DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

1:00 p.m., Tuesday, February 13, 2018

Meeting Location: 2223 W. Loop South, Room TBA; Houston, Texas 77027

Agenda

* = Handout to be distributed at the meeting

I. Call to Order — Denis Kelly and
   A. Welcoming Remarks and Moment of Reflection — Gloria Sierra, Co-Chairs
   B. Introductions
   C. Adoption of Agenda
   D. Approval of Minutes
   E. Nuts, Bolts, Petty Cash and Open Meetings Act Training — Tori Williams

II. Public Comments and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Committee Orientation — Tori Williams
   A. Review Committee Description
   B. Conflict of Interest and Voting Policy
   C. Approve 2018 Committee Goals
   D. Review the Timeline of Critical 2018 Council Activities
   E. Review the 2018 Committee meeting time and dates

IV. Training in How to Read Reports from the Administrative Agents
   A. Part A (updated documents to be provided at the meeting) — Carin Martin
      1. Service Utilization Report – Part A & MAI, dated 11/15/17
      2. Procurement Report – Part A & MAI, dated 11/15/17
   B. Part B and State Services (updated documents to be provided at the meeting) — Patrick Martin
      1. Procurement Report – dated 10/10/17
      2. Health Insurance Program Report – dated 10/09/17
   C. Criteria for FY 2018 Service Categories – March meeting — Tori Williams

V. Reports from the Administrative Agents
   A. Part A: FY 2016 Chart Reviews — Heather Keizman
      1. Oral Health – Rural Target
      2. Primary Care
      3. Vision
   B. Part A: Clinical Quality Management Committee Qtrly. Report — Heather Keizman
   C. Part B/SS Annual Consumer Involvement Report* — Patrick Martin
   D. FY 2018 Part B/SS Standards of Care — Patrick Martin
   E. Part B/SS FY16 Chart Reviews* — Tiffany Shepherd

VI. New Business
A. Elect a Committee Vice Chair

VII. Announcements

VIII. Adjourn

Optional: New members meet with committee mentor John Poole

DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

11:20 a.m., Thursday, November 16, 2017
2223 W. Loop South, Room 532; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Gloria Sierra, Co-Chair	Ted Artiaga, excused	Ma'Janae Chambers
Connie Barnes	Curtis Bellard, excused	Pamela Chambers
David Benson (via phone)	Bianca Burley	Patrick Martin, TRG
Amber David	Tom Lindstrom	Heather Keizman, RWGA
Johnny Deal	Robert Noble	Tasha Traylor, RWGA
Teresa Pruitt	John Poole	Tori Williams, Ofc of Support
Viviana Santibanez	Venita Ray, excused	Amber Harbolt, Ofc of Support
Kevin Aloysius	Samantha Robinson	Diane Beck, Ofc of Support
Rosalind Belcher	Angelica Williams	
Orfelinda Coronado		
Ronnie Galley		
Billy Ray Grant Jr.		
Shamra Hodge		
Tiffany Jones		
Crystal Starr		
Amana Turner		

Call to Order: Gloria Sierra, Co-Chair, called the meeting to order at 11:11 a.m. and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Starr, Deal) to adopt the agenda.* ***Motion carried****.*

Approval of Minutes: ***Motion #2****: it was moved and seconded (Starr, Galley) to approve the August 17, 2017 minutes.* **Motion carried.** Abstentions: David, Aloysius.

Reports from Ryan White Grants Administration: Keizman presented the attached reports:

- FY16 Part A/MAI Service Utilization dated 11/15/17
- FY17 Part A/MAI Procurement dated 11/15/17

Reports from The Resource Group: Martin presented the attached reports:

- FY17/18 Part B Procurement dated 10/10/17
- FY15/16 DSHS Procurement dated 10/10/17
- Health Insurance Assist. Service Utilization, dated 09/12/17 and 10/09/17

FY 2018 Standards of Care and Performance Measures

Recommendations from the Affected Community Committee: Williams presented the attached recommendations and Ryan White Grant Administration Eligibility Verification policy. ***Motion #3:*** *it was moved and seconded (Starr, Deal) to accept the recommendations from the Affected Community Committee.* **Motion Carried.** Abstention: Santibanez.

Recommendations from the 2017 Comprehensive Plan: Harbolt presented the attached recommendations and 2017 Q2 Activities Implementation Progress Report. ***Motion #4:*** *it was moved and seconded (Starr, Grant) to accept the recommendations and ask the Administrative Agent to report back in June 2018 on how the recommendations were incorporated into the 2018 Standards of Care.* **Motion Carried.** Abstention: Santibanez.

Part A/B: See attached. Traylor presented consumer feedback and recommended changes to the Part A/B Standards of Care. ***Motion #5:*** *it was moved and seconded (Barnes, Pruitt) to accept the recommended changes to the Part A/B Standards of Care.* **Motion Carried.**

Part A Performance Measures: See attached. ***Motion #6:*** *it was moved and seconded (Deal, Galley) to accept the Performance Measures with no changes.* **Motion Carried.**

Part B/DSHS State Services Standards of Care and Outcome Measures: Martin said that the Part B/DSHS State Services Standards of Care and Outcome Measures will be presented to the committee in February 2018.

DSHS Standards of Care for Health Insurance: Traylor presented the attached comparison of Part A and DSHS Standards of Care for health insurance. ***Motion #7:*** *it was moved and seconded (Pruitt, Deal) to provide no comments regarding the Department of State Health Services Standards of Care.* **Motion carried.**

2018 Committee Goals: See attached. ***Motion #8****: it was moved and seconded (Starr, Pruitt) to use the 2017 committee goals in 2018.* **Motion carried.** Abstention: Moses.

Announcements: Williams thanked all committee members for their hard work throughout the year.

Adjourn: The meeting adjourned at 12:28 p.m.

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

DRAFT

Scribe: D. Beck

2017 Quality Improvement Committee Meeting Voting Record for Meeting Date 11/16/17

JA = Just arrived at meeting
LR = Left room temporarily
LM = Left the meeting
C = Chaired the meeting

MEMBERS:	#1 Agenda				#2 Meeting Minutes				#3 Standards of care recommendations from Affected Community				#4 Standards of care recommendations from 2017 Comp Plan				#5 Part A Standards of care				#6 Part A Performance Measures				#7 DSHS SOC re Health Insurance				#8 2018 Committee Goals			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Gloria Sierra, Co-Chair				C				C				C				C				C				C								C
Robert Noble, Co-Chair	X				X				X				X				X				X				X				X			
Ted Artiaga	X				X				X				X				X				X				X				X			
Connie Barnes		X				X				X				X				X				X				X				X		
Curtis Bellard	X				X				X				X				X				X				X				X			
Bianca Burley	X				X				X				X				X				X				X				X			
David Benson		X				X				X				X				X				X				X				X		
Amber David		X						X		X				X				X				X				X				X		
Johnny Deal		X				X				X				X				X				X				X				X		
Tom Lindstrom	X				X				X				X				X				X				X				X			
John Poole	X				X				X				X				X				X				X				X			
Teresa Pruitt ja 11:18 am	X				X					X				X				X				X				X				X		
Venita Ray	X				X				X				X				X				X				X				X			
Viviana Santibanez		X				X						X				X		X				X				X				X		
Kevin Aloysius		X						X		X				X				X				X				X				X		
Rosalind Belcher		X				X				X				X				X				X				X				X		
Orfelinda Coronado		X				X				X				X				X				X						X		X		
Ronnie Galley		X				X				X				X				X				X				X				X		
Billy Ray Grant Jr.		X				X				X				X				X				X				X				X		
Shamra Hodge ja 11:24 am	X				X					X				X				X				X				X				X		
Tiffany Jones		X				X				X				X				X				X				X				X		
Samantha Robinson	X				X				X				X				X				X				X				X			
Crystal Starr		X				X				X				X				X				X				X				X		
Tamokia Thompson																																
Amana Turner ja 11:15 am	X				X					X				X				X				X				X				X		
Angelica Williams	X				X				X				X				X				X				X				X			

Nuts and Bolts for New Members

Staff will mail meeting packets a week in advance; if they do not arrive in a timely manner, please contact the Office of Support.

The meeting packet will have the date, time and room number of the meeting; this information is also posted on signs on the first and second floor the day of the meeting.

Sign in upon arrival and use the extra agendas on the sign in table if you didn't bring your packet.

Only Council/committee members sit at the table since they are the voting members; staff and other non-voting members sit in the audience.

The only members who can vote on the minutes are the ones who were present at the meeting. If you were absent at the meeting, please abstain from voting.

Due to County budgeting policy, there will be no petty cash reimbursements in March and possibly April so save receipts and turn them into Eric for payment in April.

Be careful about stating personal health information in meetings as all meetings are tape recorded and, due to the Open Meetings Act, are considered public record. Anyone can ask to listen to the tapes, including members of the media.

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax

MEMORANDUM

To: Members, Ryan White Planning Council
External Members, Ryan White Committees

Copy: Carin Martin

From: Tori Williams, Director, Office of Support

Date: January 25, 2018

Re: End of Year Petty Cash Procedures

The fiscal year for Ryan White Part A funding ends on February 28, 2018. Due to procedures in the Harris County Auditor's Office, it is important that all volunteers are aware of the following end-of-year procedures:

1.) Council and External Committee members must turn in all requests for petty cash reimbursements **at or before 2 p.m. on Friday, February 9, 2018.**

2.) Requests for petty cash reimbursements for childcare, food and/or transportation to meetings before March 1, 2018 **will not be reimbursed at all if they are turned in after March 30, 2018.**

3.) The Office of Support may not have access to petty cash funds between March 1 and May 31, 2018. This means that volunteers should give Rod the usual reimbursement request forms for transportation, food and childcare expenses incurred after March 1, 2018 but the Office may not be able to reimburse volunteers for these expenses until mid to late May 2018.

We apologize for this significant inconvenience. Please call Tori Williams at the number listed above if you have questions or concerns about how these procedures will affect you personally.

(OVER FOR TIMELINE)

March 1

2017.....

Beginning of
fiscal year 2017

Feb 9

2018.....

Turn in all
receipts

Feb 28

2018.....

End of
fiscal year 2017.
No money
available to write
checks until April
the end of May

March 30

2018

Turn in any remaining receipts
for fiscal year 2017 or you
will not be reimbursed for
any expenses incurred between
March 1, 2017 and Feb. 28, 2018

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpchouston.org

Memorandum

To: Members, Houston Ryan White Planning Council
External Members, Ryan White Committees

From: Tori Williams, Director, Ryan White Office of Support

Date: February 1, 2018

Re: Open Meetings Act Training

Please note that all Council members, and External Committee members, are required to take the Open Meetings Act training at least once in their lifetime. If you have never taken the training, or if you do not have a certificate of completion on file in our office, you must take the training and submit the certificate to the Office of Support before March 31, 2018. The training takes 60 minutes and can be accessed through the following link (if you have difficulty with the link, copy and paste it into Google and it should lead you to the correct area of the Attorney General's website):

https://www.texasattorneygeneral.gov/og/oma-training

If you do not have high-speed internet access, you are welcome to view the video in the Office of Support. We will make the training available in suite 240 after the Council adjourns on Thursday, February 9th; popcorn will be provided. Or, you can contact Diane Beck and make an appointment to see it on one of the computers in our office.

Upon completion of training, you will be provided with a code that is used to print a certificate of completion. Using the code, you may obtain the certificate from the Attorney General's Office in the following ways:

Print it from the Attorney General web link at:
https://www.texasattorneygeneral.gov/forms/openrec/og_certificates.php
Or, call the Office of Support with the validation code and the staff will print it for you.

We appreciate your attention to this important requirement. Do not hesitate to call our office if you have questions.

Houston Area HIV Services Ryan White Planning Council
Standing Committee Structure

(Reviewed 07-15-15)

1. Affected Community Committee

This committee is designed to acknowledge the collective importance of consumer participation in Planning Council (PC) strategic activities and provide consumer education on HIV-related matters. The committee will serve as a place where consumers can safely and in an environment of trust discuss PC work plans and activities. This committee will verify consumer participation on each of the standing committees of the PC, with the exception of the Steering Committee (the Chair of the Affected Community Committee will represent the committee on the Steering Committee).

When providing consumer education, the committee should not use pharmaceutical representatives to present educational information. Once a year, the committee may host a presentation where all HIV/AIDS-related drug representatives are invited.

The committee will consist of HIV+ individuals, their caregivers (friends or family members) and others. All members of the PC who self-disclose as HIV+ are requested to be a member of the Affected Community Committee; however membership on a committee for HIV+ individuals will not be restricted to the Affected Community Committee.

2. Comprehensive HIV Planning Committee

This committee is responsible for developing the Comprehensive Needs Assessment, Comprehensive Plan (including the Continuum of Care), and making recommendations regarding special topics (such as non-Ryan White Program services related to the Continuum of Care). The committee must benefit from external membership and expertise.

3. Operations Committee

This committee combines four areas where compliance with Planning Council operations is the focus. The committee develops and facilitates the management of Planning Council operating procedures, guidelines, and inquiries into members' compliance with these procedures and guidelines. It also implements the Open Nominations Process, which requires a continuous focus on recruitment and orientation. This committee is also the place where the Planning Council self-evaluations are initiated and conducted.

This committee will not benefit from external member participation except where resolve of grievances are concerned.

4. Priority and Allocations Committee

This committee gives attention to the comprehensive process of establishing priorities and allocations for each Planning Council year. Membership on this committee does include external members and must be guided by skills appropriate to priority setting and allocations, not by interests in priority setting and allocations. All Ryan White Planning Council committees, but especially this committee, regularly review and monitor member participation in upholding the Conflict of Interest standards.

5. Quality Improvement Committee

This committee will be given the responsibility of assessing and ensuring continuous quality improvement within Ryan White funded services. This committee is also the place where definitions and recommendations on "how to best meet the need" are made. Standards of Care and Performance Measures/Outcome Evaluation, which must be looked at within each year, are monitored from this committee. Whenever possible, this committee should collaborate with the other Ryan White planning groups, especially within the service categories that are also funded by the other Ryan White Parts, to create shared Standards of Care.

In addition to these responsibilities, this committee is also designed to implement the Planning Council's third legislative requirement, assessing the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, or assessing how well the grantee manages to get funds to providers. This means reviewing how quickly contracts with service providers are signed and how long the grantee takes to pay these providers. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the Planning Council and whether all the funds are spent. This Committee may benefit from the utilization of external members.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL. 15, 1998 **REV JANUARY 1, 2018** **POLICY No. 800.01**

CONFLICT OF INTEREST

PURPOSE

To define the policy in which the Houston Area HIV Health Services (RW) Planning Council identifies and addresses conflict of interest within the planning council (PC).

- Inherent in the system - The Ryan White Program states: The HIV health services planning council shall include representatives of...community-based organizations serving affected populations and HIV service organizations; local public health agencies...

- Must be managed - The Ryan White Program states: The PC may not be directly involved in the administration of a grant. The PC may not designate (or otherwise be involved in the selection of) particular entities as recipients of any amount provided in the grant.

AUTHORITY

The Ryan White HIV/AIDS Treatment Extension Act of 2009, Sec.2602(b)(1); Sec.2602(b)(5)(A); Sec.2602(b)(5)(B); Article VIII, Sec8.01 of the Bylaws (01/18) of the Houston Area HIV Health Services (RW) Planning Council.

DEFINITION(S)

"Conflict of Interest" (COI) is defined as an actual or perceived interest by a RWPC member in an action which results or has the appearance of resulting in personal, organizational, or professional gain. COI does not refer to persons living with HIV disease (PLWH) whose sole relationship to a Ryan White Part A or B or State Services funded provider is as a client receiving services. The potential for conflict of interest is present in all Ryan White processes: needs assessment, priority setting, comprehensive planning, allocation of funds and evaluation.

PROCESS

The rules contained in this policy apply to all RWPC members, council support, contractors and consultants to the Houston Area HIV Health Services (RW) Planning Council, all of whom shall be referred to as RWPC members in this policy.

RWPC members who have a financial interest in, are employed by, sit on Boards of Directors, or have been employed by such an entity at any time during the previous twelve months, or are members of a public or private entity seeking Ryan White Part A or B or State Services funding will not participate directly or in an advisory capacity, in the Administrative Agency's processes of selecting entities to receive Ryan White Part A or B or State Services funding within that particular service category. RWPC members shall be provided with copies of, and shall abide by local state regulations governing COI.

RWPC members must complete a COI Disclosure Form annually and/or as needed, describing the relationship of the person to each organization that can benefit from an action by the RWPC. This

information, in the form of a matrix of members and their conflicts of interest, will be provided to all members of the RWPC. Additionally all RWPC members will identify conflicts of interest during a discussion and/or vote and abstain from voting on issues pertaining to that conflict. All RWPC members are encouraged to request a review of potential COI of another member during a RWPC meeting.

The Secretary of the RWPC has responsibility for addressing actions to resolve COI when they occur (see RWPC Policy 500.01). When the Secretary has a COI, monitoring voting for COI and processing inquiries related to COI will fall to the role of the Council Vice Chair, if the Council Vice Chair has a COI the responsibility will fall to the Council Chair. If still unresolved then the responsibility will fall to the Chair of the Operation Committee.

In the event of a COI and/or during the period of review of said COI, members with a COI may participate in the discussion of the COI or questions, but shall abstain from voting on the matter.

The Operations Committee of the RWPC shall recommend to the CEO the termination of a member from the RWPC if the member refuses to complete a COI disclosure form, refuses to declare a COI, or refuses to cooperate in a COI review, or if it is determined that the member took action intended to influence the conduct of the Administrative Agency in selecting entities to receive Ryan White Part A or B or State Services funding within a particular service category or an action which resulted in or had the appearance of resulting in personal, organizational, or professional gain.

COI INQUIRY/INTRODUCTION/PROCEDURE:

A COI matrix from the information provided on the COI questionnaire will indicate the service category(ies) in which a conflict(s) occurs.

An inquiry as to whether or not an individual has a conflict of interest that has not been disclosed is handled as a privileged motion: raising a question of privilege.

Questions of privilege relate to the conduct of officers, members, and employees. In this specific case, the conduct being addressed would be not having disclosed a COI. A question of privilege (COI Inquiry) will usually take place during or after a discussion or vote. If necessary, raising a question of privilege may interrupt a member's speech.

A member of the RWPC, who feels that another member has violated the COI policy by failing to disclose a COI or by voting on an issue regarding a service category in which a conflict has been disclosed, should raise a question of privilege in order to inquire about a possible conflict. The following steps will take place:

Step 1: A member rises, addresses the chair, and then, without waiting, says, "I rise to a question of privilege."

Step 2: The Chair will at this time request the Secretary to take control of the meeting. The Secretary will direct him/her to state his/her question.

Step 3: The member will briefly express his/her complaint and propose, as a motion, a solution. The motion is the actual question of privilege or a request to inquire about a COI.

Step 4: The Secretary will attempt to process the motions to inquire as to whether a member has a COI by general consent. (General consent requires no objections). If the general consent is obtained, the motion will be discussed.

If general consent fails, the Secretary will ascertain if there is a second to the motion and then process it as a main motion (even if a main motion was interrupted).

As soon as the interrupting question of privilege is disposed of, the assembly resumes consideration of the question that was interrupted.

METHOD OF DISCLOSURE:

Annually and on an as needed basis, PC and external committee members are required to submit a Proposed Conflict of Interest Disclosure Questionnaire (RWPC Form 2, COI) to PC Support Staff.

PROCEDURE FOR COUNCIL MEMBERS WHO BECOME VENDORS AFTER JOINING THE COUNCIL:

Vendors must abide by the same conflict of interest policies that everyone else does.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 15, 1998 **REV JANUARY 1, 2018** **POLICY No. 600.01**

QUORUM, VOTING, PROXIES, ATTENDANCE

PURPOSE

This policy establishes the guidelines as to what legally constitutes a Houston Area HIV Health Services (Ryan White) Planning Council meeting. In addition, the policy will define and establish how voting is done, what constitutes a roll call vote and who monitors that process. This policy will define attendance, and the process by which a member can be removed from the council.

AUTHORITY

The adoption of the Houston Area HIV Health Services (Ryan White) Planning Council Bylaws Rev. 01/18 Article VI; (Sections 6.01-6.04).

PROCESS

QUORUM:

A majority of the members of the Council are required to constitute a quorum. A minimum of one (1) self-identified HIV+ member must also be present to constitute a quorum. If quorum is not met, the Council Chair, in consultation with the Office of Support staff, will determine when to dismiss those present. To constitute a Standing Committee quorum, at least two (2) committee members and a Chair must be present; one of these must be a self-identified HIV positive member.

VOTING:

Each council member will have only one vote on any regular business matter coming before the Council. A simple majority of members present and voting will be required to pass any matter coming before the Council except for that of proposed Bylaws changes. Proposed changes to the Bylaws will be submitted in written form for review to the full Council at least fifteen (15) days prior to voting and will require a two-thirds (2/3) majority for passage. The Chair of the Council will not vote except in the event of a tie. The Chairs of the Standing Committees shall not vote at Committee meetings except in the event of a tie. In a case where standing committees have co-chairs, only one of them may vote at Steering. The Chair of the Council is an ex-offico member of all committees (standing, subcommittee, and work groups). Ex-offico means that he/she is welcome to attend and is allowed to be a part of committee discussion. He/she is not allowed to vote. In the absence of the Chair of the Council, the next officer may assume the ex-officio role with committees. In an effort to manage agency influence over a single committee or workgroup, only one voting member (Council or External) per agency will be permitted to vote on Ryan White Planning Council committees and workgroups. If there is an unresolved tie vote and the Chair of the Committee works for the same agency as another committee member, then the information will be forwarded to the Steering Committee for resolution.

ALTERNATE PARTICIPATION:

During committee meetings any HIV+ full council member may serve as an alternate on a committee for any absent HIV+ committee member. The Chair of the Committee will

communicate to the rest of the committee that the alternate HIV+ person is there to conduct business. Alternates have full voting privileges. This rule is not applicable in full council meetings.

CONFLICT OF INTEREST AND VOTING AMONG EXTERNAL MEMBERS:

External members must declare a conflict of interest.

The number of external members on a committee (not a subcommittee or work group) should not equal or exceed the number of council members on that committee.

ROLL CALL VOTE:

When a roll call vote is taken, the Secretary will call the roll call vote, noting voting, and will announce the results of the roll call vote. The Secretary will monitor voting for possible conflicts of interest (RWPC Policy No. 800.01). The Secretary will process inquiries into votes made in conflict of interest.

ATTENDANCE:

Council members are required to attend meetings of the Houston Area HIV Health Services (Ryan White) Planning Council. External Committee members are required to attend meetings of the committee to which they are assigned. The Secretary shall cause attendance records to be maintained and shall regularly provide such records to the Chair of the Operations Committee. The Operations Committee will review attendance records quarterly.

If a Council or external committee member has 4 absences (excused or unexcused) from Council meetings or 4 absences from committee meetings within a calendar year or fails to perform the duties of a Council member described herein without just cause, that member will be subject to removal. In order to avoid such action, the following will occur: Step 1: Office of Support staff will contact the member by telephone to check on their status. Step 2: If the member continues to miss meetings, the Chair of the Planning Council will formally notify the member in writing to remind them of Council policies regarding attendance and to give the member an opportunity to request assignment to another committee. If assignment to another committee is requested, the Chair of the newly selected committee and the Planning Council Chair must approve the change. Step 3: If the Council member continues to miss meetings, the CEO will be informed of the situation and the steps taken by the Council to address the situation. If an external committee member continues to miss meetings, the Chair of the Council will be informed of the situation and the steps taken by the Council to address the situation. Step 4: The CEO has the sole authority to terminate a Council member and will notify said member in writing, if that is their decision. The CEO or the Chair of the Planning Council has the authority to terminate an external committee member and will notify said member in writing, if that is their decision.

If for two consecutive months the Office of Support is unable to make contact with a Council or external committee member by telephone and receives returned email and/or mail sent to that member, staff will send a certified letter requesting the member to contact the Office of Support by telephone or in writing to update their contact information. If the member does not respond to the certified letter within 30 days, or if the certified letter is returned to the Office of Support, the Operations Committee will be notified at their next regularly scheduled meeting. At the request of the Operations Committee, the Chair of the Planning Council and the CEO will be informed of the situation and the steps taken by the Council to address the situation. As stated above, the CEO has the sole authority to terminate a Council member and will notify said member in writing, if that is his/her decision. The CEO or the Chair of the Planning Council has the authority to terminate an external committee member and will notify said member in writing, if that is his/her decision.

Reasons for absences that would be used to determine reassignment or dismissal include: 1) sickness; 2) work related conflicts (in or out of town and vacations), and 3) unforeseeable circumstances. Any Planning Council member who is unable to attend a Planning Council meeting or standing committee meeting must notify the Office of Support prior to such meeting. The Office of Support staff will document why a member is absent.

PROXIES:

There will be no voting by proxy.

2018 Quarterly Report
Quality Improvement Committee
(May 2018)

Status of Committee Goals and Responsibilities (*means mandated by HRSA)

1. Conduct the "How to Best Meet the Needs" (HTBMN) process, with particular attention to the continuum of care with respect to HRSA identified core services.

2. Develop a process for including consumer input that is proactive and consumer friendly for the Standards of Care and Performance Measures review process.

3. Continue to improve the information, processes and reporting (within the committee and also thru collaboration with other Planning Council committees) needed to:
   a. Identify "The Un-met Need";
   b. Determine "How to Best Meet the Needs";
   c. *Strengthen and improve the description and measurement of medical and health related outcomes.

4. *Identify and review the required information, processes and reporting needed to assess the "Efficiency of the Administrative Mechanism". Focus on the status of specific actions and related time-framed based information concerning the efficiency of the administrative mechanism operation in the areas of:
   a. Planning fund use (meeting RWPC identified needs, services and priorities);
   b. Allocating funds (reporting the existence/use of contract solicitation, contract award and contract monitoring processes including any time-frame related activity);
   c. Distributing funds (reporting contract/service/re-imbursement expenditures and status, as well as, reporting contract/service utilization information).

5. Annually, review the status of committee activities identified in the current Comprehensive Plan.

Status of Tasks on the Timeline:

_____ _____
Committee Chairperson Date

DRAFT

Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2018 Council Activities

(Revised 02-01-18)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 713 572-3724.

