prior to Episode	1	0	3	10	3	3	20
	6%	0%	6%	10%	4%	6%	6%
LTC During Episode	1	0	1	14	7	1	24
	6%	0%	2%	14%	9%	2%	8%
Not LTC	16	12	44	78	71	47	268
	89%	100%	92%	76%	88%	92%	86%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

6% of charts reviewed indicated the client was lost to care prior to the review period. 8% of charts reviewed indicated the client was lost to acre during the review period. The remaining 86% of charts did not indicate a client was lost to care. In several cases efforts were noted to re-engage a client to care, including calling the last known number and even field visits to a client's last known address, sometimes successfully resulting in re-engaging a client to care and sometimes not. The 14% lost to care rate is likely lower than what actually occurs in the EMA as this sample only included clients who had a billable service encounter (meaning actual contact with a client- not efforts to retain or re-engage a client that did not result in contact) during the review period. If a client had billable contact with a non-medical or medical case manager during the review period it makes sense that they would most likely not be lost to care.

This reviewer utilized progress notes to identify clients who appeared to have been lost to care prior to or during the episode of care taking place during the review period. The tool did not allow for differentiation between prior to and during the review period so the reviewer utilized margin space of the tool to indicate if a client was lost prior to the review period. In the event the client was lost prior to the review (often indicated by a progress note stating the client attended a "RTC" or "return to care" appointment), the interventions taken to re-engage the client were often unclear.

It is notable that during this review period several sites utilized non-medical case managers (SLWs) dedicated specifically to the task of retaining or returning clients to care. It is the understanding of this reviewer that in future years the retention in care work will be funded and performed separate from non-medical case management under an Outreach service category so it may not be relevant to a qualitative review of this nature at that point.

Viral Load Suppression

Viral Load Suppression Information	Site						
	A	B	C	D	E	F	Total
Viral Load < 20	8	2	17	61	30	15	133
	44%	17%	35%	60%	37%	29%	43%
Viral Load not suppressed, but evidence	9	10	21	29	47	31	147
	50%	83%	44%	28%	58%	61%	47%
Viral Load not suppressed and no evidence of	0	0	0	5	0	1	6
	0%	0%	0%	5%	0%	2%	2%
No Viral Load data	1	0	10	7	4	4	26
	6%	0%	21%	7%	5%	8%	8%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

Of the 312 charts reviewed, 43% had evidence (lab results) of an undetectable viral load <20 copies per ml. 47% had evidence of at least one lab test during the review period that the viral load rose above 20 copies per ml, but also had evidence (progress notes) of an intervention or contact by a non-medical or medical case manager after or around the time of the lab test result. There were many cases where a client had a detectable viral load at one point in the review period, but later another result indicating their viral load was later suppressed. This positive change may correlate with the social service interventions they received (likely help accessing medication, overcoming barriers to primary care, referrals to mental health and substance use treatment, etc.) but further evaluation and adaptation of the tool would be needed to assess more closely. 2% of the charts reviewed had evidence of a detectable viral load at least once during the review period but no evidence of an intervention, contact or follow up after a viral load was detected. 8% of the charts did not have any lab tests/results in the chart- usually the case of a patient who was documented to be in primary care elsewhere but accessing non-medical case management services to access a specialty service like dental or vision care or a social service referral (housing, etc.).

It makes sense that of this sample of clients accessing non-medical and medical case management support that there would be a high percentage of individuals with an unsuppressed viral load due to the nature of support services. Considering the eligibility requirements in Standards of Care, to access non-medical and medical case management services, the clients accessing the service categories under review are likely experiencing risk factors that predispose them to having an increased viral load to begin with.

