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<table>
<tr><th colspan="2">FY 2020 Houston EMA Ryan White Part A/MAI Service Definition
Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage, Outreach, Emergency Financial Assistance - Pharmacy Assistance and Local Pharmacy Assistance Program (LPAP) Services</th></tr>
<tr><td>HRSA Service Category Title:
RWGA Only</td><td>1. Outpatient/Ambulatory Medical Care
2. Medical Case Management
3. AIDS Pharmaceutical Assistance (local)
4. Case Management (non-Medical)
5. Emergency Financial Assistance – Pharmacy Assistance
6. Outreach</td></tr>
<tr><td>Local Service Category Title:</td><td>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</td></tr>
<tr><td>Amount Available:
RWGA Only</td><td>Total estimated available funding: <u>$0.00</u> (to be determined)

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.</td></tr>
<tr><td>Target Population:</td><td>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

Outreach:
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.</td></tr>
<tr><td>Client Eligibility:
Age, Gender, Race, Ethnicity, Residence, etc.</td><td>PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.</td></tr>
<tr><td>Financial Eligibility:</td><td>See Current Approved Financial Eligibility for Houston EMA/HSDA</td></tr>
</table>

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. **Emergency Financial Assistance – Pharmacy Assistance** 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. **Outreach**

	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.
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. • Outreach: 15 Minutes = 1 Unit • Emergency Financial Assistance – Pharmacy Assistance: 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.
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. • **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. • **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
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. **Outreach**: 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 HCPH/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. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-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 30-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 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.
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 and EFA – Pharmacy Assistance 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.

<table>
<tr>
<td>Staff Requirements:</td>
<td>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 within 30 days of start of grant year, 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</td>
</tr>
</table>

	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 within 30 days of start of grant year, 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 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**		Date: **04/21/2020**
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

FY 2020 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**	
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) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
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 **Outreach:** 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.

Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current 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:** 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. **Emergency Financial Assistance – Pharmacy Assistance** 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. **Outreach** 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.
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. • Outreach: 15 Minutes = 1 Unit • Emergency Financial Assistance – Pharmacy Assistance: 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.
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. • **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. • **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
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.**

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<td>Local Service Category Definition/Services to be Provided:</td>
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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).

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	• 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. **Outreach**: 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 HCPH/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. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-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 30-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 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.
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 and EFA – Pharmacy Assistance 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 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2020 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**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Emergency Financial Assistance – Pharmacy Assistance 5. 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 Current 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:** 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. **Emergency Financial Assistance – Pharmacy Assistance** 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.
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. • Emergency Financial Assistance – Pharmacy Assistance: 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.
HRSA Service Category Definition:	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or

RWGA Only	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. • **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.
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. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-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 30-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 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.
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 and EFA – Pharmacy Assistance 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 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition
Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric

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 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2018 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

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- Service Linkage (Non-Medical Case Management) 8

Highlights from FY 2018 Performance Measures

Measures in this report are based on the 2018/2019 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

Medical Case Management

- During FY 2018, 6,083 clients utilized Part A medical case management. According to CPCDMS, 3,177 (52%) 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 clients, 13% of clients accessed mental health services at least once during this time period after utilizing medical case management.
- For clients who have lab data in CPCDMS, 73% were virally suppressed.

Outreach

- During FY 2018, 311 (39%) clients accessed primary care within three months of their first outreach visit.
- 46% of clients moved from an unsuppressed to suppressed viral load status during this time period.

Primary Medical Care

- During FY 2018, 8,059 clients utilized Part A primary medical care. According to CPCDMS, 4,624 (75%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 304 (20%) had a 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, 76% were virally suppressed during this time period.
- 71% of new clients were engaged in care during this time period.
- During FY 2018, the average wait time for an initial appointment availability to enroll in primary medical care was 12 days, while the average wait time for an appointment availability to receive primary medical care was 9 days.

Service Linkage (Non-Medical Case Management)

- During FY 2018, 7,646 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,548 (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, 49% of clients utilized primary medical care for the first time after accessing service linkage for the first time.
- The median number of days between the first service linkage visit and the first primary medical care visit was 14 days during this time period.

Ryan White Part A
HIV Performance Measures
FY 2018 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2017	FY 2018	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,913 (72.3%)	3,092 (77.4%)	**5.1%**

Ryan White Part A
HIV Performance Measures
FY 2018 Report

Medical Case Management
All Providers

For FY 2018 (3/1/2018 to 2/28/2019), 6,083 clients utilized Part A medical case management.

HIV Performance Measures	FY 2017	FY 2018	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	2,626 (50.6%)	3,177 (52.2%)	**1.6%**
15% of medical case management clients will utilize mental health services	699 (13.5%)	799 (13.1%)	**-0.4%**
45% of clients who have third-party payer coverage (e.g. Medicare, Medicaid, private insurance) after accessing medical case management	*NA	458 (7.5%)	**NA**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,004 (67.5%)	2,468 (73.4%)	**5.9%**
50% of clients will have 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	849 (36.9%)		
Less than 20% of clients will have more than a six month gap in medical care in the measurement year	660 (25.5%)	753 (24.3%)	**-1.2%**
Less than 15% of clients will be homeless or unstably housed	1,001 (19.3%)	1,022 (16.8%)	**-2.5%**

According to CPCDMS, 184 (3.0%) clients utilized primary care for the first time and 246 (4.0%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	FY 2017
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	5.0%

*Note that there was a change in the methodology of how this data is analyzed. Due to the way insurance data is collected, FY17 data cannot be re-evaluated.

Ryan White Part A
HIV Performance Measures
FY 2018 Report

Outreach Services
All Providers

HIV Performance Measures	FY 2017	FY 2018	Change
Percentage of clients who attended a primary care visit within three months of the first Outreach visit	102 (45.9%)	311 (39.1%)	**-6.8%**
Percentage of clients who attended a primary are visit within three months of the first Outreach visit and a subsequent visit 6 to 12 months thereafter	67 (30.2%)	*NA	**NA**
Percentage of clients who went from an unsuppressed VL (>=200 copies/ml) to a suppressed viral load (<200 copies/ml) in the project year	101 (48.3%)	223 (45.7%)	**-2.6%**

*Please note that due to the time parameters for this measure, data can only be produced for the previous fiscal year.

Ryan White Part A
HIV Performance Measures
FY 2018 Report

Primary Medical Care
All Providers

For FY 2018 (3/1/2018 to 2/28/2019), 8,059 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2017	FY 2018	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	4,231 (73.2%)	4,624 (74.5%)	**1.3%**
Less than 20% of clients will have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care	291 (22.2%)	304 (19.8%)	**-2.4%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since HIV diagnosis	5,694 (75.8%)	5,967 (74.0%)	**-1.8%**
30% of clients will receive an oral exam by a dentist at least once during the measurement year	1,813 (24.1%)	2,034 (25.2%)	**1.1%**
85% of clients will have a test for syphilis performed within the measurement year	5,902 (78.7%)	6,648 (82.5%)	**3.8%**
95% of clients will be screened for Hepatitis B virus infection status at least once since HIV diagnosis	6,219 (82.8%)	6,726 (83.5%)	**0.7%**
90% of clients will have a viral load test performed at least every six months during the measurement year	3,695 (81.7%)	4,063 (82.1%)	**0.4%**
90% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	7,317 (71.4%)	6,139 (76.2%)	**4.8%**
35% of clients will have 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	2,345 (23.1%)		
Less than 20% of clients will have more than a six month gap in medical care in the measurement year	1,716 (29.7%)	1,719 (27.7%)	**-2.0%**
60% of new clients will be engaged in care	318 (67.9%)	420 (70.5%)	**2.6%**
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait 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 wait 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 2018, 83% 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 = 12 Days

Agency 1:	12
Agency 2:	6
Agency 3:	7
Agency 4:	26
Agency 5:	8
Agency 6:	10

For FY 2018, 83% 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 = 9 Days

Agency 1:	8
Agency 2:	5
Agency 3:	5
Agency 4:	19
Agency 5:	6
Agency 6:	9

Clinical Chart Review Measures*	FY 2016	FY 2017
100% of eligible clients will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	100%	93.0%
100% of pregnant women living with HIV will be prescribed antiretroviral therapy	100%	100%
75% of female clients will receive cervical cancer screening in the last three years	80.1%	82.5%
55% of clients will complete the vaccination series for Hepatitis B	55.6%	51.4%
85% of clients will receive HIV risk counseling within the measurement year	69.4%	90.7%
95% of clients will be screened for substance abuse (alcohol and drugs) in the measurement year	98.6%	99.1%
90% of clients who were prescribed antiretroviral therapy will have a fasting lipid panel during the measurement year	88.9%	88.8%
65% of clients at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	72.9%	77.6%
75% of clients will have documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since HIV diagnosis	66.9%	67.2%
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	53.1%	53.5%
95% of clients will be screened for clinical depression using a standardized tool with follow-up plan documented	87.9%	96.4%
90% of clients will have ever received pneumococcal vaccine	86.7%	83.4%
100% of clients will be screened for tobacco use at least one during the two-year measurement period	99.4%	100%
Percentage of clients who received cessation counseling intervention if identified as a tobacco user	57.7%	55.7%
95% of clients will be prescribed antiretroviral therapy during the measurement year	97.6%	98.7%
85% of clients will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	69.2%	71.4%
75% of eligible reproductive-age women will receive reproductive health care (fertility desires assessed and client counseled on conception or contraception)	54.0%	34.9%
90% of clients will be screened for Intimate Partner Violence	81.9%	78.6%
100% of clients on ART will be screened for adherence	99.5%	100.0%

* To view the full FY 2017 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2018 Report

Service Linkage / Non-Medical Case Management
All Providers

For FY 2018 (3/1/2018 to 2/28/2019), 7,646 clients utilized Part A non-medical case management.

HIV Performance Measures	FY 2017	FY 2018	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)	3,259 (46.0%)	3,548 (46.4%)	**0.4%**
60% of clients will access RW primary medical care for the first time after accessing service linkage for the first time	372 (44.4%)	459 (48.9%)	**4.5%**
Mean of less than 30 days between first ever service linkage visit and first ever primary medical care visit:			
Mean	40	27	**-32.5%**
Median	19	14	**-26.3%**
Mode	1	1	**0.0%**
60% of newly enrolled clients will have a medical visit in each of the four-month periods of the measurement year	119 (43.1%)	133 (47.7%)	**4.6%**

Primary Care Chart Review Report FY 2018

Ryan White Part A Quality Management Program – Houston EMA

October 2019

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2018, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to five organizations. Approximately 13,000 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 25, 2018, 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 3/1/18 and 2/28/19. 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 7,541 clients (adults age 18+) who accessed Part A primary care (excluding vision care) and had at least two visits, at least 90 days apart, between 3/1/18 and 2/28/19. The medical charts of 635 clients were used in this review, representing 8.4% 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 41.7% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

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

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/18-2/28/19				
	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	329	51.8%	5,551	73.6%
Female	265	41.7%	1,867	24.8%
Transgender Male to Female	41	6.5%	121	1.6%
Transgender Female to Male	0	0%	2	0%
TOTAL	**635**		**7,541**	
Race				
Asian	8	1.3%	101	1.3%
African-Amer.	317	49.9%	3,777	50.1%
Pacific Islander	0	0%	5	.1%
Multi-Race	2	.3%	48	.6%
Native Amer.	2	.3%	25	.3%
White	306	48.2%	3,585	47.5%
TOTAL	**635**		**7,541**	
Hispanic				
Non-Hispanic	393	61.9%	4,774	63.3%
Hispanic	242	38.1%	2,767	36.7%
TOTAL	**635**		**7,541**	
Age				
<=24	21	3.3%	370	4.9%
25-34	164	25.8%	2,215	29.4%
35-44	185	29.1%	2,096	27.8%
45-49	86	13.5%	912	12.1%
50-64	172	27.1%	1,840	25.4%
65 and older	7	1.1%	105	1.4%
Total	**635**		**7,541**	

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

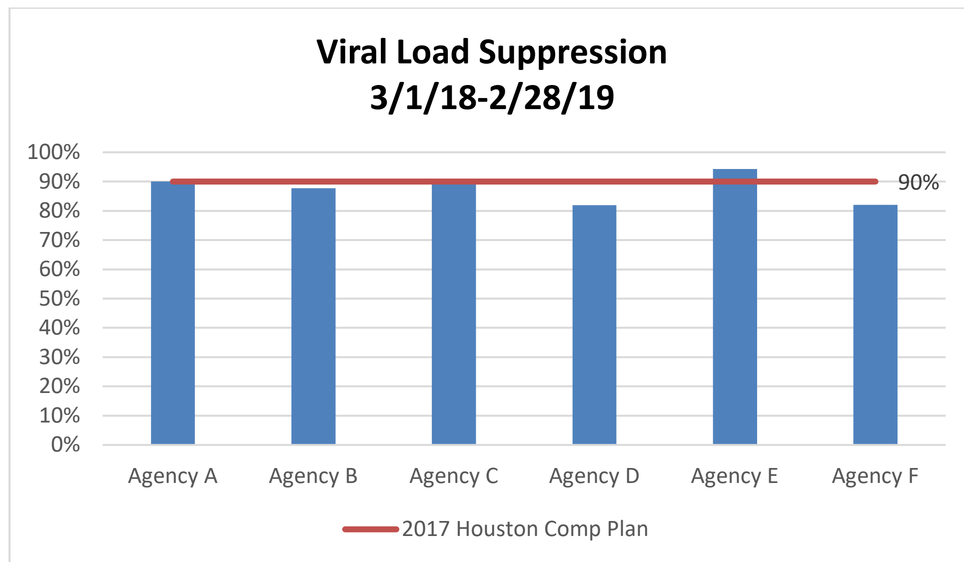
Core Performance Measures

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

	2016	2017	2018
Number of clients with viral load below limits of quantification at last test during the measurement year	544	535	553
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	615	626	630
Rate	**88.5%**	**85.5%**	**87.8%**
	2.1%	**-3%**	**2.3%**

2018 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	252	214	78
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	287	242	91
Rate	**87.8%**	**88.4%**	**85.7%**



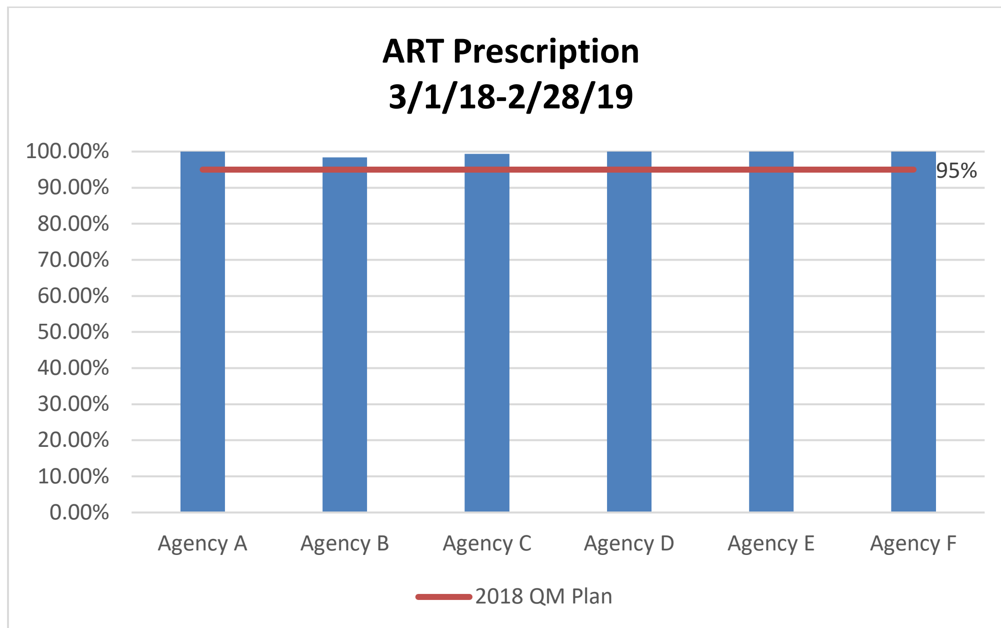
ART Prescription

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

	2016	2017	2018
Number of clients who were prescribed an ART regimen within the measurement year	620	627	631
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	**97.6%**	**98.7%**	**99.4%**
Change from Previous Years Results	**1.1%**	**1.1%**	**.7%**

- Of the 4 clients not on ART, none had a CD4 <200, 3 were long-term non-progressors, and 1 refused

2018 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	288	242	91
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	292	242	91
Rate	**98.6%**	**100%**	**100%**

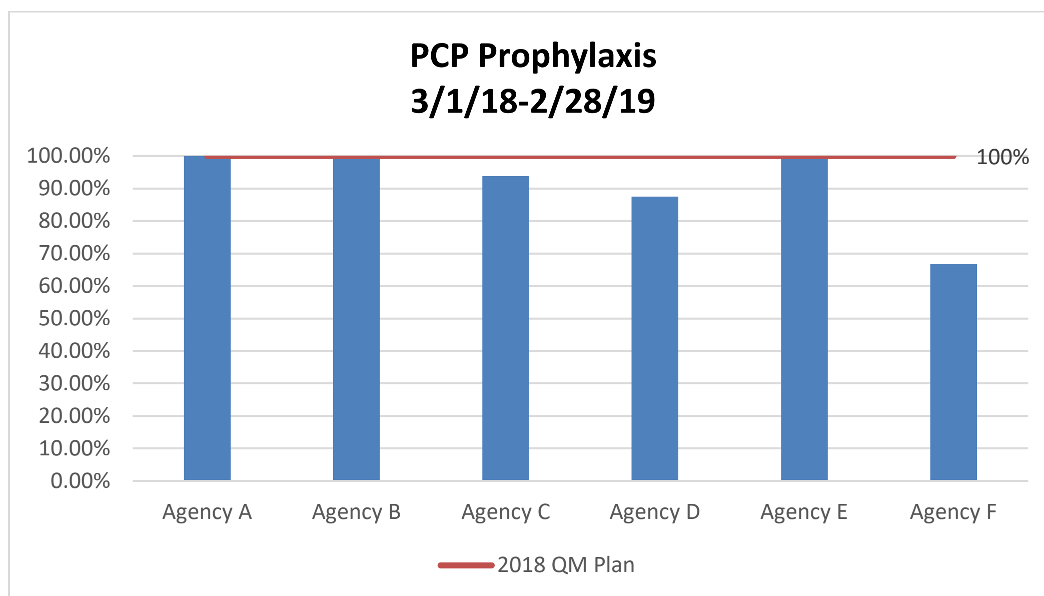


PCP Prophylaxis

- Percentage of clients living with HIV and a CD4 T-cell count below 200 cells/mm³ who were prescribed PCP prophylaxis

