Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, July 17, 2018
Meeting Location: 2223 W. Loop South, 1st Floor Conference Room; Houston, Texas 77027

Agenda

* Indicates that the report will be provided at the meeting

I. Call to Order — Denis Kelly and Gloria Sierra, Co-Chairs
   A. Moment of Reflection
   B. Adoption of Agenda
   C. Approval of Minutes

II. Public Comment

SEE ADDITIONAL PUBLIC COMMENTS BEFORE RELATED SERVICE DEFINITIONS

(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. Committee members are asked to remember that this is a time to hear from the community. It is not a time for dialogue. Committee members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Ryan White Administrative Agents
   A. Ryan White Part A — Carin Martin
      1. FY 2017 Performance Measures Highlights
   B. Ryan White Part B and State Services* — Patrick Martin

IV. Assessment of the Administrative Mechanism – Part A/MAI — Amber Harbolt

V. ADAP Eligibility Worker Service Definition — Marcus Beloit
   NOTE: 2:15 pm THMP Representative Joins Meeting via Phone — Patrick Martin

VI. Service Linkage Worker Re: Substance Abuse Treatment Service Definition — Patrick Martin

VII. Old Business
   A. Quarterly Committee Report

VIII. Announcements

IX. Adjourn

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, May 15, 2018
Meeting location: 2223 W. Loop South, Room 416; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Gloria Sierra, Co-Chair	Connie Barnes, excused	Cecilia Oshingbade, RWPC Chair
Rosalind Belcher	Dennis Kelly, excused	C. Bruce Turner, RWPC
David Benson	Tom Lindstrom, excused	Ann Robison, Montrose Center
Daphne L. Jones	Venita Ray	Patrick Martin, TRG
John Poole	Kevin Aloysius	Reachelian Ellison, TRG
Viviana Santibanez	Eddie Givens	Tiffany Shepherd, TRG via phone
Carol Suazo	Billy Ray Grant, Jr, excused	Carin Martin, RWGA
Samantha Robinson	Shamra Hodge	Tasha Traylor, RWGA
Crystal Starr	Tiffany Jones, excused	Heather Keizman, RWGA
	Pete Rodriguez	Tori Williams, Ofc of Support
	Tracy Sandles, excused	Amber Harbolt, Ofc of Support
	David Watson, excused	Diane Beck, Ofc of Support

Call to Order: Gloria Sierra, Co-Chair, called the meeting to order at 2:39 p.m. and asked for a moment of reflection.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Suazo, Starr) to approve the March 13, 2018 joint committee meeting minutes.* **Motion carried**. Abstentions: Benson, Robinson.

Motion #3*: it was moved and seconded (Starr, Suazo) to approve the March 13, 2018 Quality Improvement Committee meeting minutes.* **Motion carried**. Abstentions: Benson, Robinson.

Public Comment: Bruce Turner stated that he spoke about consumers falling off of ADAP at the How to Best Meet the Need workgroup meeting, approximately 700 individuals per year with half of those in the Houston area. He asked if the ADAP enrollment workers could reach out to those who fall off. Since it's only about 4-5 people per month maybe it would be better for Outreach workers to do it in communication with the pharmacies. Ann Robison, Montrose Center - See her attached comment from February. She stated that she wants to make sure the committee understands that, once the SAMHSA funds expire in September 2019, approximately 350 HIV-positive individuals in our area will no longer have a case manager and will be absorbed into the bigger substance abuse system, which no longer has funds marked specifically for people living with HIV. She asked that service linkage workers be bundled with clinical case management because of the importance of service linkage workers networking with treatment programs. Recently, the Gulf Coast Center discontinued their program immediately upon hearing the same news, causing many people to become homeless.

Reports from the Administrative Agents
Ryan White Part A: C.Martin presented the following attached reports:

- FY 2017 Service Utilization, dated 05/23/18
- FY 2017 Procurement, dated 05/15/18

Ryan White Part B and State Services: P.Martin presented the following attached reports:

- 2017 Chart Reviews
- FY17/18 Part B Procurement, dated 05/09/18
- FY17/18 DSHS State Services Procurement, dated 05/09/18
- FY17/18 DSHS State Services-R Procurement, dated 05/09/18
- Health Insurance Assist. Service Utilization Report, dated 05/07/18
- Health Insurance Assist. Service Utilization Report, dated 03/05/18
- FY17/18 Part B Service Utilization, dated 05/09/18

FY 2019 How to Best Meet the Need
Workgroup Recommendations, including Financial Eligibility: See attached summary of workgroup recommendations and full packet of service definitions.