General Information: The following is a list of significant activities regarding the 2018 Houston Ryan White Planning Council. Consumers, providers and members of the general public are encouraged to attend and provide public comment at any of the meetings described below. For more information on Planning Council processes or to receive monthly calendars and/or meeting packets, please contact the Office of Support at 713 572-3724 or visit our website at: www.rwpchouston.org.

Routinely, the Steering Committee meets monthly at 12 noon on the first Thursday of the month. The Council meets monthly at 12 noon on the second Thursday of the month.

Thurs. Jan. 25	Council Orientation.
Thurs. Feb. 1	12 noon. First Steering Committee meeting for the 2018 planning year.
Feb. date TBD	10:00 am. Orientation for new 2018 External Committee Members.
Thurs. Feb. 8	12 noon. First Council meeting for the 2018 planning year.
Mon. Feb. 12	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. The Council is currently funding, or recommending funding, for 17 of the 28 allowable HRSA service categories. The Proposed Idea Form is used to ask the Council to make a change to a funded service or reconsider funding a service that is not currently being funded in the Greater Houston area with Ryan White Part A, Part B or State Services dollars. The form requires documentation for why dollars should be used to fund a particular service and why it is not a duplication of a service already being offered through another funding source. Anyone can submit a Proposed Idea Form. Please contact the Office of Support at 713 572-3724 to request a copy of the required forms
Feb. 22	12 noon. Priority & Allocations Committee meets to approve the **policy on allocating FY 2018 unspent funds**, **FY 2019 priority setting process** and more.
March	EIIHA Workgroup meeting.
Thurs., March 1	5 pm Deadline for submitting a Project LEAP application form. See April 4 for description of Project LEAP. Call 713 572-3724 for an application form.
March 12	12 noon. **Consumer Training** on the How to Best Meet the Need process.
March 13	1 pm Joint meeting of the Quality Improvement, Priority & Allocations and Affected Community Committees to determine the criteria to be used to select the **FY 2019 service categories** for Part A, Part B and *State Services* funding.
Wed. April 4	**Project LEAP** classes begin. Project LEAP is a free 17-week training course for individuals living with and affected by HIV to gain the knowledge and skills they need to help plan HIV prevention and care services in the Houston Area.

(Continued)

DRAFT

Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2018 Council Activities

(Revised 02-01-18)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 713 572-3724.

Thurs. April 5	12 noon. Steering Committee meets.
Thurs. April 12	12 noon. Planning Council meets. 1:30 – 4:30 pm. **Council and Community Training for the How to Best Meet the Need process**. Those encouraged to attend are community members as well as individuals from the Quality Improvement, Priority & Allocations and Affected Community Committees. Call 713 572-3724 for confirmation and additional information.
Tentative: April 16 and/or 18	Workgroups for proposed ideas, as well as Outreach and Referral for Health Care and Support Services.
Tues. April 24	10:30 am – 4:00 pm. **How To Best Meet the Need Workgroups #1 and #2** at which the following services for FY19 will be reviewed: • Ambulatory/Outpatient Medical Care (including Emergency Financial Assistance, Local Pharmacy Assistance, Medical Case Management & Service Linkage – Adult, Rural and Pediatric) • Clinical Case Management • Health Insurance Premium & Co-pay Assistance • Medical Nutritional Therapy (including Nutritional Supplements) • Mental Health • Substance Abuse Treatment/Counseling • Non-Medical Case Management (Service Linkage at Testing Sites) • Oral Health – Untargeted & Rural • Vision Care Call 713 572-3724 for confirmation and additional information.
TENTATIVE: April 25	3:00 pm – 5:00 pm. **How To Best Meet the Need Workgroup #3** at which the following services will be reviewed: • Early Intervention Services • Home & Community-based Health Services (Adult Day Treatment) • Hospice • Linguistic Services • Transportation (van-based-Untargeted & Rural) Call 713 572-3724 for confirmation and additional information.
April 26	12 noon. Priority & Allocations Committee meets to allocate **Part A unspent funds.**
Mon. May 7	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 12 for a description of this process.) Please contact the Office of Support at 713 572-3724 to request a copy of the required forms.

(Continued)

DRAFT

Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2018 Council Activities

(Revised 02-01-18)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 713 572-3724.

May 22	10 am. **How to Best Meet the Need Workgroup** meets for recommendations on the **Blue Book**. The Operations Committee reviews the FY 2019 Council Support Budget.
May 15	1 pm. Quality Improvement Committee meets to approve the **FY 2019 How to Best Meet the Need results** and review **subcategory allocation requests**. Draft copies are forwarded to the Priority & Allocations Committee.
Mon. May 21	7:00 pm., Public Hearing on the **FY 2019 How To Best Meet the Need results**.
Tues. May 22	10:00 am. Special Quality Improvement Committee meeting to review public comments regarding **FY 2019 How To Best Meet the Need results**.
May 24	12 noon. Priority & Allocations Committee meets to recommend the **FY 2019 service priorities** for Ryan White Parts A and B and *State Services* funding.
Thurs. June 7	12 noon. Steering Committee meets to approve the **FY 2019 How to Best Meet the Need results**.
Thurs. June 14	12 noon. Council approves the **FY 2019 How to Best Meet the Need results**. **Project LEAP students present the results of their needs assessment to the Council, hence the meeting may be at an off-site location.**
June 15, 18 & 19	11 am – 4 pm. Special Priority & Allocations Committee meetings to draft the **FY 2019 allocations for RW Part A and B and *State Services* funding**.
June 19	1 pm. Quality Improvement Committee reviews the results of the assessment of the administrative mechanism and hosts Standards of Care training.
Wed. June 27	12 noon. The Priority & Allocations Committee meets to approve the **FY 2019 allocations for RW Part A and B and *State Services* funding**. LEAP students will be in attendance.
Mon. July 2	7 pm. Public Hearing on the **FY 2019 service priorities and allocations**.
Tues. July 3	10 am. Special meeting of the Priority & Allocations Committee to review public comments regarding the **FY 2019 service priorities and allocations**.
July/Aug.	Workgroup meets to complete the proposed **FY 2019 EIIHA Plan**.
Thurs. July 5	12 noon. Steering Committee approves the **FY 2019 service priorities and allocations**.
Thurs. July 12	12 noon. Council approves the **FY 2019 service priorities and allocations**.

(continued)

DRAFT

Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2018 Council Activities

(Revised 02-01-18)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 713 572-3724.

July 26	12 noon. If necessary, the Priority & Allocations Committee meets to address problems Council sends back regarding the **FY 2019 priority & allocations**. They also allocate FY **2018 carryover funds**. (**Allocate even though dollar amount will not be avail. until Aug.**)
Thurs. Aug. 2	ALL ITEMS MUST BE REVIEWED BEFORE BEING SENT TO COUNCIL – THIS STEERING COMMITTEE MEETING IS THE **LAST CHANCE TO APPROVE ANYTHING NEEDED FOR THE FY 2019 GRANT**. (Mail out date for the August Steering Committee meeting is July 26, 2018.)
Aug. 13	**Consumer Training** on Standards of Care and Performance Measures.
Mon. Sept. 10	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 12 for a description of this process.) Please contact the Office of Support at 713 572-3724 to request a copy of the required forms.
Sept. 17	**Consumer-Only Workgroup** meeting to review FY 2019 Standards of Care and Performance Measures.
Sept. 18	1 pm. Joint meeting of the Quality Improvement, Priority & Allocations and all Committees to review data reports and make suggested changes.
Sept. 17	**Consumer-Only Workgroup** meeting to review FY 2019 Standards of Care and Performance Measures.
Oct. 16	10 am. Review and possibly update the Memorandum of Understanding between all Part A stakeholders.
October or November	Community Workgroup meeting to review **FY 2019 Standards of Care & Performance Measures** for all service categories.
Oct. 25	12 noon. Priority & Allocations Committee meets to allocate FY 2018 unspent funds.
Nov/Dec/Jan.	Review the evaluation of 2018 Project LEAP. Operations Committee also hosts a How to Best Meet the Need Workgroup to make recommendations on 2019 Project LEAP.
November	The Resource Group contacts all stakeholders to see if changes need to be made to the Ryan White Part B/State Services Letter of Agreement.
Thurs. Nov. 8	12 noon. Council recognizes all external committee members.
Tues. Nov. 13	9:30 am. Commissioners Court to receive the World AIDS Day Resolution.
Sat. Dec. 1	**World AIDS Day**.
Dec. 6	12 noon. Due to a national meeting, the date for the December Council meeting will be earlier than usual. **2019 Council officers** will be elected at the meeting.

2018 Ryan White Planning Council Committee Schedule - DRAFT

(as of 02/01/18)

AFFECTED COMMUNITY

Meetings are on the Mondays following Council starting at 12 noon**.**

February 12	July 16
March 12	August 13
March 13*	September 17
April no meeting	October 15
May 14	November 12
June 18	December no mtg

COMPREHENSIVE HIV PLANNING

Meetings are on the second Thursdays starting at 2:00 pm:

February 8	August 9
March 8	September 13
April 12	October 11
May 10	November 8
June 14	December 13
July 12	

OPERATIONS

Meetings are on the Tuesdays following Council starting at 10 am:

February 20	August 21
March 20	September 25
April 24	October 23
May 22	November 20
June 26	December no mtg
July 24	

PLANNING COUNCIL

Meetings are the second Thursdays starting at 12 noon:

February 8	August 9
March 8	September 13
April 12	October 11
May 10	November 8
June 14	December 6
July 12	

PRIORITY & ALLOCATIONS

Meetings are on the fourth Thursdays starting at 12:00 pm:

February 22	July 26
March 13*	August 23
March 22	September 27
April 26	October 25
May 24	November no mtg
June 15, 18 & 19	December no mtg
Wed. June 27	

QUALITY IMPROVEMENT

Meetings are on the Tuesdays following Council starting at 1:00 pm:

February 13	August 14
March 13*	September 18
April 17	October 16
May 15	November 13
June 19	December no mtg
July 17	

STEERING

Meetings are on the first Thursdays starting at 12 noon:

February 1	August 2
March 1	September 6
April 5	October 4
May 3	November 1
June 7	November 29
July 5	December – meeting on Nov 29

***Joint meeting of the Affected Community, Priority and Allocations and Quality Improvement Committees.**

**** Time to be announced**

BOLD = Special meeting date, time or place

FY 2016 Ryan White Part A and MAI Service Utilization Report

SUR - 2nd Quarter Cumulative (3/1-8/31)																		
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**4,964**	**74%**	**26%**	**100%**	**48%**	**15%**	**2%**	**35%**	**0%**	**1%**	**5%**	**25%**	**27%**	**14%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,360	69%	31%	100%	51%	10%	2%	37%	0%	0%	3%	18%	27%	15%	35%	3%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,051	70%	30%	100%	98%	0%	1%	0%	0%	1%	10%	39%	26%	10%	15%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	778	85%	15%	100%	0%	0%	0%	100%	0%	1%	6%	29%	32%	14%	18%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	459	90%	10%	100%	0%	88%	11%	1%	0%	0%	3%	26%	23%	17%	28%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	419	70%	30%	100%	42%	27%	3%	29%	0%	0%	7%	28%	27%	15%	22%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	739	0%	100%	100%	62%	8%	1%	29%	0%	0%	2%	14%	32%	17%	32%	4%
1.g	Primary Care - Pediatric (a)	7	8	75%	25%	100%	75%	13%	0%	13%	38%	50%	13%	0%	0%	0%	0%	0%
1.h	Vision	1,600	944	74%	26%	100%	48%	13%	2%	37%	0%	0%	4%	24%	24%	15%	30%	3%
2	**Medical Case Management (f)**	**3,075**	**2,814**															
2.a	Clinical Case Management	600	637	74%	26%	100%	61%	22%	2%	15%	0%	1%	6%	29%	20%	12%	28%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	337	96%	4%	100%	55%	12%	3%	30%	0%	3%	18%	20%	20%	11%	27%	2%
2.c	Med CM - Targeted to AA (a)	550	1,002	69%	31%	100%	99%	0%	1%	0%	0%	1%	8%	34%	26%	12%	18%	1%
2.d	Med CM - Targeted to H/L(a)	550	497	88%	12%	100%	0%	0%	0%	100%	0%	1%	7%	33%	31%	12%	15%	1%
2.e	Med CM - Targeted to White and/or MSM (a)	260	200	87%	14%	100%	0%	88%	12%	1%	0%	0%	4%	22%	22%	20%	29%	4%
2.f	Med CM - Targeted to Rural (a)	150	387	69%	31%	100%	46%	25%	3%	26%	0%	1%	6%	23%	25%	14%	29%	3%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	142	0%	100%	100%	57%	10%	3%	30%	0%	2%	10%	14%	32%	11%	25%	5%
2.h	Med CM - Targeted to Pedi (a)	125	67	49%	51%	100%	78%	7%	0%	15%	52%	42%	6%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	114	96%	4%	100%	72%	20%	0%	8%	0%	0%	0%	2%	4%	4%	71%	20%
2.j	Med CM - Targeted to Youth	120	68	99%	1%	100%	60%	6%	1%	32%	0%	13%	87%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**2,858**	**78%**	**22%**	**100%**	**47%**	**16%**	**2%**	**35%**	**0%**	**0%**	**5%**	**29%**	**29%**	**14%**	**21%**	**1%**
4	**Oral Health**	**200**	**170**	**65%**	**35%**	**100%**	**35%**	**36%**	**2%**	**26%**	**0%**	**1%**	**4%**	**22%**	**28%**	**10%**	**33%**	**2%**
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	170	65%	35%	100%	35%	36%	2%	26%	0%	1%	4%	22%	28%	10%	33%	2%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**711**	**81%**	**19%**	**100%**	**40%**	**32%**	**3%**	**25%**	**0%**	**0%**	**2%**	**13%**	**20%**	**16%**	**42%**	**6%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**11**	**100%**	**0%**	**100%**	**27%**	**45%**	**0%**	**27%**	**0%**	**0%**	**0%**	**18%**	**45%**	**9%**	**27%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**348**	**77%**	**23%**	**100%**	**41%**	**21%**	**4%**	**34%**	**0%**	**0%**	**0%**	**9%**	**16%**	**21%**	**45%**	**8%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**NA**	**5**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
13	**Non-Medical Case Management**	**7,045**	**3,658**															
13.a	Service Linkage Targeted to Youth	320	93	81%	19%	100%	58%	10%	3%	29%	0%	14%	86%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	86	66%	34%	100%	57%	6%	1%	36%	0%	0%	0%	42%	19%	12%	24%	3%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	1,638	68%	32%	100%	63%	11%	1%	25%	0%	0%	0%	18%	24%	14%	40%	4%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	1,841	78%	22%	100%	50%	15%	2%	33%	2%	1%	7%	31%	23%	13%	22%	2%
14	**Transportation**	**2,850**	**1,270**															
14.a	Transportation Services - Urban	170	173	67%	33%	100%	55%	11%	2%	31%	0%	1%	9%	28%	18%	10%	29%	5%
14.b	Transportation Services - Rural	130	39	77%	23%	100%	38%	33%	0%	28%	0%	0%	8%	26%	23%	8%	31%	5%
14.c	Transportation vouchering	2,550	1,058															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Other Professional Services (e)**	**NA**	**NA**															
17	**Emergency Financial Assistance (e)**	**NA**	**NA**															
18	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**11,657**	**9,142**	**74%**	**26%**	**100%**	**52%**	**16%**	**2%**	**31%**	**1%**	**1%**	**5%**	**23%**	**24%**	**13%**	**30%**	**3%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 17 App) (b)		**NA**	**22,830**	**74%**	**26%**	**100%**	**49%**	**23%**	**3%**	**25%**	**0%**	**6%**		**18%**	**27%**	**30%**	**18%**	
***11,657** clients to be served is based on the number of unduplicated clients served in FY 2016 (update per CPCDMS)																		

FY 2016 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	954	73%	27%	100%	99%	0%	1%	0%	0%	1%	10%	38%	26%	10%	14%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	671	86%	14%	100%	0%	0%	0%	100%	0%	1%	6%	33%	30%	13%	16%	1%

RW Part A New Client Service Utilization Report

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/12 - 2/28/13)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**581**	**77%**	**23%**	**100%**	**55%**	**13%**	**2%**	**29%**	**0%**	**2%**	**8%**	**35%**	**27%**	**11%**	**16%**	**2%**
2	**LPAP**	**1,200**	**250**	**81%**	**19%**	**100%**	**53%**	**18%**	**1%**	**28%**	**0%**	**2%**	**6%**	**38%**	**29%**	**12%**	**13%**	**0%**
3.a	Clinical Case Management	400	64	91%	9%	100%	48%	25%	2%	25%	0%	3%	8%	41%	16%	14%	19%	0%
3.b-3.h	Medical Case Management	1,600	344	77%	23%	100%	54%	13%	3%	30%	0%	3%	10%	31%	27%	10%	16%	2%
3.i	Medical Case Manangement - Targeted to Veterans	60	31	97%	3%	100%	65%	23%	0%	13%	0%	0%	0%	3%	3%	3%	65%	26%
4	**Oral Health**	**40**	**10**	**40%**	**60%**	**100%**	**20%**	**40%**	**0%**	**40%**	**0%**	**0%**	**20%**	**10%**	**30%**	**10%**	**30%**	**0%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**842**	**75%**	**25%**	**100%**	**56%**	**14%**	**2%**	**28%**	**1%**	**1%**	**7%**	**31%**	**25%**	**12%**	**21%**	**2%**
12.b	**Service Linkage at Testing Sites**	**260**	**25**	**72%**	**28%**	**100%**	**44%**	**8%**	**0%**	**48%**	**0%**	**0%**	**4%**	**68%**	**16%**	**4%**	**8%**	**0%**

Footnotes:

(a) Bundled Category

(b) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.

(d) Funded by Part B and/or State Services

(e) Not funded in FY 2017

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2017 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,795,737**	**50,000**	**53,425**	**0**	**0**	**9,899,162**	**47.92%**	**9,899,162**	**0**	[redacted]	**3,249,625**	**33%**	**58%**
1.a	Primary Care - Public Clinic (a)	3,643,839	0	0	0		3,643,839	17.64%	3,643,839	0	3/1/2017	$543,297	15%	25%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	17,809	0		958,256	4.64%	958,256	0	3/1/2017	$734,807	77%	58%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	17,808	0		804,232	3.89%	804,232	0	3/1/2017	$547,381	68%	58%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,038,843	0	17,808	0		1,056,651	5.12%	1,056,651	0	3/1/2017	$350,174	33%	58%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,166,658	0	0	0		1,166,658	5.65%	1,166,658	0	3/1/2017	$584,571	50%	58%
1.f	Primary Care - Women at Public Clinic (a)	1,902,089	0	0			1,902,089	9.21%	1,902,089	0	3/1/2017	$247,740	13%	25%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2017	$8,100	52%	58%
1.h	Vision	302,000	50,000	0	0		352,000	1.70%	352,000	0	3/1/2017	$233,555	66%	58%
2	**Medical Case Management**	**2,215,702**	**0**	**227,500**	**0**	**0**	**2,443,202**	**11.83%**	**2,443,202**	**0**	[redacted]	**1,079,909**	**44%**	**58%**
2.a	Clinical Case Management	488,656	0	115,000	0		603,656	2.92%	603,656	0	3/1/2017	$306,125	51%	58%
2.b	Med CM - Public Clinic (a)	162,622	0	0	0		162,622	0.79%	162,622	0	3/1/2017	$32,784	20%	25%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	37,500	0		358,570	1.74%	358,570	0	3/1/2017	$273,789	76%	58%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	37,500	0		358,572	1.74%	358,572	0	3/1/2017	$144,029	40%	58%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	37,500	0		144,747	0.70%	144,747	0	3/1/2017	$64,713	45%	58%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.69%	348,760	0	3/1/2017	$110,356	32%	58%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.87%	180,311	0	3/1/2017	$18,314	10%	25%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.77%	160,051	0	3/1/2017	$73,529	46%	58%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.39%	80,025	0	3/1/2017	$50,026	63%	58%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.22%	45,888	0	3/1/2017	$6,245	14%	25%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,384,796**	**0**	**30,000**	**0**	**0**	**2,414,796**	**11.69%**	**2,414,796**	**0**	3/1/2017	**$1,848,312**	**77%**	**58%**
4	**Oral Health**	**166,404**	**0**	**29,717**	**0**	**0**	**196,121**	**0.95%**	**196,121**	**0**	3/1/2017	**110,300**	**56%**	**58%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	29,717			196,121	0.95%	196,121	0	3/1/2017	$110,300	56%	58%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,294,551**	**0**	**0**	**0**	**0**	**1,294,551**	**6.27%**	**1,294,551**	**0**	3/1/2017	**$837,423**	**65%**	**58%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.22%**	**45,677**	**0**	3/1/2017	**$30,413**	**67%**	**58%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**10,000**	**0**	**0**	**351,395**	**1.70%**	**351,395**	**0**	3/1/2017	**$203,448**	**58%**	**58%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
12	**Outreach Services**	**490,000**	**-70,000**				**420,000**	**2.03%**	**420,000**	**0**	7/1/2017	**$0**	**0%**	**58%**
13	**Non-Medical Case Management**	**1,231,002**	**0**	**14,000**	**0**	**0**	**1,245,002**	**6.03%**	**1,245,002**	**0**	[redacted]	**668,853**	**54%**	**58%**
13.a	Service Linkage targeted to Youth	110,793		0			110,793	0.54%	110,793	0	3/1/2017	$168,306	152%	58%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			0		100,000	0.48%	100,000	0	3/1/2017	$40,514	41%	58%
13.c	Service Linkage at Public Clinic (a)	427,000		0	0		427,000	2.07%	427,000	0	3/1/2017	$0	0%	25%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		14,000	0		607,209	2.94%	607,209	0	3/1/2017	$460,033	76%	58%
14	**Medical Transportation**	**527,362**	**-45,275**	**30,000**	**0**	**0**	**512,087**	**2.48%**	**379,865**	**132,222**	[redacted]	**208,820**	**55%**	**58%**
14.a	Medical Transportation services targeted to Urban	252,680	0	15,000	0		267,680	1.30%	267,680	0	3/1/2017	$168,306	63%	58%
14.b	Medical Transportation services targeted to Rural	97,185	0	15,000	0		112,185	0.54%	112,185	0	3/1/2017	$40,514	36%	58%
14.c	Transportation vouchering (bus passes & gas cards)	177,497	-45,275	0	0		132,222	0.64%	0	132,222	3/1/2017	$0	#DIV/0!	0%
15	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
16	**Other Professional Services**	**125,000**	**-125,000**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
17	**Emergency Financial Assistance**	**0**		**50,000**			**50,000**	**0.24%**	**0**	**50,000**	NA		**0%**	**0%**
18	**Referral for Health Care and Support Services**	**0**					**0**	**0.00%**	**0**	**0**	NA		**0%**	**0%**
BER27516	**Total Service Dollars**	**18,617,626**	**-190,275**	**444,642**	**0**	**0**	**18,871,993**	**89.09%**	**18,689,771**	**182,222**	[redacted]	**8,237,102**	**44%**	**58%**
	Grant Administration	**1,658,827**	**16,220**	**0**	**0**	**0**	**1,675,047**	**8.11%**	**1,675,047**	**0**	**N/A**	**1,324,318**	**79%**	**58%**

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2017 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
[redacted]	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.55%	1,146,388	0	N/A	$1,080,632	94%	58%
[redacted]PC	RWPC Support*	512,439	16,220		0	0	528,659	2.56%	528,659	0	N/A	243,686	46%	58%
[redacted]	**Quality Management**	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.40%**	**495,000**	**0**	**N/A**	**$478**	**0%**	**58%**
		20,771,453	**-174,055**	**444,642**	**0**	**0**	**21,042,040**	**99.59%**	**20,859,818**	**182,222**	[redacted]	**9,561,898**	**45%**	**58%**
								Unallocated	Unobligated		[redacted]			[redacted]
	Part A Grant Award:	**20,656,176**	***Carry Over:***	**0**		***Total Part A:***	**20,656,176**	**444,642**	**182,222**					

	Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	[redacted]
Core (must not be less than 75% of total service dollars)	**16,244,262**	**50,000**	**350,642**	**0**	**0**	**16,644,904**	**90.45%**	**16,644,904**	**90.45%**	
Non-Core (may not exceed 25% of total service dollars)	**1,883,364**	**-170,275**	**44,000**	**0**	**0**	**1,757,089**	**9.55%**	**1,757,089**	**9.55%**	
Total Service Dollars (does not include Admin and QM)	**18,127,626**	**-120,275**	**394,642**	**0**	**0**	**18,401,993**	[redacted]	**18,401,993**	[redacted]	
Total Admin (must be ≤ 10% of total Part A + MAI)	**1,658,827**	**16,220**	**0**	**0**	**0**	**1,675,047**	**8.11%**			
Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.40%**			

MAI Procurement Report

riority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**2,057,949**	**59,936**	**233,750**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**	[redacted]	**1,197,350**	**58%**	**25%**
) (MAI)	Primary Care - CBO Targeted to African American	1,040,245	29,968	116,875	0	0	1,187,088	50.48%	1,040,245	146,843	3/1/2017	$679,800	65%	25%
: (MAI)	Primary Care - CBO Targeted to Hispanic	1,017,704	29,968	116,875	0	0	1,164,547	49.52%	1,017,704	146,843	3/1/2017	$517,550	51%	25%
17	**Emergency Financial Assistance**	0	0	50,000			50,000	2.13%	0	50,000			#DIV/0!	0%
18	**Referral for Health Care and Support Services**	0	0	347,746			347,746	14.79%	0	347,746			#DIV/0!	0%
[redacted]	**Total MAI Service Funds**	**2,057,949**	**59,936**	**631,496**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**	[redacted]	**1,197,350**	**58%**	**25%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	[redacted]	**0**	**0%**	**0%**
[redacted]	**Total MAI Funds**	**2,057,949**	**59,936**	**631,496**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**	[redacted]	**1,197,350**	**58%**	**25%**
	MAI Grant Award	**2,117,885**	***Carry Over:***	**0**		***Total MAI:***	**2,117,885**							[redacted]
	Combined Part A and MAI Orginial Allocation Total	**22,829,402**												

otnotes:

All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.
(a)	Single local service definition is four (4) HRSA service categories (Pcare, LPAP, MCM, Non Med CM). Expenditures must be evaluated both by individual service category and by combined service categories.
a.1)	Single local service definition is three (3) HRSA service categories (does not include LPAP). Expenditures must be evaluated both by individual service category and by combined service categories.
(b)	Adjustments to reflect actual award based on Increase funding scenario.
(c)	Funded under Part B and/or SS
(d)	Not used at this time
(e)	10% rule reallocations

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1617 DSHS State Services

Procurement Report

September 1, 2016 - August 31, 2017

Chart reflects spending through August 2017

Spending Target: 100%

Revised 10/19/2017

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Mental Health Services*	$300,000	15%		$300,000	15%	9/1/2016	$222,165	74%
7	Health Insurance Premiums and Cost Sharing**	$1,043,312	53%		$1,043,312	53%	9/1/2016	$1,064,453	102%
9	Hospice **	$414,832	21%		$414,832	21%	9/1/2016	$343,640	83%
11	EIS - Incarcerated	$166,211	8%		$166,211	8%	9/1/2016	$153,632	92%
16	Linguistic Services	$48,000	2%		$48,000	2%	9/1/2016	$56,175	117%
Total Houston HSDA		1,972,355	100%	$0	$1,972,355	100%		1,840,065	93%

* Service utilization is lagging

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: Part A 02/29/17, Part B 03/31/17, State Services 8/31/17

** The agency has seen a drop in clients and is currently performing outreach to increase spending

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-08/31/2017

Revised: 10/9/2017

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	Dollar Amount of Requests	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1732	$152,169.45	664			*0*
Medical Deductible	326	$75,531.03	209			*0*
Medical Premium	7108	$2,439,693.44	961			*0*
Pharmacy Co-Payment	5232	$496,687.66	1423			*0*
APTC Tax Liability	1	$213.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	15	$11,886.21	9	*NA*	*NA*	*NA*
Totals:	14414	$3,152,408.37	3267	0	$0.00	

Comments: This report represents services provided under all grants.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2015 Outcome Measures, 2015 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Early Intervention Services (EIS)‡ (Incarcerated) (Harris County Jail)	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ___Yes ✔ No			
Health Insurance Premium & Co-Pay Assistance **Part A** **Part B** **State Services**	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ___Yes ✔ No			

‡ Service Category for Part B/State Services only.