	2016	2017	2018
Number of clients with CD4 T-cell counts below 200 cells/mm³ who were prescribed PCP prophylaxis	48	53	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 • had a CD4 T-cell count below 200 cells/mm³, or any other indicating condition	48	57	66
Rate	**100%**	**93%**	**93.9%**
Change from Previous Years Results	**7%**	**-7%**	**.9%**

2018 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm³ who were prescribed PCP prophylaxis	30	21	11
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/mm³, or any other indicating condition	33	22	11
Rate	**90.9%**	**95.5%**	**100%**



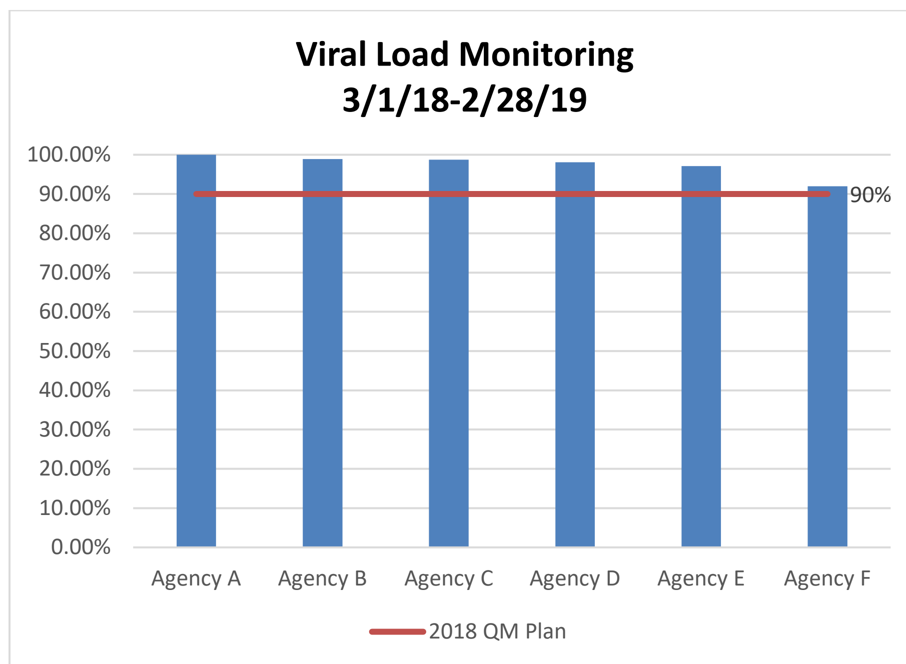
All Ages Performance Measures

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

	2016	2017	2018
Number of clients who had a viral load test performed at least every six months during the measurement year	601	622	624
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	**94.6%**	**98%**	**98.3%**
Change from Previous Years Results	**1.7%**	**3.4%**	**.3%**

2018 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	284	239	91
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	292	242	91
Rate	**97.3%**	**98.8%**	**100%**



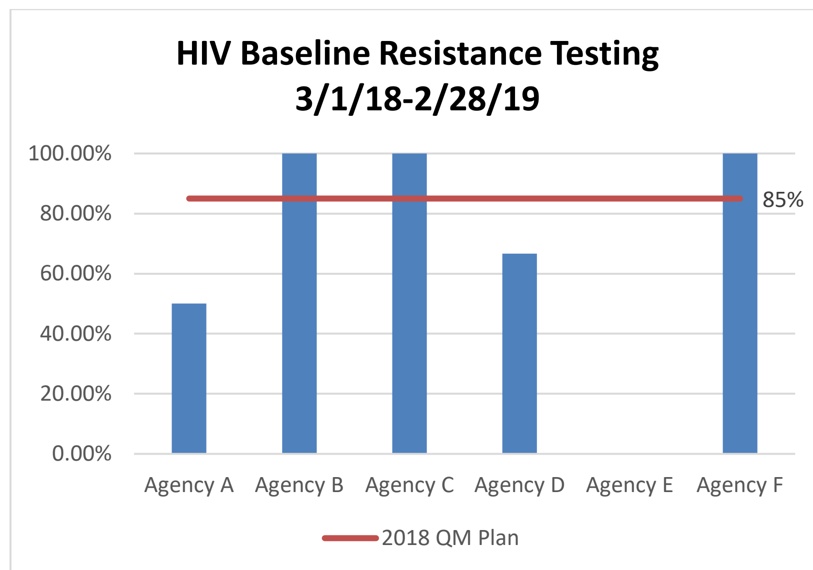
HIV Drug Resistance Testing Before Initiation of Therapy

- 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

	2016	2017	2018
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	9	5	6
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	13	7	8
Rate	**69.2%**	**71.4%**	**75%**
Change from Previous Years Results	**-.8%**	**2.2%**	**3.6%**

2018 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	2	3
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	3	3
Rate	**50%**	**66.7%**	**100%**

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



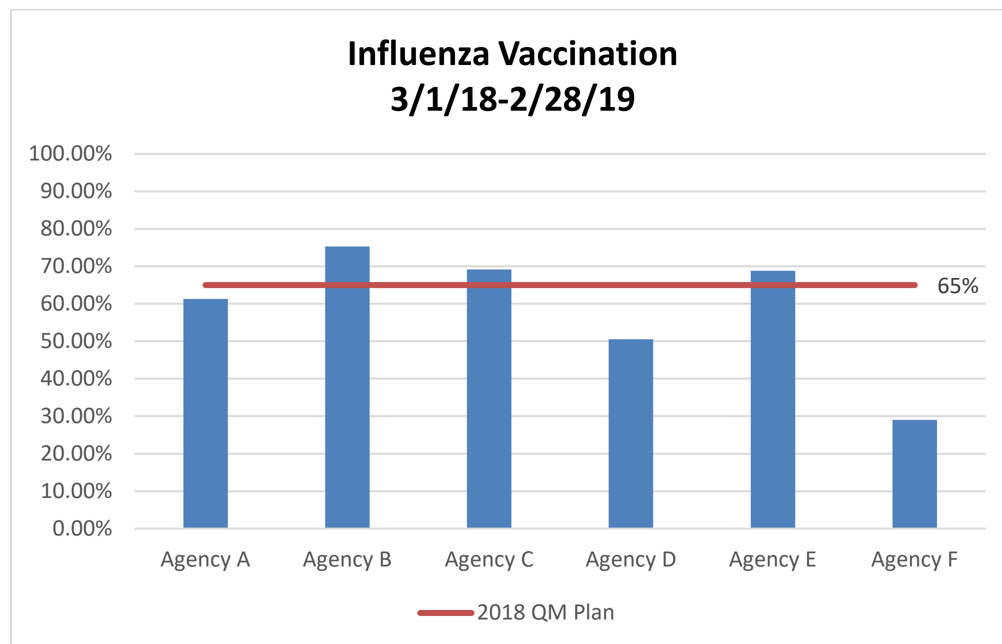
Influenza Vaccination

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

	2016	2017	2018
Number of clients who received influenza vaccination within the measurement year	312	310	336
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	588	579	534
Rate	**53.1%**	**53.5%**	**62.9%**
Change from Previous Years Results	**-3.2%**	**.4%**	**9.4%**

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

2018 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	124	145	61
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	233	210	81
Rate	**53.2%**	**69%**	**75.3%**

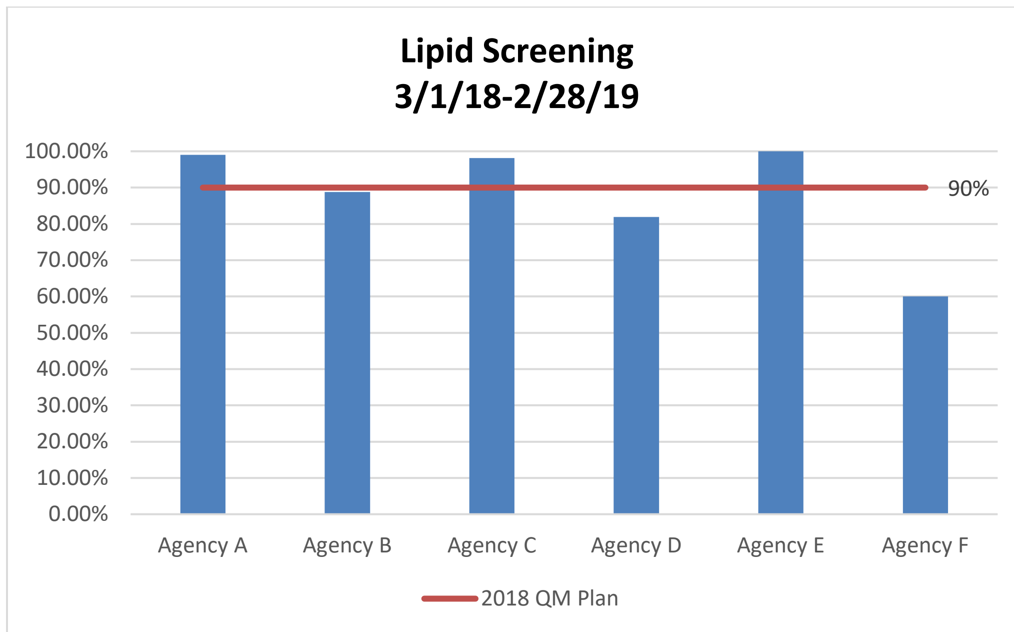


Lipid Screening

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

	2016	2017	2018
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	551	557	567
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	620	627	631
Rate	**88.9%**	**88.8%**	**89.9%**
Change from Previous Years Results	**.5%**	**-.1%**	**1.1%**

2018 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	256	219	82
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	288	242	91
Rate	**88.9%**	**90.5%**	**90.1%**

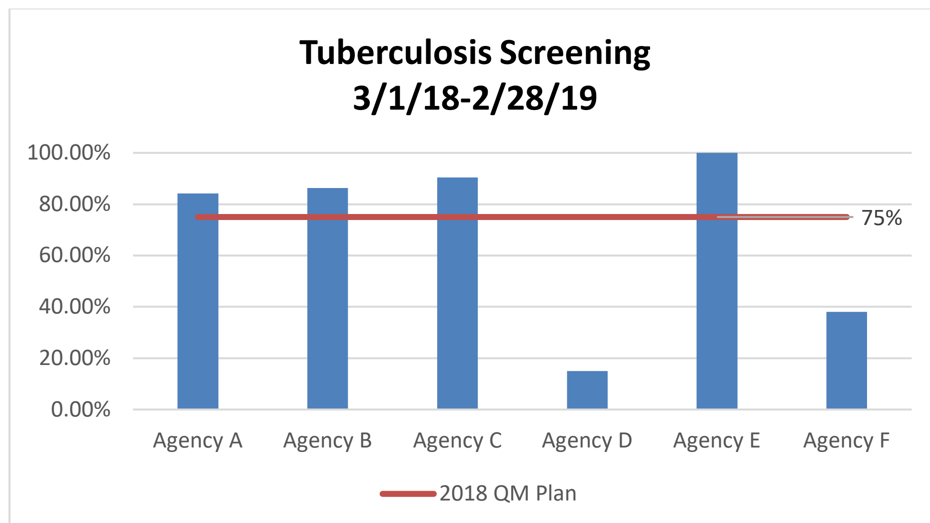


Tuberculosis Screening

- 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

	2016	2017	2018
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	382	375	401
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.	571	558	565
Rate	**66.9%**	**67.2%**	**71%**
Change from Previous Years Results	**-.2%**	**.3%**	**3.8%**

2018 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	177	164	57
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.	269	208	84
Rate	**65.8%**	**78.8%**	**67.9%**



Adolescent/Adult Performance Measures

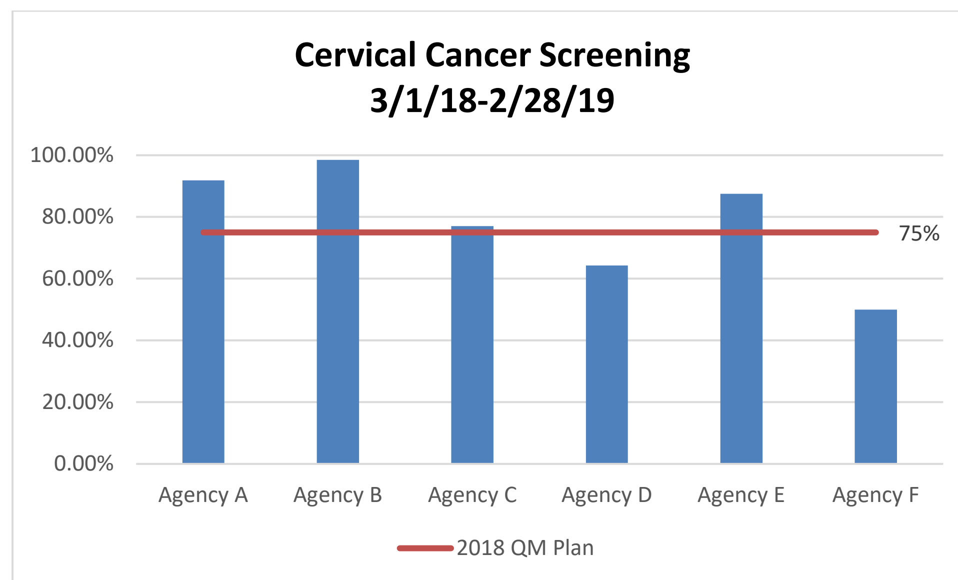
Cervical Cancer Screening

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

	2016	2017	2018
Number of female clients who had Pap screen results documented in the previous three years	229	226	199
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*	286	274	244
Rate	**80.1%**	**82.5%**	**81.6%**
Change from Previous Years Results	**11.9%**	**2.4%**	**-.9%**

- 20.6% (41/199) of pap smears were abnormal

2018 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	97	94	8
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	115	112	15
Rate	**84.3%**	**83.9%**	**53.3%**



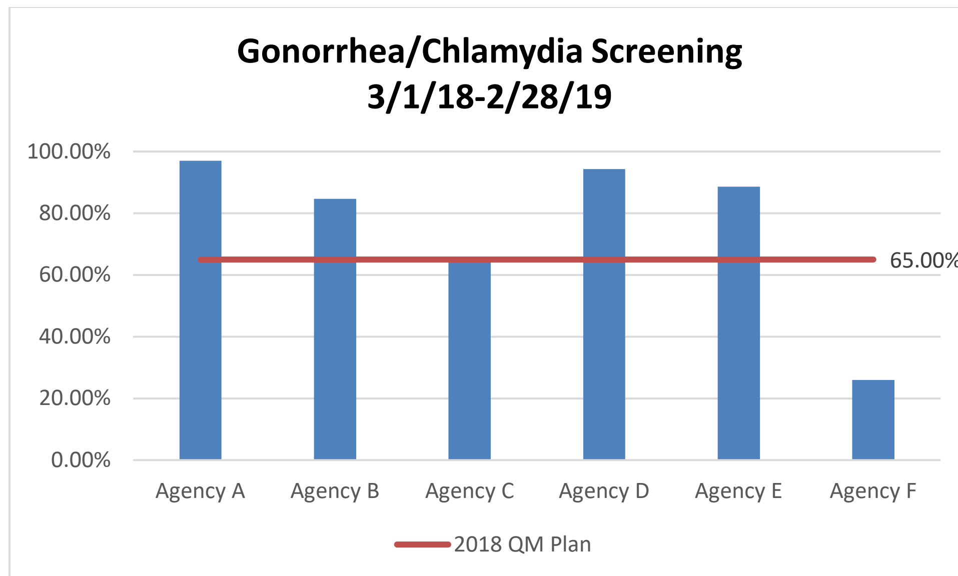
Gonorrhea/Chlamydia Screening

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

	2016	2017	2018
Number of clients who had a test for Gonorrhea/Chlamydia	463	493	501
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	**72.9%**	**77.6%**	**78.9%**
Change from Previous Years Results	**3.3%**	**4.7%**	**1.3%**

- 19 cases of chlamydia and 16 cases of gonorrhea were identified

2018 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	199	61
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**79.5%**	**82.2%**	**67%**