Workgroup recommendation regarding Referral for Health Care and Support Services: The committee would like to have more information about the number of consumers falling off of ADAP, including why this happens and if they are following up with these individuals. P. Martin will ask the State for information. ***Motion #4****: it was moved and seconded (Benson, Starr) to table the Referral for Health Care and Support Services (ADAP Enrollment Workers) service definition until more information is available.* **Motion carried**.

Workgroup recommendation regardnig Clinical Case Management: C. Martin said that there are three years left on the clinical case management contract. The suggested change will cause the service to be rebid. She suggested adding a target for substance abuse sites to the non-medical service linkage category. ***Motion #5****: it was moved and seconded (Benson, Belcher) to create up to five (5) service linkage worker positions targeting outpatient substance abuse treatment.* **Motion carried**. Abstentions: Robinson.

Motion #6*: it was moved and seconded (Suazo, Benson) to approve the How to Best Meet the Need workgroup recommendations for the FY 2019 Ryan White Part A, MAI, Part B and State Services service definitions and financial eligibility; create up to five service linkage worker positions targeting outpatient substance abuse treatment; and table the Referral for Health Care and Support Services service definition until more information becomes available.* **Motion carried**. Abstentions: S. Robinson, Starr.

HIV Targeting Chart: ***Motion #7****: it was moved and seconded (Belcher, Suazo) to approve the attached Targeting Chart for FY 2019 Service Categories for Ryan White Part A, B, MAI and State Services Funding.* **Motion carried**.

Checklist for Assessment of the Administrative Mechanism: Harbolt presented the attached checklist. ***Motion #8****: it was moved and seconded (Starr, Belcher) to approve the attached checklist for the Houston Ryan White Administrative Mechanism with no changes.* **Motion carried**.

Part B/SS Annual Consumer Involvement Report: Reachelian Ellison presented the attached report.

Part B/SS FY16 Chart Reviews: Tiffany Shepherd reviewed the attached reports.

Announcements: The co-chairs will present the How to Best Meet the Need recommendations at a Public Hearing at 7:00 p.m. on Monday, May 21, 2018, at the City Hall Annex located at 900 Bagby Street in Downtown Houston. If significant public comment is received, there will be a Special Committee Meeting at 9:00 a.m., Tuesday, May 22, 2018 in Room 240. There are no available rooms for the June 19, 2018 Quality Improvement Committee meeting so it has been cancelled.

P. Martin said the SIRR Re-Entry Summit featuring information on resources for the recently released will be on June 27, 2018 at the Kashmere Multiservice Center.

Adjourn: The meeting was adjourned at 4:28 p.m.

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

Scribe: D. Beck

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

2018 Quality Assurance Meeting Voting Record for Meeting Date 05/15/18

MEMBERS:	#1 Agenda				#2 Joint Meeting Minutes				#3 Meeting Minutes				#4 Table Referral for Health Care and Support Services			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Gloria Sierra, Co-Chair				C				C				C				C
Denis Kelly, Co-Chair	X															
Ted Artiaga		X				X				X				X		
Rosalind Belcher ja 2:18 pm	X				X				X					X		
Connie Barnes	X															
David Benson		X						X				X		X		
Daphne L. Jones ja 2:16 pm	X				X				X					X		
Tom Lindstrom	X															
John Poole ja 2:14 pm	X				X				X					X		
Venita Ray	X															
Viviana Santibanez		X				X				X				X		
Carol Suazo		X				X				X				X		
Kevin Aloysius	X															
Eddie Givens	X															
Billy Ray Grant, Jr.	X															
Shamra Hodge	X															
Tiffany Jones	X															
Samantha Robinson		X						X				X		X		
Pete Rodriguez	X															
Tracy Sandles	X															
Crystal Starr		X				X				X				X		
David Watson	X															

MEMBERS:	#5 Service Linkage Workers targeting Sub Ab Tmnt				#6 HTBMN Recommendations				#7 HIV Targeting Chart				#8 Admin Assessment Checklist			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Gloria Sierra, Co-Chair				C				C				C				C
Denis Kelly, Co-Chair	X															
Ted Artiaga		X				X				X				X		
Rosalind Belcher		X				X				X				X		
Connie Barnes	X															
David Benson		X						X				X		X		
Daphne L. Jones		X				X				X				X		
Tom Lindstrom	X															
John Poole lm 3:39 pm		X				X			X				X			
Venita Ray	X															
Viviana Santibanez		X				X				X				X		
Carol Suazo		X				X				X				X		
Kevin Aloysius	X															
Eddie Givens	X															
Billy Ray Grant, Jr.	X															
Shamra Hodge	X															
Tiffany Jones	X															
Samantha Robinson				X				X		X				X		
Pete Rodriguez	X															
Tracy Sandles	X															
Crystal Starr		X						X		X				X		
David Watson	X															

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FY 2017 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

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

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TABLE OF CONTENTS

Highlights from FY 2017 Performance Measures

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

Clinical Case Management

- During FY 2017, from 3/1/2017 through 2/28/2018, 1,265 clients utilized Part A clinical case management. According to CPCDMS, 632 (50%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 328 (26%) clients accessed mental health services at least once during this time period after utilizing clinical case management.
- For clients who have lab data in CPCDMS, 71% were virally suppressed

Local Pharmacy Assistance

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

Medical Case Management

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

Primary Medical Care

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

Non-Medical Case Management / Service Linkage

- During FY 2017, 7,084 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,259 (46%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.