Co-occurring Conditions

Co-occurring Condition	Site	
	Total	% of Total
No Substance Use/MH dx	196	63%
Depression dx	73	23%
STD Dx	70	22%
Hypertension	69	22%
Other Substance Use	44	14%
Anxiety dx	39	13%
Diabetes II	32	10%
Other Mental Health dx	27	9%
Bipolar dx	25	8%
Homelessness noted	16	5%
Hep C	16	5%
Alcohol use disorder	13	4%
Cancer/Leukemia	5	2%
Pregnancy during episode	3	1%

Of the 312 charts reviewed 63% indicated no substance use or mental health diagnosis or problem. Progress notes and the problem lists/dashboards in the EHRs were utilized to identify co-occurring conditions. The most common mental health diagnosis or problem indicated was a depressive disorder at 23%. 22% of the charts reviewed indicated an STD/STI diagnosis. Anecdotally syphilis was identified frequently, however the review tool did not easily allow for documentation of specific STI/STD diagnoses and thus it is impossible to know for sure. This could be worth future consideration and may indicate additional training needs for support service staff who may be instrumental in helping clients access medication and treatment for various co-occurring conditions that ultimately affect the client's health outcomes.

Hypertension and Diabetes II were also noted by this reviewer as common co-occurring conditions. In many cases where a client had seemingly well managed HIV care, they were struggling with hypertension or diabetes and would likely benefit from additional support around those co-occurring conditions. This would likely require additional training and access to information and resources for the support staff tasked with helping a client navigate those conditions.

"Other Substance Use" (frequently methamphetamine, crack and marijuana) was noted in 14% of the charts. Again, the review tool did not allow for indication of specific substances being used besides alcohol so specific data is not available about the other substances being used.

Conclusion

The HIV care systems clients and providers must navigate in order to access and provide care is complex and at times burdensome. It is clear that non-medical and medical case managers play an important and useful role in helping clients overcome barriers to support services and primary care. Both non-medical and medical case managers appear to spend much of their time helping clients with eligibility and paperwork requirements mandated by the local, state and federal programs under which client's are served in order to access basic needs like medications, housing, transportation, primary and specialty medical care including dental and vision services and mental health or substance use treatment. The ways in which the most complex cases are funneled to the licensed medical case managers should continue to be evaluated and perhaps re-worked in some cases to ensure licensed medical case managers are being appropriately utilized to serve the most at risk and vulnerable clients who will benefit from the highest level of case management support available. Alternatively, consideration should be given to suggestions put forth by case management providers during the prior year's chart review process that may allow for billing simple information and referral encounters by licensed staff at a lower rate to give the sites flexibility in how they utilize available staff in their existing agency systems while still honoring and fulfilling their contract agreements and the standards of care.

Appendix

Review Tool

MCM and SLW Chart Review Tool

Services received 3/1/13-2/28/14

/____/____/201___/ **Client Case Status:** ☐ Open/Active ☐ Closed ☐ Unk

Brief Assessment Date 1:		**Brief Assessment Date 2:**	
Comp Assessment Date 1:		**Comp Assessment Date 2:**	
Service Plan Date 1:		**Service Plan Date 2:**	
Case Closure Date:			
Last OAMC Date:			
Last MCM Date:			

HIV/AIDS STAGE OF ILLNESS UPDATE, AND BEHAVIORAL HEALTH CONDITIONS

1. Most current documented HIV stage? ☐ HIV+, not AIDS ☐ AIDS ☐ HIV+/Status Unk
2. Was the client identified as needing MH/SA therapy/counseling? ☐ Yes ☐ No ☐ NA ☐ Unk
3. Does the client have an active diagnosis of the following diagnoses? (Check ALL That Apply)
   - ☐ Alcohol abuse/dependence
   - ☐ Other substance abuse/substance dependence
   - ☐ Depression
   - ☐ Bipolar disorder
   - ☐ Anxiety disorders
   - ☐ Other mental disorders _____
4. Was the client reported to have any of these conditions? (Check ALL That Apply)
   - ☐ Sexually transmitted infections (STIs)
   - ☐ Pregnancy
   - ☐ Homeless

SERVICE LINKAGE

5. How was the client assisted by a SLW in the observation period
   - ☐ **NA (Client not assisted by SLW)**
   - ☐ Brief assessment
   - ☐ SLW referred client to OAMC
   - ☐ OAMC visit scheduled by SLW
   - ☐ SLW accompanied the client to OAMC visit
   - ☐ SLW called client to remind about the OAMC visit
   - ☐ Client did not keep OAMC appointment and SLW contacted the client
   - ☐ Other SLW activity: _____