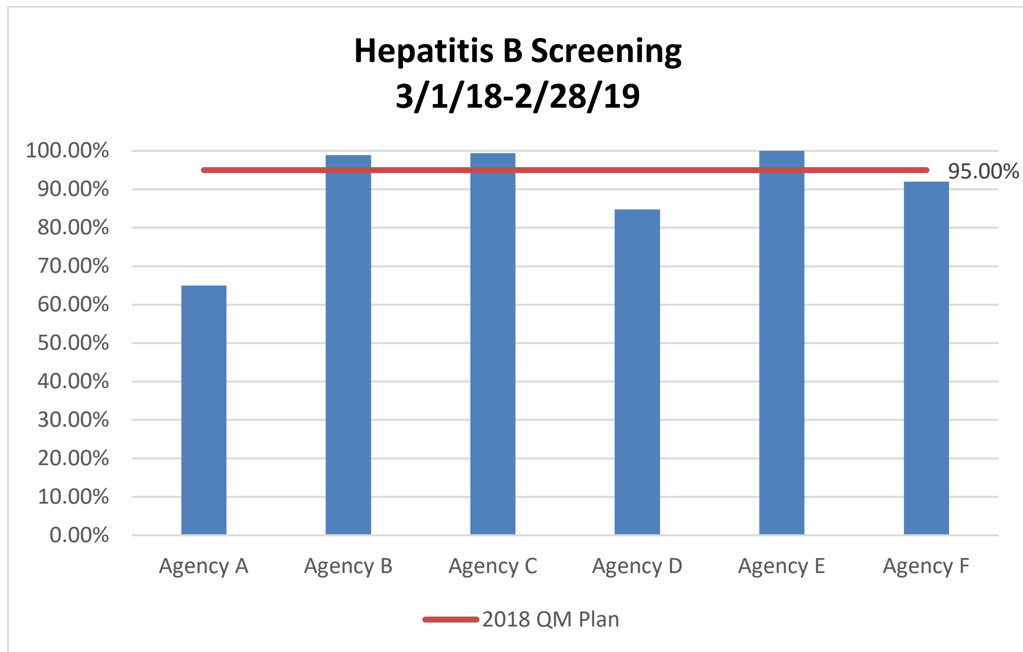
Hepatitis B Screening

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

	2016	2017	2018
Number of clients who have documented Hepatitis B infection status in the health record	610	553	577
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	**96.1%**	**87.1%**	**90.9%**
Change from Previous Years Results	**-3.7%**	**-9%**	**3.8%**

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

2018 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	266	220	81
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**91.1%**	**90.9%**	**89%**

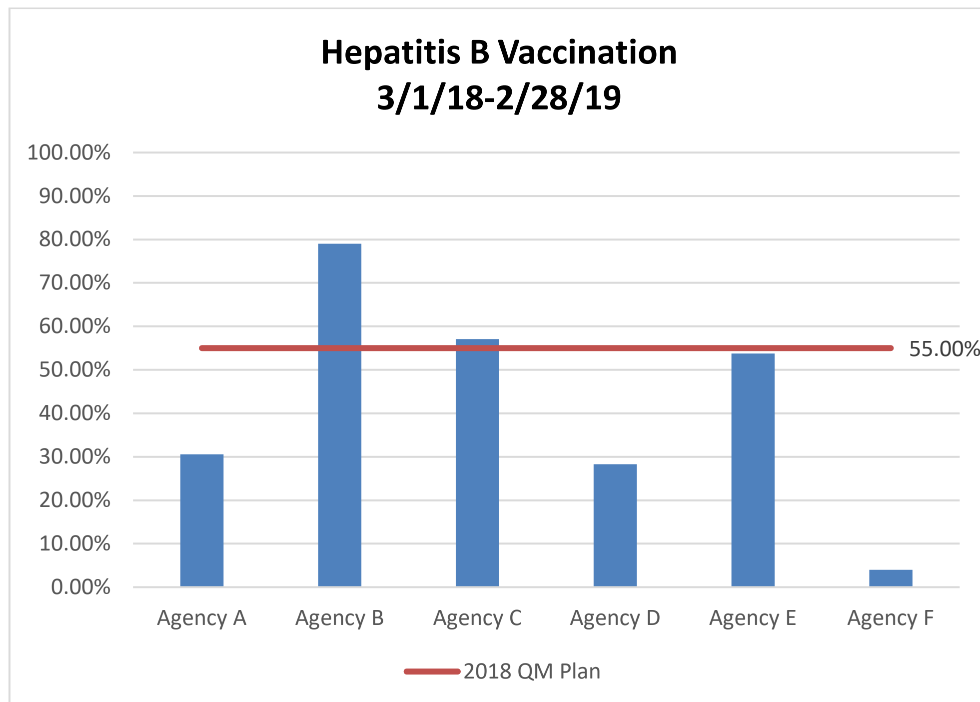


Hepatitis B Vaccination

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

	2016	2017	2018
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	179	196	171
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	322	381	347
Rate	**55.6%**	**51.4%**	**49.3%**
Change from Previous Years Results	**-4.3%**	**-4.2%**	**-2.1%**

2018 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	60	89	21
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	136	160	50
Rate	**44.1%**	**55.6%**	**42%**



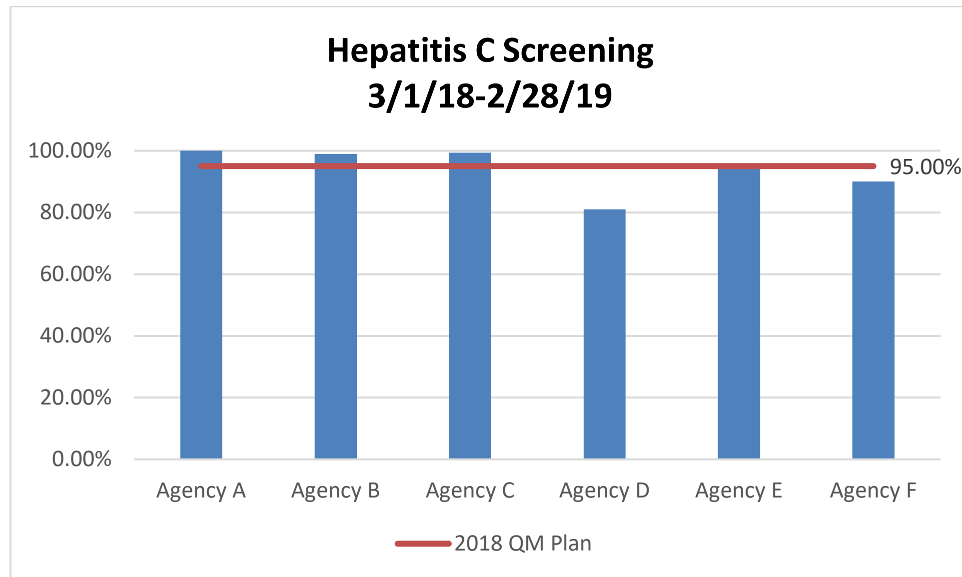
Hepatitis C Screening

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

	2016	2017	2018
Number of clients who have documented HCV status in chart	629	589	604
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	**99.1%**	**92.8%**	**95.1%**
Change from Previous Years Results	**-.6%**	**-6.3%**	**2.3%**

- 7.2% (46/635) were Hepatitis C positive, including 11 acute infections only and 19 cures

2018 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	273	234	87
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**93.5%**	**96.7%**	**95.6%**

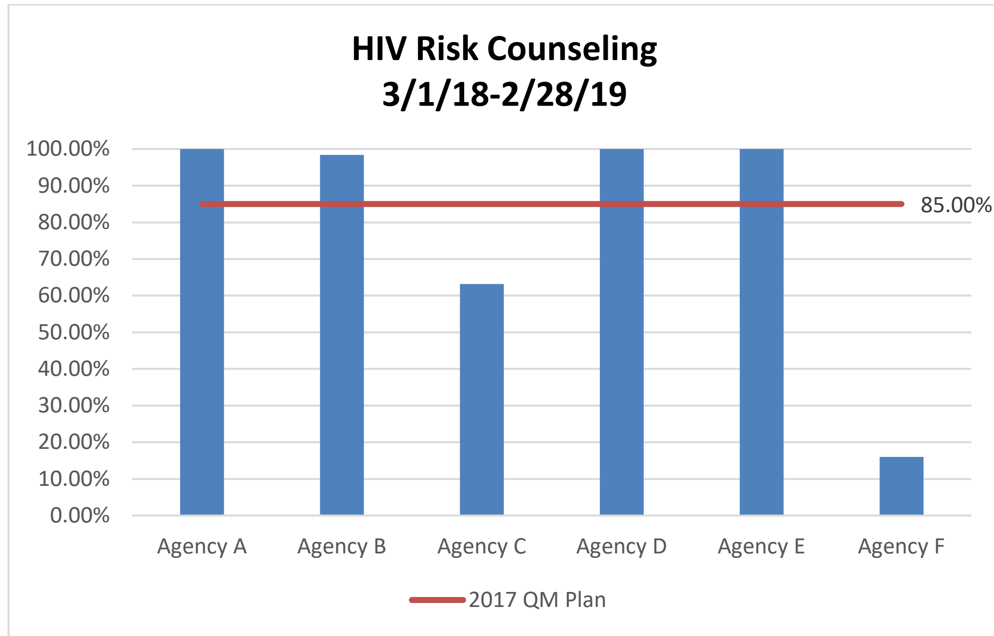


HIV Risk Counseling

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

	2016	2017	2018
Number of clients, as part of their primary care, who received HIV risk counseling	441	576	533
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	**69.4%**	**90.7%**	**83.9%**
Change from Previous Years Results	**-1.9%**	**21.3%**	**-6.8%**

2018 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	246	211	69
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**84.2%**	**87.2%**	**75.8%**

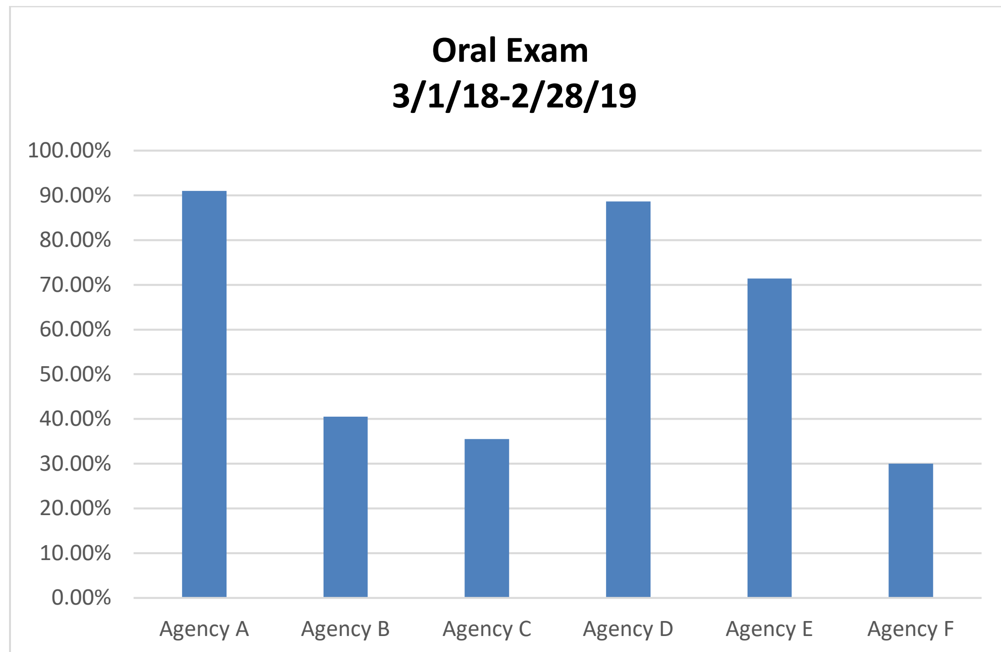


Oral Exam

- 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

	2016	2017	2018
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	327	272	355
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	**51.5%**	**42.8%**	**55.9%**
Change from Previous Years Results	**-2%**	**-8.7%**	**13.1%**

2018 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	165	142	44
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**56.5%**	**58.7%**	**48.4%**



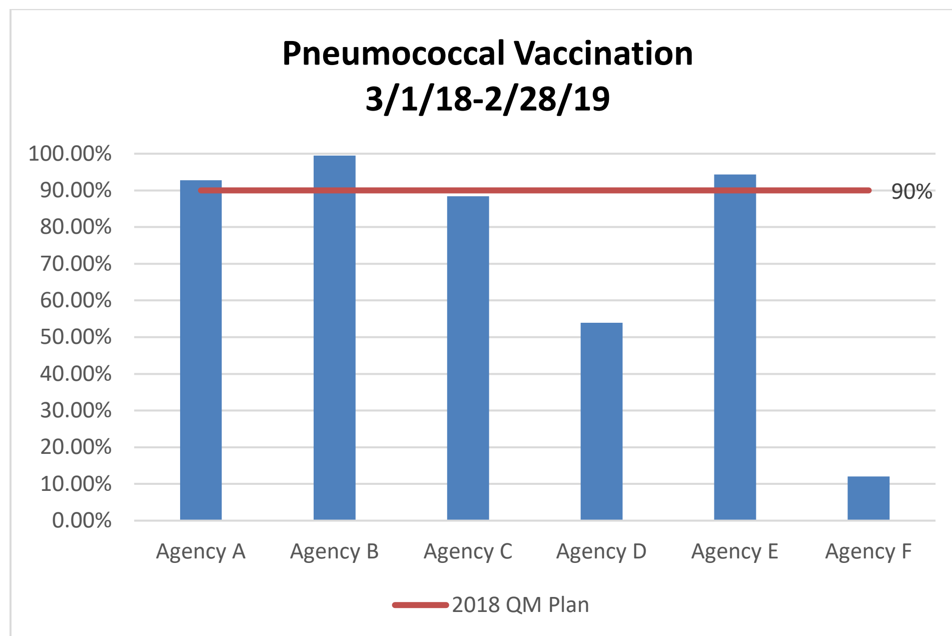
Pneumococcal Vaccination

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

	2016	2017	2018
Number of clients who received pneumococcal vaccination	534	514	507
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	616	616	610
Rate	**86.7%**	**83.4%**	**83.1%**
Change from Previous Years Results	**-1.1%**	**-3.3%**	**-.3%**

- 330 clients (65.1%) received both PPV13 and PPV23 (FY17- 60.5%, FY16- 49.4%)

2018 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	224	204	70
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	282	233	85
Rate	**79.4%**	**87.6%**	**82.4%**

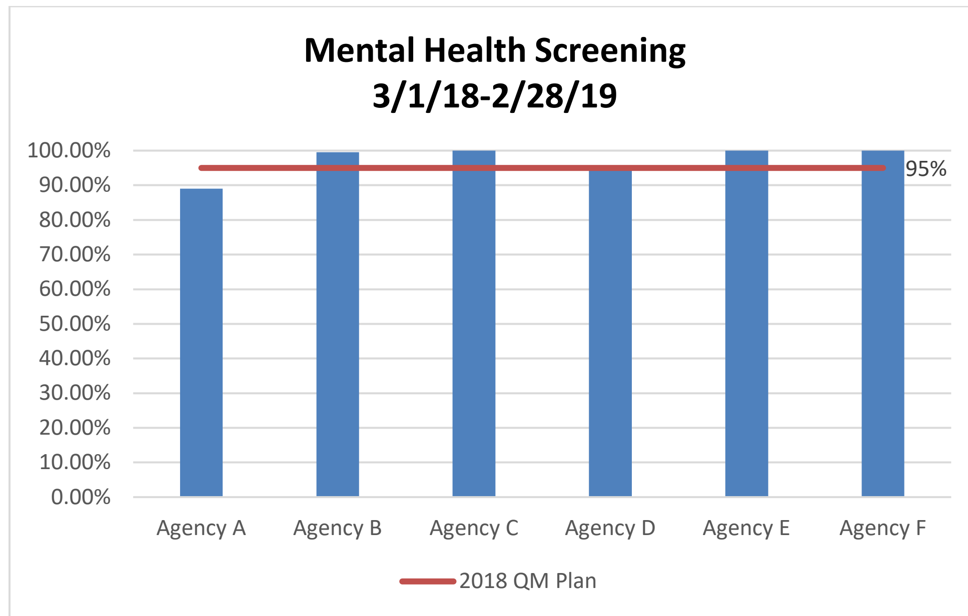


Preventative Care and Screening: Mental Health Screening

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

	2016	2017	2018
Number of clients who received a mental health screening	558	612	623
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	**87.9%**	**96.4%**	**98.1%**
Change from Previous Years Results	**-4.4%**	**8.5%**	**1.7%**

- 24.3% (154/635) had mental health issues. Of the 75 who needed additional care, 66 (88%) were either managed by the primary care provider or referred; 8 clients refused a referral.