- Among these clients, 372 (43%) clients utilized primary medical care for the first time after accessing service linkage for the first time.
- Among these clients, the median number of days between the first service linkage visit and the first primary medical care visit was 18 days during this time period.

Substance Abuse Treatment

- During FY 2017, 12 (46%) clients utilized primary medical care after accessing Part A substance abuse treatment services.
- Among clients with viral load tests, 67% were virally suppressed during this time period.

Transportation

- Van-Based Transportation:
  - During FY 2017, 498 (66%) clients accessed primary care after utilizing van transportation services.
  - Among van-based transportation clients, 388 (52%) clients accessed LPAP services at least once during this time period after utilizing van transportation services.

- Bus Pass Transportation:
  - During FY 2017, 809 (34%) clients accessed primary care after utilizing bus pass services.
  - Among bus pass clients, 471 (20%) clients accessed LPAP services at least once during this time period after utilizing bus pass services.
  - Among bus pass clients, 1,833 (76%) clients accessed any RW or State service after accessing bus pass services.

Vision Care

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

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Clinical Case Management
All Providers

For FY 2017 (3/1/2017 to 2/28/2018), 1,265 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2016	FY 2017	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	685 (48.7%)	632 (50.0%)	**1.3%**
Percentage of clinical case management clients who utilized mental health services	360 (25.6%)	328 (25.9%)	**0.3%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	501 (69.0%)	466 (71.1%)	**2.1%**
Percentage of clients who were homeless or unstably housed	322 (22.9%)	217 (17.2%)	**-5.7%**

According to CPCDMS, 27 (2.1%) clients utilized primary care for the first time and 96 (7.6%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2016
*Percentage of clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year	41%
Percentage of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment	30%

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

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Local Pharmacy Assistance
All Providers

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

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Medical Case Management
All Providers

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

HIV Performance Measures	FY 2016	FY 2017	Change
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,553 (50.3%)	2,626 (50.6%)	**0.3%**
Percentage of medical case management clients who utilized mental health services	616 (12.1%)	699 (13.5%)	**1.4%**
Increase in the percentage of clients who have third-party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	1,909 (37.6%)	1,764 (34.0%)	**-3.6%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,032 (67.7%)	2,004 (67.5%)	**-0.2**
Percentage of clients who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	770 (40.3%)		
Percentage of clients who did not have a medical visit in the last six months of the measurement year	591 (23.9%)	660 (25.5%)	**1.6%**
Percentage of clients who were homeless or unstably housed	1,190 (23.5%)	1,001 (19.3%)	**-4.2%**

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

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

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

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Medical Nutritional Supplements
All Providers

HIV Performance Measures	FY 2016	FY 2017	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	378 (77.8%)	384 (80.7%)	**2.9%**
90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year	9 (75.0%)	6 (60.0%)	**-15.0%**

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Oral Health Care
All Providers

HIV Performance Measures	**FY 2017**
75% of HIV-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up	No data is available

Clinical Chart Review Measures*	**FY 2015**	**FY 2016**
75% of oral health clients will have a dental health history (initial or updated) at least once in the measurement year	93%	87%
75% of oral health clients will have a medical health history (initial or updated) at least once in the measurement year	83%	87%
90% of oral health clients will have a dental treatment plan developed and/or updated at least once in the measurement year	81%	94%
85% of oral health clients will receive oral health education at least once in the measurement year	80%	88%
90% of oral health clients will have a periodontal screen or examination at least once in the measurement year	92%	84%
60% oral health clients will have a Phase 1 treatment plan that is completed within 12 months	86%	71%

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

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Primary Medical Care
All Providers