Umair A. Shah, M.D., M.P.H.
Executive Director

Harris County
Public Health
Building a Healthy Community

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

Oral Health Care-Rural Target Chart Review FY 2016

Ryan White Part A Quality Management Program–Houston EMA

December 2017

CONTACT:

Heather Keizman
Project Coordinator–Clinical Quality Improvement
Harris County Public Health & Environmental Services
Ryan White Grant Administration
2223 West Loop South, RM 431
Houston, TX 77027
713-439-6037
hkeizman@hcphes.org

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

Follow HCPH on Twitter @hcphtx and like us on Facebook

Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health & Environmental Services. During FY 16, a comprehensive review of client dental records was conducted for services provided between 3/1/16 to 2/28/17. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

The primary purpose of this annual review process is to assess Part A oral health care provided to persons living with HIV in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S Health and Human Services Department for oral health care targeting individuals with HIV/AIDS. Therefore, Ryan White Grant Administration has adopted general guidelines from peer-reviewed literature that address oral health care for the HIV/AIDS population, as well as literature published by national dental organizations such as the American Dental Association and the Academy of General Dentistry, to measure the quality of Part A funded oral health care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 16 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research and a series of working meetings between Ryan White Grant Administration. By studying the processes of previous dental record reviews and researching the most recent HIV-related and general oral health practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for oral health care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: basic client information, completeness of the health history, hard & soft tissue examinations, disease prevention, and periodontal examinations.

The Chart Review Process

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from HIV-related and general oral health care guidelines available in peer-reviewed literature, and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters

Review Area	Documentation Criteria
Health History	Completeness of Initial Health History: includes but not limited to past medical history, medications, allergies, substance use, HIV MD/primary care status, physician contact info, etc.; Completed updates to the initial health history
Hard/Soft Tissue Exam	Findings—abnormal or normal, diagnoses, treatment plan, treatment plan updates
Disease Prevention	Prophylaxis, oral hygiene instructions
Periodontal screening	Completeness

The Sample Selection Process

The sample population was selected from a pool of 284 unduplicated clients who accessed Part A oral health care between 3/1/16 and 2/28/17. The medical charts of 75 of these clients were used in the review, representing 26% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/16 and 2/28/17 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving rural-targeted oral health care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who received rural-targeted oral health care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of persons with HIV or AIDS. Table 2 compares the review sample population with the Ryan White Part A rural-targeted oral health care population as a whole.

Table 2. Demographic Characteristics of FY 16 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	35	46.7%	122	43%
White	39	52%	159	56%
Asian	1	1.3%	2	.7%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	0	0%	0	0%
Multi-Race	0	0%	1	.4%
	75		**284**	
Hispanic Status				
Hispanic	17	22.7%	71	25%
Non-Hispanic	58	77.3%	213	75%
	75		**284**	
Gender				
Male	47	62.7%	189	68.6%
Female	26	34.7%	93	32.8%
Transgender	2	2.7%	2	.7%
	75		**284**	
Age				
18 – 24	4	5.3%	15	5.3%
25 – 34	15	20%	58	20.4%
35 – 44	21	28%	82	28.9%
45 – 54	20	26.7%	74	26.1%
55 – 64	11	14.7%	45	15.9%
65+	3	4%	10	3.5%
	75		**284**	

Findings

Clinic Visits

Information gathered during the 2016 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

A complete and thorough assessment of a patient's medical history is essential among individuals infected with HIV or anyone who is medically compromised. Such information, such as current medication or any history of alcoholism for example, offers oral health care providers key information that may determine the appropriateness of prescriptions, oral health treatments and procedures. The form that is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will focus on the assessment of information that is of particular importance among HIV/AIDS patients compared to patients in the general population.

Assessment of Medical History

	2014	2015	2016
Primary Care Provider	67%	88%	93%
Dental Health History*	97%	93%	87%
Medical Health History*	81%	83%	87%
Medical History 6 month Update	59%	94%	100%
Medication Review	61%	91%	88%
Allergies Recorded	81%	93%	88%
Documentation of HIV Status	6%	71%	88%
Documentation of Opportunistic Infection Status	53%	93%	88%
Tobacco Use	81%	95%	87%
Substance Abuse	80%	95%	87%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2014	2015	2016
Vital Signs	96%	99%	95%
CBC documented	59%	63%	78%
Screening for Antibiotic Prophylaxis	83%	91%	52%

Prevention and Detection of Oral Disease

Maintaining good oral health is vital to the overall quality of life for individuals living with HIV/AIDS because the condition of one's oral health often plays a major role in how well patients are able manage their HIV disease. Poor oral health due to a lack of dental care may lead to the onset and progression of oral manifestations of HIV disease, which makes maintaining proper diet and nutrition or adherence to antiretroviral therapy very difficult to achieve. Furthermore, poor oral health places additional burden on an already compromised immune system.

	2014	2015	2016
Oral Health Education*	87%	80%	88%
Clinical Tooth Chart	100%	99%	94%
Intraoral Exam	92%	88%	88%
Extraoral Exam	91%	88%	86%
Periodontal screening*	91%	92%	84%
X-rays present	94%	92%	91%
Treatment plan*	89%	81%	94%

*HIV/AIDS Bureau (HAB) Performance Measures

Procedures Performed

	2014	2015	2016
Extractions	32%	29%	29%
Fillings	59%	60%	37%
Root Canals	7%	11%	4%
Dentures	13%	11%	15%
Crowns	11%	17%	15%

Conclusions

Overall, oral health care services continues its trend of high quality care. The Houston EMA oral health care program has established a strong foundation for preventative care and we expect continued high levels of care for Houston EMA clients in future.

Appendix A – Resources

Dental Alliance for AIDS/HIV Care. (2000). *Principles of Oral Health Management for the HIV/AIDS Patient*. Retreived from: http://aidsetc.org/sites/default/files/resources_files/Princ_Oral_Health_HIV.pdf.

HIV/AIDS Bureau. (2013). *HIV Performance Measures*. Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

Mountain Plains AIDS Education and Training Center. (2013). Oral Health Care for the HIV-infected Patient. Retrieved from: http://aidsetc.org/resource/oral-health-care-hiv-infected-patient.

New York State Department of Health AIDS Institute. (2004). *Promoting Oral Health Care for People with HIV Infection*. Retrieved from: http://www.hivdent.org/_dentaltreatment_/pdf/oralh-bp.pdf.

U.S. Department of Health and Human Services Health Resources and Services Administration. (2014). *Guide for HIV/AIDS Clinical Care.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau Special Projects of National Significance Program. (2013). *Training Manual: Creating Innovative Oral Health Care Programs.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

Umair A. Shah, M.D., M.P.H.
Executive Director

Harris County
Public Health
Building a Healthy Community

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

Primary Care Chart Review Report FY 2016

Ryan White Part A Quality Management Program – Houston EMA

December 2017

CONTACT:

Heather Keizman, RN, MSN, WHNP-BC
Project Coordinator-Clinical Quality Improvement
Harris County Public Health & Environmental Services
Ryan White Grant Administration Section
2223 West Loop South, RM 431
Houston, TX 77027
713-439-6037

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

Follow HCPH on Twitter @hcphtx and like us on Facebook

PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

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

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

Introduction

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

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

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

Tool Development

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

Chart Review Process

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

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

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

Tale 1. Data Collection Parameters

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

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

The Sample Selection Process

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

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

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

Characteristics of the Sample Population

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

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

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

Report Structure

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

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

Findings

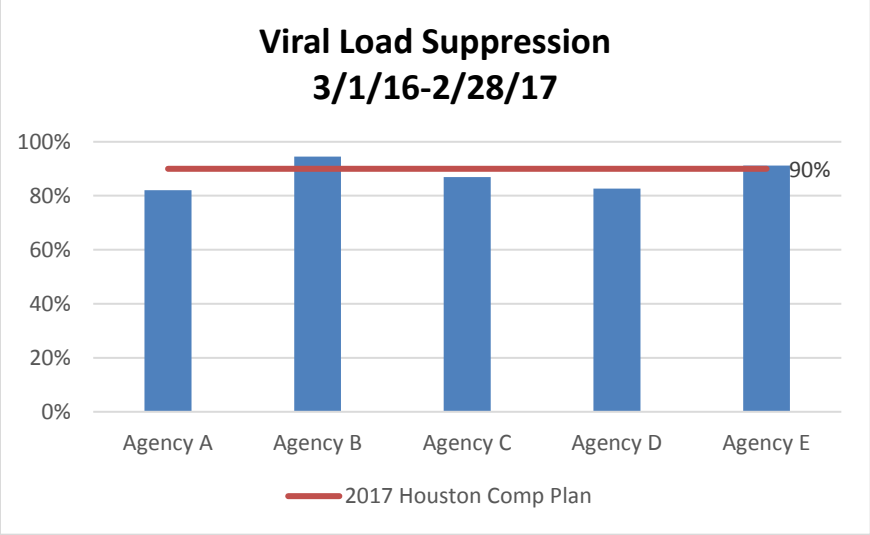
Core Performance Measures

Viral Load Suppression

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

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

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



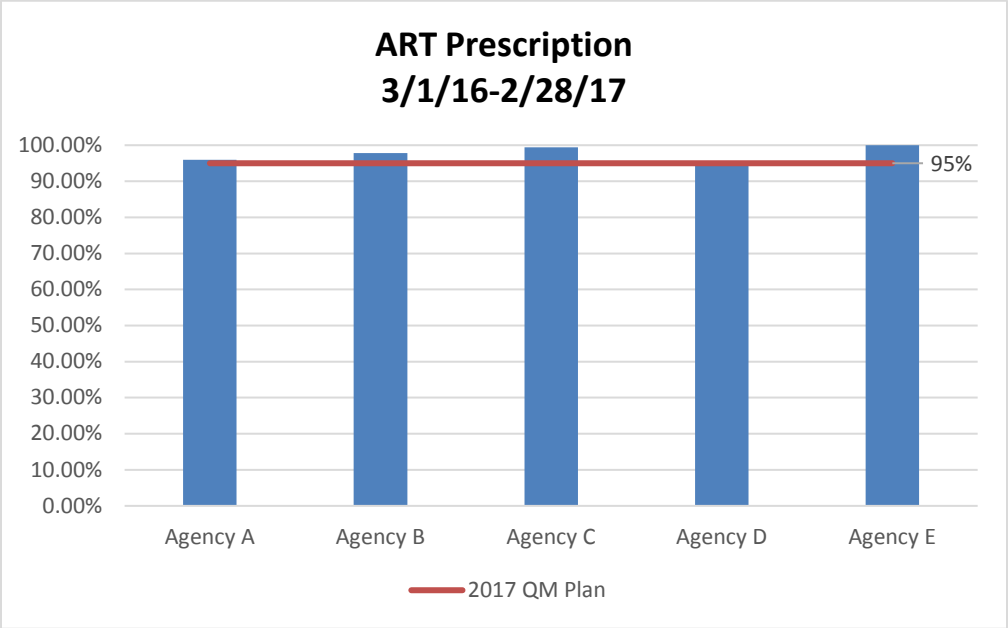
ART Prescription

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

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

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

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

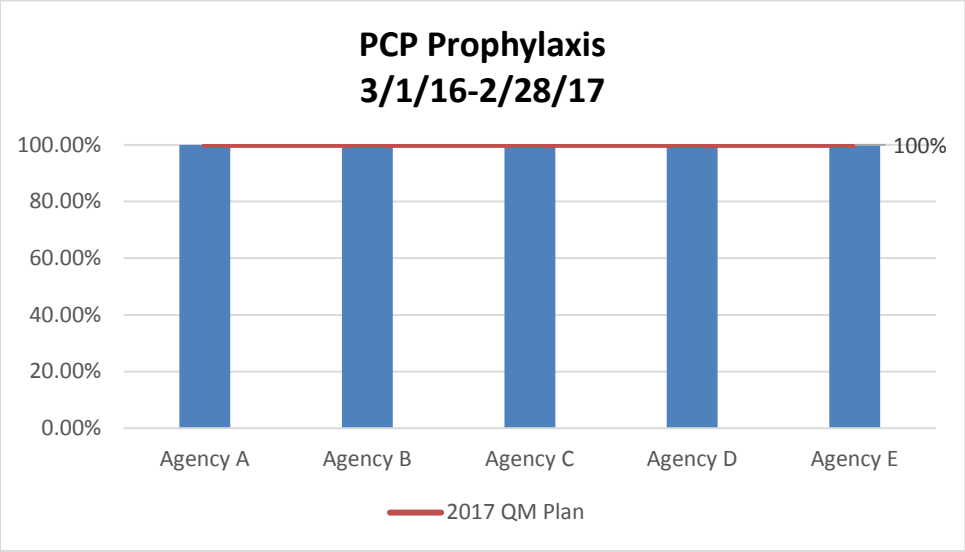


PCP Prophylaxis

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

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

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



All Ages Performance Measures

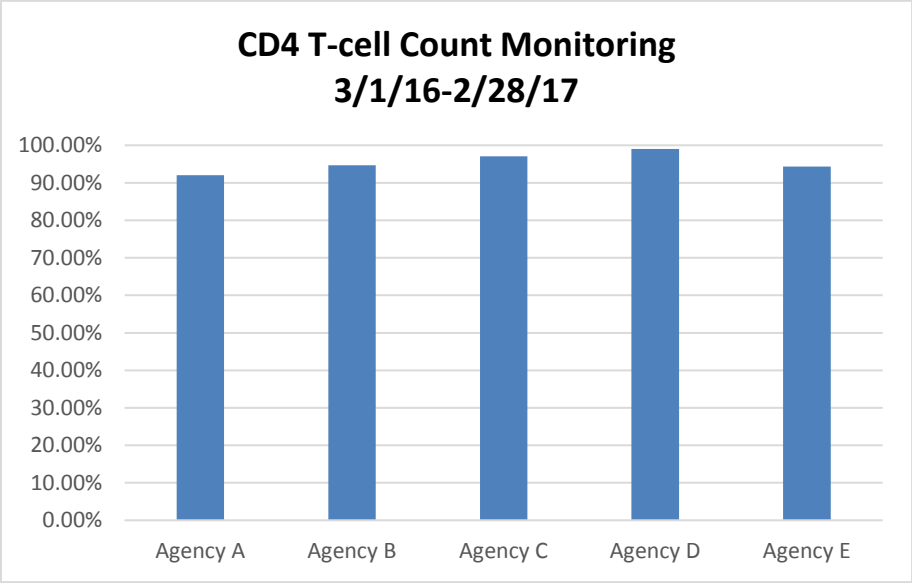
CD4 T-Cell Count

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

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

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

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

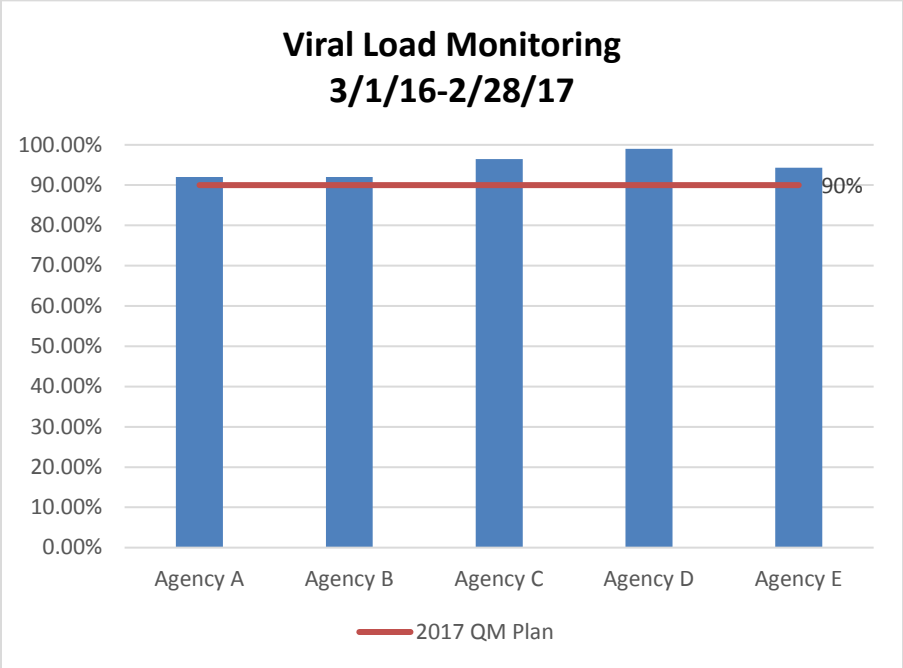


Viral Load Monitoring

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

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

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



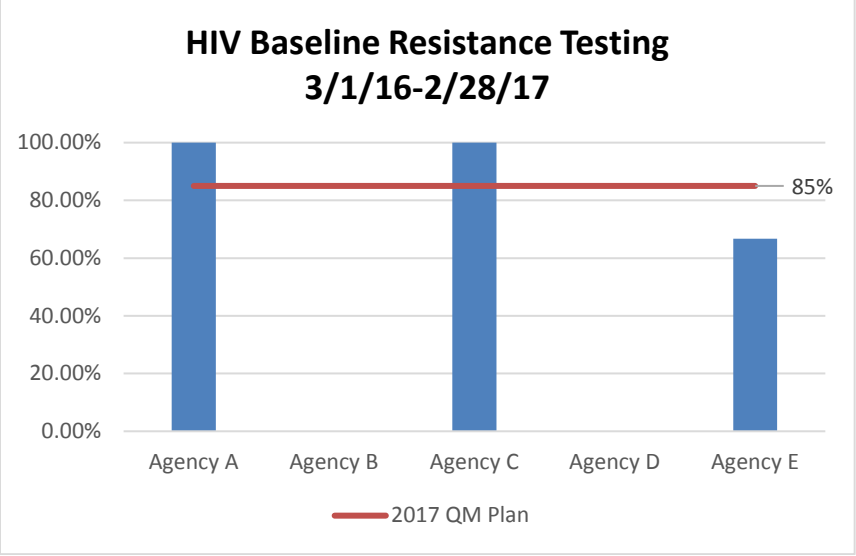
HIV Drug Resistance Testing Before Initiation of Therapy