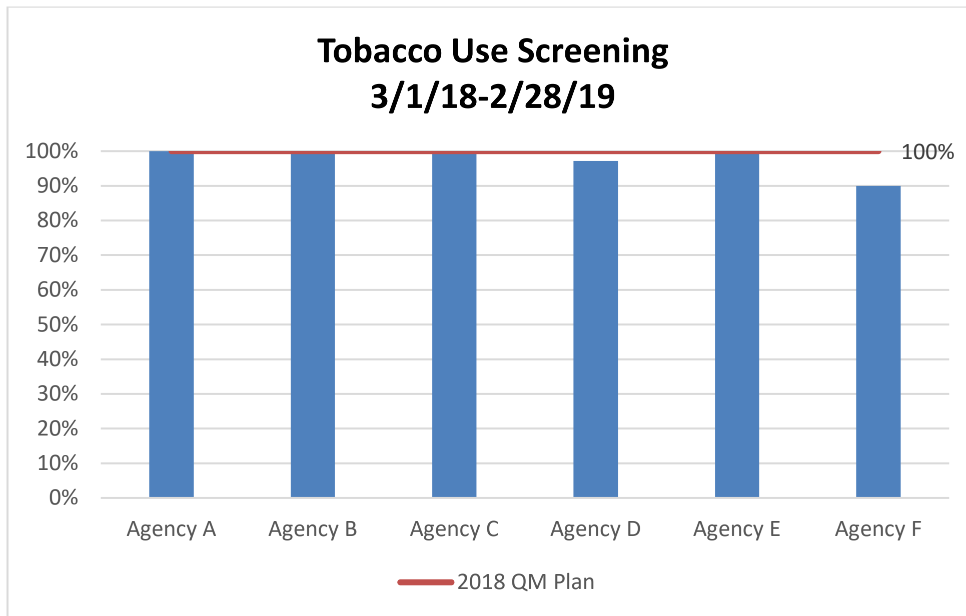


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

- 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

	2016	2017	2018
Number of clients who were screened for tobacco use in the measurement period	631	635	627
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.4%**	**100%**	**98.7%**
Change from Previous Years Results	**-.6%**	**.6%**	**-1.3%**

- Of the 627 clients screened, 177 (28.2%) were current smokers.
- Of the 177 current smokers, 120 (67.8%) received smoking cessation counseling, and 13 (7.3%) refused smoking cessation counseling



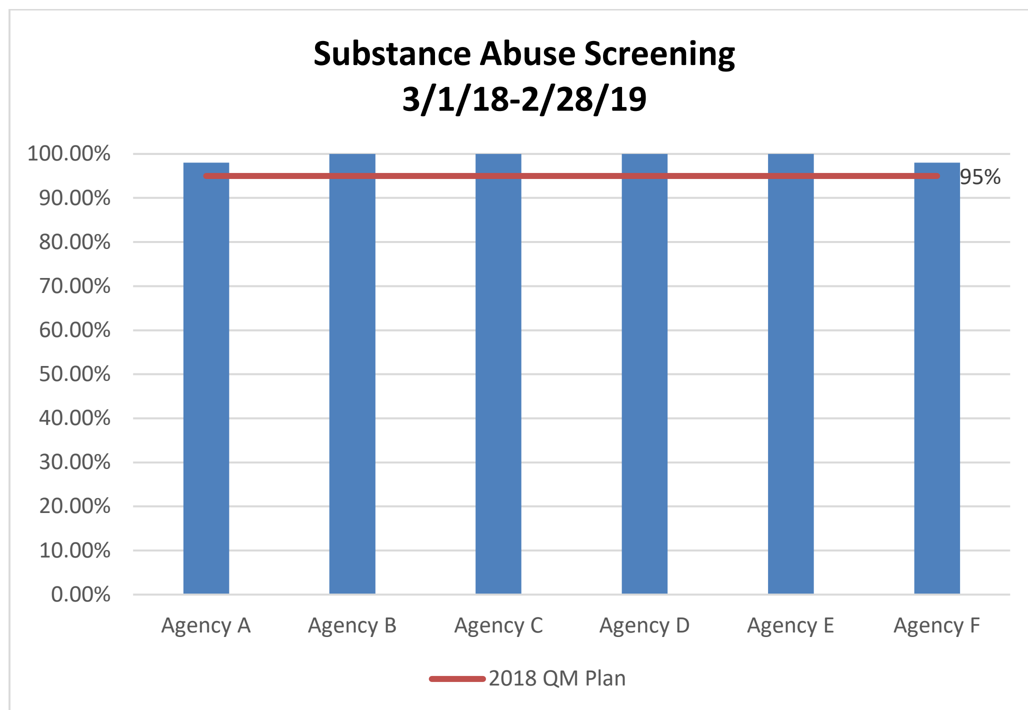
Substance Use Screening

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

	2016	2017	2018
Number of new clients who were screened for substance use within the measurement year	626	629	631
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.6%**	**99.1%**	**99.4%**
Change from Previous Years Results	**-.1%**	**.5%**	**.3%**

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

- 5.4% (34/635) had a substance use disorder. Of the 34 clients who needed referral, 27 (79.4%) received one, and 6 (17.6%) refused.

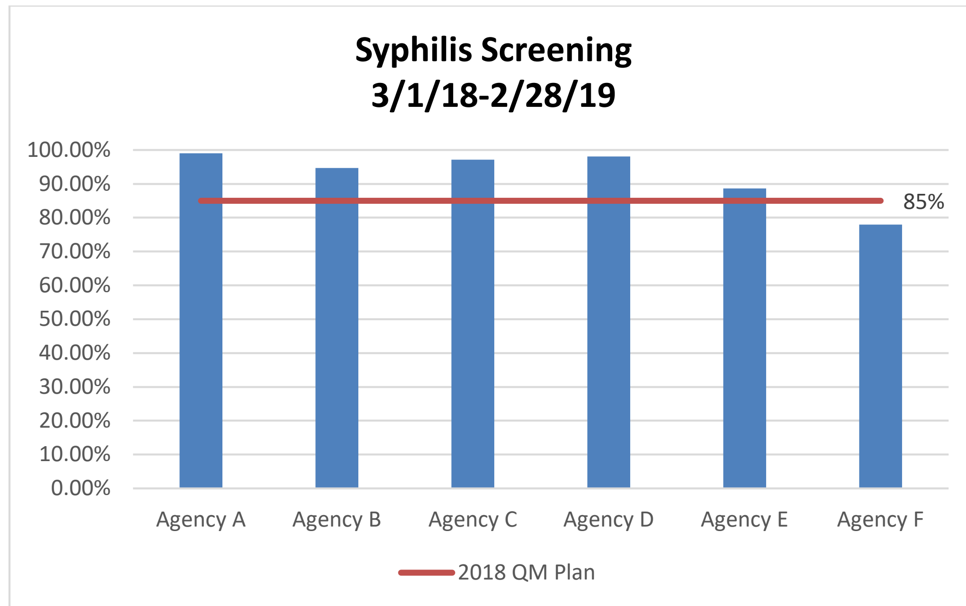


Syphilis Screening

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

	2016	2017	2018
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	597	587	602
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%**	**92.4%**	**94.8%**
Change from Previous Years Results	**-.3%**	**-1.6%**	**2.4%**

- 7.9% (50/635) new cases of syphilis diagnosed

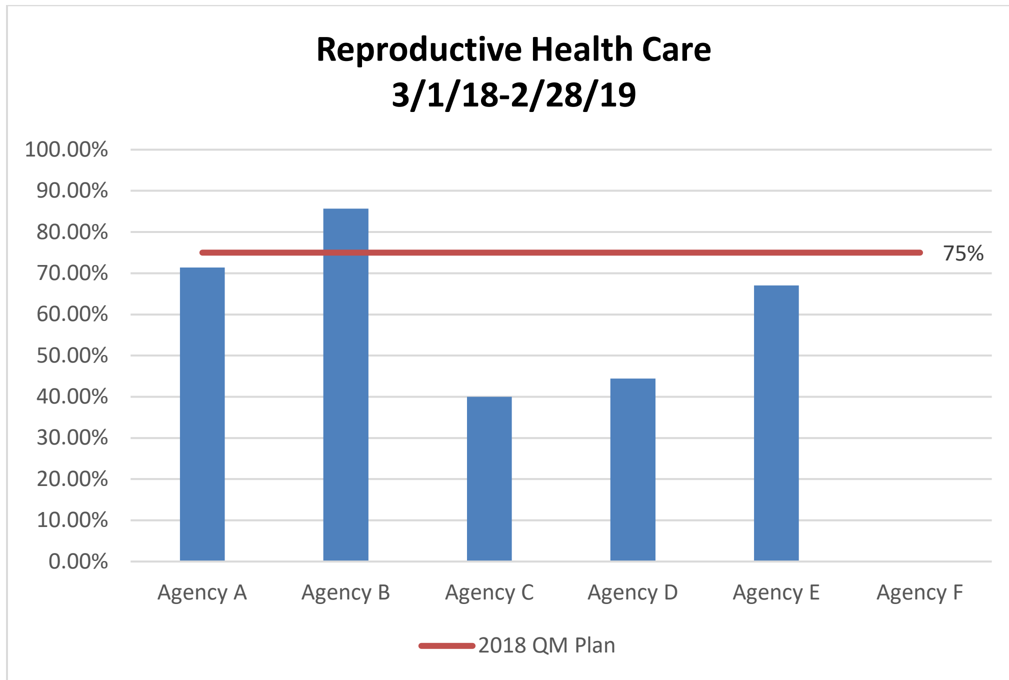


Other Measures

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)

	2016	2017	2018
Number of reproductive-age women who received reproductive health assessment and care	34	22	29
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	63	63	54
Rate	**54%**	**34.9%**	**53.7%**
Change from Previous Years Results	**4.7%**	**-19.1%**	**18.8%**

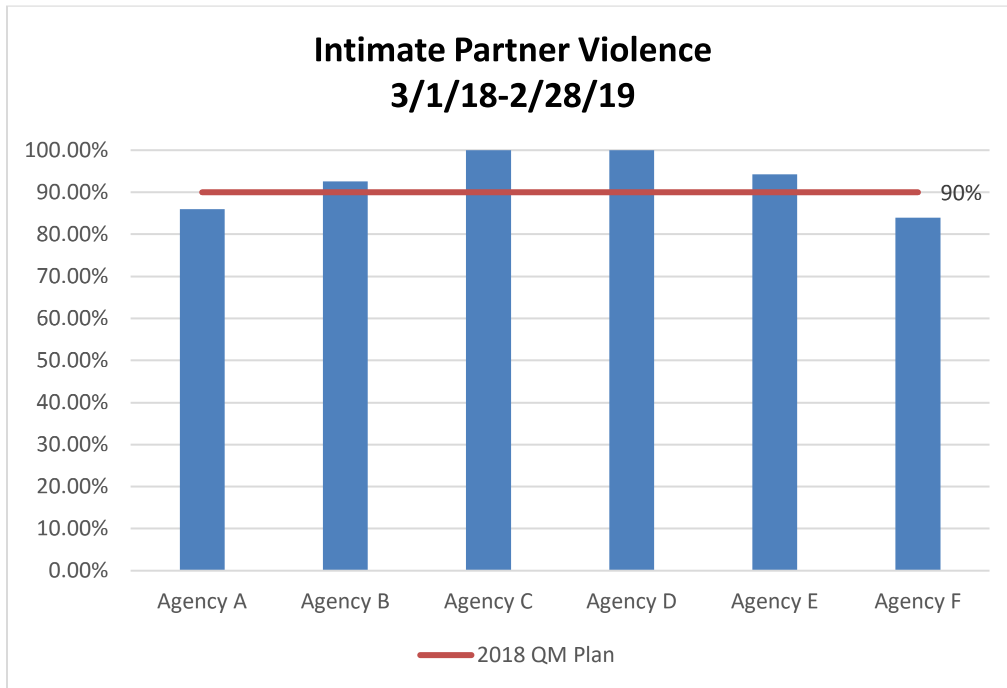


Intimate Partner Violence Screening

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

	2016	2017	2018
Number of clients who received screening for current intimate partner violence	520	499	592
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	**81.9%**	**78.6%**	**93.2%**
	-7.7%	**-3.3%**	**14.6%**

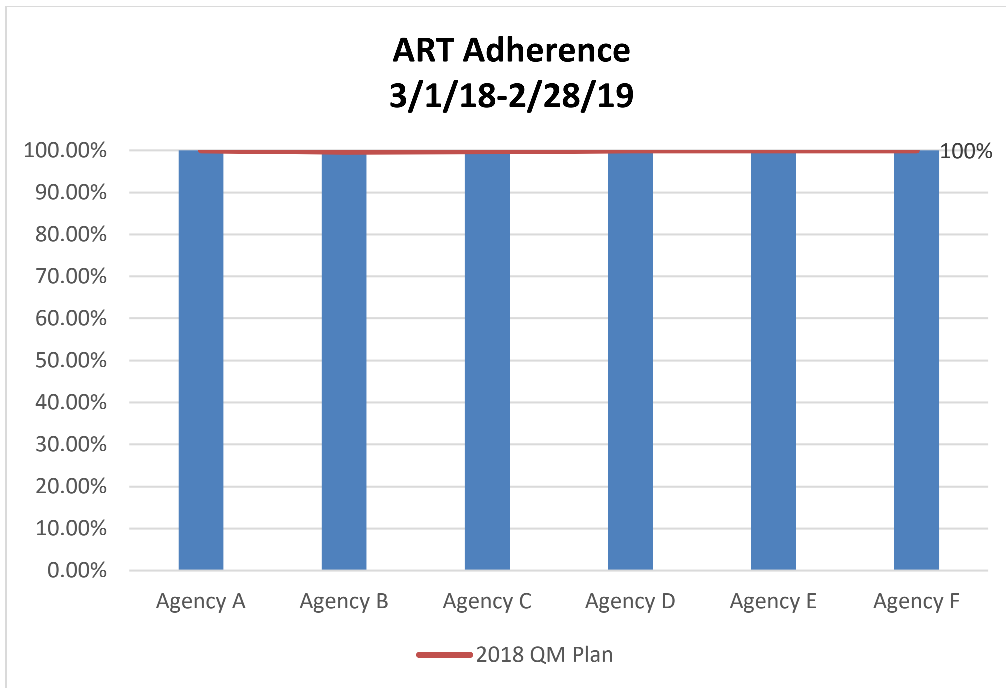
* 3/635 screened positive



Adherence Assessment & Counseling

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

	Adherence Assessment		
	2016	2017	2018
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	617	627	631
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	620	627	631
Rate	**99.5%**	**100%**	**100%**
Change from Previous Years Results	**.5%**	**.5%**	**0%**



ART for Pregnant Women

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

	2016	2017	2018
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	3	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	3	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

	2016	2017	2018
Number of diabetic clients whose last HbA1c in the measurement year was <8%	51	48	35
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	70	74	67
Rate	**72.9%**	**64.9%**	**52.2%**
Change from Previous Years Results	**15.5%**	**-8%**	**-12.7%**

- 635/635 (100%) of clients where screened for diabetes and 67/635 (10.6%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2016	2017	2018
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	133	166	145
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	180	206	180
Rate	**73.9%**	**80.6%**	**80.6%**
Change from Previous Years Results	**-1.8%**	**6.7%**	**0%**

- 145/635 (22.8%) of clients 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

	2016	2017	2018
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	133	150	141
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	180	171	164
Rate	**73.9%**	**87.7%**	**86%**
Change from Previous Years Results	**-1.8%**	**13.8%**	**-1.7%**

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

	2016	2017	2018
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	82	93	127
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	152	151	160
Rate	**53.9%**	**61.6%**	**79.4%**
Change from Previous Years Results	**3.2%**	**7.7%**	**17.8%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year. However, Viral Load Suppression has slightly increased, as has Influenza Vaccination, Intimate Partner Violence Screening, and Reproductive Health Care. HIV Risk Counseling experienced a decrease in performance. While some measures still demonstrate racial and ethnic disparities, the gap appears to be closing for other measures, including Viral Load Suppression. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 18
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

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Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 609 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2018- February 28, 2019. The chart review was conducted by the Project Coordinator for Quality Management Development, a Licensed Master Social Worker on the Ryan White Grant Administration team. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation as a, "range of client-centered services that link clients with health care, psychosocial, and other services," including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments." Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

While traditional, community-based case management models tend to provide intensive, individualized assistance to a limited and defined number of clients on a social worker's "case load," case management in this time and place resembles more of a "revolving door" model. This evolution is not unique to the Ryan White system of care. The National Association of Social Workers has identified this transformation of case management in the health care setting as a growing challenge for medical social workers[1]. Social workers have become sought out by health care institutions in order to add professionals to their practice who specialize in holistic, person-centered approaches. However, as the health care system itself changes, the role of a medical case managers has adapted to include the more administrative tasks that are necessary for managed care facilitates and reimbursement models to function.

In practical terms, this means that case managers are now more often performing tasks that registered nurses, benefits specialists, and medical assistants are equally skilled to perform, such as scheduling and reminders, basic health education, and insurance or coverage navigation. While it is clear that these are invaluable functions in the HIV treatment setting, it is a distinct shift away from the type of psychosocial work that social workers are trained to do, such as supportive counseling, task-centered motivational change, service planning and intensive follow-up, and accompaniment through the social services system. Unfortunately, as the HIV epidemic shifts to disproportionately impact low-income, marginalized communities with lower social capital and higher incidence of mental health concerns, this the exact type of professional help that is sorely underutilized in HIV care.

[1] National Association of Social Workers. (2016). *NASW Standards for Social Work Practice in Health Care Settings.*

While this description is certainly not true of all agencies or client records reviewed, the data presented in this year's chart review paints an overall picture of a case management system that is characterized by in-the-moment, on-demand requests, rather than ongoing contact at regular intervals. More than half of the clients in the sample (56%) had 3 or less interactions from a case manager within the review year and less than 11% of the medical case management clients received two "care plans" within the year. These findings are consistent with last year's review, in which the previous chart abstractor noted that, "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."

At the individual agency level, there are many noteworthy and innovative practices that were highlighted throughout the chart review process and quality management site interviews. For example, a lead case manager at one agency regular conducts chart review on the next day's patients in order to brief and essentially "pre-round" with the medical provider on their patient list. Another agency engages clients in their own assessments by having the patient self-administer the form so that it may be used as a conversation starter and way to build rapport, rather than a "cold interview" technique. Yet another agency has adapted their physical clinic layout to utilize a "pod" model in which at least one medical case manger and one service linkage worker is assigned to a provider, which functionally and closely resembles a case load model. One agency has an entirely separate benefits department that handles eligibility and enrollment for coverage programs, freeing up that responsibility from the case management team. All of these practices highlight opportunities and strengths within our Ryan White system for case management to continue as a value-added service for People Living with HIV.

The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

This tool has been developed with input from case management providers and previous chart abstractors and continues to be refined to prompt a more detailed chart review process. Since the tool and sample collection method continue to be revised each year, a retrospective comparison is not offered in this report, though previous reports are available upon request.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments and lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. Any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

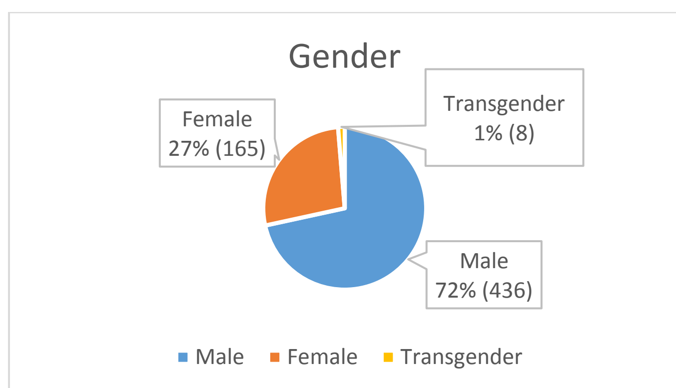
The chart abstraction tool was also reviewed by the Ryan White Grant Administration Quality Management team, the supervisors of the case management staff at each agency, and a Clinical Quality Improvement committee convened by Ryan White Grant Administration.