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

HIV Performance Measures	FY 2016	FY 2017	Change
90% of clients will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,205 (75.3%)	4,231 (73.2%)	**-2.1%**
Less than 20% of clients who have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care	266 (17.9%)	291 (22.2%)	**4.3%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD4 cell counts or percentages performed during the measurement year at least three months apart	3,782 (67.7%)	4,010 (69.4%)	**1.7%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,486 (74.2%)	5,694 (75.8%)	**1.6%**
Percentage of clients who received an oral exam by a dentist at least once during the measurement year	1,837 (24.8%)	1,813 (24.1%)	**-0.7%**
85% of clients will have a test for syphilis performed within the measurement year	5,960 (80.7%)	5,902 (78.7%)	**-2.0%**
95% of clients will be screened for Hepatitis B virus infection status (ever)	5,846 (79.1%)	6,219 (82.8%)	**3.7%**
90% of clients will have a viral load test performed at least every six months during the measurement year	3,584 (79.7%)	3,695 (81.7%)	**2.0%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	7,189 (71.3%)	7,317 (71.4%)	**0.1%**
Percentage of clients who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,248 (23%)		
Percentage of clients who did not have a medical visit in the last six months of the measurement year	1,542 (27.6%)	1,716 (29.7%)	**2.1%**
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	**Data below**		
Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network who had a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	**Data below**		

For FY 2017, 60% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 13 Days

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

For FY 2017, 60% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 12 Days

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

Clinical Chart Review Measures*	FY 2015	FY 2016
100% of clients will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	93.0%	100%
100% of pregnant women will be prescribed antiretroviral therapy	100%	100%
75% of female clients will receive cervical cancer screening in the last three years	68.2%	80.1%
55% of clients will complete the vaccination series for Hepatitis B	59.9%	55.6%
85% of clients will receive HIV risk counseling within the measurement year	71.3%	69.4%
95% of clients will be screened for substance abuse (alcohol and drugs) in the measurement year	98.7%	98.6%
90% of clients who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	88.4%	88.9%
65% of clients at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	69.6%	72.9%
75% of clients for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	67.1%	66.9%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	56.3%	53.1%
95% of clients will be screened for clinical depression using a standardized tool with follow-up plan documented	92.3%	87.9%
90% of clients will have ever received pneumococcal vaccine	87.8%	86.7%
100% of clients will be screened for tobacco use at least one during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user	100%	99.4%
95% of clients will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	96.5%	98.6%
85% of clients will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	70.0%	69.2%

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

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Non-Medical Case Management / Service Linkage
All Providers

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

HIV Performance Measures	**FY 2016**	**FY 2017**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	3,072 (45.0%)	3,259 (46.0%)	**1.0%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage for the first time	508 (52.5%)	372 (42.9%)	**-9.6%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	36	35	**-2.8%**
Median	21	18	**-14.3%**
Mode	14	1	**-92.9%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	132 (46.3%)	119 (43.1%)	**-3.2%**

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Substance Abuse Treatment
All Providers

HIV Performance Measures	FY 2016	FY 2017	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	18 (62.1%)	12 (46.2%)	**-15.9%**
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	17 (73.9%)	14 (66.7%)	**-7.2%**
Change in the rate of program completion over time	See data below		

***Overall, the number of clients who received primary care in FY 2017 was 15 (62.5%), with 12 receiving the services through Ryan White and 3 receiving the services through other insurance such as Medicare.**

Number of clients completing substance abuse treatment program during FY 2017 (March 2017 to February 2018): **16**

Number of clients engaged in substance abuse treatment program during FY 2017: **24**

Number of clients completing substance abuse treatment during FY 2017 who entered treatment in FY 2016: **4**

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Transportation
All Providers

Van-Based Transportation	**FY 2016**	**FY 2017**	**Change**
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Van Transportation services	493 (69.1%)	498 (66.2%)	**-2.9%**
35% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	386 (54.1%)	388 (51.6%)	**-2.5%**

Bus Pass Transportation	**FY 2016**	**FY 2017**	**Change**
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Bus Pass services	914 (37.3%)	809 (33.5%)	**-3.8%**
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	535 (21.8%)	471 (19.5%)	**-2.3%**
A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services	1,955 (79.7%)	1,833 (75.8%)	**-3.9%**

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Vision Care
All Providers

HIV Performance Measures	**FY 2017**
75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve or stay the same over time	See ocular disorder table

Clinical Chart Review Measures*	**FY 2015**	**FY 2016**
100% of vision clients will have a medical health history (initial or updated) at least once in the measurement year	100%	100%
100% of vision clients will have a vision history (initial or updated) at least once in the measurement year	100%	100%
100% of vision clients will have a comprehensive eye exam at least once in the measurement year	100%	100%