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

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

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

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



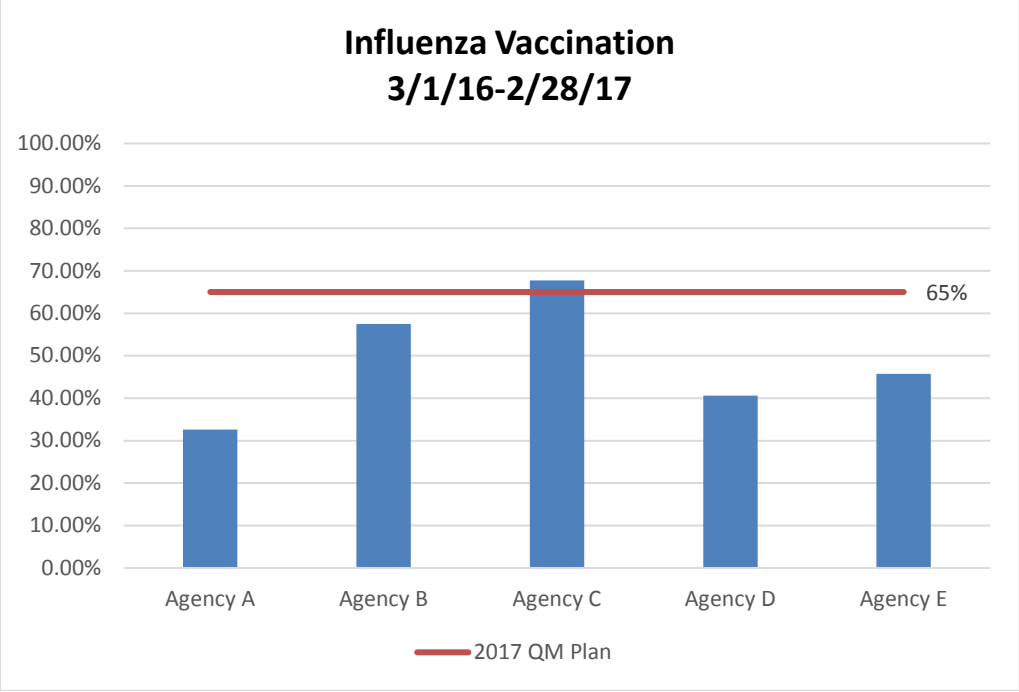
Influenza Vaccination

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

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

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

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

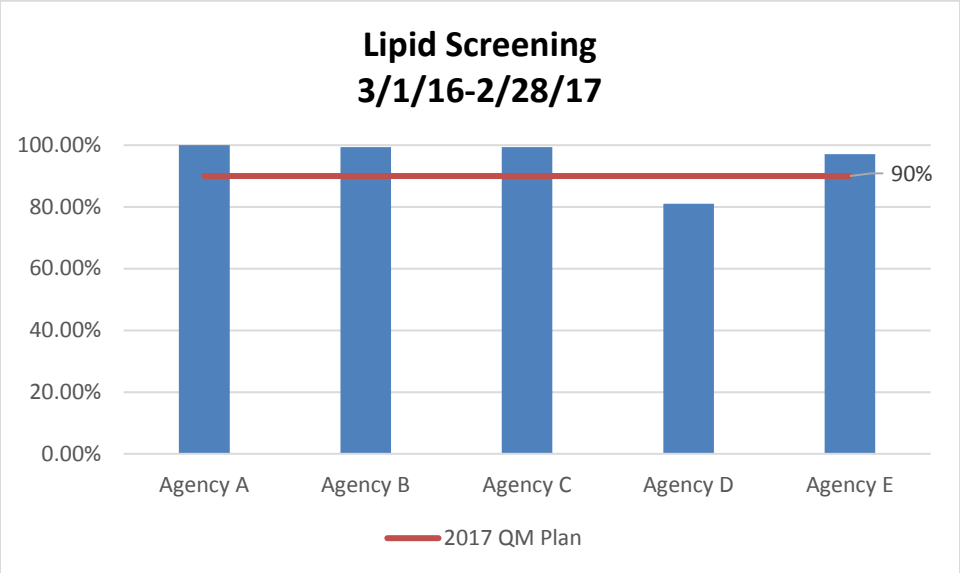


Lipid Screening

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

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

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

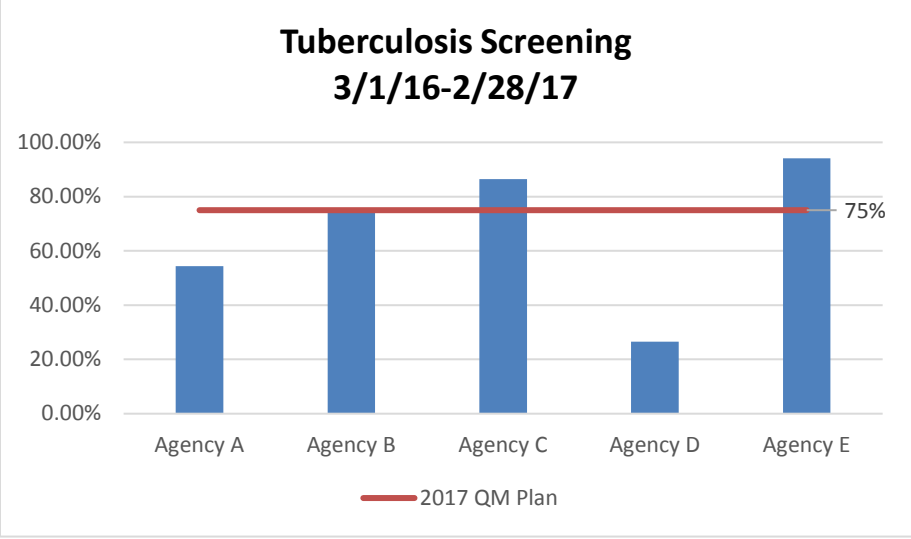


Tuberculosis Screening

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

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

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



Adolescent/Adult Performance Measures

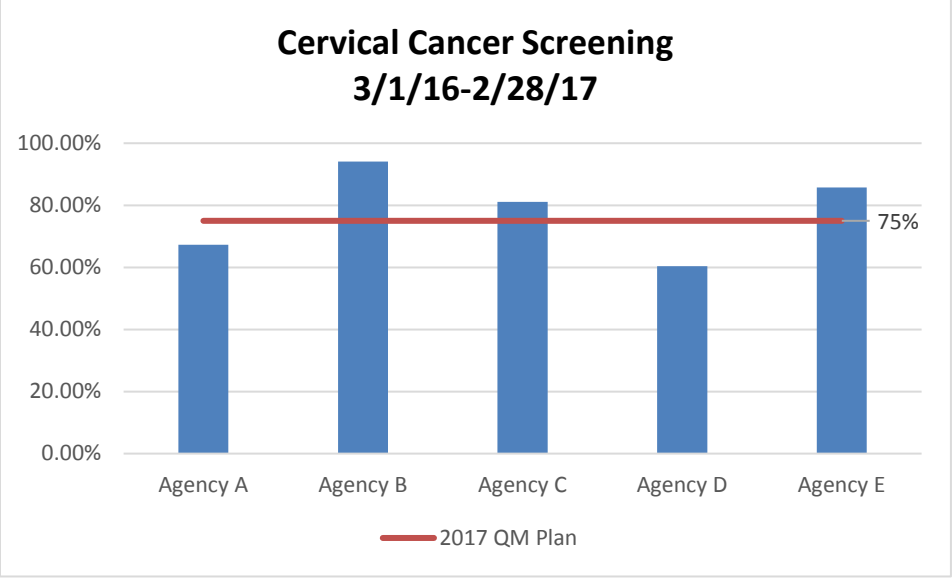
Cervical Cancer Screening

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

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

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

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



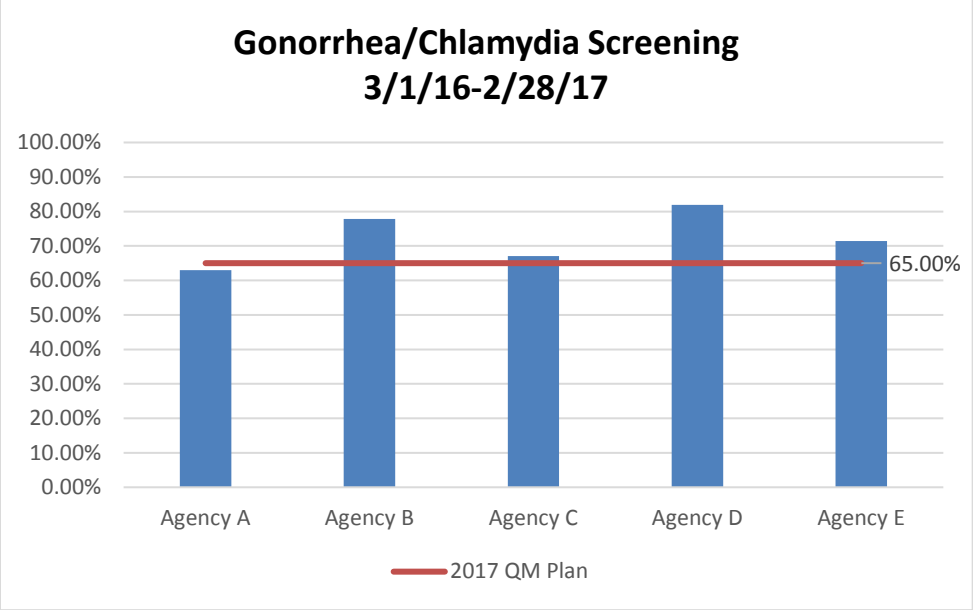
Gonorrhea/Chlamydia Screening

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

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

- 13 cases of CT and15 cases of GC were identified

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



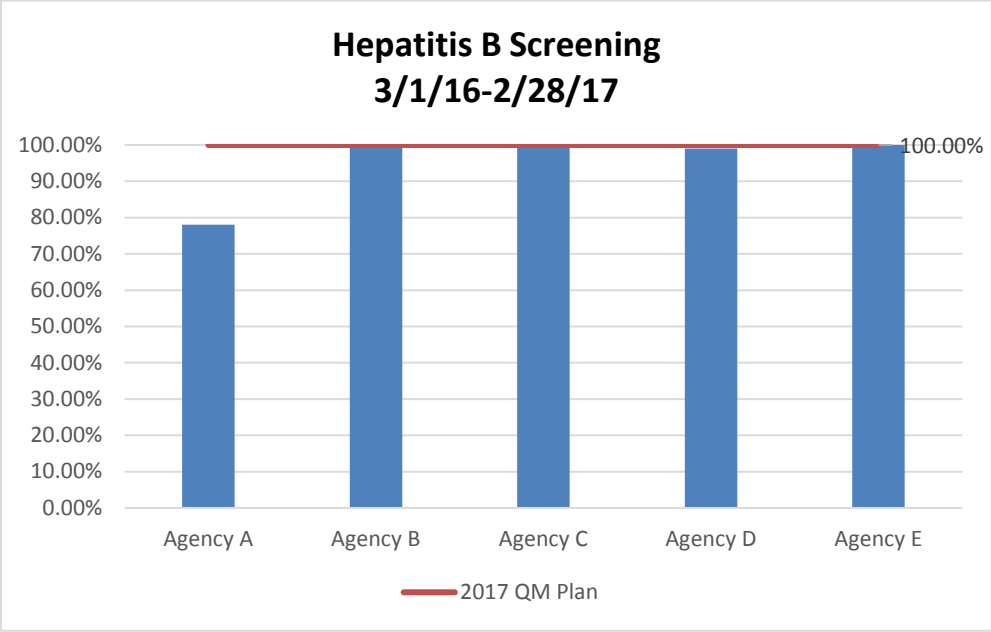
Hepatitis B Screening

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

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

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

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

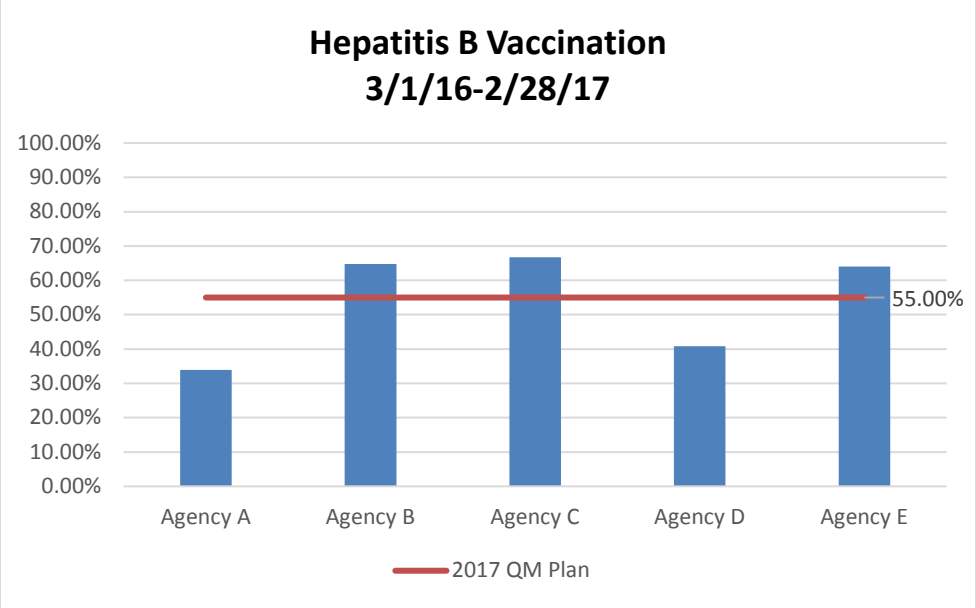


Hepatitis B Vaccination

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

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

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



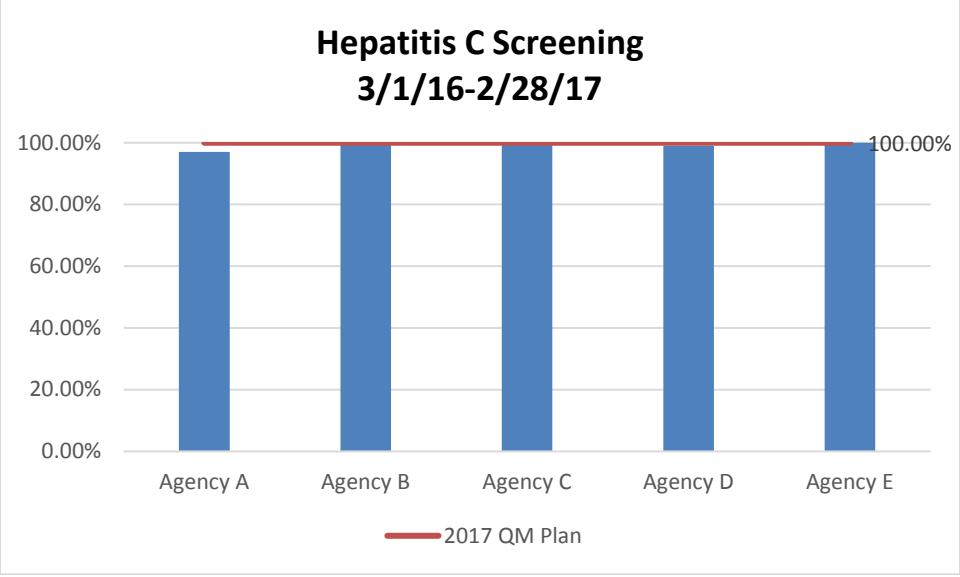
Hepatitis C Screening

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

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

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

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

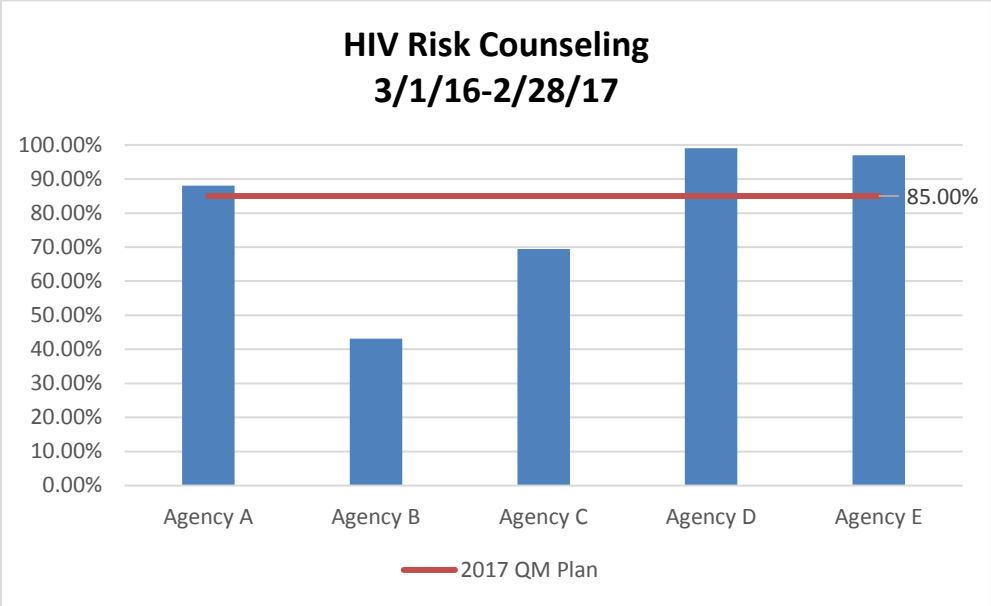


HIV Risk Counseling

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

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

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

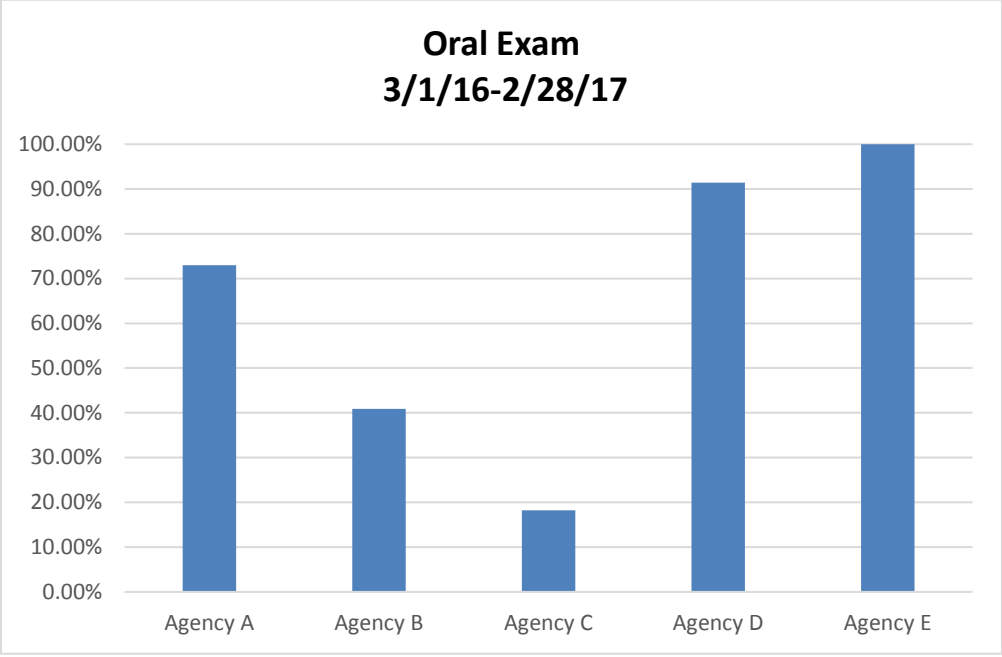


Oral Exam

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

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

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



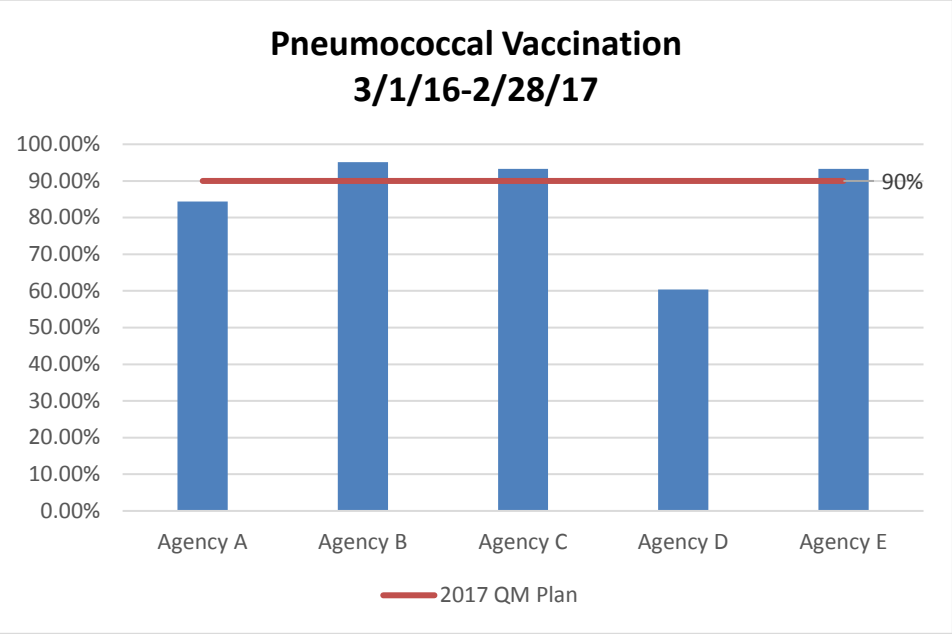
Pneumococcal Vaccination

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

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

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

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

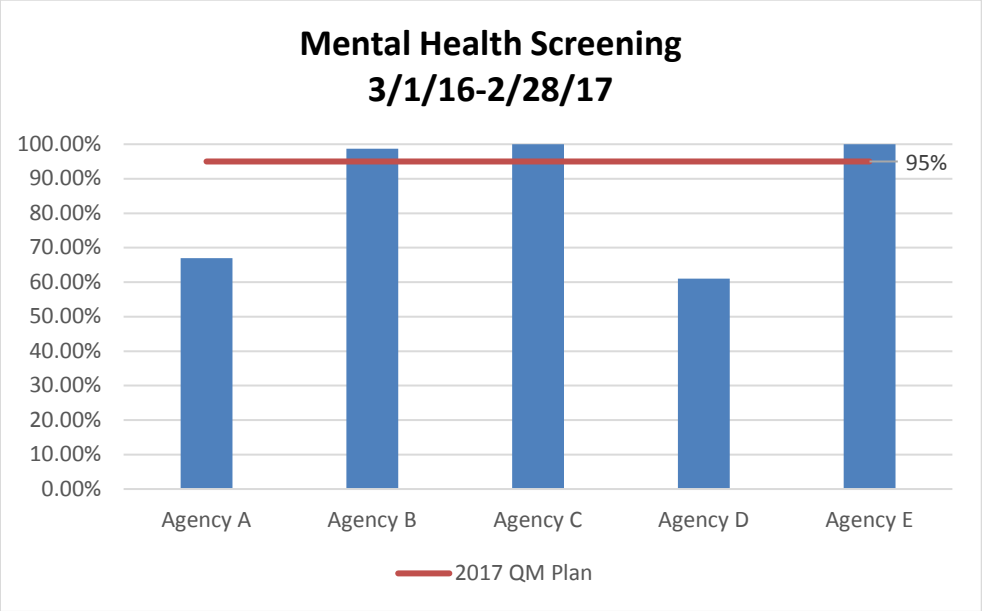


Preventative Care and Screening: Mental Health Screening

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

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

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

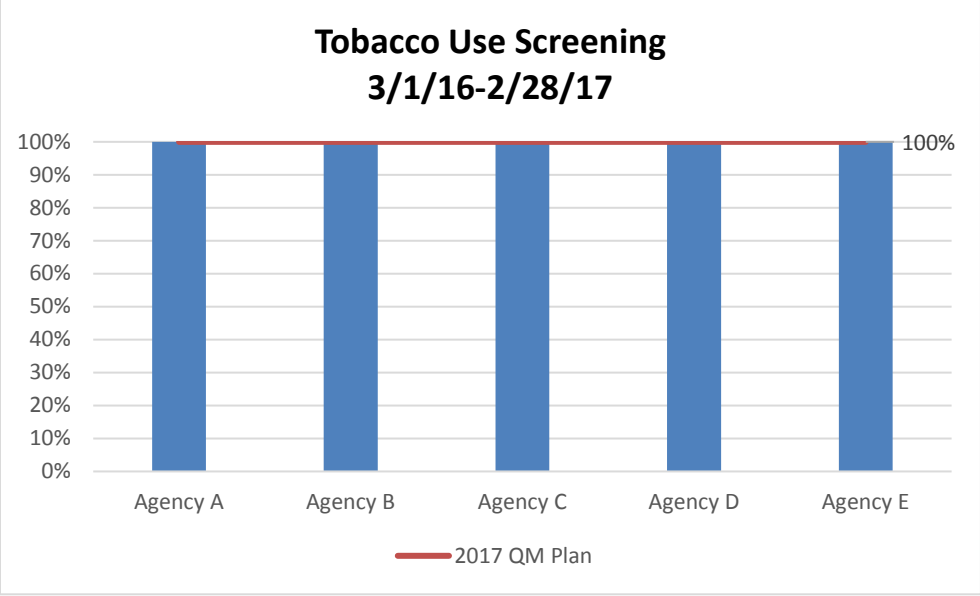


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

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

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



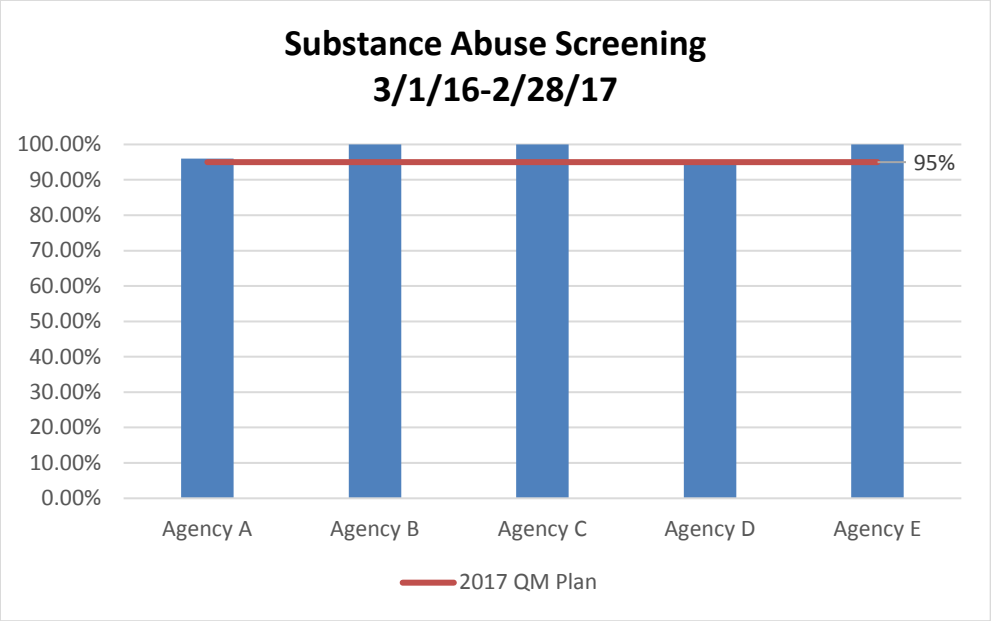
Substance Abuse Screening

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

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

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

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

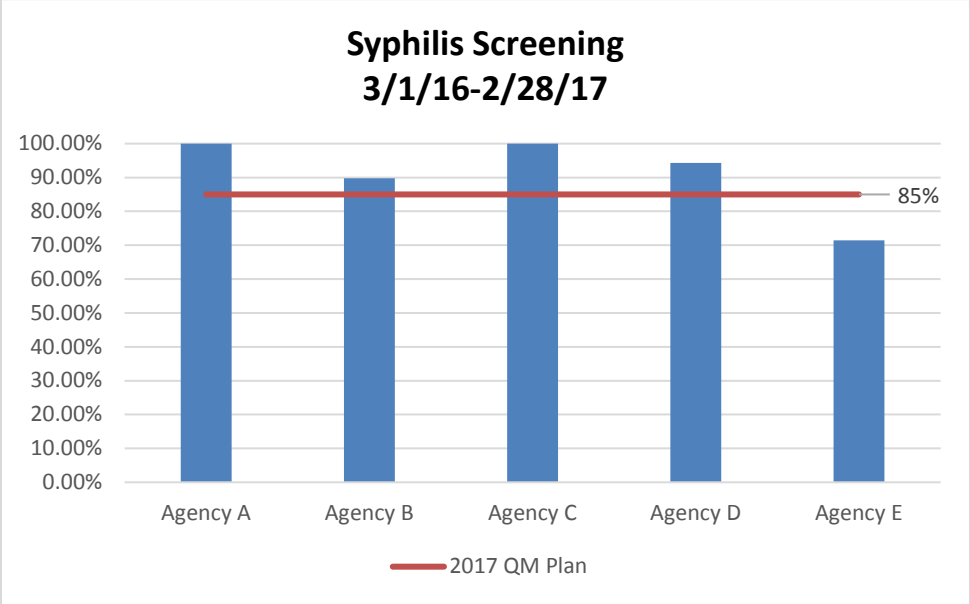


Syphilis Screening

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

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

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

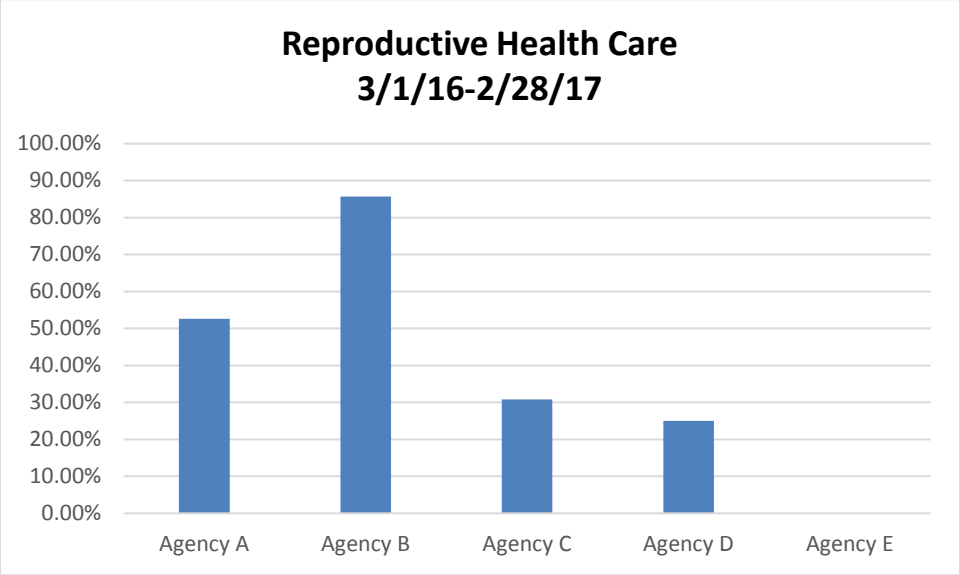


Other Measures

Reproductive Health Care

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

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

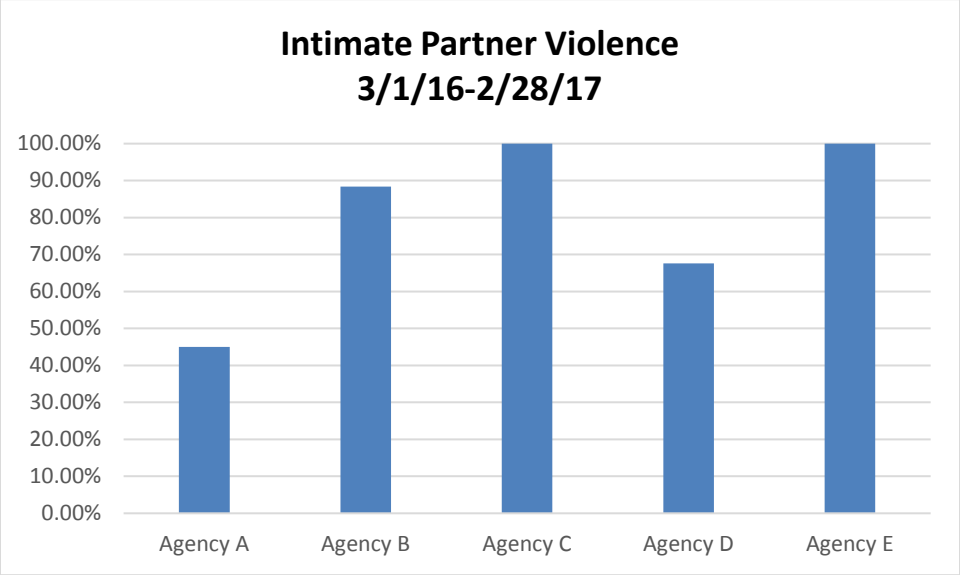


Intimate Partner Violence Screening

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

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

* 3/635 screened positive

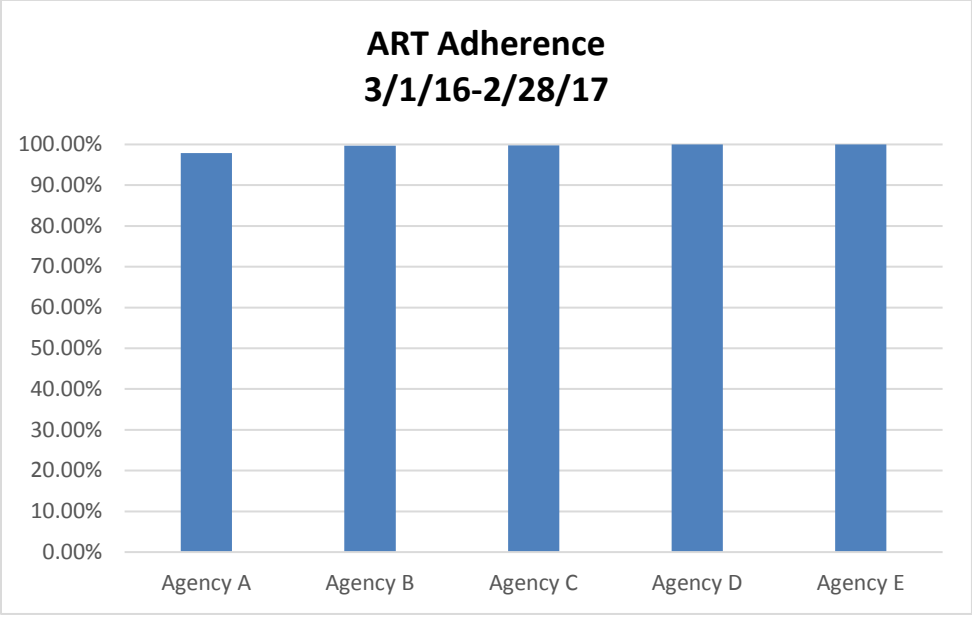


Adherence Assessment & Counseling

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

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

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



ART for Pregnant Women

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

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

Primary Care: Diabetes Control

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

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

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

Primary Care: Hypertension Control

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

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

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

Primary Care: Breast Cancer Screening

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

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

Conclusions

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

Umair A. Shah, M.D., M.P.H.
Executive Director

Harris County
Public Health
Building a Healthy Community

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

Vision Care Chart Review Report FY 2016

Ryan White Part A Quality Management Program–Houston EMA

December 2017

CONTACT:

Heather Keizman, RN, MSN, WHNP-BC
Project Coordinator–Clinical Quality Improvement
Harris County Public Health & Environmental Services
Ryan White Grant Administration
2223 West Loop South, RM 431
Houston, TX 77027
713-439-6037
hkeizman@hcphes.org

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

Follow HCPH on Twitter @hcphtx and like us on Facebook

Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health & Environmental Services. During FY 16, a comprehensive review of client vision records was conducted for services provided between 3/1/16 to 2/28/17.