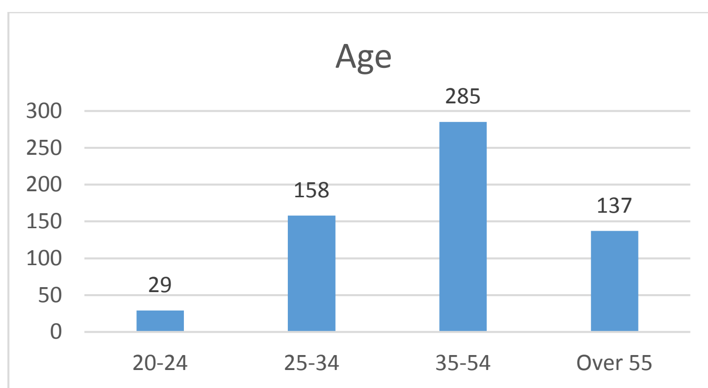
The Sample

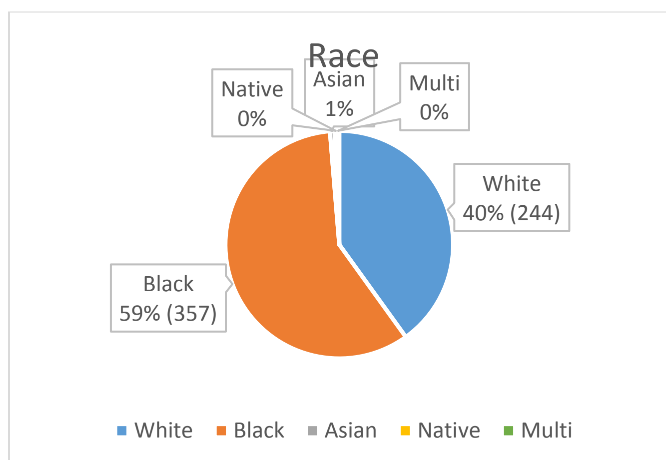
In order to conduct a thorough and comprehensive review, a total of 609 client records were reviewed across seven agencies for the 2018-2019 grant year. This included sixty (60) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator[2] based on the total eligible population that received case management services at each site.

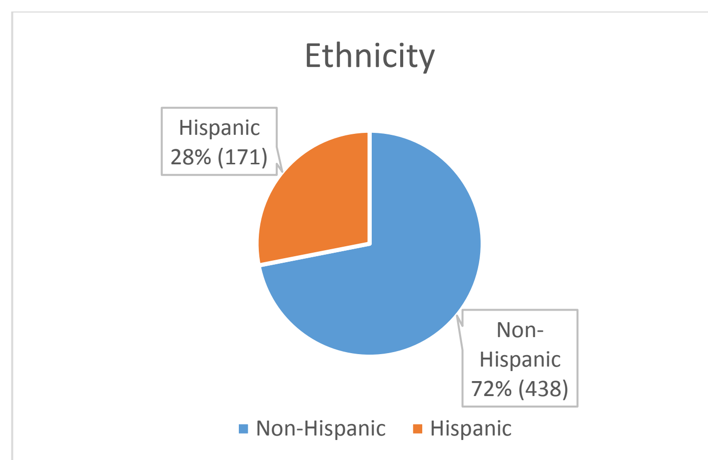
Agency	A	B	C	D	E	F	G
# of Charts Reviewed	67	105	97	70	105	105	60
TOTAL	609 (549 excluding non-PCare site)						

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2018- February 28, 2019 grant year was queried from the Centralized Patient Care Data Management System data base. The total eligible population from which the sample was drawn was a pool of 11,159 case management clients. The number of clients selected at each site is proportional to the number of case management clients served there. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.









[2] New York Department of Health AIDS Institute. (2006). *HIVQUAL Workbook: Guide for quality improvement in HIV care.* NY: U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau.

Health insurance coverage type was also analyzed according to the client's registration. More than half of the sample (55%) was uninsured; 24% was enrolled in either Medicaid, Medicare, or some combination; 7% had a private or commercial plan; and an additional 14% had an unknown insurance coverage status.

Cumulative Data Summaries

APPOINTMENTS & ENCOUNTERS
The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters for an HIV-related primary care appointment with a medical provider was counted. Any number of appointments above three per year was simply coded as 3 appointments. Any Viral Load/CD4 count lab test that accompanied the appointment was also recorded, which is shared on page 9.

# of appointments	A	B	C	D	E	F	TOTAL
0 appts.	6 (9%)	14 (13%)	15 (15%)	1 (1%)	11 (10%)	7 (7%)	54 (10%)
1 appts.	12 (18%)	13 (12%)	20 (21%)	12 (17%)	26 (25%)	24 (23%)	107 (19%)
2 appt.	23 (34%)	17 (16%)	21 (22%)	37 (53%)	44 (42%)	34 (32%)	176 (32%)
3 + appts.	26 (39%)	61 (58%)	41 (42%)	20 (29%)	24 (23%)	40 (38%)	212 (39%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*549 (100%)*

The overall sample trends towards a higher number of primary care appointment in the year, with the majority of the case management review clients having at least 3 appointments in the year (39%), followed by 32% of the clients having 2 appointments in the year, 19% having 1 appointment, and 10% of the sample having had 0 appointments.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The dates and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, Non-Medical Case Manager or Outreach Worker) and a general description of what was discussed during the encounter were also recorded.

*"Overall, the average number of case management encounters for the entire sample was **five (5)**."*

The distribution of frequency of case management encounters could be described as an inverted bell curve, with most of the clients clustering either at the low end of one encounter (29%) within the year or more than 5 encounters (30%).

# of CM encounters	A	B	C	D	E	F	G	TOTAL
1	1 (2%)	23 (21%)	20 (21%)	29 (41%)	53 (50%)	33 (31%)	15 (25%)	174 (29%)
2	2 (3%)	22 (21%)	10 (10%)	17 (24%)	22 (21%)	21 (20%)	3 (5%)	97 (16%)
3	3 (4%)	15 (14%)	13 (13%)	8 (11%)	8 (8%)	16 (15%)	4 (7%)	67 (11%)
4	3 (4%)	14 (13%)	13 (13%)	5 (7%)	5 (5%)	7 (7%)	1 (2%)	48 (8%)
5	3 (4%)	9 (9%)	9 (9%)	7 (10%)	7 (7%)	3 (3%)	4 (7%)	42 (7%)
Over 5	55 (82%)	22 (21%)	32 (33%)	4 (6%)	10 (10%)	25 (24%)	33 (55%)	181 (30%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*60 (100%)*	*609 (100%)*
Range	1-51	1-15	1-17	1-6	1-24	1-25	1-82	1-82
Average	11.8	3.75	5	2.4	2.8	4	11	5

29% of the clients in the sample had just one case management encounter within the review year while another 30% had more than five, with the highest amount of encounters for one client being 82 within the grant year. Overall, the average number of encounters for the entire sample was five case management encounters. Neither race nor gender had a significant impact on the average number of encounters. The average number of encounters for clients who had contact with a Medical Case Manager was double that of those who did not have contact with a Medical Case Manager throughout the year, at six and three encounters, respectively. The agency with the highest average frequency of case management encounters averaged nearly one encounter per month, at 11.8.

*The average number of encounters for clients who had contact with a Medical Case Manager was **six**, while the average for those who did not work with an MCM was **three**.*

VIRAL SUPPRESSION

Any results of HIV Viral Load + CD4 count laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as "Suppressed." Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as "Unsuppressed." Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as "Mixed Status," and clients who had no laboratory tests done within the entire year were coded as "Unknown."

Therefore, it is important to note that the "VL Suppression Rate" is presented in two different ways in the chart below. The top rate, in blue, is the more conservative analysis of the percentage of clients who were coded as "Suppressed." In other words, it is the percentage of clients within the sample who were suppressed for *all* of their recorded labs during the year, which could be loosely interpreted as "durably suppressed." The second VL Suppression Rate offered in red is the more standardly used HRSA HAB Performance Measure[3] of having the *most recent* laboratory result on file under 200 copies/mL.

VL Status	A	B	C	D	E	F	TOTAL
VL Suppression Rate	69% 73%	55% 59%	55% 60%	66% 67%	59% 60%	64% 64%	60% 63%
Suppressed	46 (69%)	58 (55%)	53 (55%)	46 (66%)	62 (59%)	67 (64%)	332 (60%)
Mixed Status	8 (12%)	17 (16%)	12 (12%)	11 (16%)	9 (9%)	11 (10%)	68 (12%)
Unknown	5 (7%)	17 (16%)	19 (20%)	2 (3%)	15 (14%)	7 (7%)	65 (12%)
Unsuppressed	8 (12%)	13 (12%)	13 (13%)	11 (16%)	19 (18%)	20 (19%)	84 (15%)
NO INTERVENTION	6 (9%)	16 (15%)	10 (10%)	1 (1%)	11 (10%)	4 (4%)	48 (9%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*549 (100%)*

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate between 60-63%, depending on which estimate is used. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to a number of factors, most likely of which is the difference in characteristics of the two reviews' samples. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, "fluctuating viral load" is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

Of particular interest in this review was the role of case management staff when a client received an unsuppressed laboratory result. For clients who were coded as "Unsuppressed," "Mixed Status," or "Unknown," the overall narrative of the client record was also reviewed to understand whether intervention from case management would have been appropriate and whether a CM staff did intervene to better coordinate care, encourage retention, or provide education on medication adherence. Overall, less than 10% of the sample (9%) was unsuppressed at some point during the review year *and* did not receive case management intervention when it would have been appropriate.

[3] Health Resources and Services Administration HIV/AIDS Bureau. (2019, December). Performance Measure Portfolio. Retrieved from https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered "New to Care," if they were receiving services for the first time at that particular agency (so not necessarily new to HIV treatment or the Houston Ryan White system of care). "Lost to Care" was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. "Re-engaged in Care" was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

Care Status	A	B	C	D	E	F	TOTAL
New to Care	6 (9%)	23 (22%)	5 (5%)	13 (19%)	6 (6%)	3 (3%)	56 (10%)
Lost to Care	6 (9%)	11 (10.5%)	12 (12%)	3 (4%)	9 (9%)	9 (9%)	50 (9%)
Re-engaged in Care	3 (4.5%)	6 (6%)	12 (12%)	2 (3%)	15 (14%)	14 (13%)	52 (10%)
New + Later Lost	3 (4.5%)	4 (4%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	8 (1%)
Re-engaged + Lost	0 (0%)	9 (8.5%)	5 (5%)	1 (1%)	2 (2%)	1 (1%)	18 (3%)
Coordination of Care	*94% (17 of 18)*	*70% (37 of 53)*	*65% (22 of 34)*	*85% (17 of 20)*	*94% (30 of 32)*	*78% (21 of 27)*	*78% (144 of 184)*
N/A	49 (73%)	52 (49%)	63 (65%)	50 (71%)	73 (69%)	78 (74%)	365 (67%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*549*

Overall, 10% of the sample was considered New to Care, 9% was Lost to Care, and 10% was Re-engaged in Care. An additional 1% initiated services and were later lost, and 3% returned to care and were then later lost to care again within the same year. Notably, two agencies had a higher than average percentage of New to Care clients within their sample, with 22% of Agency B clients and 19% Agency D clients being new.

When a client's attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as "Coordination of Care" were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance or introduction at the first appointment, or home visits. For agencies funded for Outreach Services, several progress notes appeared for clients who were lost or re-engaged in care. In the future, a more focused chart review sample of Outreach services may help to shed light on the benefits of this service category.

Every agency reviewed had policies and procedures in place for retention in care, as evidenced by both materials submitted as part of the Quality Management site visit and the percentage of New, Lost, and Re-engaged clients who received some type of retention in care service or service attempt. 78% of the clients within the sample who would have been subject to Coordination of Care services were contacted or assisted by staff in an effort to retain them in care. Some agencies had remarkably high Coordination of Care rates, at 94%.

COMORBIDITIES
In an effort to understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

MENTAL HEALTH & SUBSTANCE ABUSE (history or active)

Any diagnosis of a mental health disorder (MH) or substance abuse issue (SA) was recorded in the chart review tool, including a history of mental illness or substance abuse. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SA diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or substance abuse, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SA issues. Any conditions other than alcohol abuse, other substance abuse, depression, bipolar disorder, anxiety, or schizophrenia were recorded as "Other." The most common types of conditions that became coded as "Other" were Post-Traumatic Stress Disorder and Adjustment Disorder.

	A	B	C	D	E	F	G	TOTAL
% of sample w/ MH or SA issue	**51%**	**45%**	**49%**	**39%**	**53%**	**61%**	**80%**	53% (323 of 609)
Alcohol abuse/ dependence	9 (13%)	8 (8%)	7 (7%)	1 (1%)	4 (4%)	9 (9%)	6 (10%)	44 (7%)
Other Substance Abuse/ Dependence	7 (10%)	15 (14%)	19 (20%)	11 (16%)	38 (36%)	27 (26%)	13 (22%)	130 (21%)
Depression	15 (22%)	34 (32%)	24 (25%)	9 (13%)	22 (21%)	41 (39%)	12 (20%)	157 (26%)
Bipolar Disorder	6 (9%)	10 (10%)	7 (7%)	6 (9%)	6 (6%)	5 (5%)	9 (15%)	49 (8%)
Anxiety	13 (19%)	11 (10%)	17 (18%)	5 (7%)	5 (5%)	15 (14%)	6 (10%)	72 (12%)
Schizophrenia	3 (4%)	2 (2%)	1 (1%)	0 (0%)	7 (7%)	1 (1%)	2 (3%)	16 (3%)
Other	12 (18%)	16 (15%)	27 (28%)	6 (9%)	9 (9%)	16 (15%)	32 (53%)	118 (19%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*60*	*609*

Overall, 53% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SA issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE ABUSE REFERRALS

For clients with an *active* diagnosis of a mental health or substance abuse issue, the chart abstractor recorded if they were referred or already engaged in MH/SA services. This measure was *not* inclusive of clients who had a previous history of symptoms or whose recovery treatment was considered long complete. Because of this, the percentage in the top row of the previous chart and the percentage of clients considered "N/A" for a MH/SA referral do not equal 100%.

Received MH Referral?	A	B	C	D	E	F	G	TOTAL
N/A	39 (58%)	64 (61%)	54 (56%)	46 (66%)	68 (65%)	50 (48%)	7 (12%)	328 (54%)
Yes	25 (37%)	28 (27%)	38 (39%)	24 (34%)	35 (33%)	52 (50%)	53 (88%)	255 (42%)
No	3 (5%)	13 (12%)	5 (5%)	0 (0%)	2 (2%)	3 (3%)	0 (0%)	26 (4%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*60 (100%)*	*609 (100%)*

Overall, 54% of the sample would not have been appropriate for a MH or SA referral based on the information available in their medical record. An additional 42% either did receive a referral or were already engaged in treatment and 4% did not receive a referral. This means that 91% of the sample (or 255 out of 281 individuals) who should have received a referral did receive one, according to their medical chart.

91% of the sample with active MH or SA symptoms was either referred for further counseling or treatment or already engaged in services.

MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 31% and 23% prevalence within the sample, respectively. Insomnia was the most common co-occurring condition that was coded in the "Other" category.

	A	B	C	D	E	F	TOTAL
Opportunistic Infection	2 (3%)	2 (2%)	2 (2%)	1 (1%)	4 (4%)	3 (3%)	14 (3%)
STI	11 (16%)	38 (36%)	37 (38%)	28 (40%)	23 (22%)	32 (30%)	169 (31%)
Diabetes	11 (16%)	12 (11%)	4 (4%)	4 (6%)	20 (19%)	8 (8%)	59 (11%)
Cancer	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (4%)	1 (1%)	5 (1%)
Hepatitis	4 (6%)	24 (23%)	6 (6%)	4 (6%)	17 (16%)	7 (7%)	62 (11%)
Hypertension	12 (18%)	18 (17%)	25 (26%)	13 (19%)	28 (27%)	29 (28%)	125 (23%)
Other	14 (21%)	15 (14%)	15 (15%)	18 (26%)	21 (20%)	6 (6%)	89 (16%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*549*

SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified "Social Condition" within the sample. 4% of the sample reported experiencing some other type of social issue, the most common of which being a disclosed history of childhood sexual abuse.

	A	B	C	D	E	F	G	TOTAL
Homelessness or housing-related issues	4 (6%)	11 (10%)	9 (9%)	11 (16%)	8 (8%)	11 (10%)	6 (10%)	60 (10%)
Pregnancy or pregnancy-related issues	2 (3%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	4 (1%)
Recently released	0 (0%)	5 (5%)	2 (2%)	5 (7%)	5 (5%)	6 (6%)	5 (8%)	28 (5%)
Intimate Partner Violence	3 (4%)	2 (2%)	0 (0%)	2 (3%)	2 (2%)	3 (3%)	2 (3%)	14 (2%)
Other	3 (4%)	2 (2%)	3 (3%)	3 (4%)	5 (5%)	7 (7%)	2 (3%)	25 (4%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*60*	*609*

CASE MANAGEMENT ROLE DELEGATION

One area of interest for the Ryan White Grant Administration Quality Management team is to quantify and better help address the workflow and role delegation of medical case management and non-medical case management staff within the Ryan White system of care. According to the service category definitions and funding structure, care should be taken to ensure that clients are assigned to work with case management staff according to their level of need.

Individuals who have higher, more intensive levels of need that interfere with their ability to stay successful in HIV treatment should be assigned to work with a licensed social worker for medical case management services. Individuals who have lower, more intermittent need that could be assisted through straight forward referral and follow-up (versus ongoing management) are more appropriate for non-medical case management services by Service Linkage Workers. Client needs and acuity levels should be assessed at intake and monitored throughout regular periods in the year to continuously evaluate what services and staff would be the best “fit” for a client’s individual needs. In this way, resources can be appropriately allocated within the system of care and clients can be assigned to work with someone who can best meet their needs.

For these reasons, the chart abstractor documented what type of case manager each client worked with (a Medical Case Manager or Service Linkage Worker) and whether that client met the specified eligibility criteria for medical case management. It was also not uncommon for clients to work with both a Medical Case Manager *and* Service Linkage Worker within the same year, either because their level of need changed or to ensure that a client’s issues were addressed in a timely manner, regardless of whether the most appropriate staff member was available in the clinic.