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

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Accommodation Spasm	2	0								
Acute Retinal Necrosis										
Anisocoria	9	6					6	100%		
Bacterial Retinitis										
Cataract	256	102			1	6%	82	80%	19	19%
Chalazion	1	1			1	100%				
Chorioretinal Scar	12	5					4	80%	1	20%
Chorioretinitis	1	1					1	100%		
CMV Retinitis - Active										
CMV Retinitis - Inactive										
Conjunctivitis	23	9	1	11%	3	33%	4	44%	1	11%
Covergence Excess										
Convergence Insufficiency										
Corneal Edema										
Corneal Erosion										
Corneal Foreign Body										
Corneal Opacity	57	15					15	100%		
Corneal Ulcer										
Cotton Wool Spots										
Diabetic Retinopathy	3	2			1	50%			1	50%
Dry Eye Syndrome	679	305			1	0%	296	97%	8	3%
Ecchymosis	1	0								
Esotropia	1	0								
Exotropia	10	5	1	20%			4	80%		
Glaucoma	8	4					2	50%	2	50%
Glaucoma Suspect	127	66	5	8%	16	24%	38	58%	7	11%
Iritis	3	1	1	100%						
Kaposi Sarcoma										
Keratitis	14	1	1	100%						
Keratoconjuctivitis										
Keratoconus	6	0								
Lagophthalmos	1	1					1	100%		
Macular Hole	1	0								
Meibomianitis										
Molluscum Contagiosum										
Optic Atrophy	15	1					1	100%		
Papilledema	1	0								

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Paresis of Accommodation										
Pseudophakia	9	3					3	100%		
Refractive Change/Transient										
Retinal Detachment	2	1							1	100%
Retinal Hemorrhage	1	0								
Retinopathy HTN	2	1					1	100%		
Retinal Hole/Tear	1	1					1	100%		
Suspicious Optic Nervehead(s)	1	0								
Toxoplasma Retinochoriochitis										
Thyroid Eye Disease										
Visual Field Defect	21	6					6	100%		
Vitreous Degeneration	2	1							1	100%
Other	314	98			5	5%	88	90%	5	5%
Total	**1,584**	**636 (40%)**	**9**	**1%**	**28**	**4%**	**553**	**87%**	**46**	**7%**

DRAFT

Houston Area
Ryan White HIV/AIDS Program
Assessment of the Administrative Mechanism

Part A and Minority AIDS Initiative (MAI)
Fiscal Year 2017

Prepared by
Houston Area Ryan White Planning Council
Office of Support
Approved:

Houston Area
Ryan White HIV/AIDS Program
Assessment of the Administrative Mechanism
Part A and Minority AIDS Initiative (MAI)
Fiscal Year 2017

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Background

The Ryan White CARE Act requires local Planning Councils to "assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area."[1] To meet this mandate, a time-specific document review of local procurement, expenditure, and reimbursement processes for Ryan White HIV/AIDS Program funds is conducted annually by local Planning Councils.[2] The observation process is not intended to evaluate either the local administrative agencies for Ryan White funds or the individual service providers funded by Ryan White.[3] Instead, it produces information about procurement, expenditure, and reimbursement processes for the local *system* of Ryan White funding that can be used for overall quality assurance purposes.

In the Houston eligible area, the Ryan White Planning Council has conducted an assessment of the administrative mechanism for Ryan White Part A and Minority AIDS Initiative (MAI) funds each fiscal year beginning in 2006. In 2012, the Planning Council began assessing the administrative mechanism for Part B and Texas State General Funds (State Services) as well. Consequently, the assessment tool used to conduct the assessment was amended to accommodate Part B and State Services processes. The new tool was developed and approved by the Quality Assurance Committee of the Planning Council on March 21, 2013 and approved by the Full Council on April 11, 2013.

Methodology

In July 2018, the approved assessment tool was applied to the administrative mechanism for Part A and MAI funds. The approved assessment tool will be applied to the administrative mechanism for Part B and State Services funds in November 2018. The contract periods designated in the tool are:

- Part A and MAI: March 1, 2017 – February 28, 2018 (FY17)
- Part B: April 1, 2017 –March 31, 2018 (FY 1718)
- State Services: Most recent completed FY

The tool evaluated three areas of each administrative mechanism: (1) the procurement and Request for Proposals (RFP) process, (2) the reimbursement process, and (3) the contract monitoring process. As outlined in the tool, 10 data points and their respective data sources were assessed for each administrative mechanism for the specified time frames. Application of the checklist, including data collection, analysis, and reporting, was performed by the Ryan White Planning Council Office of Support staff. All data and documents reviewed in the process were publicly available. Findings from the assessment process have been reported for each administration mechanism independently and are accompanied by the respective completed assessment tool.