The primary purpose of this annual review process is to assess Part A vision care provided to persons living with HIV and AIDS in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S Public Health Service for general vision care targeting individuals with HIV/AIDS. Therefore, Ryan White Grant Administration has adopted general guidelines published by the American Optometric Association, as well as internal standards determined by the clinic, to measure the quality of Part A funded vision care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 16 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research conducted by the Ryan White Grant Administration. By researching the most recent vision practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for vision care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: completeness of the Client Intake Form (CIF), CD4 and VL measures, eye exams, and prescriptions for lenses. See Appendix A for a copy of the tool.

The Chart Review Process

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from vision care guidelines and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters	
Review Area	**Documentation Criteria**
Laboratory Tests	Current CD4 and Viral Load Measures
Client Intake Form (CIF)	Completeness of the CIF: includes but not limited to documentation of primary care provider, medication allergies, Hx of medical problems, Ocular Hx, and current medications
Complete Eye Exam (CEE)	Documentation of annual eye exam; completeness of eye exam form; comprehensiveness of eye exam (visual acuity, refraction test, binocular vision assessment, fundus/retina exam, and glaucoma test)
Ophthalmology Consult (DFE)	Performed/Not performed
Lens Prescriptions	Documentation of the Plan of Care (POC) and completeness of the dispensing form

The Sample Selection Process

The sample population was selected from a pool of 2,010 unduplicated clients who accessed Part A vision care between 3/1/16 and 2/28/17. The medical charts of 150 of these clients were used in the review, representing 7.5% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/16 and 2/28/17 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving vision care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who receive vision care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of persons with HIV or AIDS. Table 2 compares the review sample population with the Ryan White Part A vision care population as a whole.

Table 2. Demographic Characteristics of FY 16 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	75	50%	980	49%
White	71	47.3%	975	49%
Asian	2	1.3%	23	1%
Native Hawaiian/Pacific Islander	2	0%	3	<1%
American Indian/Alaska Native	0	0%	10	<1%
Multi-Race	0	0%	19	<1%
TOTAL	**150**		**2,010**	
Hispanic Status				
Hispanic	51	34%	1,306	35%
Non-Hispanic	99	66%	704	65%
TOTAL	**150**		**2,010**	
Gender				
Male	110	73.3%	1,471	73%
Female	39	26%	521	26%
Transgender Male to Female	1	.7%	18	<1%
Transgender Female to Male	0	0%	0	0
TOTAL	**150**		**2,010**	
Age				
<= 24	6	4%	84	4%
25 – 34	29	19.3%	412	21%
35 – 44	36	24%	456	23%
45 – 54	47	31.3%	618	31%
55 – 64	26	17.3%	364	18%
65+	6	4%	76	4%
TOTAL	**150**		**2,010**	

Findings

Laboratory Tests

Having up-to-date lab measurements for CD4 and viral load (VL) levels enhances the ability of vision providers to ensure that the care provided is appropriate for each patient. CD4 and VL measures indicate stage of disease, so in cases where individuals are in the late stage of HIV disease, special considerations may be required.

Patient chart records should provide documentation of the most recent CD4 and VL information. Ideally this information should be updated in coordination with an annual complete eye exam. As noted in the table below, significant decreases were noted in lab documentation compared to previous years.

	2013	2014	2015	2016
CD4	49%	48%	64%	91%
VL	49%	48%	64%	91%

Client Intake Form (CIF)

A complete and thorough assessment of a patient's health history is essential when caring for individuals infected with HIV or anyone who is medically compromised. The agency assesses this information by having patients complete the CIF. Information provided on the CIF, such as ocular history or medical history, guides clinic providers in determining the appropriateness of diagnostic procedures, prescriptions, and treatments. The CIF that is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will highlight findings for only some of the data collected on the form.

Below are highlights of the findings measuring completeness of the CIF.

	2013	2014	2015	2016
Primary Care Provider	51%	52%	50%	50%
Medication Allergies	93%	100%	100%	100%
Medical History	99%	100%	100%	100%
Current Medications	96%	100%	100%	100%
Reason for Visit	99%	100%	100%	100%
Ocular History	99%	100%	100%	100%

Eye Examinations (Including CEE/DFE) and Exam Findings

Complete and thorough examination of the eye performed on a routine basis is essential for the prevention, detection, and treatment of eye and vision disorders. When providing care to individuals with HIV/AIDS, routine eye exams become even more important because there are a number of ocular manifestations of HIV disease, such as CMV retinitis.

CMV retinitis is usually diagnosed based on characteristic retinal changes observed through a DFE. Current standards of care recommend yearly DFE performed by an ophthalmologist for clients with CD4 counts <50 cells/mm3 (2). One client in this sample had CD4 counts <50 cells/mm3.

	2013	2014	2015	2016
Complete Eye Exam	100%	99%	100%	100%
Dilated Fundus Exam	53%	94%	95%	98%
Internal Eye Exam	100%	100%	100%	100%
Documentation of Diagnosis	100%	99%	100%	100%
Documentation of Treatment Plan	100%	99%	100%	100%
Visual Acuity	100%	100%	100%	100%
Refraction Test	99%	98%	100%	99%
Observation of External Structures	56%	100%	100%	100%
Glaucoma Test	99%	100%	100%	100%
Cytomegalovirus (CMV) screening	55%	94%	95%	98%

Ocular Disease

Thirteen clients (8.7%) demonstrated ocular disease, including blindness, amyloid pterygium, cataracts, glaucoma, and foreign body. Two clients received treatment for ocular disease, 6 clients were referred to a specialty eye clinic, and 5 clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 95% (97%-FY15) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 16 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 16-Vision Chart Review Data Collection Tool

Mar 1, 16 to Feb 28, 17

Pt. ID # _____ Site Code:_____

CLIENT INTAKE FORM (CIF)

1. PRIMARY CARE PROVIDER documented: Y - Yes N - No
2. MEDICATION ALLERGIES documented: Y - Yes N - No
3. MEDICAL HISTORY documented: Y - Yes N - No
4. CURRENT MEDS are listed: Y - Yes N - No
5. REASON for TODAY's VISIT is documented: Y - Yes N - No
6. OCULAR HISTORY is documented: Y - Yes N - No

CD4 & VL

7. Most recently documented CD4 count is within past 12 months: Y - Yes N - No
8. CD4 count is < 50: Y - Yes N - No
9. Most recently documented VL count is within past 12 months: Y - Yes N – No

EYE CARE:

10. COMPLETE EYE EXAM (CEE) performed: Y - Yes N - No
11. Eye Exam included ASSESSMENT OF VISUAL ACUITY: Y - Yes N - No
12. Eye Exam included REFRACTION TEST: Y - Yes N - No
13. Eye Exam included OBSERVATION OF EXTERNAL STRUCTURES: Y - Yes N - No
14. Eye Exam included GLAUCOMA TEST (IOP): Y - Yes N - No
15. Internal Eye Exam findings are documented: Y - Yes N - No
16. Dilated Fundus Exam (DFE) done within year: Y - Yes N - No
17. Eye Exam included CYTOMEGALOVIRUS (CMV) SCREENING: Y - Yes N – No
18. New prescription lenses were prescribed: Y - Yes N - No
19. Eye Exam written diagnoses are documented: Y - Yes N - No
20. Eye Exam written treatment plan is documented: Y - Yes N - No
21. Ocular disease identified? Y - Yes N – No
22. Ocular disease treated appropriately? Y - Yes N - No
23. Total # of visits to eye clinic within year:_____

Revised March, 2013

Appendix B – Resources

1. Casser, L., Carmiencke, K.., Goss, D.A., Knieb, B.A., Morrow, D., & Musick, J.E. (2005). Optometric Clinical Practice Guideline—Comprehensive Adult Eye and Vision Examination. *American Optometric Association*. Retrieved from http://www.aoa.org/Documents/CPG-1.pdf on April 15, 2012.

2. Heiden D., Ford N., Wilson D., Rodriguez W.R., Margolis T., et al. (2007). Cytomegalovirus Retinitis: The Neglected Disease of the AIDS Pandemic. *PLoS Med* 4(12): e334. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2100142/ on April 15, 2012.

3. International Council of Ophthalmology. (2011). *ICO International Clinical Guideline, Ocular HIV/AIDS Related Diseases.* Retrieved from http://www.icoph.org/resources/88/ICO-International-Clinical-Guideline-Ocular-HIVAIDS-Related-Diseases-.html on December 15, 2012.

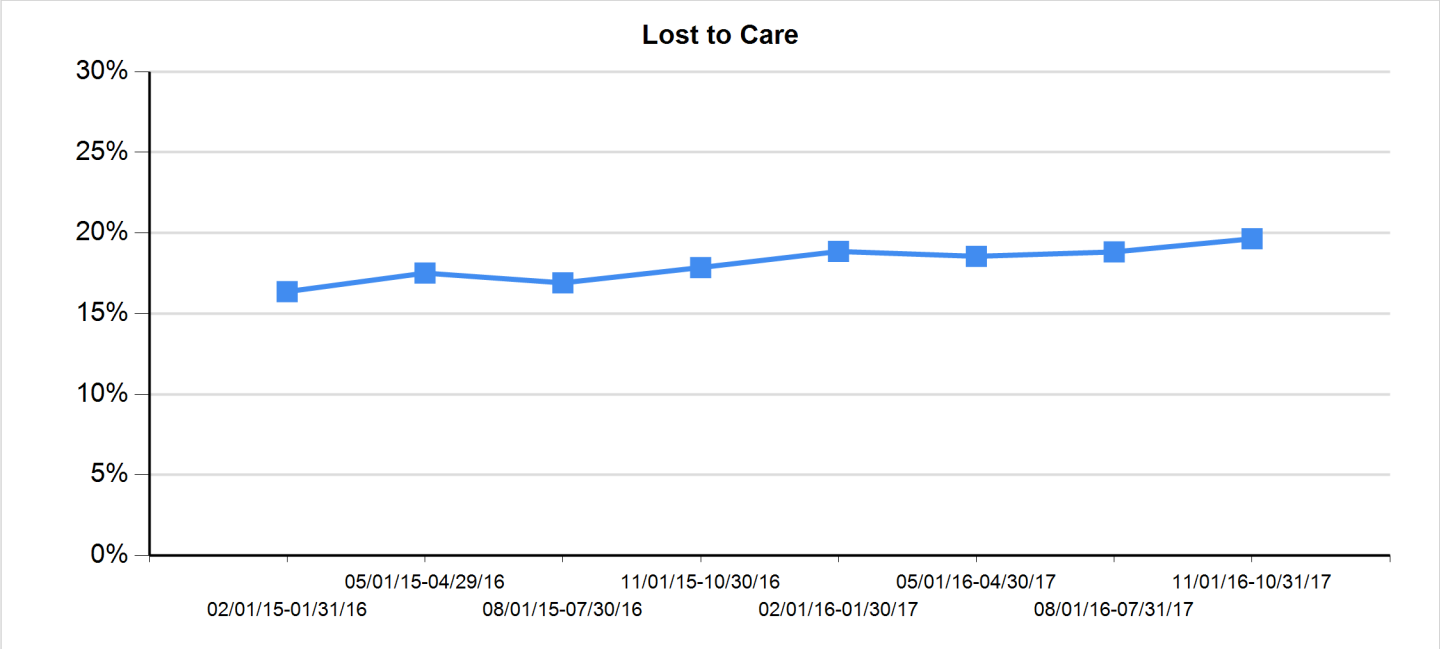
4. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed July 25, 2013.

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

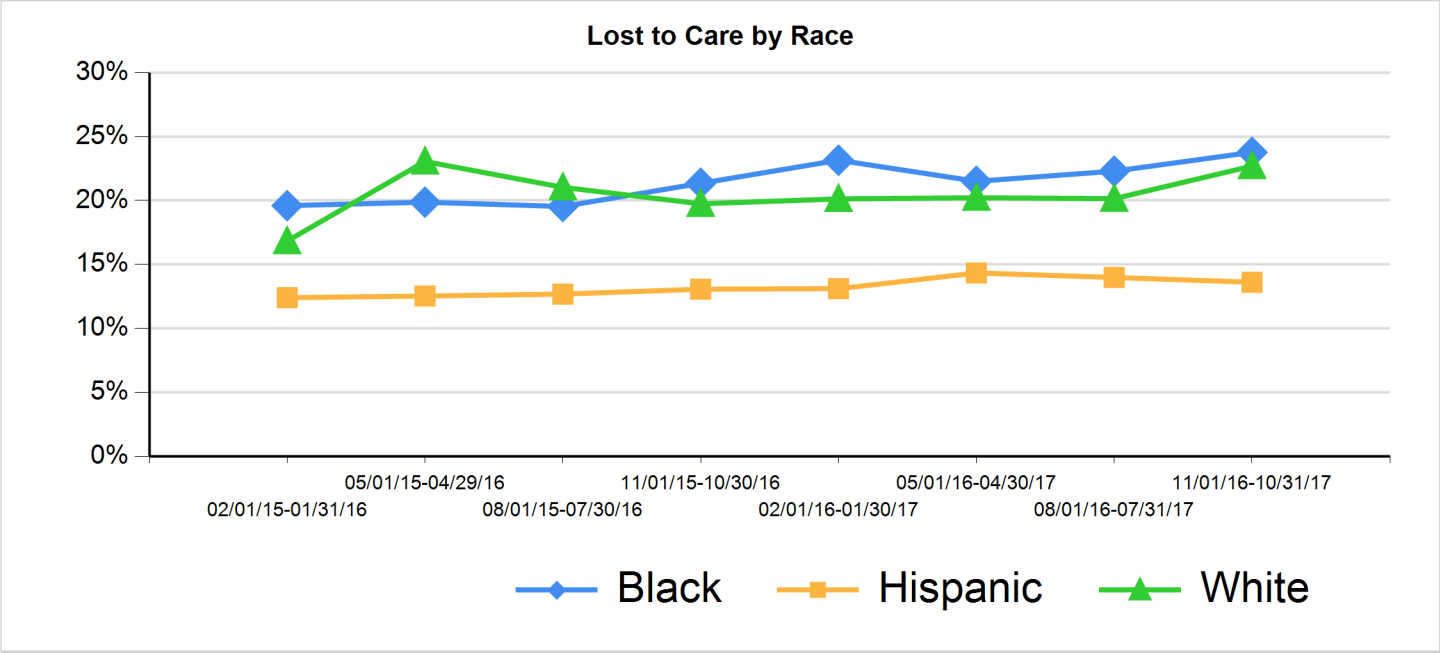
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **11/1/2016**

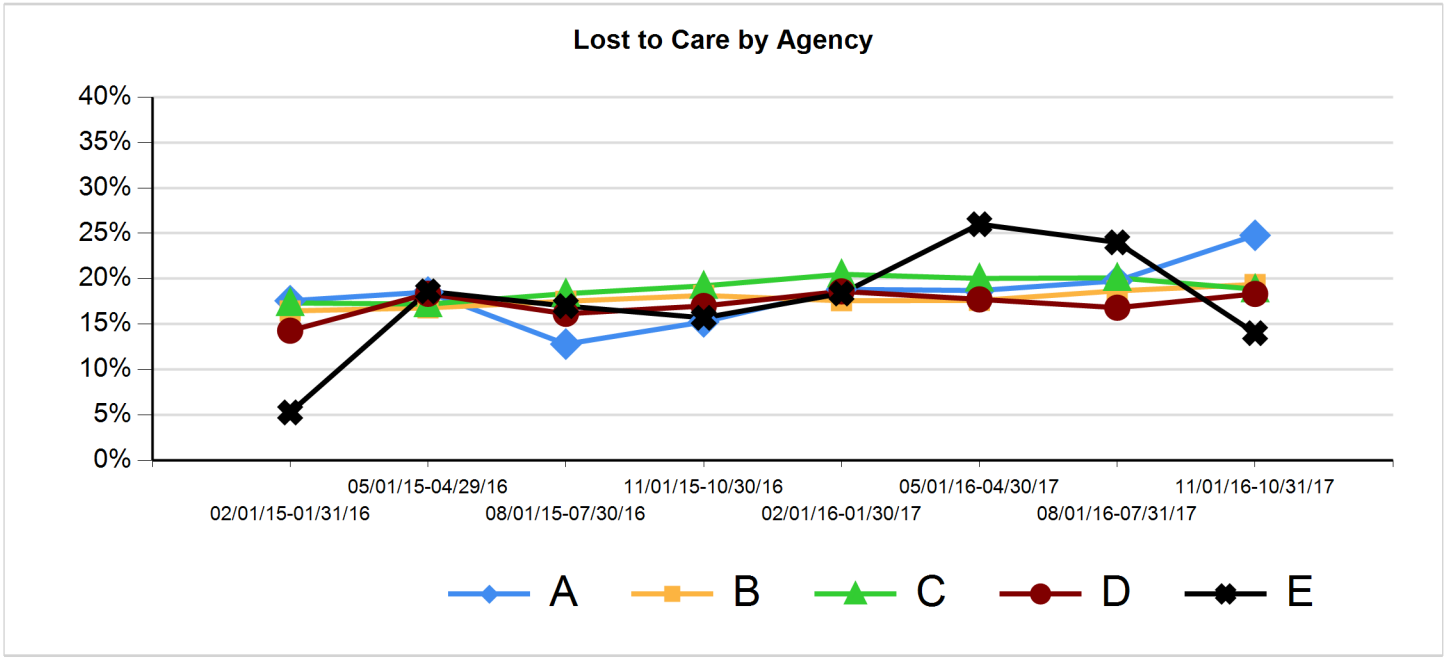
Lost to Care				
In+Care Campaign Gap Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	959	964	1,004	1,068
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	5,087	5,196	5,333	5,438
Percentage	18.9%	18.6%	18.8%	19.6%
Change from Previous Quarter Results	1.0%	-0.3%	0.3%	0.8%



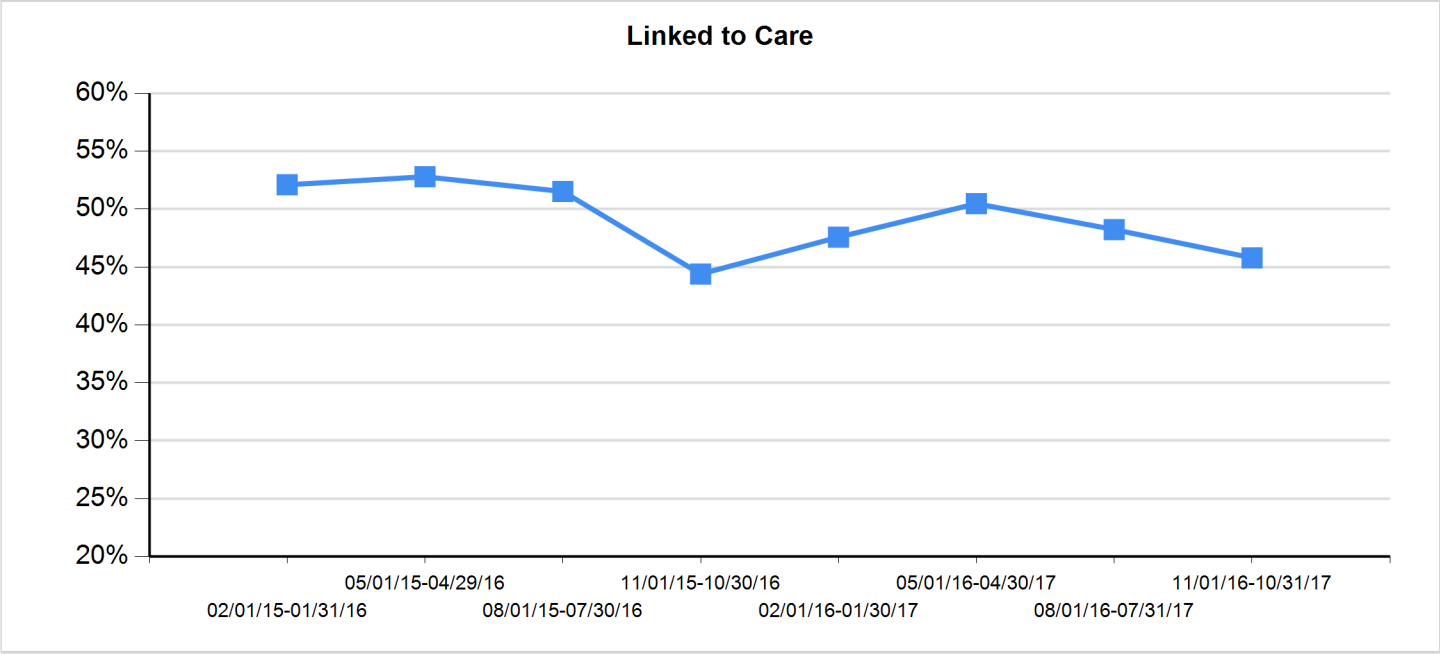
Lost to Care by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	533	278	134	560	279	141	617	278	155
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,479	1,940	663	2,512	1,996	700	2,596	2,043	683
Percentage	21.5%	14.3%	20.2%	22.3%	14.0%	20.1%	23.8%	13.6%	22.7%
Change from Previous Quarter Results	-1.6%	1.2%	0.1%	0.8%	-0.4%	-0.1%	1.5%	-0.4%	2.6%



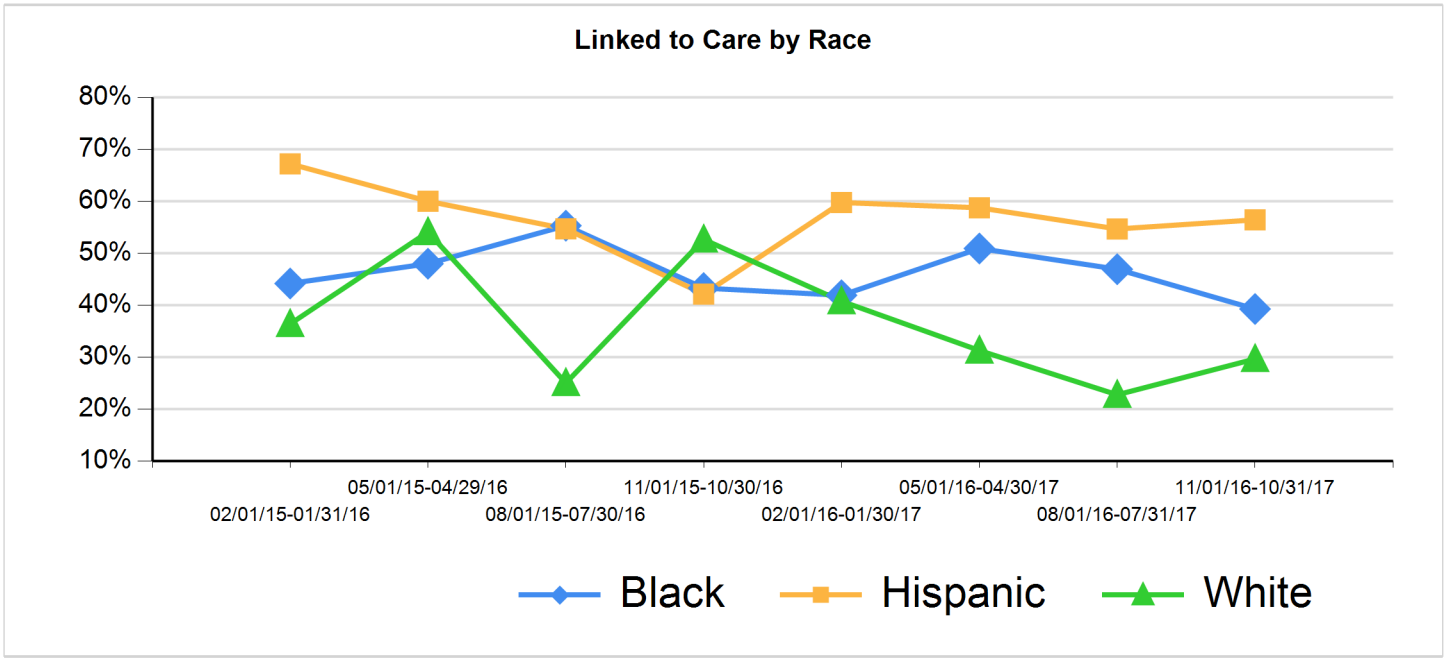
Lost to Care by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	133	353	310	204	12	166	375	293	232	7
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	673	1,892	1,543	1,214	50	670	1,937	1,555	1,266	50
Percentage	19.8%	18.7%	20.1%	16.8%	24.0%	24.8%	19.4%	18.8%	18.3%	14.0%
Change from Previous Quarter Results	1.1%	1.1%	0.1%	-0.9%	-2.0%	5.0%	0.7%	-1.2%	1.5%	-10.0%