	A	B	C	D	E	F	TOTAL
Worked with MCM	51 (76%)	67 (64%)	70 (72%)	34 (49%)	16 (15%)	47 (45%)	285 (52%)
Met criteria for MCM	*37 (73%)*	*34 (51%)*	*68 (97%)*	*30 (88%)*	*16 (100%)*	*44 (94%)*	*229 (80%)*
Worked primarily with SLW	17 (25%)	48 (46%)	62 (64%)	40 (57%)	96 (91%)	59 (56%)	322 (59%)
Met criteria for MCM	*3 (18%)*	*11 (23%)*	*8 (13%)*	*7 (18%)*	*16 (18%)*	*11 (19%)*	*56 (17%)*
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*549*

52% of the sample worked with a Medical Case Manager (licensed social worker) at any point within the review year and 80% of those clearly met the eligibility criteria for medical case management. An additional 7% of the sample was marked as “unknown” for whether they met the medical case management eligibility criteria, as a way for the chart abstractor to acknowledge that there may be more detail to the client’s case than the information available in the medical record.

59% of the sample *primarily* worked with a Service Linkage Worker (SLW) within the review year, meaning that they either only worked with an SLW, or all of their interactions except for one were with an SLW. Of those, 17% had some information available in their medical record indicating that they technically met the criteria for medical case management and may have been considered more appropriate to work with a licensed social worker.

COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp. Assessments	A	B	C	D	E	F	G	TOTAL
0	18 (27%)	28 (27%)	23 (24%)	2 (3%)	10 (10%)	7 (7%)	13 (22%)	101 (17%)
1	27 (40%)	34 (32%)	14 (14%)	31 (44%)	3 (3%)	38 (36%)	15 (25%)	162 (27%)
2	6 (9%)	2 (2%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	4 (7%)	16 (3%)
N/A	16 (24%)	41 (39%)	60 (62%)	36 (51%)	91 (87%)	58 (55%)	28 (47%)	330 (54%)
Completion Rate	**97%**	**70%**	**46%**	**100%**	**93%**	**91%**	**91%**	94% (570 out of 609)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*60*	*609*

The date of each assessment was recorded in the chart abstraction tool. The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined in the previous section, 48% of the sample did not work with a Medical Case Manager within the year. An additional 6% were served by a Medical Case Manager for a one-time, immediate need which was justified by staffing needs, most often an ADAP application or re-certification issue. 17% of the sample received zero comprehensive assessments, 27% received one, and 3% received two.

Completion Rate for this analysis was defined as the percentage of eligible medical case management clients who were assessed *at least once* throughout the year *or* had a documented reason for why they did not receive a comprehensive assessment (most often this was because the client declined or because they were no longer receiving medical case management services), *or*¸ they had evidence of an assessment just outside of the chart review dates. By this calculation, 94% of clients who should have received an assessment within the year did indeed receive one.

SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action will be taken to address the needs that are identified on the comprehensive assessment. A service plan can be thought of as an informal, working contract between client and social worker of who will be accountable for which actions in order for the client to meet their determined treatment goals. As with the comprehensive assessment, the date of each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of Service Plans	A	B	C	D	E	F	G	TOTAL
0	25 (37%)	32 (30%)	32 (33%)	4 (6%)	10 (10%)	7 (7%)	20 (33%)	130 (22%)
1	22 (33%)	30 (29%)	5 (5%)	29 (41%)	3 (3%)	38 (36%)	11 (18%)	138 (23%)
2	4 (6%)	2 (2%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	1 (2%)	11 (2%)
N/A	16 (24%)	41 (39%)	60 (62%)	36 (61%)	91 (87%)	58 (55%)	28 (47%)	330 (54%)
Completion Rate	**73%**	**64%**	**22%**	**94%**	**93%**	**91%**	**72%**	**87%** (527 out of 609) **11%** (29 out of 279)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*60 (100%)*	*609 (100%)*

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. One common reason for this, as documented frequently in the client medical records, is that clients would often decline to continue on to complete the service plan, given the amount of time they had already spent in the clinic for the lengthy comprehensive assessment interview, in addition to whatever medical appointment they may have attended on that day.

Completion rates were calculated in two different ways. The first calculation, in blue, is the more liberal analysis that is consistent with the manner used to calculate the completion rate for comprehensive assessment. It is the percentage of eligible clients who received *at least one* service plan throughout the year *or* had a documented reason for why they did not complete the service plan *or* they had evidence of a completed service plan just outside of the review dates. By this calculation, 87% of clients who should have received a service plan within the year did indeed receive one.

The second, more conservative measurement in red is the more universally accepted standard for care planning in Ryan White Case Management Services, consistent with the HAB HRSA Performance Measure for Case Management[4]. This is the number of clients who were receiving case management services within the year and received at least two service plans within the year, excluding those had a documented reason for not completing a second care plan, such as only being enrolled in case management for only some of the year.

[4] Health Resources and Services Administration HIV/AIDS Bureau. (2019, December). Performance Measure Portfolio: MCM Measures. Retrieved from https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/mcmmeasures.pdf

BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief Assessments	A	B	C	D	E	F	TOTAL
0	7 (10%)	6 (6%)	15 (15%)	2 (2%)	16 (15%)	14 (13%)	60 (11%)
1	10 (15%)	28 (27%)	37 (38%)	37 (53%)	49 (47%)	41 (39%)	202 (37%)
2	0 (0%)	1 (1%)	0 (0%)	1 (1%)	5 (5%)	4 (4%)	11 (2%)
N/A	50 (75%)	70 (67%)	45 (46%)	30 (43%)	35 (33%)	46 (44%)	276 (50%)
Completion rate	**94%**	**97%**	**77%**	**98%**	**86%**	**97%**	**91%** (248 out of 273)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*549 (100%)*

Dates of any brief assessments were recorded, along with any justification of why an assessment was not completed if one would have been expected. 50% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 11% of the sample received zero brief assessments, 37% received one, and 2% received two.

Completion rates represent the percentage of eligible clients who received *at least one* assessment within the review year *or* had a documented reason as to why one was not completed *or* had evidence of a completed assessment just outside of the review period.

ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 173 Comprehensive Assessments and 211 Brief Assessments were reviewed and recorded in order to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The top five most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Transportation, and 5) Mental Health. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. For example, it was much more common for "Dental Care" to be identified as a need at agencies who had dental care co-located or easily available within their organization. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	Count	Percentage %
Medical/Clinical	141	37%
Dental Care	123	32%
Vision Care	108	28%
Transportation	99	26%
Mental Health	95	25%
Insurance Benefits	85	22%
Medication Adherence	79	21%
Housing/Living Situation	66	17%
Substance/Alcohol Use	65	17%
HIV Education/Prevention	50	13%
Support System	34	9%
Employment/Income	34	9%
HIV-Related Legal	31	8%
Self-Efficacy	30	8%
Basic Necessities/Life Skills	29	8%
Nutrition/Food Pantry	22	6%
Family Planning/Safer Sex	15	4%
Financial Assistance	14	4%
Abuse History	12	3%
Cultural/Linguistic	9	2%
General Education/Vocation	9	2%
Vaccination	8	2%
Hearing Care	8	2%
Home Care Needs	5	1%
Client Strengths	4	1%
Child Care/Guardianship	2	1%
Other	2	1%
		Out of 384 assessments

Conclusion

The 2018-2019 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement.

Overall, we continue to learn more about the needs of this patient population by expanding the sample size of the review and adding new elements to the chart abstraction tool. The top three most common co-occurring conditions were: Sexually Transmitted Infections (31%), Depression (26%), and Hypertension (23%). Diabetes was also relatively common (11%) and it has been suggested that providing overview information on nutrition counseling and diabetes management may be a useful topic for future frontline case management trainings. In addition, 53% of the overall sample had a history or active diagnosis of a mental health or substance abuse issue. 10% of the sample was homeless or unstably housed. The prevalence of these complex co-morbidities further emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also many areas of high performance displayed in this chart review. Most (39%) of the clients in the sample had at least three HIV-related primary care appointments within the review year. While the measurement for Viral Load Suppression changed from last year's chart review, there was a marked improvement in overall VL suppression from 43% to this year's 60%. Case Management staff demonstrated a high level of coordination of care in many areas. For example, 91% of those with active mental health or substance abuse symptoms either received a referral for further treatment or counseling or were already engaged in services. 78% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management in an effort to retain them in care. And finally, when a client was found to be virally unsuppressed through a laboratory test, case management staff were often involved to follow-up with clients and provide medication adherence counseling. Less than 10% of sample was found to be virally unsuppressed at some time throughout the year and did not receive attention and intervention from case management staff.

Case Management staff demonstrated high levels of coordination of care:

- 91% MH and SA referral rate

- 78% of New, Lost, or Returning to Care clients were assisted by CM

- <10% of sample was unsuppressed without intervention

The review also highlighted that there are still many opportunities for refinement in case management workflow and service provision. Termination planning and review for case closure were inconsistently practiced across agencies. The discrepancy between the completion rate for one assessment versus two assessments per year is striking. This indicates that, as a case management system, we are good at initiating services, but need to dedicate much more attention to following clients throughout their care. It is quite possible that the 11% performance rate of 2 care plans within a year for medical case management clients is artificially low if many of those clients could be considered "closed" for case management and excluded from the calculation. However, without proper case closure documentation in the medical chart and, worse, without communication to the client to follow-up with them or manage service expectations, those cases are considered "open" for all intents and purposes.

This lack of follow-through is further evidenced in the frequency of contact with a case manager. More than half (56%) of the sample had three or fewer interactions with the case manager. If the ideal standard is for a client to be formally assessed at least twice throughout the year to discuss their history, present concerns, barriers, and goals, with follow-through in between those formal sit-downs to work through the issues identified in the care plan, it leaves room to wonder how clients can be adequately served. Further training and capacity building in the areas of assessment and interview techniques, as well as continuing to refine case management role delegation, may help improve quality in these areas.

Appendix (Case Management Chart Review Tool)

INSURANCE, BENEFITS, AND INCOME INFORMATION

Health Insurance: ☐ Uninsured ☐ Medicaid ______ ☐ Medicare_______ ☐ Commercial _________
☐ VA ☐ Other? ________

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income $:	Spouse Income $:	Other Income $:	TOTAL HOUSEHOLD INCOME $:

Did the client lose insurance or coverage during the review period? ☐ Y N ☐ Unk. ☐
If so, were they provided with information/education or assistance? ☐ Y N ☐ NA ☐

CASE MANAGEMENT SERVICES

What types of services were provided by a **Medical Case Manager** (MCM?)	What types of services were provided by a **Service Linkage Worker** (SLW?)	Was the client referred for **Clinical Case Management** services in the review period?
☐ **NA (Client not assisted by MCM)** ☐ Comprehensive assessment ☐ Service Plan ☐ Medication adherence counseling ☐ Coordination of medical care ☐ Transportation ☐ ADAP/medication assistance ☐ Eligibility ☐ Community resource/benefits brokerage ☐ Other ________________ Did client meet criteria for MCM? Y ☐ N ☐ Unk. ☐	☐ **NA (Client not assisted by SLW)** ☐ Brief assessment ☐ SLW referred client to OAMC ☐ OAMC visit scheduled by SLW ☐ SLW accompanied client to OAMC ☐ SLW called client to remind about OAMC visit ☐ Client did not keep OAMC appt. and SLW contacted them ☐ ADAP/medication assistance ☐ Transportation voucher ☐ Eligibility Were any of the above services provided by an Outreach Worker? Y ☐ N ☐ Unk. ☐	☐ **No- not applicable** ☐ No- applicable, but no referral documented ☐ Yes- and there is evidence of coordination of services ☐ Yes- and there is no evidence of coordination of services ☐ Yes- but client refused services or is already engaged in treatment

Was the case discharged/closed for CM during the review period? Y ☐ N ☐ NA ☐ Unk. ☐
If yes.......
- Client met agency criteria for closure? Y ☐ N ☐ NA ☐ Unk. ☐
- Client completed treatment program (CCM) Y ☐ N ☐ NA ☐ Unk. ☐
- Date and reason noted? Y ☐ N ☐ NA ☐ Unk. ☐
- Summary of services received? Y ☐ N ☐ NA ☐ Unk. ☐
- Referrals noted? Y ☐ N ☐ NA ☐ Unk. ☐
- Instructions given to client at discharge? Y ☐ N ☐ NA ☐ Unk. ☐

ASSESSMENTS & SERVICE PLANS

		If no assessment or plan:		
Brief Assess. Date 1:	Brief Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Comp. Assess. Date 1:	Comp. Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Service Plan Date 1:	Service Plan Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete

COMPLETED ASSESSMENTS

	MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief					NEXT MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief				
Domain	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)
Medical/Clinical										
Vaccination										
Nutrition/Food Pantry										
Dental Care										
Vision Care										
Hearing Care										
Home Care Needs										
Basic Necessities/Life Skills										
Mental Health										
Substance/Alcohol Use										
Abuse History										
Housing/Living Situation										
Support System										
Child Care/Guardianship										
Insurance Benefits										
Transportation										
HIV-Related Legal										
Cultural/Linguistic										
Self-Efficacy										
HIV Education/Prevention										
Family Planning/Safer Sex										
Employment/Income										
General Education/Vocation										
Financial Assistance										
Medication Adherence										
Client Strengths										
Other										

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Linkage to Care for Newly Enrolled Clients
Performance Improvement Activity (PIA)
For Case Management Supervisors
2018-2019 (and beyond)

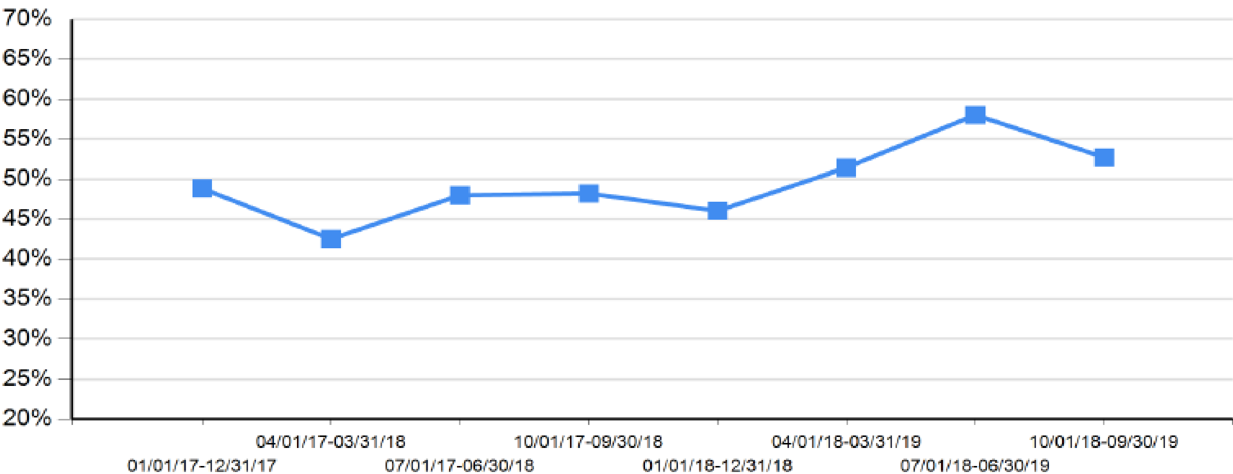
Key Highlights

- Following clients through their first year of care in a new clinic may be considered an effective intervention for HIV treatment outcomes.
- Clinic workflows should be optimized to ensure a patient-centered experience and effective treatment monitoring. It was surprising to find that many patients were not automatically prompted to schedule a follow-up visit, or asked for their input on what dates and times would work best for them, or that many did not have a recent (within 6 months) CD4 and VL lab on file.
- While HIV treatment management is down trending towards two primary care appointments per year, the findings from this activity suggest that new clients (without distinguishing between newly diagnosed, new to treatment, or just new to your clinic) may still benefit from having appointments scheduled every 3 months.

Project Description

Linkage to Care (L2C) is one important indicator used to predict treatment outcomes for new patients in HIV management. L2C performance measures vary across local and regional jurisdictions. The HRSA HAB Performance Measure Portfolio includes a Systems-Level Linkage to HIV Medical Care measure that is defined as the percentage of patients who attend a routine HIV medical care visit within 1 month of diagnosis. The Houston Ryan White Part A system includes three different Linked to Care measures for monitoring as part of Clinical Quality Improvement activities, one of which provided the basis for this Case Management Performance Improvement Activity.

This "Linked to Care 1" measurement monitors the number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year. This measure has hovered around 50% for the last couple years.



Deeper analysis was desired to better understand patients' experience in their first year of care as newly enrolled clients, particularly given that the Ryan White case management service models include Service Linkage Workers and intensive Medical Case Management aimed at new patients. By engaging Case Management (CM) Supervisors to prompt their staff to take a close look at newly enrolled clients, the intent of this PIA was to improve L2C performance.

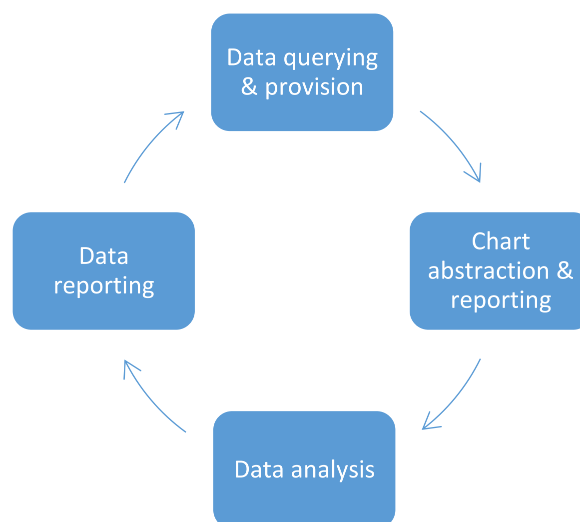
For the purposes of this activity, new clients were defined as:

- Newly enrolled clients during the specified three-month period with at least one medical visit
- Excluding those who are insured and who are virally suppressed (<200 copies/ml)

With this definition in mind, it is important to understand that this activity is not necessarily aimed at understanding newly diagnosed patients or even new-to-treatment patients, though these populations may be captured in the data sets.