[1]Ryan White Program Manual, Section V, Chapter 1, Page 4
[2]Ibid, Page 7
[3]Ibid, Page 8

Part A and Minority AIDS Initiative (MAI)
Contract Period: March 1, 2017 – February 28, 2018 (FY17)

Summary of Findings

I. Procurement/Request for Proposals Process

a) The Administrative Agent (**AA**) for Part A and MAI typically processes extensions of Part A and MAI contracts and positions with Commissioners Court prior to receipt of the Notice of Grant Award (**NGA**). As a result of this practice, 13 days elapsed between receipt of the initial NGA and extension of positions for FY17. Forty-two days elapsed between receipt of the initial NGA by the AA and contract execution with funded service providers, and there were no lapses in services to consumers.

b) Due to the extensions of Part A and MAI contracts and positions described in (a) above, 100% of the FY17 Part A and MAI grant award was procured to funded service providers by the first day of the contract period (3/1/17), or within the 1st quarter of the contract period. The AA procured Outreach Services following the final NGA, and Emergency Financial Assistance following receipt of MAI carryover funds. As such, the AA's timely procurement process resulted in no gaps in procured funds to service providers.

c) The AA procured funds in FY17 only to Planning Council-approved Service Categories. Moreover, the amounts of funds procured per Service Category at the beginning of the contract period matched Planning Council-approved final allocations for level funding for FY17. During the contract period, the AA applied Planning Council-approved policies for the shifting of funds within Service Categories, including application of the increased funding scenarios for Part A and MAI, billing reconciliations, and receipt of carry-over funds in approved categories.

d) Beginning in FY12, Part A and MAI services could be contracted for up to four years, with Service Categories rotated for bidding every three years. According to this schedule, bundled Community-Based and Rural Primary Medical Care, Local Pharmacy Assistance Program (LPAP), Medical Case Management, Service Linkage, Emergency Financial Assistance, and Outreach, along with urban and rural van-based Medical Transportation under Part A was slated for the Request for Proposal (RFP) process during FY17 for FY18 contracts. These Service Categories were competitively bid via a RFP process during the FY17 contract period for service contracts beginning in FY18.The RFP issued by the AA for these services contains information about the grant application process, which took place via the Harris County Purchasing Agent. The AA also held a pre-proposal conference for the RFP. These steps indicate that the AA maintained a grant award process that provided potential bidders with information on applying for grants through the Purchasing Agent as well as the opportunity to address questions prior to submission.

e) As described in (d) above, the AA issued an RFP during the FY17 contract period for these services that included the FY18 Planning Council-adopted Service Category definitions. This indicates that the AA maintained a grant award process that adhered potential bidders to Planning Council-approved definitions for contracted Service Categories.

f) The AA procured 100% of total service dollars for both Part A and MAI by the end of the contract period, including the addition of reconciliations and carry-over funds.

g) There were unspent service dollars in both Part A and MAI at the end of the FY17 contract period that occurred in Primary Care, Clinical Case Management, Medical Case Management, Outreach Services, Service Linkage, Medical Transportation, and Emergency Financial Assistance. The total amount of unspent service funds for both Part A and MAI was $1,083,345, or 5.0% of the total allocation for service dollars for the contract period. Ninety-eight percent (98%) of FY16 Part A service dollars and 89% of MAI service dollars were expended by the end of the fiscal year.

h) In FY16, the AA continued to communicate to the Planning Council the results of the procurement process, including agendizing procurement reports at Committee and Full Council meetings throughout the contract period.

II. Reimbursement Process

i) **Pending receipt of Final FY17 Annual Contractor Reimbursement Report (CER) Tracking Summary**

III. Monitoring Process

j) The AA continued to use the Standards of Care as part of the FY18 contract selection and monitoring process that took place in FY17, and clearly indicated this in various quality management policies, procedures, and plans, including the AA's Policy and Procedure for Performing Site Visits and the AA's current Quality Management Plan. Moreover, the RFP issued during the FY17 contract period states that the AA will monitor for compliance with Standards of Care during site monitoring visits of contracted agencies.