LOST TO CARE AND COORDINATION ACTIVITIES

6. Was the client lost to OAMC care? ☐ Yes ☐ No ☐ NA
7. Was there acknowledgement in the chart that the client was lost to OAMC care? ☐ Yes ☐ No ☐ NA
8. What activities did the **MCM** undertake because the client was lost to care? (Check all that apply)
   - ☐ **NA (Client not lost to care)**
   - ☐ No activities documented to contact client lost to care
   - ☐ Letter to client's last known address
   - ☐ Telephone call to client's last known telephone number
   - ☐ Telephone call to client's emergency contact person
   - ☐ Referral to outreach program: _____
9. Did the MCM receive information from the program about the client's status? ☐ Yes ☐ No ☐ NA
   a. Client status? _____

January 2015 MCM Chart Review Data Collection Tool 1

10. Was there evidence of coordination of services between MCM, clinician, and support service providers in the chart?
    - ☐ Yes, there is coordination of services
    - ☐ There is no evidence of coordination of services
    - ☐ Client refusal documented in client's records
    - a. Evidence: _____

NEEDS REQUIRING COMPREHENSIVE CASE MANAGEMENT

CPCDMS Insurance Status: Uninsured

11. **Insurance, Benefits, and FPL**

Health Insurer	Coverage?	Disability/Survivor Benefits
Medicaid	Full? Managed Care? Share of Cost? Medically Needy? QMB?	SSA Old Age (≥ 65 Years)
Medicare	Part A? Part B? Part D?	SSA SSI
Commercial Name?		SSA SSDI
VA		Survivor Benefits (Widow, Widower, Child)
Other Insurers Name?		Commercial Disability/Worker's Comp

Client	Spouse/partner	Client's children	Client's Mother	Client's father	Client's sisters	Client's brothers	Other		HOUSEHOLD SIZE
1	1	1 2 3 4 5 6 7 8	1	1	1 2 3	1 2 3	1 2 3	→	1 2 3 4 5 6 7 8 9 10 UNK

Client 1	$	Other Member1	$	Total Income:
Client 2	$	Other Member2	$	$
Spouse	$	Other Income	$	

CLINICAL CASE MANAGEMENT

12. Was the client referred for **clinical case management** services in the review period?
    ☐ Yes ☐ No ☐ Unk

    If YES, was there evidence of coordination of services between primary care provider and clinical case management at least every three months in the client's chart?
    - ☐ Yes, there is coordination of services
    - ☐ There is no evidence of coordination of services
    - ☐ Client refusal documented in client's record
    - ☐ NA, client not referred to clinical case management services

CASE DISCHARGE/TERMINATION/CLOSURE

13. Was case discharged/closed case during the review period? ☐1. Yes ☐ 0. No ☐ 8. NA ☐ 9. Unk

Case Closure	Closure 1	Closure 2	Closure 3
Client met agency criteria for closure?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Date of closure noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Summary of services received noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Referrals noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Instructions given to client at discharge noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Reason for closure			
All goals met / no needs	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client continues no show, lack of follow-up	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client refused service	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client died	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client lost to care	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client moves out of service area	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client incarcerated	Y N Unk NA	Y N Unk NA	Y N Unk NA
Unk, unclear, contradictory documentation	Y N Unk NA	Y N Unk NA	Y N Unk NA

14. If an assessment was completed, were the following components assessed, addressed in the service plan, and addressed by referrals?

Worker Completing Assessment:	Assessment		Service Plan		Referral		Follow-up to Achieve Goal Documented?
	Domain Assessed?	Need Identified?	Resources Identified?	Timelines?	Referral Made?	Follow-up to Referral?	
Basic Necessities							
Benefits							
Children/Dependents							
Cultural/Linguistic							
Dental Care							
Emergency Financial Assistance							
Family Planning/Safer Sex							
Food/Nutrition							
General Education, Vocation, Literacy							
Health Insurance							
Health Insurance Premium Assistance							
Hearing Care							
HIV Ed/Prevention							
HIV Medications							
Housing Services							
Income							
Legal							
Mental Health Treatment							
Outpatient Ambulatory Medical Care							
Self-Efficacy							
Substance Abuse Treatment							
Support System							
Translation Services							
Transportation							
Treatment Adherence							
Vision Care Other:							

Addendum:

15. Viral load suppressed during review period?

- Yes
- No, intervention/follow up/linkage by SLW/MCM documented
- No, ***no documentation*** of intervention/follow up/linkage by SLW/MCM
- Unknown; no lab results containing VL information documented during review period

16. Was there a primary care visit within review period?

- Yes
- No

17. If no to 16, was there documentation by SLW/MCM to link client back to care?

- Yes
- No
- Not applicable (client moved out of EMA, client deceased, client refused service, etc.)