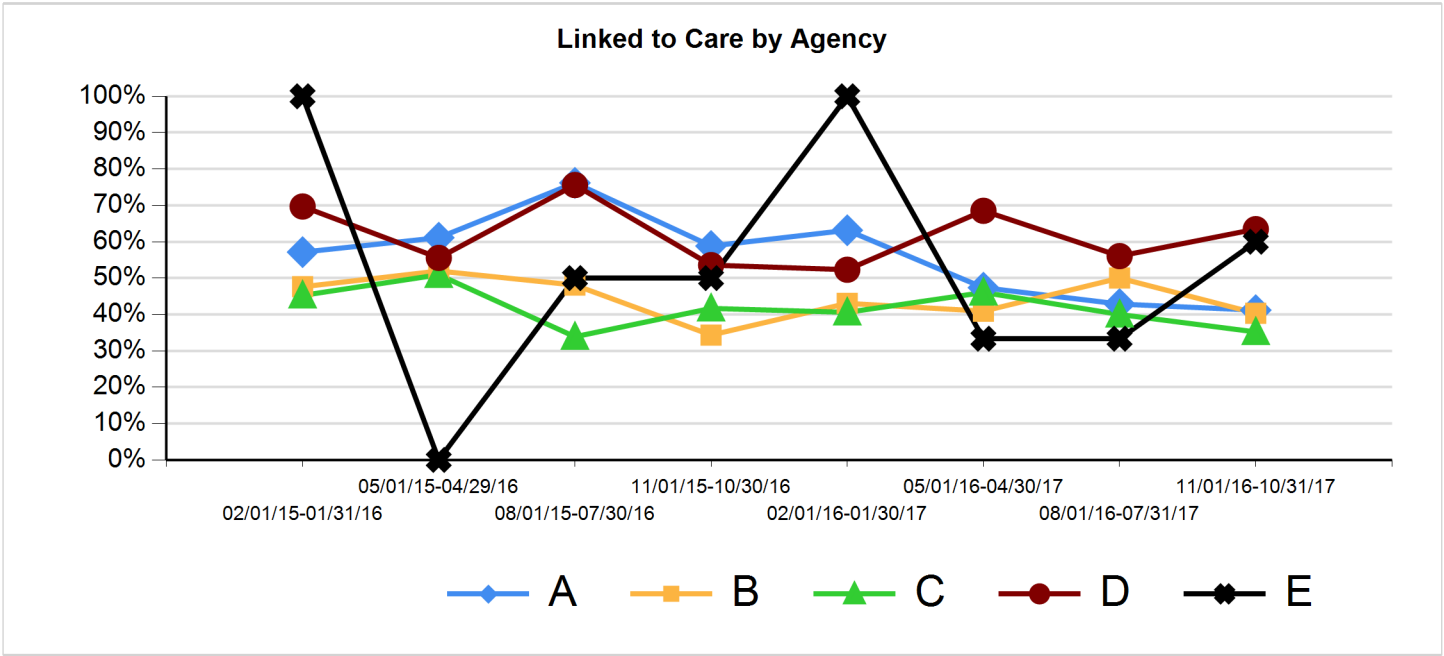
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of newly enrolled uninsured HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	108	108	109	87
Number of newly enrolled uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	227	214	226	190
Percentage	47.6%	50.5%	48.2%	45.8%
Change from Previous Quarter Results	3.2%	2.9%	-2.2%	-2.4%
* exclude if vl<200 in 1st 4 months				



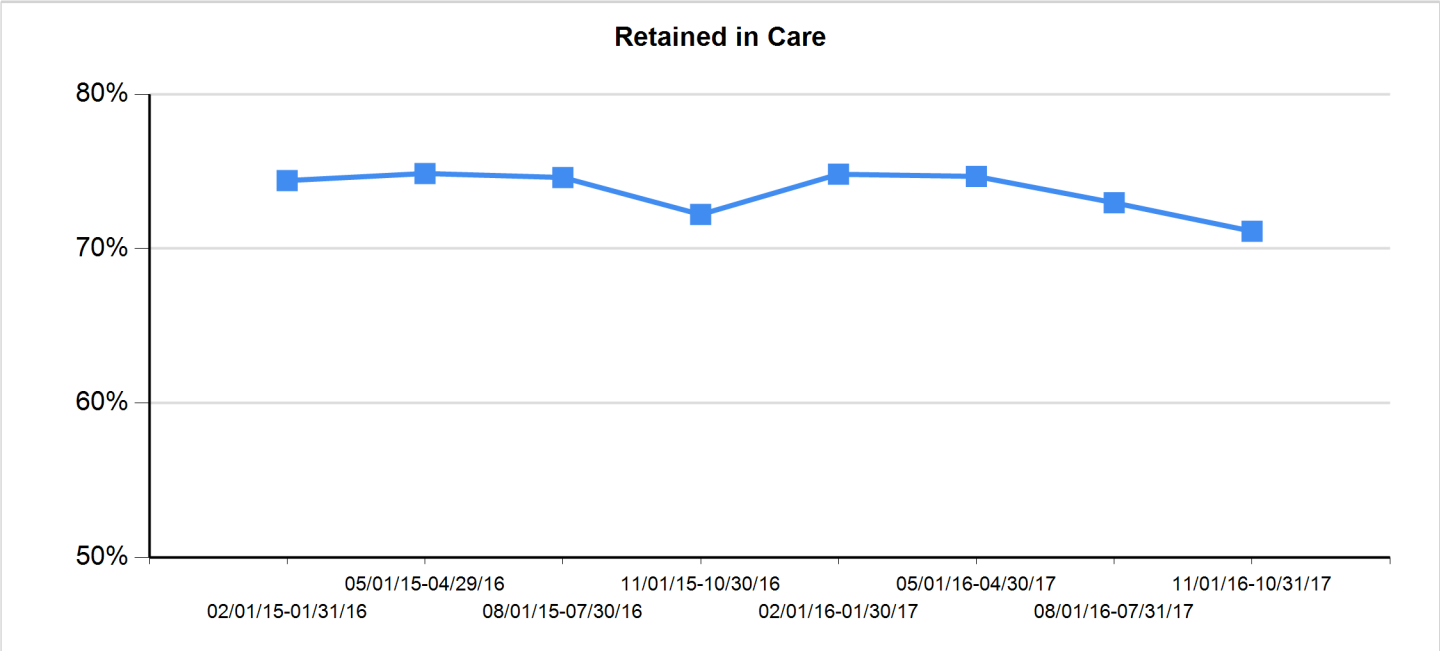
Linked to Care by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled uninsured HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	57	37	10	53	47	5	31	44	8
Number of newly enrolled uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	112	63	32	113	86	22	79	78	27
Percentage	50.9%	58.7%	31.3%	46.9%	54.7%	22.7%	39.2%	56.4%	29.6%
Change from Previous Quarter Results	9.0%	-1.0%	-9.5%	-4.0%	-4.1%	-8.5%	-7.7%	1.8%	6.9%
* exclude if vl<200 in 1st 4 months									



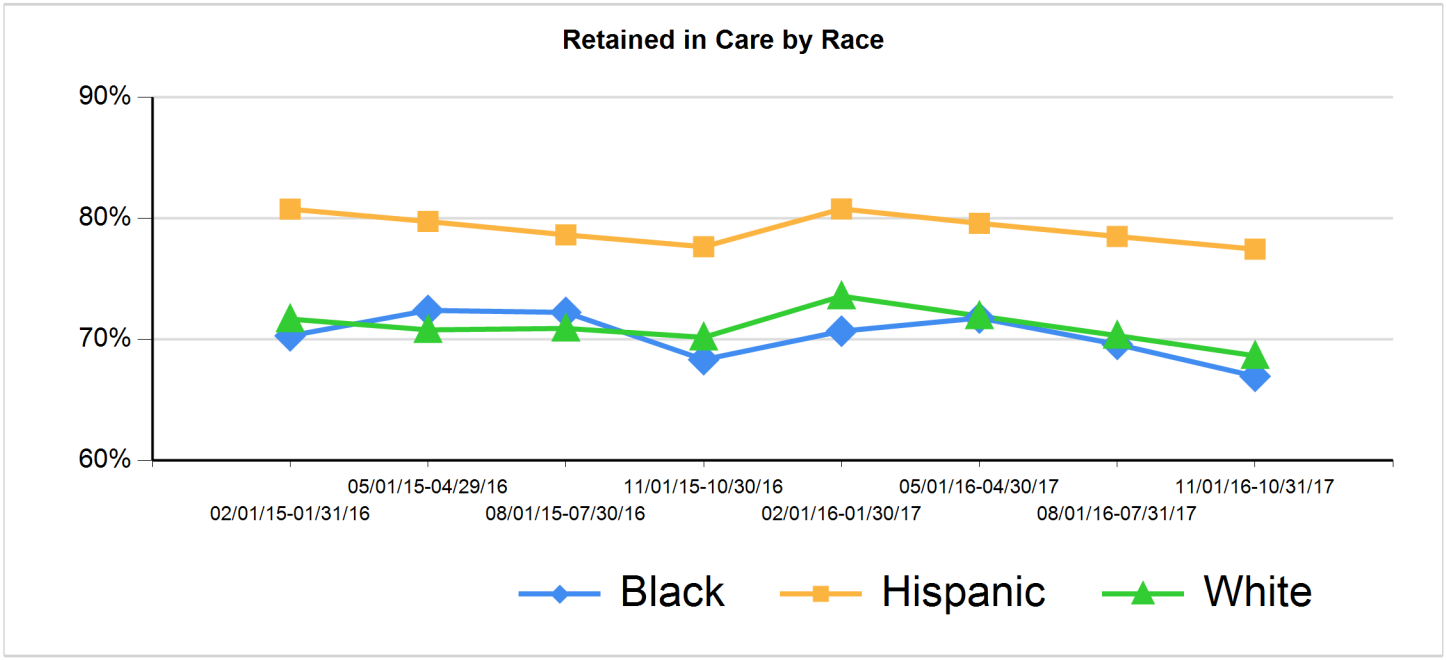
Linked to Care by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of newly enrolled uninsured HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	6	39	26	37	1	7	25	19	33	3
Number of newly enrolled uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	14	78	65	66	3	17	62	54	52	5
Percentage	42.9%	50.0%	40.0%	56.1%	33.3%	41.2%	40.3%	35.2%	63.5%	60.0%
Change from Previous Quarter Results	-4.5%	9.1%	-6.1%	-12.5%	0.0%	-1.7%	-9.7%	-4.8%	7.4%	26.7%
* exclude if vl<200 in 1st 4 months										



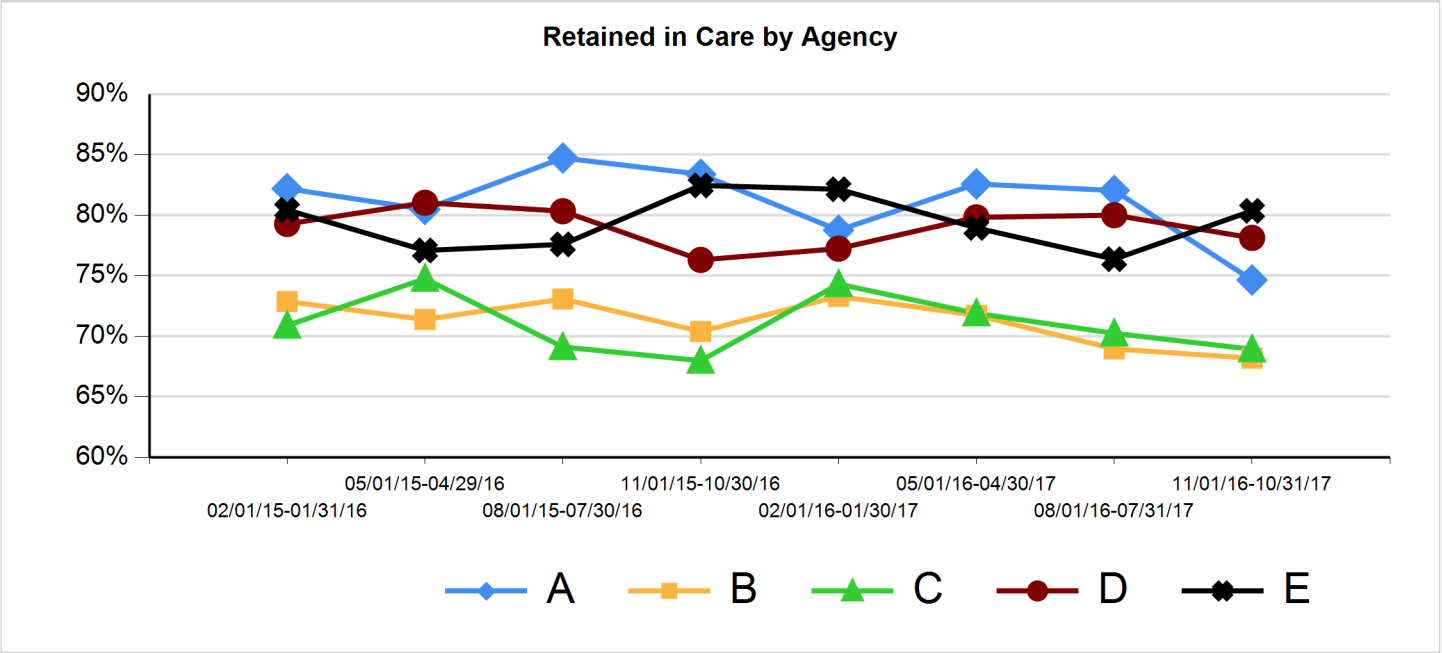
Retained in Care				
Houston EMA Medical Visits Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year*	4,187	4,253	4,285	4,225
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	5,596	5,695	5,872	5,940
Percentage	74.8%	74.7%	73.0%	71.1%
Change from Previous Quarter Results	2.6%	-0.1%	-1.7%	-1.8%
* Not newly enrolled in care				



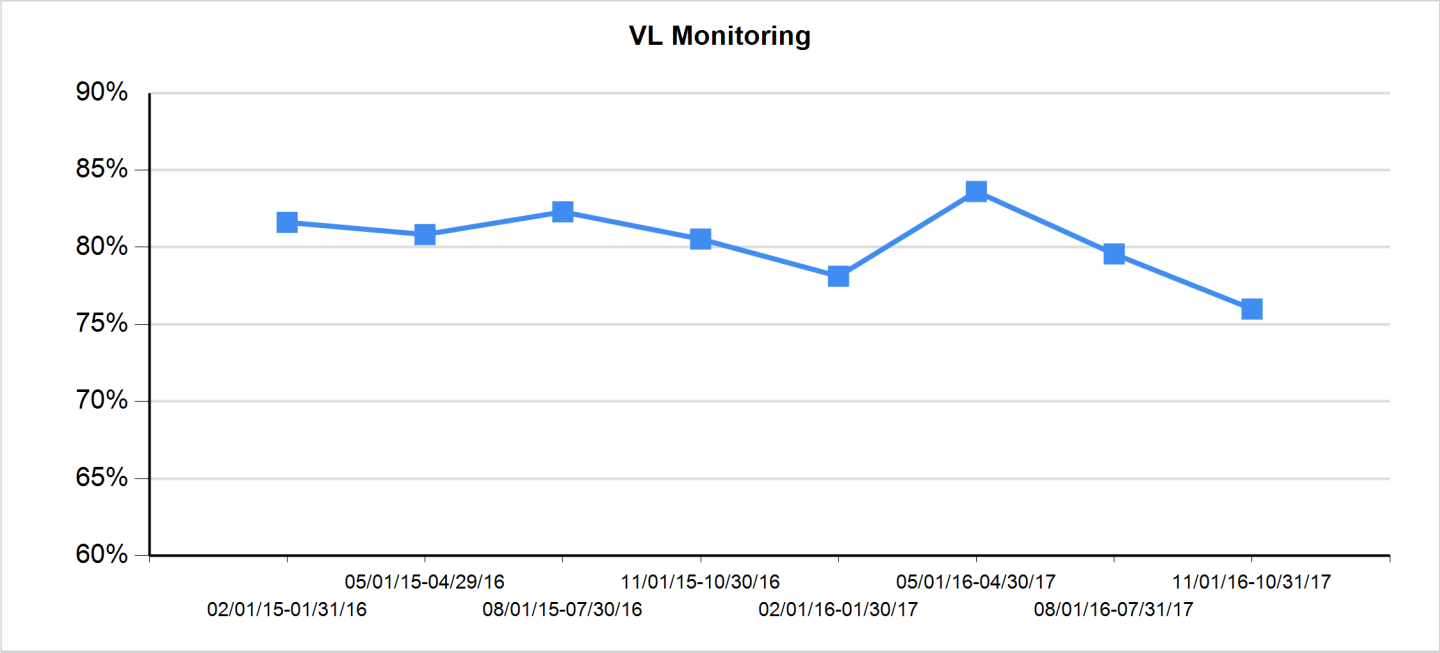
Retained in Care by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	1,991	1,636	530	1,964	1,671	549	1,921	1,685	525
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	2,775	2,056	737	2,823	2,129	781	2,870	2,176	765
Percentage	71.7%	79.6%	71.9%	69.6%	78.5%	70.3%	66.9%	77.4%	68.6%
Change from Previous Quarter Results	1.1%	-1.2%	-1.6%	-2.2%	-1.1%	-1.6%	-2.6%	-1.1%	-1.7%



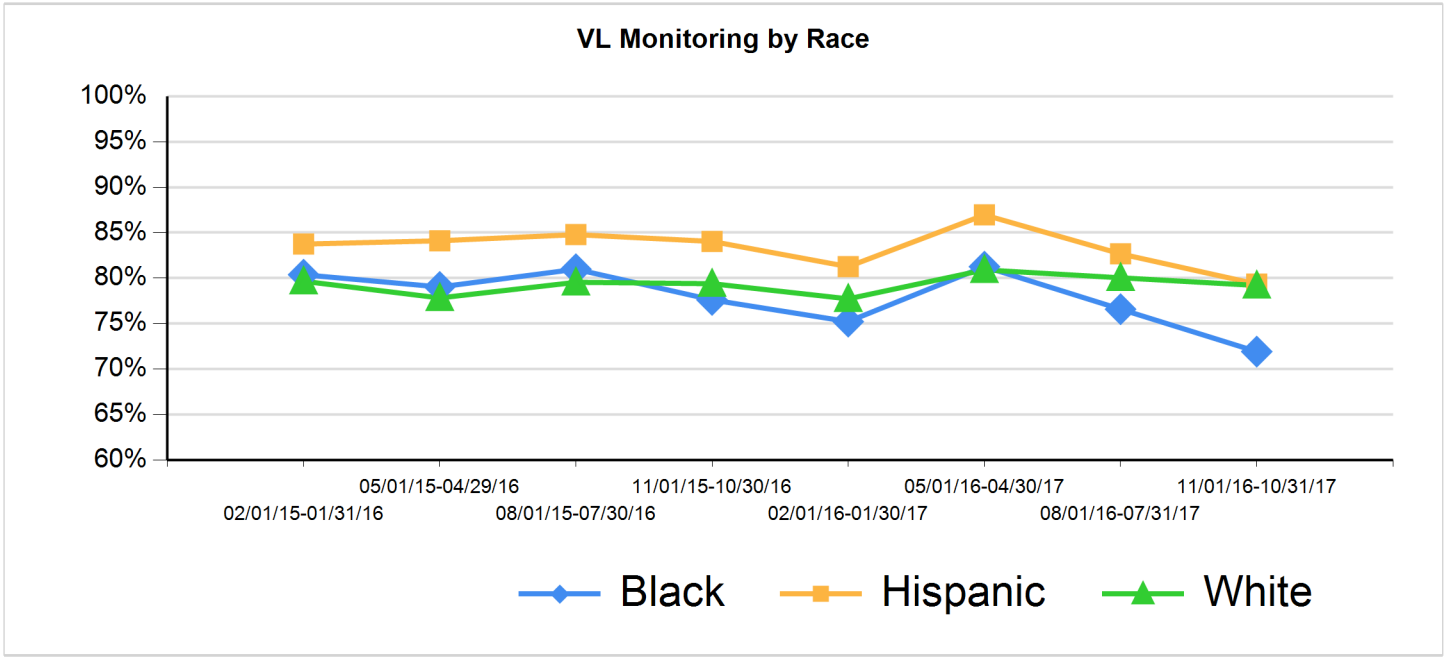
Retained in Care by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	580	1,428	1,253	1,104	42	524	1,431	1,213	1,118	45
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	707	2,071	1,784	1,380	55	702	2,099	1,760	1,431	56
Percentage	82.0%	69.0%	70.2%	80.0%	76.4%	74.6%	68.2%	68.9%	78.1%	80.4%
Change from Previous Quarter Results	-0.5%	-2.8%	-1.7%	0.2%	-2.6%	-7.4%	-0.8%	-1.3%	-1.9%	4.0%



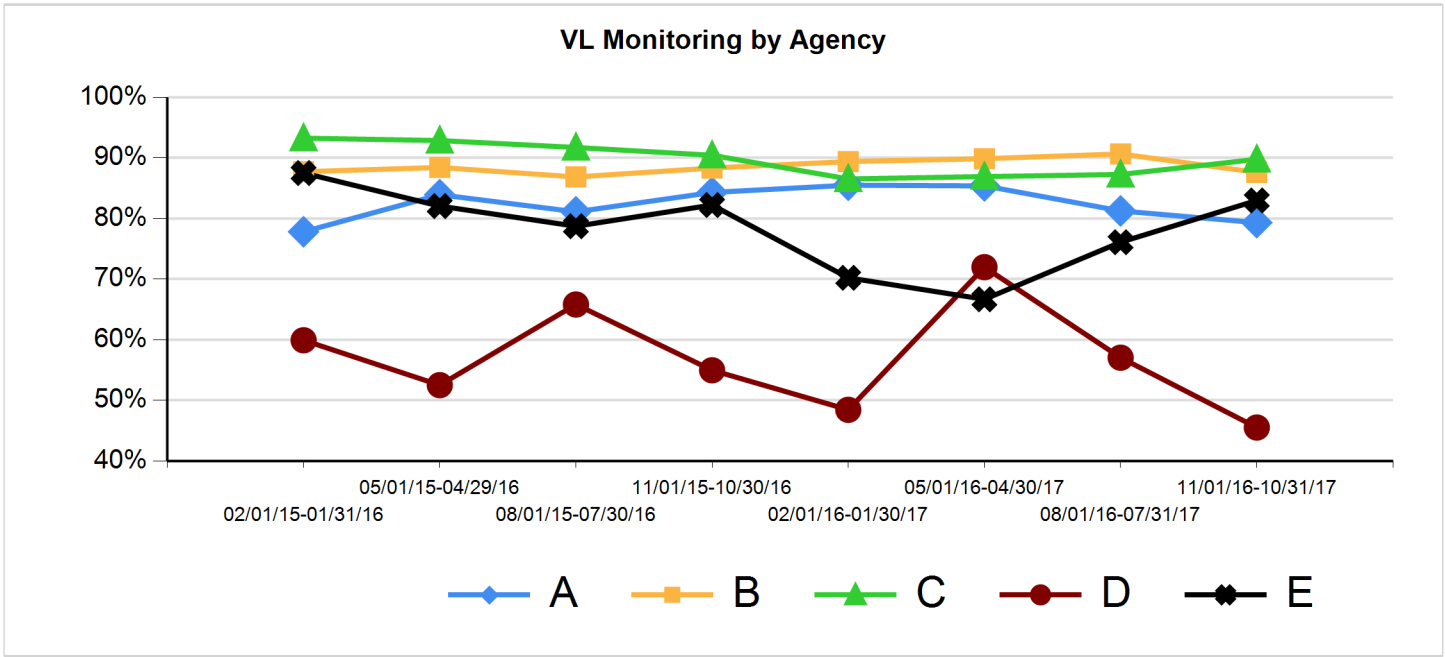
Viral Load Monitoring				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	3,524	3,812	3,652	3,439
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	4,511	4,559	4,590	4,525
Percentage	78.1%	83.6%	79.6%	76.0%
Change from Previous Quarter Results	-2.4%	5.5%	-4.1%	-3.6%