Administrative Assessment Checklist -- Part A and MAI		Contract Period: 3/1/17 - 2/28/18 (FY17)	
Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	• The Administrative Agent (**AA**) for Part A and MAI typically processes extensions of Part A and MAI contracts and positions with Commissioners Court prior to receipt of the Notice of Grant Award (**NGA**) in order to prevent lapses in services to consumers. • For the FY17 contract period, extensions of positions and contract renewals for Part A and MAI service providers were approved at Commissioners Court meetings on 1/31/2017. The Part A and MAI NGA was received on 1/18/17 (partial) and 6/16/17 (final), and agreements were executed at the Court meetings on 02/28/17, and amended to reflect the final NGA on 6/27/17 and 8/22/17. *Conclusion*: Because the AA rapidly processed contract and position extensions, 13 days elapsed between receipt of the initial NGA and extension of positions for FY17. Forty-two days elapsed between receipt of the initial NGA by the AA and contract execution with funded service providers.	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	FY17 Part A and MAI NGA (issued 1/18/17 and 6/16/17) Commissioner's Court Agendas (1/31/17, 2/28/17, 6/27/17, 8/22/17)
b) What percentage of the grant award was procured by the: ☒ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	• FY17 procurement reports from the AA indicate that all allocated funds in each Service Category except Outreach Services and Emergency Financial Assistance were procured by 3/1/17, the first day of the contract period. This is due to the contract and position extensions processed by the AA prior to receipt of the NGA, as described in (a) above. The AA procured Outreach Services on 7/1/17 following receipt of the final NGA, and Emergency Financial Assistance following receipt of MAI carryover funds on 12/1/17. *Conclusion*: Because of contract and position extensions processed by the AA in anticipation of the grant award, 100% of the Part A and MAI grant award was procured by the 1st quarter of the contract period, or upon receipt of carryover funds.	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	FY17 Part A and MAI Procurement Report provided by the AA to the PC (Printed 7/9/18)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
c) Did the awarding of funds in specific categories match the allocations established by the Planning Council?	• The Planning Council makes allocations per Service Category for each upcoming contract period based on the assumption of level funding. It then designs scenarios to be applied in the event of an increase or decrease in funding per the actual NGA. The Planning Council further permits the AA to re-allocate funds within Service Categories (up to 10%) without pre-approval throughout the contract period for standard business practice reasons, such as billing reconciliations, and to apply carry-over funds as directed. In addition, the Planning Council allows the AA to shift funds in the final quarter of the contract period in order to prevent the grantee from leaving more than 5% of its formula funds unspent. • The most recent FY17 procurement report from the AA (dated 7/9/18) shows that the Service Categories and amounts of funds per Service Category procured at the beginning of the contract period matched the final Planning Council-approved allocations for level funding for FY17, except for Emergency Financial Assistance. On 06/08/17, the Planning Council approved a motion to bundle Emergency Financial Assistance with Ambulatory Outpatient Medical Care and Local Pharmacy Assistance Program, and fund using MAI carryover funding. Upon receipt of the final NGA, the 10% reallocation rule described above was applied for the $115,275 (0.6%) decrease in Part A Formula and Supplemental. The AA applied the Increase Scenario to the $59,936 (2.9%) increase in MAI. As a result, total allocations for FY17 did not match the original level-funding allocations approved by the Planning Council, but MAI did match the Final FY17 Allocations Worksheet after application of the Increase Funding Scenario. *Conclusion*: The AA procured funds in FY17 only to Planning Council-approved Service Categories, and the amounts of funds per Service Category procured at the beginning of the contract period were a match to final allocations approved by the Planning Council for level funding. The AA applied Planning Council-approved policies for the shifting of funds within Service Categories during the contract period, including increased funding scenarios, billing reconciliations, and receipt of carryover funds.	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	FY17 Part A and MAI Procurement Report provided by the AA to the PC (Printed 7/9/18) PC Meeting Minutes (6/8/17) PC FY17 Allocations Level Funding Scenario Worksheet (7/14/16) PC Final FY17 Allocations Increase Scenario (6/14/16)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
d) Does the AA have a grant award process which: ☒ Provides bidders with information on applying for grants? ☒ Offers a bidder's conference?	• Beginning in FY12, Part A and MAI services could be contracted for up to four years, with Service Categories rotated for bidding every three years. According to this schedule, bundled Community-Based and Rural Primary Medical Care, Local Pharmacy Assistance Program (**LPAP**), Medical Case Management, Service Linkage, Emergency Financial Assistance, and Outreach, along with urban and rural van-based Medical Transportation under Part A was slated for the Request for Proposal (**RFP**) process during FY17 for FY18 contracts. • The RFP issued on 09/14/17 for the above Service Categories (Job No. 17/0278) contains information about the process for applying for grants through the Harris County Purchasing Agent (see, for example, "Vendor Instructions," page 9, and "Suggestions for Completing Proposals," page 24). • Moreover, the AA held a pre-proposal conference for the RFP on 10/24/17 with the stated purpose to "discuss and clarify the RFP requirements and answer vendor questions regarding the proposal review and award process." *Conclusion*: A review of the RFP issued in FY17 indicates that the AA has maintained a grant award process that provides potential bidders with information on how to apply for grants via the Harris County Purchasing Agent as well as the opportunity to address questions about the grant award process.	Confirmation of communication by the AAs to potential bidders specific to the grant award process	Part A and MAI RFP issued in FY17 for FY18 contracts - Job No. 17/0278 (09/14/17) Courtesy Notice for Pre-Proposal Conference in FY17 for FY18 contracts (10/24/17)
e) Does the REQUEST FOR PROPOSALS incorporate service category definitions that are consistent with those defined by the Planning Council?	• The RFP issued in FY17 (on 09/14/17) (Job No. 17/0278) for services to be contracted for FY18 includes the FY18 Planning Council-adopted Service Category definitions for this service category (see "Service Category Specifications," pages 36-69). *Conclusion*: The RFP issued in FY17 includes Service Category definitions that are consistent with those defined by the Planning Council.	Confirmation of communication by the AAs to potential bidders specific to PC products	Part A and MAI RFP issued in FY17 for FY18 contracts - Job No. 17/0278 (09/14/17)
f) At the end of the award process, were there still unobligated funds?	• The most recent procurement report produced on 7/9/18 shows that 100% of total service dollars for Part A and MAI were procured by the end of the contract period, including the addition of reconciliations and carry-over funds. *Conclusion*: There were no unobligated funds for the contract period.	Comparison of final amounts procured and total amounts allocated in each service category	FY17 Part A and MAI Procurement Report provided by the AA to the PC (Printed 7/9/18)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
g) At the end of the year, were there unspent funds? If so, in which service categories?	• The most recent FY17 procurement report produced on 7/9/18 shows unspent service dollars as follows: (i) Part A: $468,236 in unspent service dollars with less than 95% of the amount procured expended in the following Service Categories: Primary Care – CBO Targeted to White/MSM – 57% expended Primary Care – CBO Targeted to Rural – 91% expended Primary Care – Women at Public Clinic – 65% expended Primary Care – Pediatric – 74% expended Clinical Case Management – 76% expended Med. Case Management – Targeted to H/L – 63% expended Med. Case Management – Targeted to White/MSM – 82% expended Med. Case Management – Targeted to Rural – 82% expended Med. Case Management – Targeted to Women at Public Clinic – 42% expended Med. Case Management – Targeted to Pedi. – 60% expended Med. Case Management – Targeted to Veterans – 86% expended Outreach Services – 35% expended Service Linkage – Targeted to Newly Diagnosed/Not in Care – 85% expended Service Linkage – Public Clinic – 0% expended Med. Transportation – Targeted to Rural – 76% expended (ii) MAI: $615,109 with less than 95% of the amount procured expended in the following Service Categories: Primary Care – CBO Targeted to Hispanic – 79% expended Emergency Financial Assistance – 0% expended • The total amount of unspent service funds for both Part A and MAI in FY1 was $1,083,345, or 5.0% of the total service dollar allocation. *Conclusion*: There were $1,083,345 in unspent funds in Part A and MAI. The Service Categories listed above had less than 95% of the amount procured expended in FY17. Unspent funds represented 5.0% of the total FY17 Part A and MAI allocation for service dollars. Ninety-eight percent (98%) of FY17 Part A service dollars and 89% of MAI service dollars were expended by the end of the fiscal year.	Review of final spending amounts for each service category	FY17 Part A and MAI Procurement Report provided by the AA to the PC (Printed 7/9/18)