18. If any conditions applicable under 3 or 4, was there an attempt to link client to SLW/MCM care?

- Yes
- No, client was virally suppressed
- No, client had viral load and no linkage attempts documented

19. Progress notes: Were the five most recent progress notes (involving face to face or phone contact) in the review period dated, signed, indicative of the type of service delivered, the nature and extent of the service and the next steps or future plans?

F2F/PC date	Dated		Signed		Type of service noted?		Nature and extent of service noted?		Next steps or future plans noted?		Progress notes clear and concise?	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Project STYLE (Strength Through Youth Livin' Empowered) Young MSM of Color

Highlights from the Special Projects of National Significance (SPNS) Program

This fact sheet contains highlights from the University of North Carolina at Chapel Hill's *Project STYLE* Intervention, launched in response to rising HIV rates within young men who have sex with men (YMSM) of color. Project STYLE was designed to reach HIV-positive Black and Latino YMSM at college and university campuses through a social marketing campaign and linking them into care.

Setting: North Carolina

Target Population: Black and Latino young men (ages 17–24) who have sex with men

Background

Young (aged 13–24) MSM (YMSM) are a population with specific risk factors for HIV infection and if infected, have greater likelihood of poorer health outcomes than older populations living with HIV. Several factors can pose as barriers to effective HIV prevention approaches among YMSM, including: inadequate reach of HIV prevention education to YMSM, low levels of awareness and perception of risk among young people, risky sexual behavior due to substance and/or alcohol use, and social issues commonly faced by sexual minority youth such as stigma, sexual violence, social and family isolation. [1] In addition, racial/ethnic differences are associated with different diagnoses trends among YMSM. Project STYLE is an innovative model of care designed to engage, link, and retain HIV-positive Black and Latino YMSM, ages 17–24 into HIV primary care. YMSM have been disparately impacted by HIV since the start of the HIV epidemic in the U.S., and encompass groups historically unaware of their HIV status and/or not connected to care. These include underserved youth, racial/ethnic minorities, and sexual and gender minorities.[2]

Unmet Needs

In 2014, the CDC estimated that MSM accounted for 80% of youth ages 13–24 diagnosed with HIV.[3] These trends have translated into heavy HIV burdens among older populations of Black and Latino YMSM. Of these newly diagnosed YMSM, 55% were Black and 23% were Latino. In 2015, the CDC estimated that Black MSM have a 1 in 2 lifetime risk of HIV infection, while Latino MSM have a 1 in 4 lifetime risk.[4]

Intervention Objectives

The objectives of *Project STYLE* were to reach HIV-positive Black and Latino YMSM at college and university campuses through a social marketing campaign and link them into care.

Key Considerations for Replication

- **Ensure staff possess the skills and cultural competency** necessary to delivery and/or provide linkage to HIV care and ancillary services to HIV-positive Black and Latino YMSM.
- **Create partnerships and linkages** with agencies in your area already working with HIV-positive Black and Latino YMSM
- **Create a social marketing campaign** that reflects input from Black and Latino YMSM, as well as community stakeholders and current/potential service partners

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who have access to the target populations. *(Materials should raise HIV awareness, speak directly to Black and Latino YMSM, and be disseminated through print and online outlets)*

- **Establish an Advisory Board** to help oversee and provide input during the ongoing creation and roll out the intervention.
- **Supplement social marketing efforts** with intensified in-person outreach, such as HIV informational town halls or HIV testing at venues and events (i.e. health fairs, dance clubs, and college campuses, frequented by Black and Latino YMSM).
- **Obtain referrals of HIV-positive Black and Latino YMSM** from aligned entities including local and state health departments, HIV studies, clinics, faith- and community-based organizations (FBOs/CBOs), and AIDS service organizations (ASOs).
- **Link HIV-positive Black and Latino YMSM** into a tightly integrated medical and social support network. This should be a warm handoff, with an HIV Outreach Worker linking newly diagnosed/re-engaged YMSM with a case manager and a medical appointment within 72-hours of identification.
- **Ensure medical and support staff work together** to stay connected with HIV-positive Black and Latino YMSM and support retention in care.