Each phase of the PIA is designed to repeat three times for a total of four quarters of data reporting. These four "cohorts," as they are referred to, are data sets for clients who were considered newly enrolled for the following time frames:

- Quarter/Cohort 1: March-May 2018
- Quarter/Cohort 2: June-August 2018
- Quarter/Cohort 3: September-November 2018
- Quarter/Cohort 4: December 2018-February 2019



Each quarter, the CPCDMS data base was queried by the Ryan White Grant Administration epidemiologist to provide a client list for CM Supervisors of their newly enrolled clients for that 3-month period. Supervisors were then instructed to conduct a chart review for each client on their list to complete each relevant data field. Results were then returned to RWGA Quality Management staff for analysis, after which the results were compiled and reported out to each agency for reflection and discussion, before repeating.

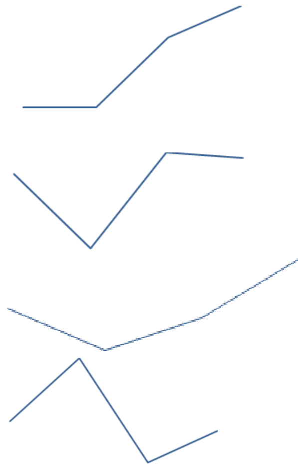
Phase 1 of PIA: Quarterly Linkage to Care

The first phase of the L2C PIA aimed to monitor performance of case managers for successful linkage to care of newly enrolled clients seeking HIV primary care treatment. For this phase of the activity, successful "linkage" was defined as the presence of an initial HIV-related primary care appointment during the specified time range, followed by attendance at a follow-up appointment during the next 3-month period.

Each quarter, CM Supervisors were provided a list of new clients who enrolled during the specified time frame. They were instructed to return the list in the following quarter, reviewing the patient chart to determine: 1) whether they were scheduled for a "next" primary care appointment in a following quarter, 2) whether they attended that next appointment, 3) whether they were enrolled or receiving case management services, 4) and whether they were virally suppressed. This activity was repeated for four quarters to measure trends and improvement.

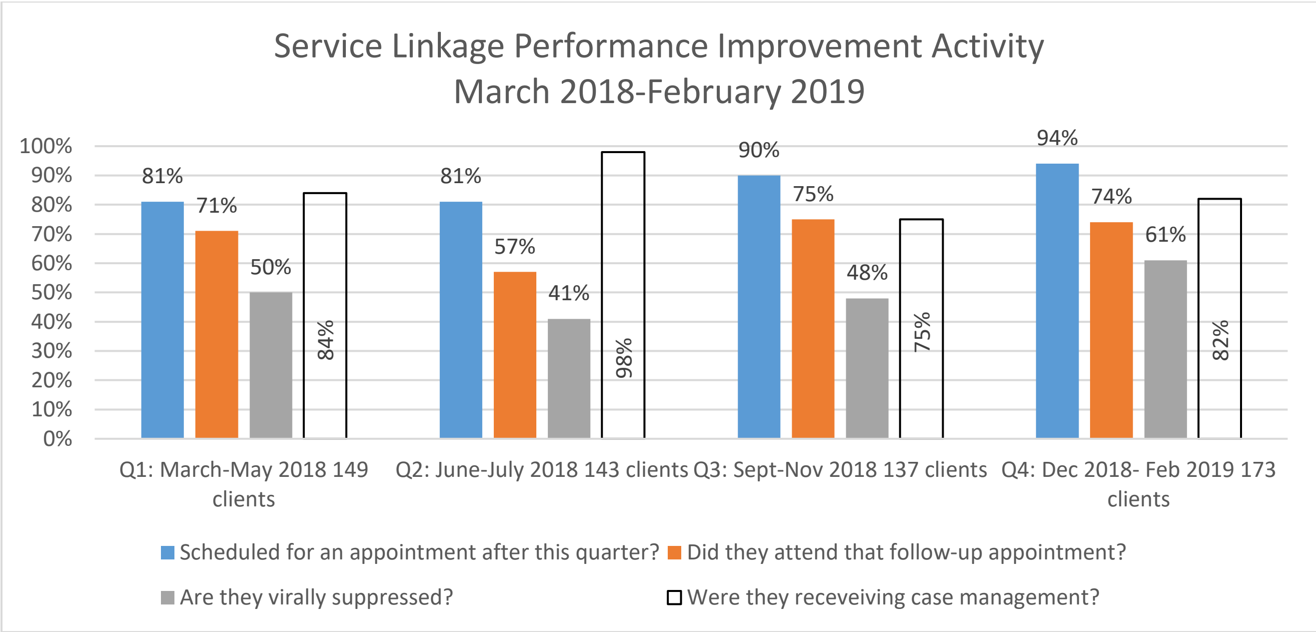
	Q1: March-May 2018 149 clients	Q2: June-July 2018 143 clients	Q3: Sept-Nov 2018 137 clients	Q4: Dec 2018- Feb 2019 173 clients
Scheduled for an appointment in the next quarter?	81%	81%	90%	94%
Did they attend that follow-up appointment?	71%	57%	75%	74%
Are they virally suppressed?	50%	41%	48%	61%
Are they receiving case management?	84%	98%	75%	82%

Linear progression



While performance did not improve linearly throughout this project phase, performance certainly had a marked improvement from the first quarter to the last. For example, 81% of clients from the first cohort at the beginning of the study were scheduled for a follow-up appointment. By the last quarter, 94% of the final cohort had been scheduled for a follow-up appointment. Similarly, viral load suppression increased from 50% to 61%.

These findings suggest that by virtue of providing focused attention to newly enrolled clients and assigning responsibility to particular staff to query patient health and attendance records and follow-up, outcomes can improve.



Phase 2 of PIA: Retrospective "Second Look" Cohort Study

Following the completion of the first performance monitoring phase of the PIA for Year 1, the second year of the PIA initiated a retrospective cohort study. This phase of the PIA is currently ongoing, with two cohorts worth of data available. The purpose of this phase is to take a "second look" at each original cohort, one year later, to further understand what their first year in care has been like.

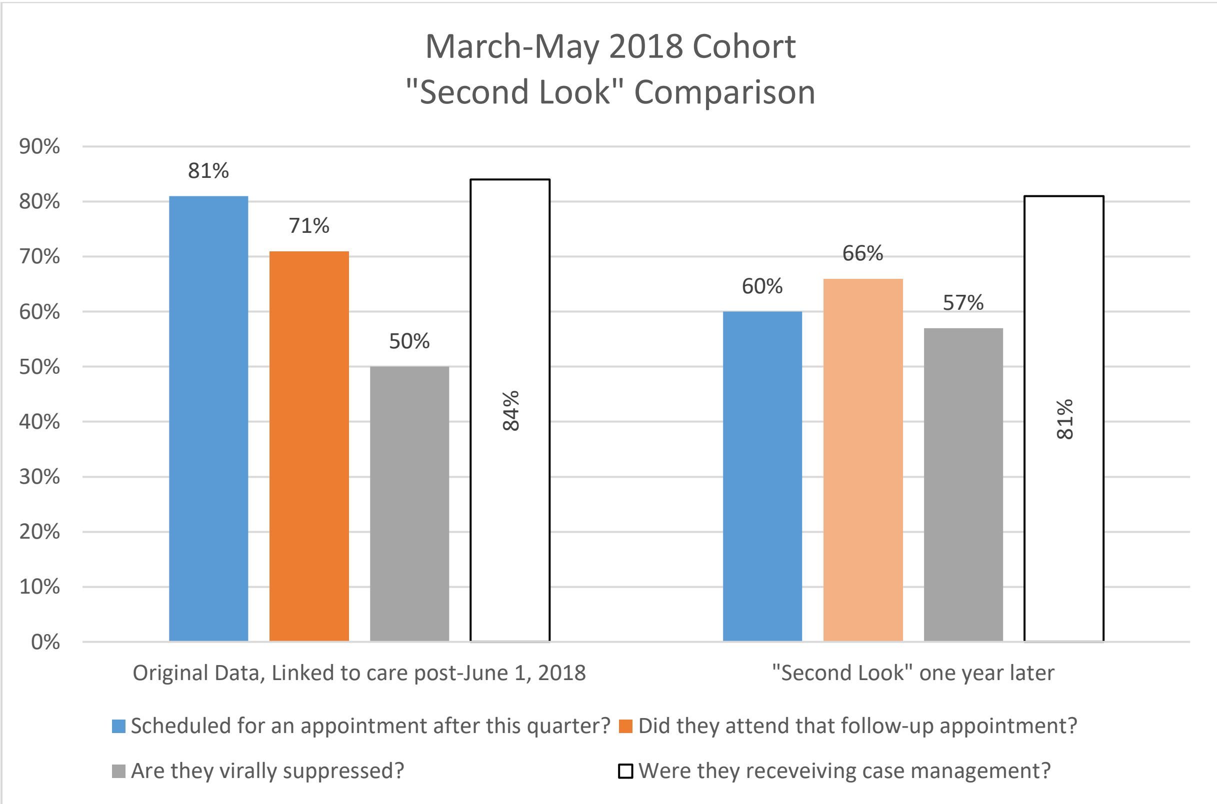
CM Supervisors were prompted to conduct a chart review for each of the clients on their original cohort list, identifying the following items: 1) Did the client have an HIV primary care appointment scheduled in each of the following quarters of their last year in care? 2) Have they been scheduled for a post-last quarter appointment, indicating they would be successfully "linked" to a second year of treatment in that facility? 3) When was their last laboratory CD4 and VL test performed and were they virally supressed at that point in time? And finally, 4) were they enrolled in case management services during the year and, if so, how many case management encounters did they have?

For the purposes of this phase of the activity, attendance at a follow-up appointment from the first point in time will be compared to presence of lab work in the last 6 months.

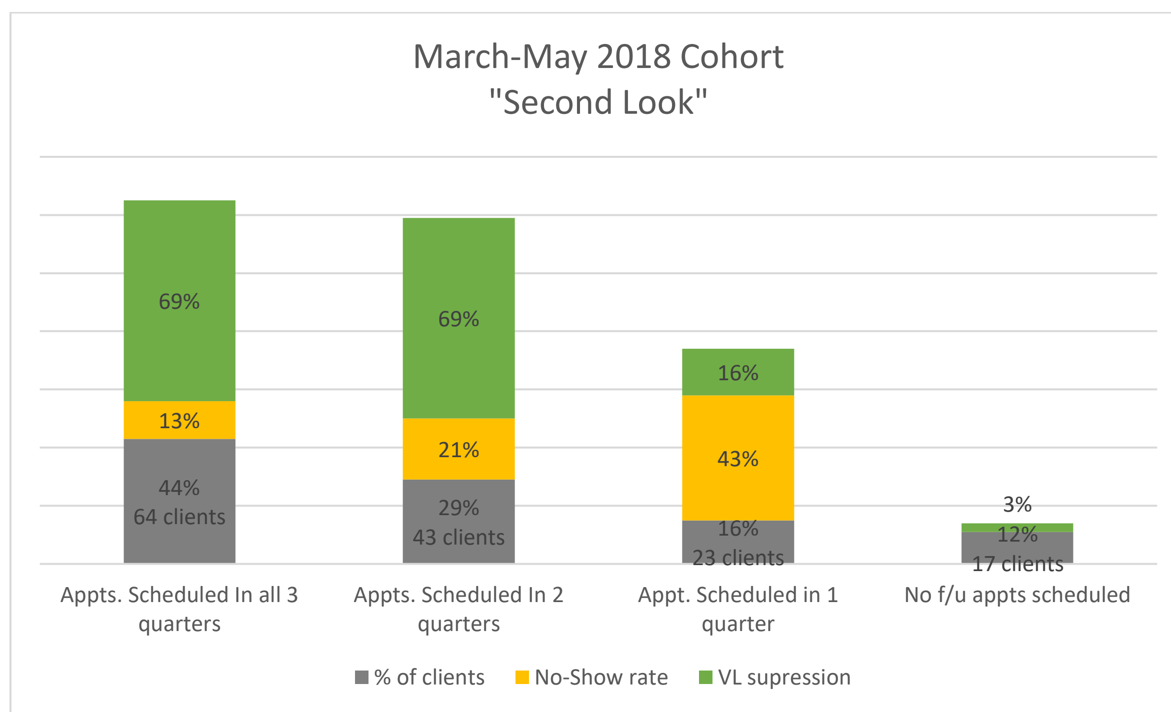
As with Phase 1, Phase 2 is expected to take one year to complete. To date, two cohorts have been re-examined for their second look.

Cohort 1: March-May 2018

The following comparison is of the March-May 2018 Cohorts June 2018 data and their June 2019 status. Data was returned for 147 of the original 149 clients.



By June 2019, 60% of the original cohort had been scheduled for an appointment sometime after June 1st, 2019, indicating they were still engaged in care. 66% have had lab work completed in the last 6 months. 57% were known to be virally supressed in the last 6 months. 81% had received case management services over the last year, with an average of **5** encounters.



Client outcomes were also examined to understand whether the number of scheduled appointments in the year had an impact on viral load suppression. 44% of clients were scheduled for an HIV primary care appointment in each of the following three quarters examined, while 29% had an appointment scheduled in two of the quarters, 16% with an appointment in just 1 quarter, and 12% with no follow-up appointments scheduled. It is of note that of the 17 clients who were not followed-up with at all, 1 appeared to have established care at a different Ryan White clinic, 1 was deceased, 1 was no longer in CPCDMS, and 14 had no further appointments in the RW-A system.

Clients who were scheduled for either three or two appointments had the same VL suppression rate at 69%, while clients with two appointments scheduled had a 43% suppression rate.

No-show rates were also examined. Clients with 3 follow-up appointments (one in each of the next quarters) had a 13% no-show rate and clients with 2 scheduled appointments had a 21% no-show rate. 43% of clients who were scheduled for one appointment did not attend that appointment.

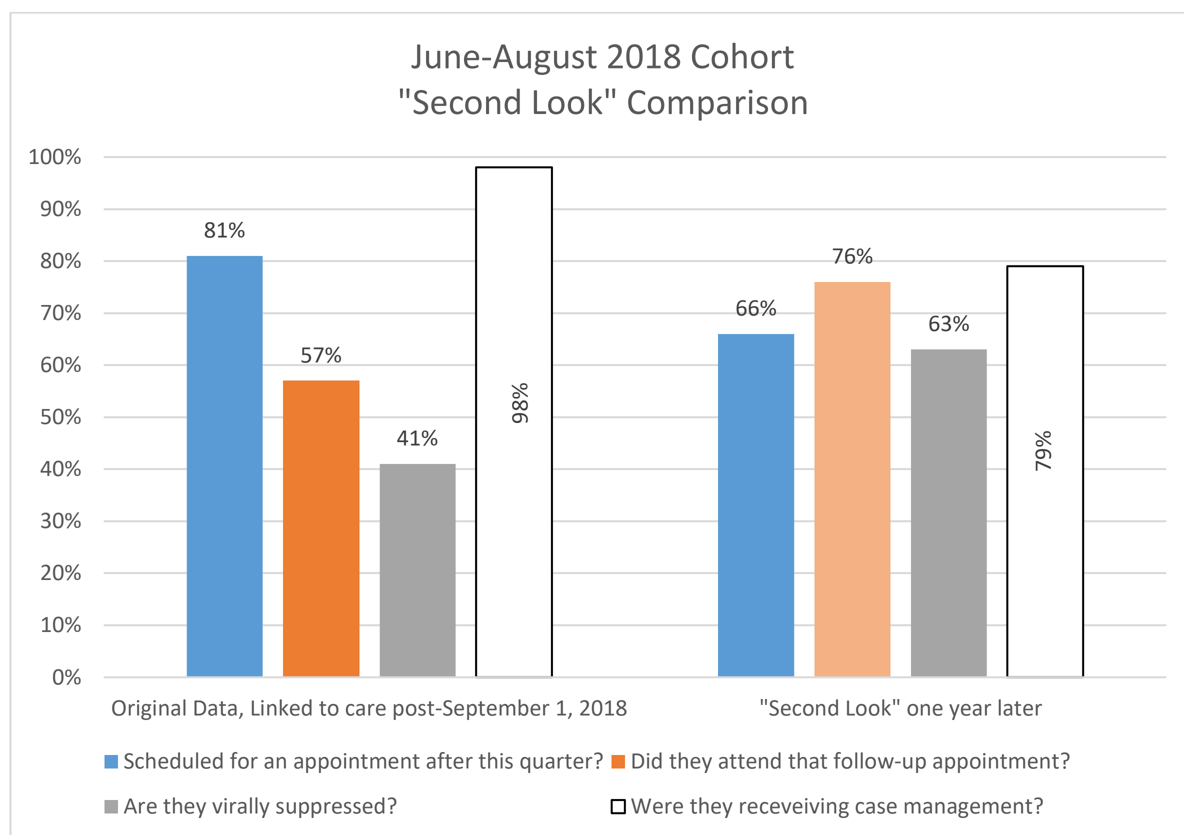
While these findings suggest that scheduling two appointments per year may be sufficient for clients to achieve the ultimate indicator of viral load suppression, even in their first year of care, more analysis was needed to understand the impact of no-show and cancellation rates.

	Number/Percentage	VL Suppression Rate
3 appointments attended	44 (30%)	84%
2 appointments attended	45 (31%)	87%
1 appointment attended	30 (20%)	23%
0 appointments attended	28 (19%)	12%

When actual number of appointments attended was analyzed, clients who attended 2 appointments had the highest viral load suppression rate at 87%, followed closely by patients who attended 3 appointments at 84%. There are likely many confounding variables and factors that would influence why patients with less appointments achieve viral load suppression (slightly) more often. For example, long-term survivors who have a wealth of experience in managing their care may be more likely to opt for fewer appointments. Providers may make the decision to schedule and encourage more appointments to monitor patients who are having trouble with treatment adherence.