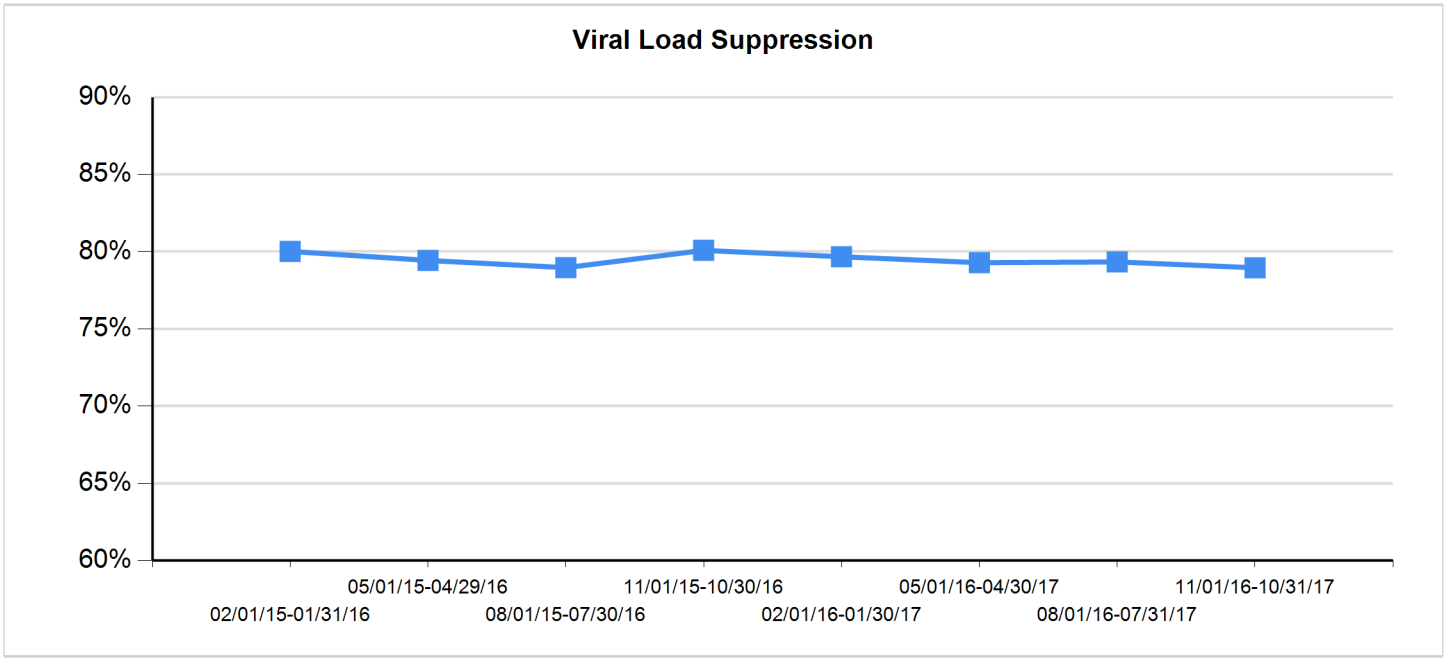
VL Monitoring Data by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	1,743	1,506	466	1,625	1,464	473	1,485	1,421	449
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	2,145	1,732	576	2,122	1,771	591	2,065	1,791	567
Percentage	81.3%	87.0%	80.9%	76.6%	82.7%	80.0%	71.9%	79.3%	79.2%
Change from Previous Quarter Results	6.0%	5.7%	3.2%	-4.7%	-4.3%	-0.9%	-4.7%	-3.3%	-0.8%



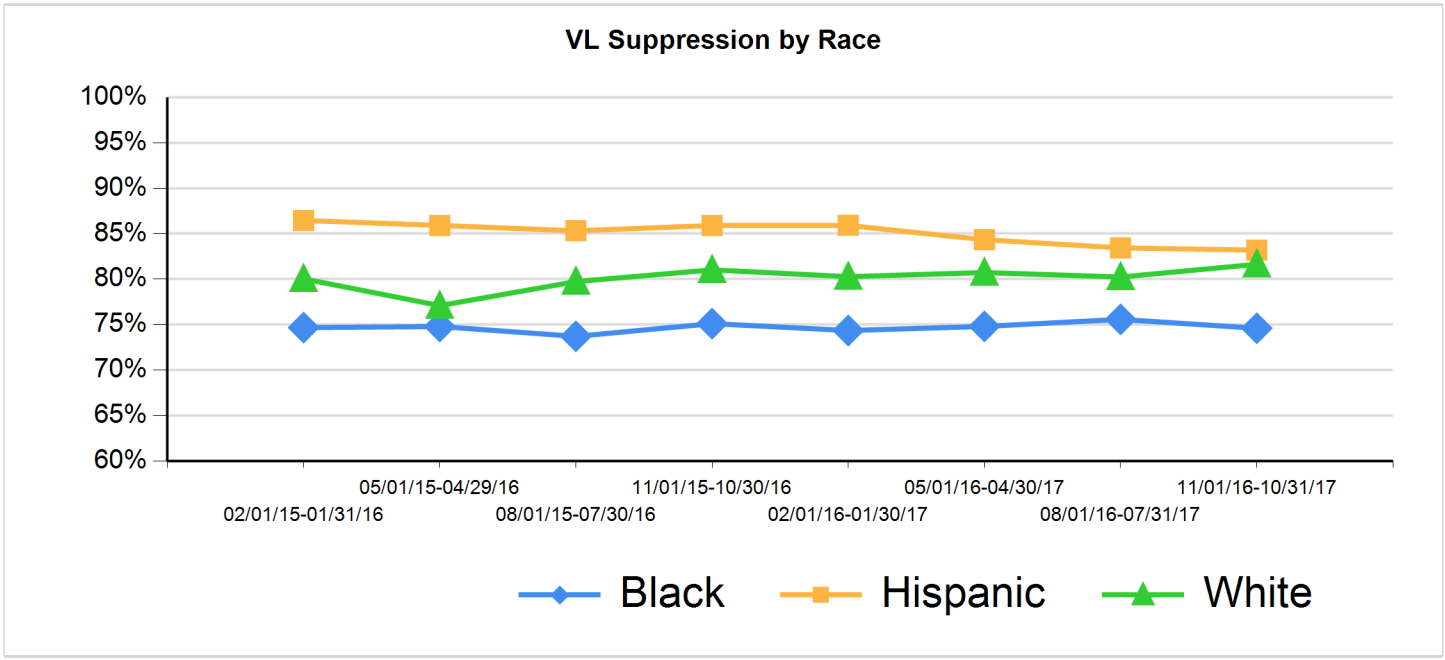
VL Monitoring by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	468	1,348	1,110	665	35	418	1,294	1,140	537	39
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	576	1,487	1,272	1,166	46	527	1,477	1,270	1,180	47
Percentage	81.3%	90.7%	87.3%	57.0%	76.1%	79.3%	87.6%	89.8%	45.5%	83.0%
Change from Previous Quarter Results	-4.1%	0.8%	0.3%	-14.9%	9.4%	-1.9%	-3.0%	2.5%	-11.5%	6.9%



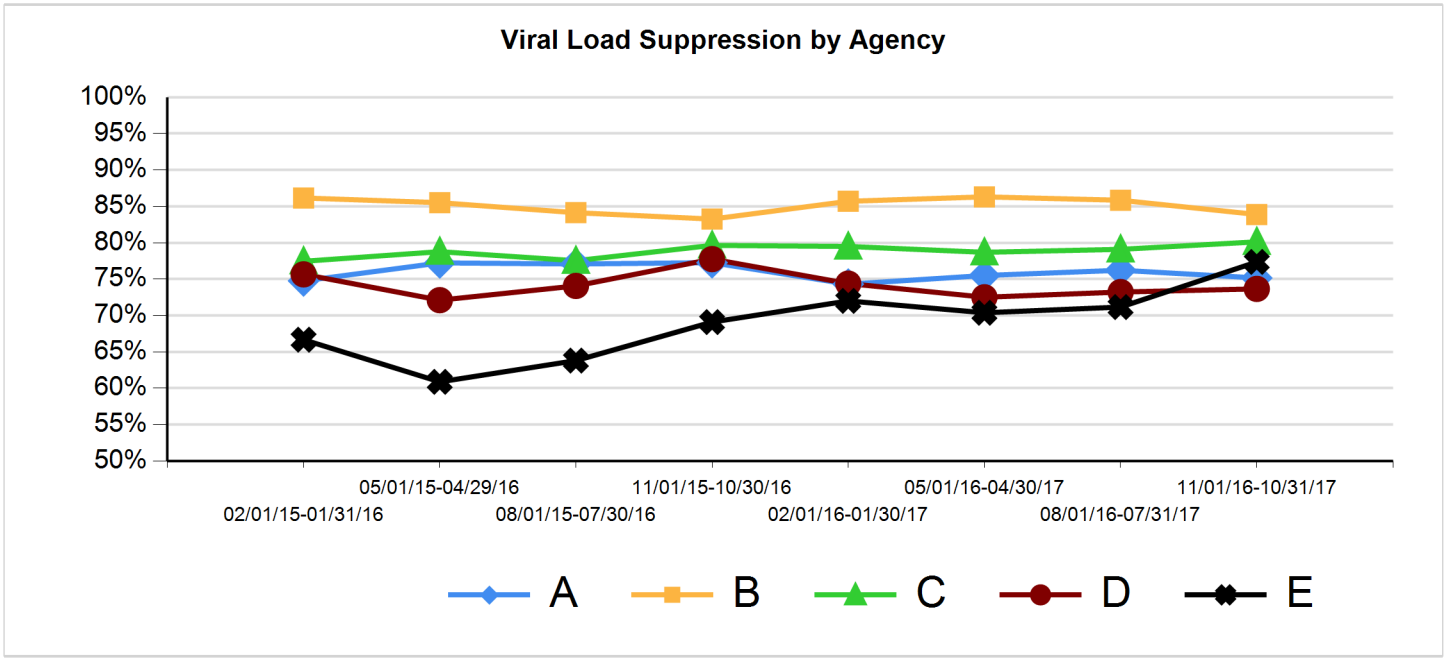
Viral Load Suppression				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	4,174	4,218	4,250	4,157
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	5,239	5,320	5,357	5,265
Percentage	79.7%	79.3%	79.3%	79.0%
Change from Previous Quarter Results	-0.4%	-0.4%	0.0%	-0.4%



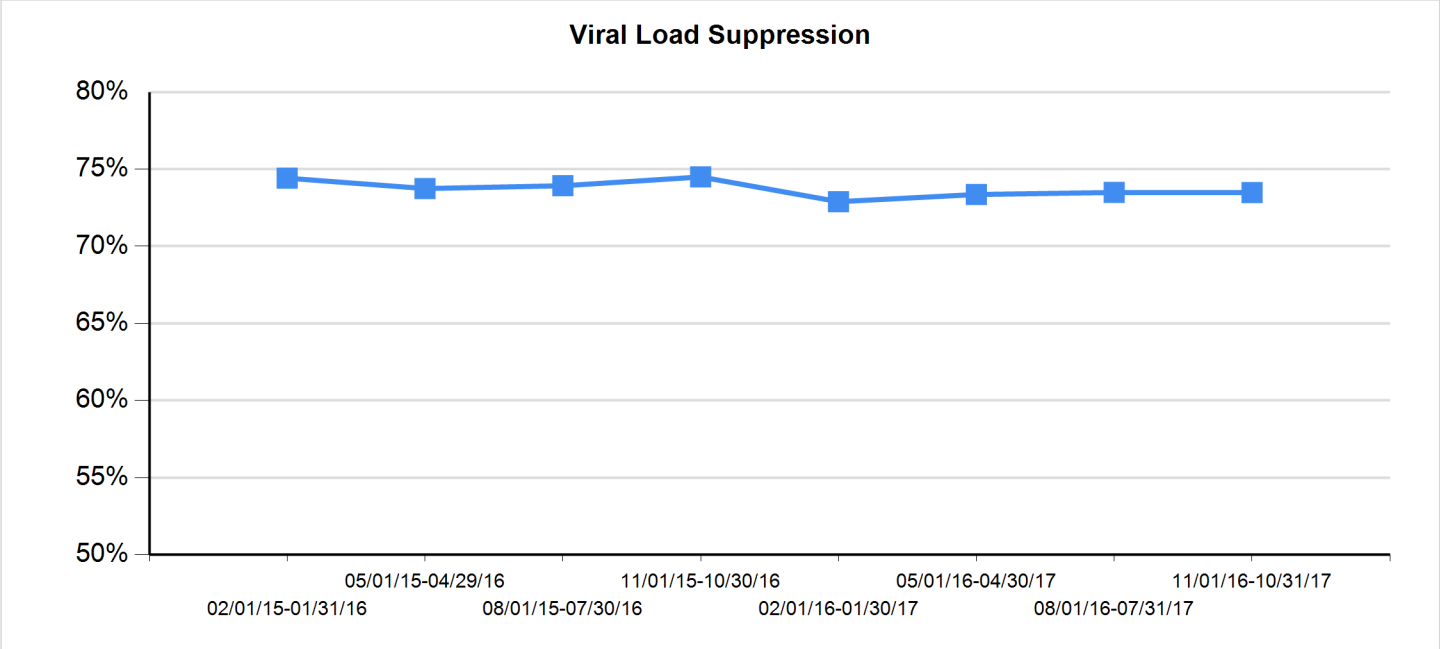
VL Suppression by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	1,932	1,625	561	1,933	1,652	560	1,864	1,643	551
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,583	1,927	695	2,558	1,980	698	2,499	1,975	675
Percentage	74.8%	84.3%	80.7%	75.6%	83.4%	80.2%	74.6%	83.2%	81.6%
Change from Previous Quarter Results	0.5%	-1.6%	0.5%	0.8%	-0.9%	-0.5%	-1.0%	-0.2%	1.4%



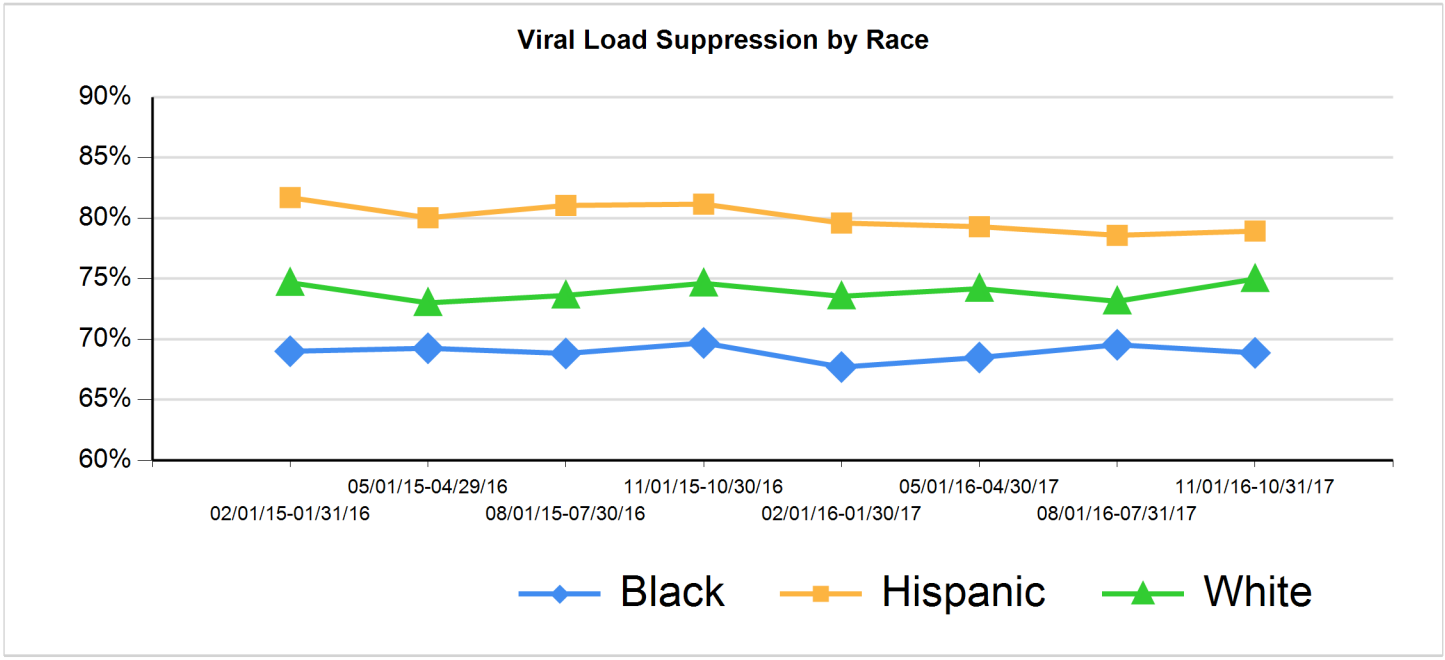
VL Suppression by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	532	1,528	1,184	998	37	490	1,447	1,165	1,040	41
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	698	1,780	1,497	1,363	52	652	1,725	1,454	1,412	53
Percentage	76.2%	85.8%	79.1%	73.2%	71.2%	75.2%	83.9%	80.1%	73.7%	77.4%
Change from Previous Quarter Results	0.7%	-0.5%	0.4%	0.7%	0.8%	-1.1%	-2.0%	1.0%	0.4%	6.2%



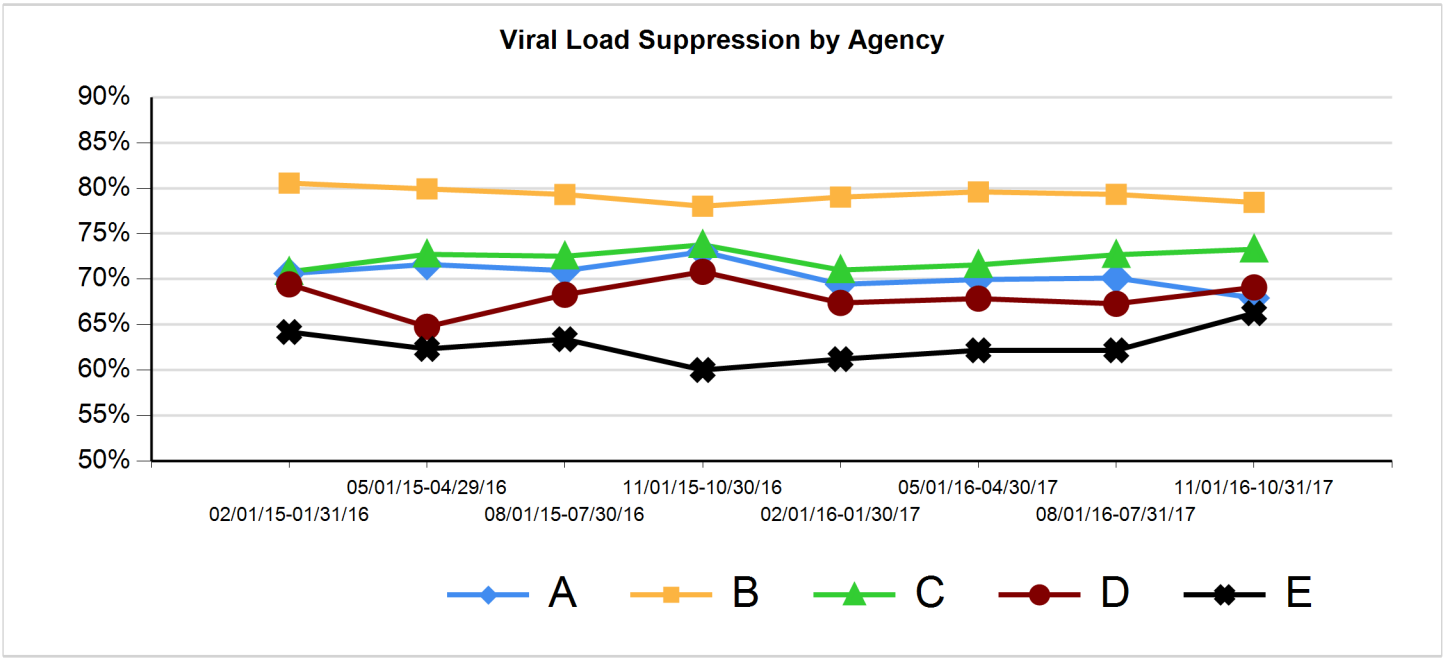
Viral Load Suppression 2- HAB Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	5,400	5,527	5,647	5,586
Number of HIV-infected clients who have had at least 1 medical visit with a provider with prescribing privileges	7,408	7,534	7,684	7,602
Percentage	72.9%	73.4%	73.5%	73.5%
Change from Previous Quarter Results	-1.6%	0.5%	0.1%	0.0%



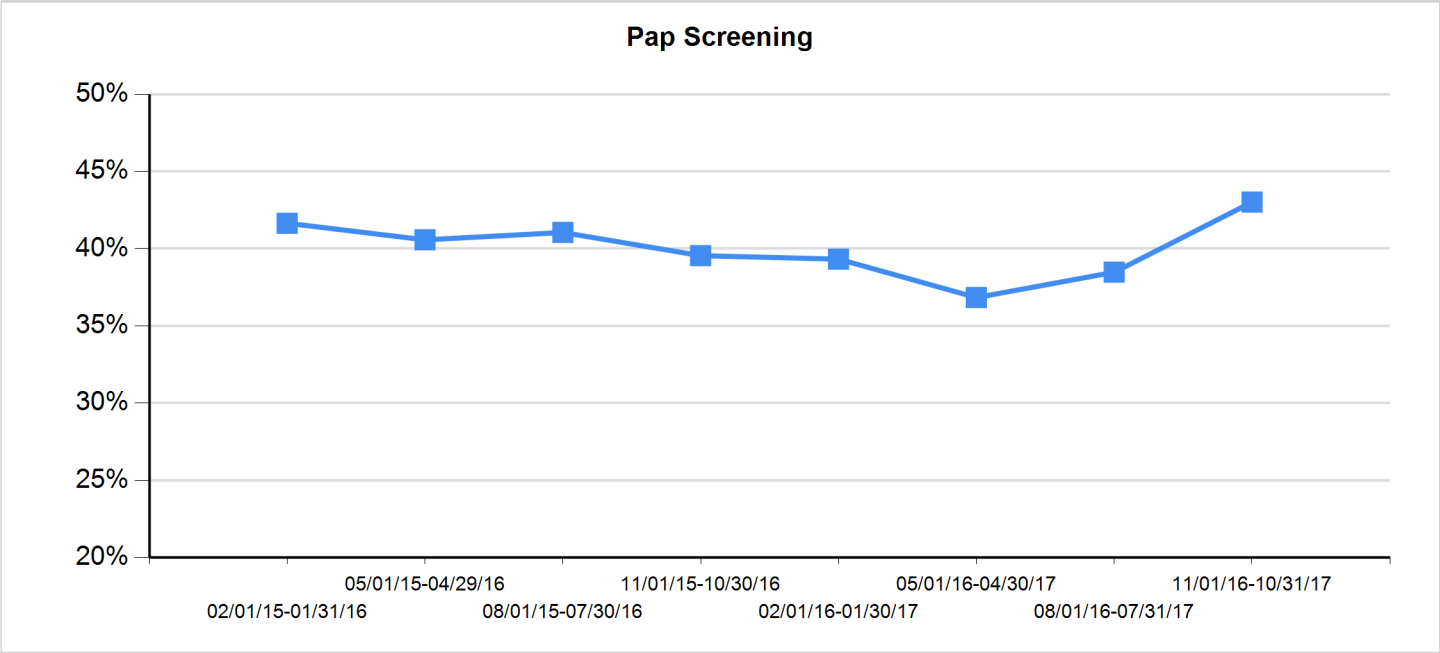
VL Suppression by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	2,549	2,099	741	2,632	2,128	743	2,586	2,113	752
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	3,722	2,647	999	3,785	2,708	1,016	3,755	2,677	1,003
Percentage	68.5%	79.3%	74.2%	69.5%	78.6%	73.1%	68.9%	78.9%	75.0%
Change from Previous Quarter Results	0.8%	-0.3%	0.6%	1.1%	-0.7%	-1.0%	-0.7%	0.3%	1.8%



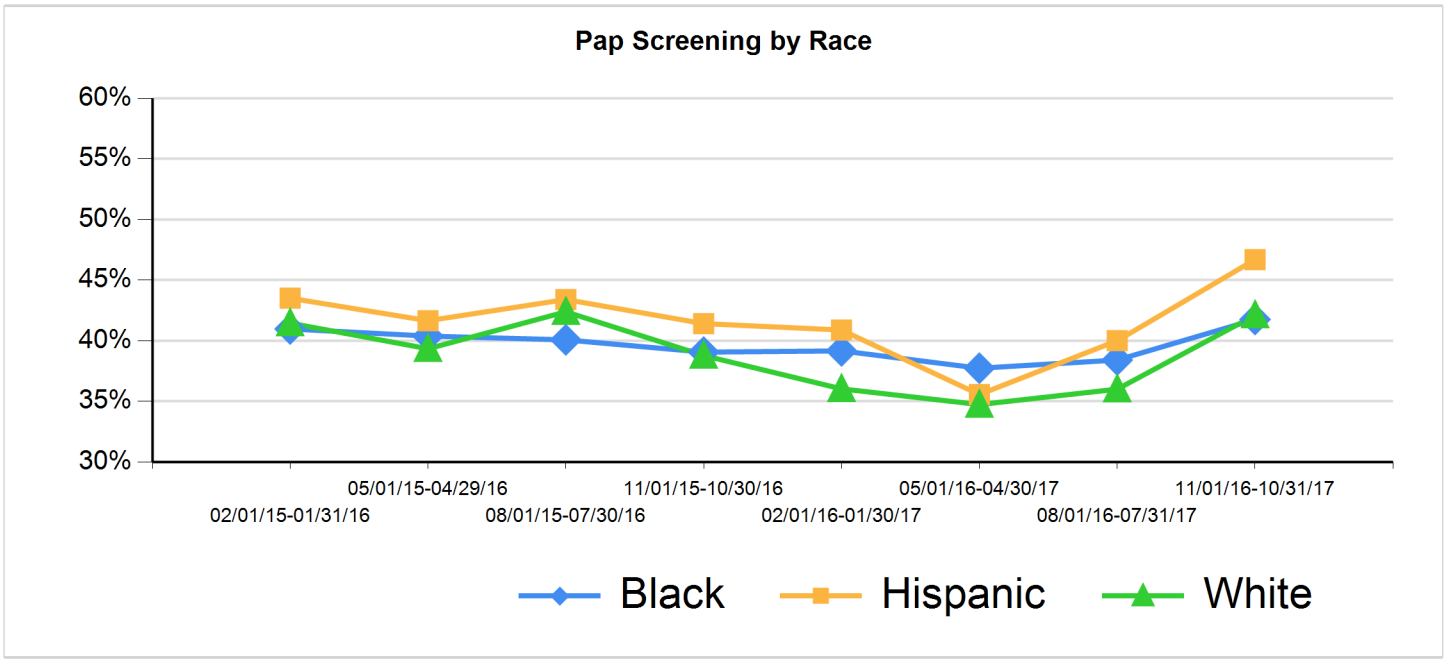
Viral Load Suppression by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	603	2,220	1,676	1,197	46	561	2,146	1,670	1,245	53
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	860	2,799	2,306	1,779	74	826	2,736	2,279	1,802	80
Percentage	70.1%	79.3%	72.7%	67.3%	62.2%	67.9%	78.4%	73.3%	69.1%	66.3%
Change from Previous Quarter Results	0.2%	-0.3%	1.1%	-0.6%	0.0%	-2.2%	-0.9%	0.6%	1.8%	4.1%