Intervention Staff Requirements

To replicate the University of North Carolina at Chapel Hill's *Project Style* intervention, the following positions and capacity are necessary.

- **Peer Outreach Workers**—serve as the public face of the intervention; facilitate HIV education and testing events.
- **Case Managers**—coordinate with Peer Outreach Workers to schedule initial medical appointment.
- **HIV Primary Care Providers**—An infectious disease board-certified physician with expertise delivering HIV primary care.
- **Research Support Panel**—collects, tracks, and analyzes study data.
- **Advisory Board**—An interagency/community comprised of community members and stakeholders, current/potential service partners, and Black and Latino YMSM representatives.

RESOURCES

This fact sheet is part of the ***Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond*** resources from the Integrating HIV Innovative Practices (IHIP) project.

- **Integrating HIV Innovative Practices (IHIP). Engaging Hard-to-Reach Populations: Outreach. (Webinar). April 18, 2013. Available at: https://careacttarget.org/library/engaging-hard-reach-Populations-outreach.**
- ***Integrating HIV Innovative Practices (IHIP).* Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care: Tools from the Integrating HIV Innovative Practices Program Training Manual and Curriculum. 2012. Available at: https://careacttarget.org/ihip/engagement.**
- **Outreach, Care, and Prevention to Engage HIV Seropositive Young MSM of Color Initiative. Available at: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-initiative-outreach-care-and-prevention-engage-hiv-seropositive-young-msm-color-2004-2009**

Notes

[1] U.S. Centers for Disease Control and Prevention. HIV and Young Men Who Have Sex with Men. https://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hiv_factsheet_ymsm.pdf

[2] NIMHD. *Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes*. October 6, 2016. https://www.nimhd.nih.gov/about/directors-corner/message.html.

[3] CDC. *HIV Surveillance Report 2014*. 2015; 26.

[4] 2016 Conference on Retroviruses and Opportunistic Infections (CROI). *Gay and Bisexual Men of Color Face Greatest Risk of HIV*. Boston, MA. February 2016. http://www.cdc.gov/nchhstp/newsroom/2016/croi-2016.html.

Patient Navigation Intervention

Highlights from the Special Projects of National Significance (SPNS) Program

This fact sheet contains highlights from the Virginia Department of Health's *Patient Navigation* Intervention, focused on using patient navigation in linking newly diagnosed persons to care within 30 days of diagnosis. This intervention also targets those who have fallen out of care, who have never received care, or are at risk of being lost-to-care.

Setting: Central and Southwest Regions of Virginia

Target Population: Newly diagnosed PLWH; PLWH who have fallen out of care, have never received care, or are at risk of being lost to care