Cohort 2: June-August 2018

Most recently, this activity was repeated for Cohort 2, the June-August 2018 set of clients. Data was returned for 131 of the original 143 clients.

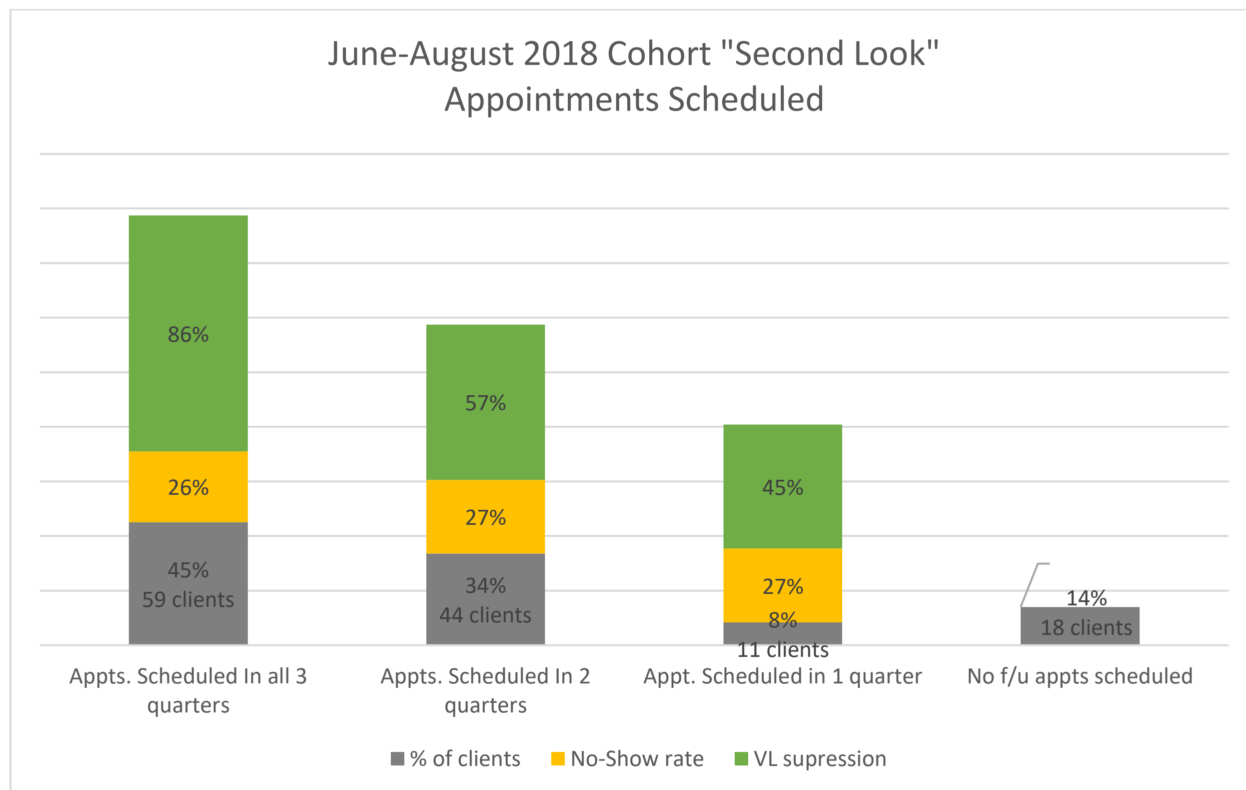


By October 2019, 66% of the original cohort had been scheduled for an appointment sometime after September 1st, 2019. 76% have had lab work completed in the last 6 months. 63% were known to be virally supressed in the last 6 months. This marks an improvement on all clinical measures from the first cohort.

79% had received case management services over the last year, with an average of **5** encounters. It is also noteworthy that the less appointments a patient was scheduled for, the more number of case

management encounters they averaged. This suggests that case management staff may have been attempting to engage and retain clients who were less likely to be successfully linked to care.

Just like the first cohort, clients outcomes were analyzed based on number of scheduled appointments. The results were dissimilar to the first cohort.



45% of clients were scheduled for a primary care appointment in each of the three quarters examined, while 34% had an appointment scheduled in two of the quarters, 8% with an appointment in just 1 quarter, and 14% with no follow-up appointments scheduled.

Unlike the first cohort, clients scheduled for three additional appointments had the highest VL suppression rate at 86%, while clients with two appointments scheduled had a 57% suppression rate.

No-show rates were similar across groups, with about a quarter of appointments resulting in “no-show” or cancellations, regardless of how many they were scheduled.

When clients from this cohort were analyzed by number of appointments actually attended, the effect of appointment frequency was even more pronounced. Clients who attended all three follow-up appointments achieved a 93% VL suppressions rate, followed by clients attending 2 appointments at 74%.

	Number/Percentage	VL Suppression Rate
3 appointments attended	42 (32%)	93%
2 appointments attended	35 (27%)	74%
1 appointment attended	23 (18%	52%
0 appointments attended	31 (24%)	16%

Conclusions

While this PIA is only 1.5 years of the way completed through its projected 2 years of study, there have been a few key findings thus far.

First, the theory that continuous monitoring of newly enrolled clients would improve treatment outcomes seems to have been correct, as is consistent with quality improvement and management frameworks. While performance improvement for the first phase of the PIA was not linear, performance did improve from the first cohort to the last. Anecdotally, the CM supervisors have reported that providing a list of new clients for review each quarter is a helpful activity. As a result, RWGA has continued to provide these cohort lists at the agencies' request even though that phase of the PIA has concluded.

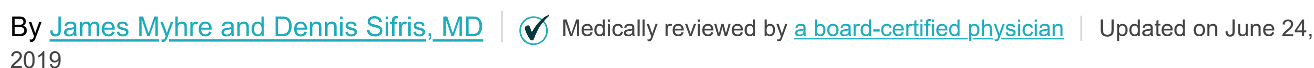
Second, this quarterly prompt to conduct a focused chart review has revealed that many clinic practices that were assumed to be occurring as part of routine HIV care were indeed not. For example, the CM Supervisors were surprised to learn that only 81% of clients in the first cohort had been scheduled for a follow-up appointment, a process which should be automatic and consistent. This revelation may have been what prompted the continuous improvement for this measure; scheduling for a follow-up appointment was the only measurement that had a clear linear progression towards improvement. In addition, participating in this activity highlighted a gap in clinic workflow in the way of laboratory testing, which is a cornerstone of HIV treatment and management. It was not uncommon for clients to be missing a recent (within the last 6 months) CD4 and VL lab result, even if they had been regularly attending face-to-face provider appointments. Clinics tend to have a different workflow for scheduling provider and lab appointments. Further study, possibly including internal environmental walk-through audits, should be conducted to optimize a patient-centered experience and to understand why so many clients do not regularly have HIV labs conducted.

Finally, the results of this PIA suggest that scheduling HIV-related primary care appointments every three months may be optimal as compared to the down trending preference for 2-3 appointments per year, particularly for new clients. While the second phase of this activity is still ongoing, results from the first two retrospective cohort studies suggest that not only are 3 follow-up appointments correlated with higher viral load suppressions rates, but scheduling patients for an appointment every quarter can help to ensure that they make it to at least a few appointments each year, given the cancellation and no-show occurrence.

verywell health

Does HIV Treatment as Prevention Work?

Strategy aims to reverse rates in high-risk communities



By James Myhre and Dennis Sifris, MD | Medically reviewed by a board-certified physician | Updated on June 24, 2019

HIV Treatment as Prevention (TasP) is an evidence-based strategy by which persons with an undetectable viral load are far less likely to transmit the virus to an uninfected sexual partner.

While TasP was initially seen as a means of reducing individual risk when the concept was first introduced in 2006, it was only in 2010 that evidence from the HTPN 052 study suggested that it could be implemented as a population-based prevention tool.

Research Breakthrough

The HTPN 052 trial—which studied the impact of antiretroviral therapy (ART) on transmission rates in serodiscordant heterosexual couples—was stopped nearly four years early when it was shown that individuals on treatment were 96 percent less likely to infect their partners than participants who weren't.

The results of the trial led many to speculate whether TasP might also slow, if not altogether stop, the spread of HIV by reducing the so-called "community viral load." In theory, by reducing the average viral load within an infected population, HIV transmission would eventually become so rare as to stop the epidemic in its tracks.

Undetectable = Untransmittable

The HTPN 052 was only the starting point in the journey to implement TasP. Between 2010 and 2018, two studies—called PARTNER1 and PARTNER2—aimed to evaluate the risk of transmission in gay and heterosexual mixed-status couples in whom the HIV-infected partner was virally suppressed

This was considered significant since only 2 percent of couples in the HTPN 052 was gay (a group statistically at highest risk of HIV infection). By contrast, nearly 70 percent of the couples in the PARTNER1 and PARTNER2 studies was gay.

> At the end of the trial periods, not one HIV infection was reported among any of the couples despite the absence of condoms during anal and vaginal sex.

Based on these results of the PARTNER1 and PARTNER2 studies, the researchers concluded that the risk of HIV transmission when the viral load is fully suppressed is zero. The results were conveyed to the public under the new public health campaign "U=U" (Undetectable = Untransmittable).

Challenges in Implementation

Prior to the introduction of newer-generation antiretroviral drugs, TasP was considered inconceivable due to high levels of drug toxicities and viral suppression rates that only hovered around 80 percent, even for those with perfect adherence.

The picture has largely changed in recent years, with the introduction of more effective, cheaper medications. Even in heavily hit countries like South Africa, the availability of low-priced generics (as little as $10 per month) has placed the concept closer within reach.

While all of these facts point to TasP as a vital part of an individual-based prevention strategy, does it necessarily mean that it would on a population-based scale?

From the start, it was clear that there would be a number of strategic hurdles to overcome if TasP were to be feasible:

1. It would require high coverage of HIV testing and treatment, particularly in underserved, high-prevalence communities. In the U.S., as many as one in five people with HIV are fully unaware of their status. In response, the U.S. Prevention Services Task Force is now recommending the once-off testing of all Americans ages 15 to 65 as part of a routine doctor's visit.
2. It would require intensifying the follow-up of existing patients. According to the Centers for Disease Control and Prevention (CDC), only 44 percent of Americans diagnosed with HIV are linked to medical care. Research suggests that the fear of disclosure and the lack of HIV-specific care are among the reasons that so many delay treatment until the appearance of symptomatic disease.
3. It would require the means by which to ensure population-based adherence, the success of which is highly variable and hard to predict. According to the CDC, of HIV-positive people currently on therapy, nearly one in four are unable to maintain the necessary adherence to achieve complete viral suppression.
4. Finally, the cost of implementation is seen to be a major obstacle particularly as global HIV funding continues to be severely reduced.

Evidence in Support to TasP

The city of San Francisco may be the closest thing to a proof of concept for TasP. With gay and bisexual men comprising nearly 90 percent of the city's infected population, consistent, targeted intervention has resulted in a low rate of undiagnosed cases.

> The widespread distribution of ART resulted in a 33 percent drop in new infections in San Francisco from 2006 to 2008. Moreover, by 2010, universal treatment on diagnosis increased the rate of undetectable viral loads among city residents by 600 percent.

But most agree that San Francisco has a unique dynamic to other HIV populations. There is still insufficient evidence to support whether TasP will bring down infection rates in the same fashion elsewhere.

In fact, a 2015 study from the University of North Carolina has suggested that real-world efficacy of TasP may fall short in certain key populations. The study, which looked at 4,916 serodiscordant couples in the Henan province of China from 2006 to 2012, studied the impact of ART on transmission rates in a population where consistent condom usage was relatively high (63 percent) and the rate of sexually transmitted infections and extramarital sex was extremely low (0.04 and 0.07 percent, respectively).

According to the study, 80 percent of the HIV-positive partners, all of whom were newly treated at the start of the trial, had been placed on ART by 2012. During that time, the drop in new infection correlated to an overall reduction in risk of around 48 percent.

Moreover, as the study progressed and more HIV-positive partners were placed on ART, rates appeared to drop even further. From 2009 to 2012, the consistent use of ART reduced HIV risk by some 67 percent, nearly three times what was seen from 2006 to 2009 when it was only 32 percent.

A Word From Verywell

As compelling as these results are, TasP should not be considered an infallible strategy even among committed, serodiscordant couples. In the end, taking HIV medication is not the same thing as achieving an undetectable viral load.

> In fact, according to the CDC, only 59.8 percent of people with HIV are virally suppressed. These not only include people who refuse testing and treatment but those who fail to take their drugs every day as prescribed.

With that being said, the aims of the strategy remain strong. This is especially true for couples wanting to have children or individuals at high risk of infection. In such cases, pre-exposure prophylaxis (PrEP) can also be prescribed to further protect the HIV-negative partner. When used together, TasP and PrEP can reduce the risk of infection to near-negligible rate.

Always discuss these options with your doctor before embarking on any such strategy.

Article Sources

Verywell Health uses only high-quality sources, including peer-reviewed studies, to support the facts within our articles. Read our editorial process to learn more about how we fact-check and keep our content accurate, reliable, and trustworthy.

- Charlebois, B.; Das, M.; Porco, T.; and Havlir, D. The Effect of Expanded Antiretroviral Treatment Strategies on the HIV Epidemic among Men Who Have Sex with Men in San Francisco. *Clinical Infectious Diseases.* April 15, 2011; 52(8):1046-1049. DOI: 10.1093/cid/cir085.
- Cohen, M.; Chen, Y.; McCauley, M. et al. Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine.* August 11, 2011; 365(6):493-505. DOI: 10.1056/NEJMoa1105243.
- Gill, V.; Lima, V.; Zhang, W. et al. Improved Virological Outcomes in British Columbia Concomitant with Decreasing Incidence of HIV Type 1 Drug Resistance Detection. *Clinical Infectious Diseases.* January 1, 2010; 50(1): 98-110. DOI: 10.1086/648729.
- Rodger, A.; Cambiano, V.; Bruun, T. et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. *Lancet.* 2019 May 2; pii: S0140-6736(19)30418-0. DOI: 10.1016/S0140-6736(19)30418-0.
- Smith, K.; Westreich, D.; Liu, H. et al. Treatment to Prevent HIV Transmission in Serodiscordant Couples in Henan, China, 2006 to 2012. *Clinical Infectious Diseases.* March 13, 2015; pii: civ200. DOI: 10.1093/cid/civ200.
- U.S. Centers for Disease Control and Prevention (CDC). Vital Signs: HIV Prevention Through Care and Treatment - United States. *Morbidity and Mortality Weekly Report (MMWR).* December 2, 2011; 60(47):1618-1623.

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NEWS HEALTH & MEDICINE

A more convenient, monthly treatment for HIV cleared a key hurdle

Once-a-month injection of antiretrovirals works just as well as a daily pill regimen, trials show

In two clinical trials, a monthly injection of antiretroviral drugs was shown to be just as effective as a daily pill regimen at controlling HIV.
SERGII PETRUK/ISTOCK /GETTY IMAGES PLUS

By Jonathan Lambert
MARCH 4, 2020 AT 5:00 PM

People living with HIV are one step closer to having a once-a-month treatment alternative to downing two or more pills a day.

There is no cure for HIV, the virus that causes AIDS. But combination antiretroviral therapy, or ART, can effectively halt the replication of the virus, nearly eliminating it from the bloodstream and prolonging life expectancy (*SN: 11/15/19*). For the therapy to work, though, people must stick to a daily regimen of two or more pills, which experts say can be a challenge for many.

Now, the results of two phase III clinical trials suggest that a monthly shot of antiretroviral drugs works just as well as daily pills, researchers report March 4 in two studies in the *New England Journal of Medicine*. If approved by regulators, the therapy could be a more convenient treatment for the estimated 1.1 million people living with HIV in the United States.

"From a patient perspective, these results are very positive," says Elizabeth Tolley, an epidemiologist at FHI 360, a public health nonprofit based in Durham, N.C. Stigma can make people reluctant to keep HIV drugs around the house or to take them each day in front of a loved one, she says. A monthly alternative could be a better option for many.

The injectable ART is a long-acting combination of HIV drugs cabotegravir and rilpivirine. One of the phase III clinical trials — the gold standard for getting regulatory approval for a new drug — was led by Chloe Orkin, an HIV researcher at Queen Mary University of London. She enrolled 566 participants who had never tried ART, so they first took the pill version, which included a combination of other HIV drugs, for 20 weeks to get the virus under control. Then, the participants either transitioned to once-a-month shots or continued using pills.

The other trial, led by Susan Swindells, an internist at the University of Nebraska Medical Center in Omaha, enrolled 616 participants whose HIV had been controlled by ART pills for at least six months.

In both trials, participants were randomly assigned to get the monthly shot treatment or continue taking pills. After 48 weeks, there was no significant difference in the viral load of participants for each treatment, suggesting that monthly shots work just as well as pills. Most patients did report some pain or swelling with the shot.

"There are pluses and minuses" to each option, says Marc Siegel, an infectious disease physician at George Washington University in Washington, D.C. A "patient won't have to remember to take a pill every day, though they will have to visit the doctor's office once a month."

Monthly shots may be more feasible for people who struggle with housing instability and don't have a place to store pills, Siegel says. "If we can figure out how to help these people get to a clinic, we might be able to reach a group that's been harder to treat."

A version of this article appears in the March 28, 2020 issue of *Science News*.

CITATIONS

C. Orkin *et al.* Long-acting cabotegravir and rilpivirine after oral induction for HIV-1 infection. *New England Journal of Medicine.* Published online March 4, 2020. doi:10.1056/NEJMoa1909512.

S. Swindells *et al.* Long-acting cabotegravir and rilpivirine for maintenance of HIV-1 suppression. *New England Journal of Medicine.* Published online March 4, 2020. doi:10.1056/NEJMoa1904398.