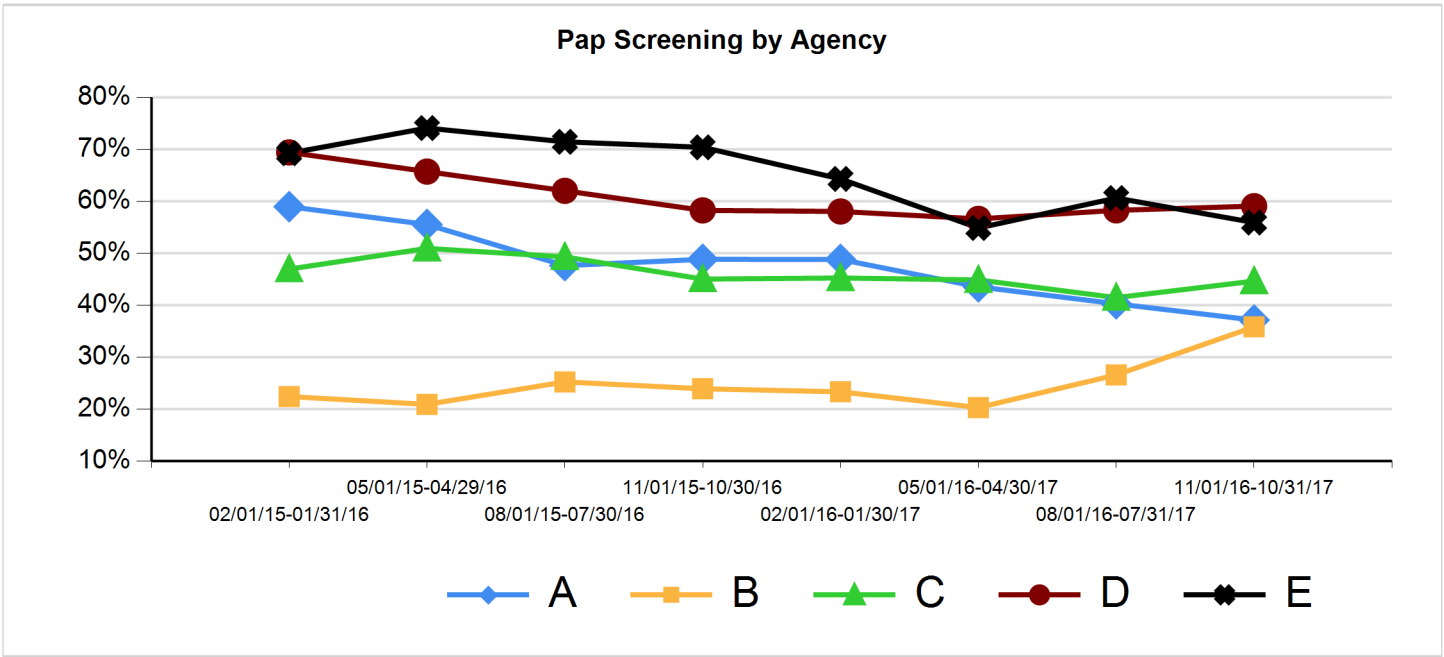
Cervical Cancer Screening				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	733	705	751	822
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,864	1,914	1,952	1,911
Percentage	39.3%	36.8%	38.5%	43.0%
Change from Previous Quarter Results	-0.2%	-2.5%	1.6%	4.5%



Cervical Cancer Screening Data by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	452	181	58	467	208	63	496	240	72
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,198	509	167	1,216	520	175	1,188	514	171
Percentage	37.7%	35.6%	34.7%	38.4%	40.0%	36.0%	41.8%	46.7%	42.1%
Change from Previous Quarter Results	-1.4%	-5.3%	-1.3%	0.7%	4.4%	1.3%	3.3%	6.7%	6.1%



Pap Smear Screening by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	97	234	162	258	20	82	305	174	261	19
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	241	881	391	443	33	221	852	390	442	34
Percentage	40.2%	26.6%	41.4%	58.2%	60.6%	37.1%	35.8%	44.6%	59.0%	55.9%
Change from Previous Quarter Results	-3.3%	6.3%	-3.4%	1.6%	5.8%	-3.1%	9.2%	3.2%	0.8%	-4.7%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v3.5.0 6/2/17 [MAI=ALL]", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

Dated 10/23/17

1819 Standard of Care
Table of Contents

1819 HOUSTON HSDA STANDARDS OF CARE
SUMMARY OF CHANGES

HEALTH INSURANCE ASSISTANCE

9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)* 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. *Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017)*	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIC funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a clients failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIP funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price. 8. Life insurance and other elective policies are not covered.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

MENTAL HEALTH SERVICES

9.1	Scope of Work Agency will provide the following services: **Individual Therapy/counseling** is defined as 1-on-1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person. Mental health services include Mental Health Assessment; Treatment Planning; Treatment Provision; Individual psychotherapy; Family psychotherapy; Conjoint psychotherapy; Group psychotherapy; Drop-In Psychotherapy Groups; and Emergency/Crisis Intervention. Also included are Psychiatric medication assessment, prescription and monitoring and Psychotropic medication management. General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for non-HIV infected family members or significant others. Mental health services can be delivered via Telehealth subject to federal guidelines, Texas State law, and DSHS policy.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.10	Client Orientation Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will be provided to all clients and include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's	• Documentation in client record indicates compliance. • Annual Client Interviews indicates compliance. • Percentage of new clients with documented evidence of orientation to services available in the client's primary record

	responsibilities for delivering them • Patient rights including the grievance process	
9.11	Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self Assessment/Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation.	• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment. • Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record
9.12	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: • Statement of the goal(s) of counseling and description of the mental health issue • Goals and objectives • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review	• Documentation in client record. • Exceptions noted in client file. • Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. • Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. • Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

9.14	Psychiatric Referral Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	• Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.
9.15	Psychotropic Medication Management: Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10	• Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. • Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.
9.16	Progress Notes Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment	• Legible, signed and dated documentation in client record. • Percentage of client's with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.

	• Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	
9.17	Coordination of Care: Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.
9.18	Referrals: As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

9.20	Discharge Summary Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	• Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record. • Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.

RYAN WHITE PART B/DSHS-STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
COMMUNITY-BASED HEALTH SERVICES

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

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

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

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

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

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
EARLY INTERVENTION SERVICES FOR THE INCARCERATED

DEFINITION:
Early Intervention Services are designed to bring HIV-positive individuals into Outpatient Ambulatory Medical Care through counseling, testing, and referral activities.

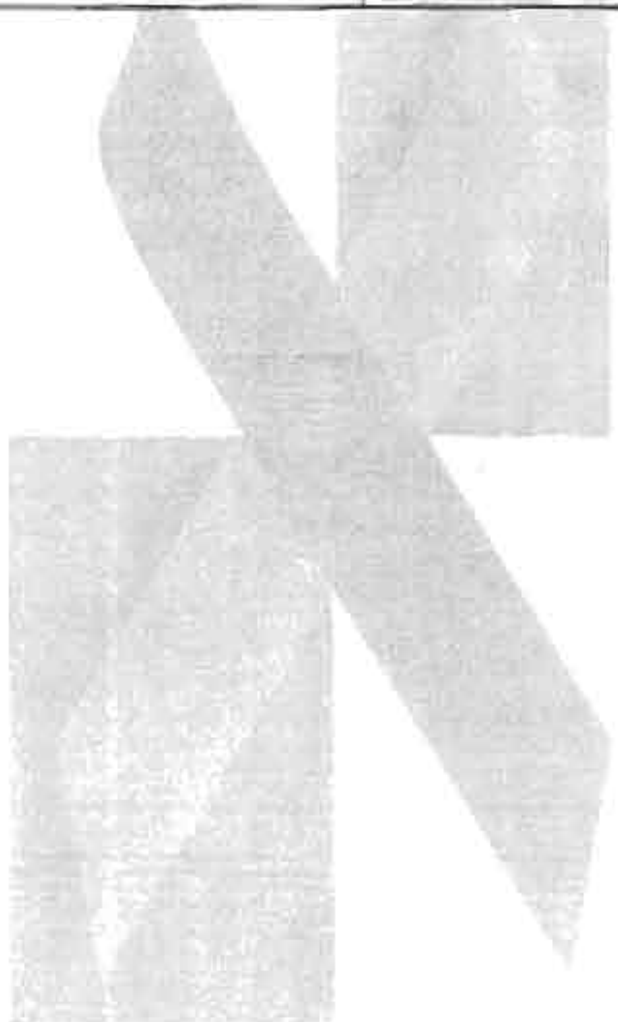
#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service The goal of Early Intervention Services (EIS) is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care, educating and motivating clients on the importance and benefits of getting into care, through expanding key points of entry. The provision of EIS includes: • HIV Testing and Targeted counseling** • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care Early intervention Services for the Incarcerated specifically includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, establishment of THMP/ADAP eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning. **Limitation: Ryan White Part B funds can only be used for HIV testing as necessary to supplement, not supplant, existing funding.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Agency License The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.	• Review of agency
9.3	Program Policies and Procedures Agency will have a policy that: • Defines and describes EIS services (funded through Ryan White or other sources) that include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found • Requires monitoring of referrals into care and treatment	• Program's Policies and Procedures indicate compliance with expectations.
9.4	Staff Qualifications All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. Supervisors must possess a degree in a health/social service field or equivalent experience.	• Review of personnel files indicates compliance
9.5	Continuing Education Each staff will complete a minimum of 12 hours of training annually to remain current on HIV care.	• Evidence of training will be documented in the staff personnel records.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Supervision Each agency must have and implement a written plan for supervision of all Early Intervention staff. Supervisors must review a 10 percent sample of each staff member's client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Each supervisor must maintain a file on each staff supervised and hold supervisory sessions on at least a monthly basis. The file must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
9.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV-positive status • Language(s) spoken and Literacy level (client self-report) *Due to client's state of incarceration, this service is excluded from the requirement to document income and residency.*	• Documentation of HIV status is present in the client file. • Documentation in compliance with TRG Policies for Documentation of HIV Status.
9.8	CPCDMS Update/Registration As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.	• Current registration of client is present in CPCDMS.
9.9	Assessment of Client Staff will complete an intake assessment form for all clients served. The assessment will include identified needs upon release, assessment of support system upon release, and desired provider to receive referral information on.	• Intake assessment form is present in the client file.
9.10	Provision of Client Education Staff provide client with education regarding the disease and its management, risk reduction, medication adherence and other health-related education.	• Documentation of client education is present in the client file.
9.11	Increase Health Literacy Staff assesses client ability to navigate medical care systems and provides education to increase client ability to advocate for themselves in medical care systems.	• Documentation of health literacy evaluation and education is present in the client file.

#	STANDARD	MEASURE
9.12	Coordination of Care Staff assists in the coordination of client medical care while incarcerated including, but not limited to, medical appointments and medications.	• Documentation of coordination of care is present in the client file.
9.13	Medication Regimen Establishment/Transition Staff assists clients to become eligible for TXMP/ADAP medication program prior to release. Staff assists client with transition of medication from correctional facility to outside pharmacy.	• Documentation of THMP/ADAP application and its submission is present in client file. • Documentation of connection/referral to outside pharmacy.
9.14	Transitional Team Multidisciplinary (TTMD) Review Staff creates opportunities for MDT review with all involved agencies to discuss client's case.	• Schedule of available times for TTMD reviews with involved agencies available for review. • Documentation of TTMD reviews present in client file.
9.15	Discharge Planning Staff conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Creation of a discharge plan.	• Documentation of review of services present in client file. • Documentation of client discharge plan is present in client file.
9.16	HIV Testing and Targeted Counseling According to the HRSA National Monitoring Standards all four components must be present. Part B funds can only be used for HIV testing to supplement, not supplant, existing funding. • If Ryan White Part B funds are used for HIV testing, agency must submit a waiver to TRG and document the reason(s) necessary to supplement existing funding.	• Review of monthly expenses indicates compliance • Waiver are present when funds are utilized for testing
9.17	Referral Process Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral will include a packet with a. A copy of the Harris County Jail Intake/Assessment Form, b. Proof of HIV diagnosis, c. A list of current medications, and d. Provide client ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community.	• Documentation of referral present in client file • Documentation of referral feedback present in client file. • Copy of "known to me as" letter present in client file.

#	STANDARD	MEASURE
9.18	MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting clients into ongoing care.	• Review of MOUs at annual quality compliance reviews. • Documentation of communication and referrals with agencies covered by MOUs is present in client file.



RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE - DRAFT

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Compliance with Regional Health Insurance Assistance Policy The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Annual Review of agency shows compliance with established policy.
9.3	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary. Agencies must maintain referral relationships with organizations or individuals who can provide income tax preparation assistance.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
9.4	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required. Minimum of two (2) hours training for all relevant staff on how to indentify advance premium tax credits and liabilities.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.5	Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
9.6	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)* 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. *Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017).*	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIC funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a clients failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIP funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price. 8. Life insurance and other elective policies are not covered.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

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

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

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HOSPICE SERVICES

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

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

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

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

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

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

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

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

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

References:

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

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

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

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

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

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

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

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

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

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

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

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

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self Assessment/Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation.	• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment. • Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record
9.12	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: • Statement of the goal(s) of counseling and description of the mental health issue • Goals and objectives • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review	• Documentation in client record. • Exceptions noted in client file. • Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. • Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client s primary record. • Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Treatment Plan (Cont'd) Initial treatment plans must be completed no later than the third counseling session. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals as clinically indicated. The treatment plan will be signed by the mental health professional rendering service.	
9.13	Treatment Plan Review Treatment plans shall be reviewed and modified at least every 90 days or more frequently as clinically indicated. -The plan must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures.	• Review of Agency Policies and Procedures Manual indicates compliance. • Client's records • Exceptions noted in client files.
9.14	Psychiatric Referral Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	• Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.
9.15	Psychotropic Medication Management: Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	• Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. • Percentage of clients with changes to psychotropic psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

9.16	Progress Notes Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	• Legible, signed and dated documentation in client record. • Percentage of client's with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.
9.17	Coordination of Care: Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.
9.18	Referrals: As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

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

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

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

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

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

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

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

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

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

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

References

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

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

FYI

Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV

HIV treatment has dramatically improved the health, quality of life, and life expectancy of people living with HIV (Cohen, 2011; Farnham, 2013; Farnham, 2013; Samji, 2013). Moreover, since breakthrough research in 2011 also showed the profound impact of HIV treatment in preventing the sexual transmission of HIV among heterosexual HIV-discordant couples, HIV treatment has transformed the HIV prevention landscape (Cohen, 2011). The Centers for Disease Control and Prevention (CDC) has worked with prevention partners across the nation to prioritize efforts to maximize the impact of HIV treatment in prevention and has responded with new initiatives that help diagnose HIV-infected individuals earlier, link or re-engage them to effective HIV care and treatment, and support adherence to HIV treatment, with the ultimate goal of achieving viral suppression (https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-ps18-1802-factsheet.pdf).

These interventions across the care continuum (https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf) are essential to help those living with HIV stay healthy, live longer, and reduce the risk of further transmission to partners. Additionally, to increase awareness of the full range of prevention strategies now available, CDC has worked to implement multiple education campaigns and provide online risk reduction tools and resources with information on different prevention strategies and their effectiveness (https://www.cdc.gov/actagainstaids/index.html; https://wwwn.cdc.gov/hivrisk/; https://effectiveinterventions.cdc.gov/).

* People living with HIV who take HIV medicine as prescribed and get and stay virally suppressed have effectively no risk of sexually transmitting HIV to HIV-negative partners.

Over the past year, as new research has provided even stronger evidence on the prevention benefit of HIV treatment and viral suppression, CDC has joined with other federal agencies as part of an effort led by the U.S. Department of Health and Human Services (HHS) to review the latest evidence and ensure that these findings are communicated in a way that is consistent and accurate. As part of CDC's continued efforts to communicate evidence around effective prevention strategies, this fact sheet summarizes the latest scientific evidence regarding the effectiveness of HIV treatment and viral suppression in preventing the sexual transmission of HIV, and provides an update on evolving prevention messages developed by the HHS workgroup,[1] as well as CDC's next steps to evaluate and update messages in our communications and prevention activities.

The Evidence

In 2011, the interim results of the HPTN052 clinical trial were released (Cohen, 2011) demonstrating a 96% reduction in HIV transmission risk among heterosexual HIV-discordant couples for those starting antiretroviral therapy (ART) versus those delaying ART initiation. In addition to the powerful initial results, subsequent analyses published in 2016 demonstrated that there were no HIV transmissions between these couples when the HIV-positive partner had a suppressed viral load (defined as having a viral load less than 400 copies per milliliter) (Cohen, 2016).

Some HIV infections were observed among couples in the treatment condition; however, most of these were not genetically linked to the primary HIV-positive partner in the study, indicating that they came from another partner outside the study. Only a limited number of linked sexual transmissions of HIV were observed; however, this

1. The HHS workgroup includes senior leaders, communicators, and subject matter experts from the Office of HIV/AIDS Infectious Disease Policy (OHAIDP) in HHS, the Centers for Disease Control and Prevention (CDC), National Institutes for Health (NIH), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA).

All content is based on the most recent data available in December 2017.

was while the HIV-positive partner was not virally suppressed. In other words, linked HIV transmissions only occurred either:

- In the months *after* the HIV-positive partner began ART but *before* the HIV-positive partner was virally suppressed, or
- When the ART regimen failed and the HIV-positive partner did not maintain viral suppression.

Two recently conducted studies, PARTNER and Opposites Attract, have reported similar results on the effectiveness of taking ART and achieving and maintaining viral suppression in preventing the sexual transmission of HIV — that is, no linked infections were observed while the HIV-positive partner was virally suppressed while the couples engaged in condomless sex with no exposure to pre-exposure prophylaxis (PrEP) (Rodger, 2016; Bavinton, 2017). In these two studies, viral suppression was defined as less than 200 copies per milliliter, although most HIV-positive participants were undetectable in the PARTNER study (<50 copies/mL; Rodger, 2016). These studies also quantified the extent of sexual exposure. Over 500 heterosexual couples, with about half having a male HIV-infected partner (PARTNER), and more than 650 male-male couples (Opposites Attract) from 14 European countries, Australia, Brazil, and Thailand engaged in over 70,000 episodes of condomless vaginal or anal intercourse, while also not taking PrEP, during approximately 1,500 couple years of observation.

The studies reported transmission risk estimates and their corresponding 95% confidence intervals as:

- PARTNER study (Rodger, 2016): 0.0 (0.00 – 0.30) per 100 couple years
- Opposites Attract study (Bavinton, 2017): 0.0 (0.00 – 1.56) per 100 couple years

When combining the data from both PARTNER and Opposites Attract studies, the combined transmission risk estimate is 0.0 (0.0 – 0.25) per 100 couple years (unpublished data). Relevant person-time data have not been reported for HPTN052 to be combined with these two studies. CDC is now working with HPTN052 investigators to examine these data. When HPTN052 data can be combined with these two studies, the upper bound of a combined transmission risk estimate is expected to be smaller than 0.25 per 100 couple years including additional years of follow-up time.

Updating Prevention Messages

Given the significance of these recent findings, HHS convened scientific and communication leadership across several federal agencies to review the latest evidence and develop updated messages to communicate that evidence to the public in a clear, concise, consistent, and accurate manner.

In September 2017, the HHS workgroup agreed on the following interim message, to be tested with multiple audiences, which summarizes the scientific evidence of the effectiveness of HIV treatment and viral suppression in preventing the sexual transmission of HIV:

> **People living with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners.**

The term “effectively no risk” was selected by the HHS workgroup as the interim language to describe the magnitude of the estimated risk of transmitting HIV to a sexual partner when an HIV-positive individual is taking ART daily as prescribed and then achieves and maintains an undetectable viral load. “Effectively no risk” was chosen to reflect the fact that there have been no linked infections observed in studies among thousands of sexually active HIV-discordant couples engaging in female-male and male-male sex without a condom or PrEP over several thousand person-years of follow-up, while the HIV-positive partner is virally suppressed.

Although these studies provide extremely strong evidence, they are based on a finite number of observations that result in point estimates (zero) and corresponding 95% confidence intervals that indicate the precision or uncertainty associated with those estimates. In these studies, the lower bounds of confidence intervals are all zero, but the upper bounds of the confidence intervals are very small but greater than zero, which implies the possibility of a non-zero risk. Although these three studies found no cases of HIV transmission over several thousand person-years of follow-up, these data, even when combined, cannot statistically rule out the possibility that the true risk is greater than zero.

Because "effectively no risk" might have different meanings in different audiences or populations, the HHS workgroup agreed that message testing was critical to evaluate the understanding of this interim message and to determine how best to communicate the evidence and potential challenges with successfully implementing this prevention strategy among people living with HIV and their sexual partners.

Maximizing the Effectiveness of the Prevention Strategy in Practice

The success of this prevention strategy is contingent on achieving and maintaining an undetectable viral load. Data show, however, that not all HIV-positive individuals on ART are virally suppressed, while even fewer maintain viral suppression over time. CDC's national surveillance data estimate that 58% of persons living with diagnosed HIV in the United States in 2014 were virally suppressed, defined as less than 200 copies/mL at most recent test (CDC, 2017). In addition, while most (about 80%) HIV-positive persons in the United States in HIV clinical care (defined as either receiving HIV medical care or having a viral load test) were virally suppressed at their last test, almost 20% were not (CDC, 2016; CDC, 2017; Marks, 2016). Also, about two-thirds achieved and maintained viral suppression over twelve months, which means about one-third (or about 33%) did not maintain viral suppression over that time period (CDC, 2016; Marks, 2016).

To help all individuals living with HIV and their partners get maximal benefit from this prevention strategy, it will be important to give providers, those living with HIV, and their partners clear information regarding the challenges with achieving and maintaining viral suppression. These challenges include the following:

- **Time to viral suppression:** Most people will achieve an undetectable viral load within 6 months of starting ART. Many will become undetectable very quickly, but it could take more time for some.
- **Importance of regular viral load testing:** Regular viral load testing is critical to confirm that an individual has achieved and is maintaining an undetectable viral load. Just because someone was virally suppressed in the past does not guarantee they are still virally suppressed. It is not known if viral load testing should be conducted more frequently than currently recommended for treatment to achieve maximal protection if relying on treatment and viral suppression as a prevention strategy.
- **Adherence challenges:** Taking HIV medicines as prescribed is the best way to achieve and maintain an undetectable viral load. Poor adherence, such as missing multiple doses in a month, could increase a person's viral load and their risk for transmitting HIV. People who are having trouble taking their HIV medicine as prescribed can work with health care providers to improve their adherence. If an individual is experiencing adherence challenges, other prevention strategies could provide additional protection until the individual's viral load is confirmed to be undetectable.
- **Stopping HIV medication:** If an individual stops taking their HIV medicine, their viral load can increase very quickly (e.g., within a few days) and eventually returns to around the same level it was before starting their HIV medicine. People who have stopped taking their HIV medicine should talk to their health care provider as soon as possible about their own health and consider using other strategies to prevent sexual HIV transmission.
- **Protection against other STIs:** Taking HIV medicine and achieving and maintaining an undetectable viral load does not protect you or your partner from getting other sexually transmitted infections. Other prevention strategies are needed to provide protection from STIs.

Next Steps in Communicating the Evidence

To help ensure prevention partners are aware of the effectiveness of this powerful HIV prevention strategy, CDC summarized the scientific evidence and the interim HHS-wide prevention message in a Dear Colleague Letter (https://www.cdc.gov/hiv/library/dcl/dcl/092717.html) for National Gay Men's HIV/AIDS Awareness Day (NGMHAAD) on September 27, 2017. CDC is currently updating key web pages to summarize the evolving science and message updates (https://www.cdc.gov/hiv/risk/art/index.html).

CDC is currently conducting message testing to better understand how to most effectively communicate the science on optimal use of HIV treatment and viral suppression for prevention and the real world requirements for its success. We will continue to update campaigns, websites, and other communications materials as messaging evolves and is improved based upon research findings.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

References

Bavinton B, Grinsztejh B, Phanuphak N, et al. HIV treatment prevents HIV transmission in male serodiscordant couples in Australia, Thailand and Brazil. Presented at the 9th IAS Conference on HIV Science (IAS 2017), Paris, France; July 25, 2017.

Centers for Disease Control and Prevention. Behavioral and clinical characteristics of persons receiving medical care for HIV infection—Medical Monitoring Project, United States, 2014 Cycle (June 2014–May 2015). *HIV Surveillance Special Report* 17. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published December 2016. Accessed November 1, 2017.

Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2015. *HIV Surveillance Supplemental Report 2017*;22(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published July 2017. Accessed November 1, 2017.

Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2011;365:493-505.

Cohen MS, Chen YQ, McCauley M, et al. Antiretroviral therapy for the prevention of HIV-1 transmission. N Engl J Med 2016;375:830-9.

Farnham PG, Holtgrave DR, Gopalappa C, Hutchinson AB, Sansom SL. Lifetime costs and quality-adjusted life years saved from HIV prevention in the test and treat era. J Acquir Immune Defic Syndr 2013;64(2):e15-8.

Farnham PG, Gopalappa C, Sansom SL, et al. Updates of lifetime costs of care and quality-of-life estimates for HIV-infected persons in the United States: Late versus early diagnosis and entry into care. J Acquir Immune Defic Syndr 2013;64:183-9.

Marks G, Patel U, Stirratt MJ, et al. Single viral load measurements overestimate stable viral suppression among HIV patients in care: Clinical and public health implications. J Acquir Immune Defic Syndr 2016;73:205-12.

Rodger AJ, Cambiano V, Bruun T, et al. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. JAMA 2016;316(2):171-81.

Samji H, Cescon A, Hogg RS, et al. Closing the gap: Increases in life expectancy among treated HIV-positive individuals in the United States and Canada. PLoS ONE 8(12): e81355. Doi:10.1371/journal.pone.0081355.

Coffee Social with Poztive people and Poztive Friends

Empire Café located at 1732 Westheimer Rd. Houston 77098. 1/2 PRICE Dessert and free COFFEE Refills. 2nd and 4th Monday from 2PM till 4PM.

We are meeting January 8th and January 22nd to have a social and meet old and new friends. This Social will be held every Month. Please join our NEW SOCIAL. For more info call Denis at 832-578-9891.