Theoretical Basis: Collaborative Learning Model

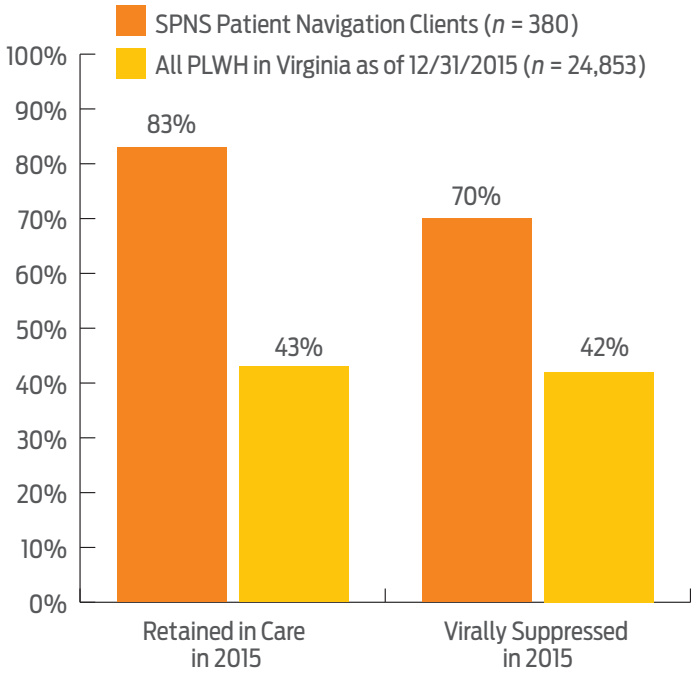
Background

Following a diagnosis of HIV, linking people living with HIV (PLWH) to HIV services is the next step on the HIV care continuum. Early initiation of HIV treatment is associated with improved outcomes along the HIV care continuum. Lower CD4 T cell counts at the time of treatment initiation is associated with shorter life expectancy and a lower likelihood of full rebound of CD4 counts.[1,2] Thus, linkage to care soon after diagnosis can be an important strategy for supporting PLWH. HHS guidelines indicate that all PLWH should be initiated in treatment, and as early as possible. Patient navigation support for PLWH has been demonstrated to improve efficiency and effectiveness of linkage to care interventions.[3] The Virginia Department of Health sought to promote timely linkage to and retention in care through the guidance and support of health workers known as Patient Navigators.

Unmet Needs

Underserved populations, including many racial, ethnic, and sexual minorities, face numerous structural, financial, and cultural barriers that impede their linkage to and engagement in care.[4] As such, addressing these key areas by increasing social support services; integrating one-stop-shop care delivery; removing structural barriers; providing financial support services; and using peer navigators or care coordinators, can help improve linkage to care for PLWH.

HIV Care Outcomes Among VDH SPNS Patient Navigation Clients Served 9/1/2013–8/31/2015



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Intervention Objectives

The objectives of the *Patient Navigation* Intervention were to create more timely and effective linkages to and retention in medical care for PLWH through the guidance and support of Patient Navigators.

Key Considerations for Replication

- **Engage potential partners and stakeholders** early in the planning process, and include diverse planning partners (e.g., service providers, community members, PLWH)
- **Research the availability of similar interventions** in the local area to avoid duplication or confusion and identify opportunities for partnerships and coordination
- **Develop a clear and comprehensive protocol** for Patient Navigators to follow
- **Client encounters should take place routinely** (more frequently at the start of navigation), be face-to-face whenever possible, and documented by the Patient Navigator
- **PLWH may enter the intervention at varying stages of the HIV care continuum,** and may need to re-engage with the intervention at some point
- **Navigators and PLWH work collaboratively** to develop a linkage-to-care plan; clients should be informed during intake that the transitioning out (once appropriate) will take place
- **Linkage to non-HIV-related services** (e.g., mental health, housing, transportation, education) can be facilitated by the Patient Navigator

Intervention Staff Requirements

To replicate the Virginia Department of Health's Patient Navigation intervention, the following positions and capacity are necessary.

- **Patient Navigators**—must possess specific knowledge and skills including being able to solve problems creatively and effectively; direct clients to community resources/information; and build working relationships. **Programs may be able to rely on community health workers or other staff dedicated to linkage-to-care efforts if a patient navigator is not available.*
- **Patient Navigator Supervisors**—A variety of staff serve to manage/supervise Patient Navigators including administrative staff, nurse managers, and physicians.

RESOURCES

This fact sheet is part of the ***Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond*** resources from the Integrating HIV Innovative Practices (IHIP) project.

- **SPNS Initiative: Systems Linkages and Access to Care, 2011–2016: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-systems-linkages-and-access**
- **VDH Active Referral Intervention Case Study: http://careacttarget.org/ihip**

Notes

[1] Althoff KN, Gange SJ, Klein MB, et al. Late presentation for human immunodeficiency virus care in the United States and Canada. Clin Infect Dis. Jun 1 2010;50(11):1512–1520. http://www.ncbi.nlm.nih.gov/pubmed/20415573.

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