Section II: Reimbursement Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
h) Does the ADMINISTRATIVE AGENT have a method of communicating back to the Planning Council the results of the procurement process?	• The Memorandum of Understanding (MOU) (signed 3/1/12) between the CEO, Planning Council, AA, and Office of Support requires the AA to "inform the Council no later than the next scheduled [.] Steering Committee meeting of any allocation changes" (page 4). • In addition, FY17 Part A and MAI procurement reports from the AA were agendized for Planning Council meetings occurring on 11/09/17, 12/14/17, 03/08/18, and 06/14/18. Results of the procurement process were also provided during the AA report. *Conclusion*: The AA was required to and maintained a method of communicating back to the Planning Council the results of the procurement process, including agendized procurement reports to Committees and Full Council.	Confirmation of communication by the AAs to the PC specific to procurement results	Houston EMA MOU (signed 3/1/12) PC Agendas (11/09/17, 12/14/17, 3/08/18, 6/14/18)
i) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA? What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: ☐ Within 20 days? ☐ Within 35 days? ☐ Within 50 days?	****Pending receipt of Final FY17 Annual Contractor Reimbursement Report (CER) Tracking Summary****	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	****Pending receipt of Final FY17 Annual Contractor Reimbursement Report (CER) Tracking Summary****

Section III: Contract Monitoring Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
j) Does the ADMINISTRATIVE AGENT use the Standards of Care as part of the contract monitoring process?	• As described in (d) above, the AA issued an RFP during the FY17 contract period for bundled Community-Based and Rural Primary Medical Care, Local Pharmacy Assistance Program (**LPAP**), Medical Case Management, Service Linkage, Emergency Financial Assistance, and Outreach, along with urban and rural van-based Medical Transportation for FY18 contracts. Page 26 of the RFP states that the AA will monitor for compliance with the Standards of Care during site monitoring visits of contracted agencies. Directions to current Standards of Care document is also provided. • In addition, the AA's Site Visit Guidelines used during the FY17 contract period includes the process for reviewing compliance with Standards of Care. • The AA's Quality Management Plan (dated 1/17) states that the RWGA Clinical Quality Improvement Project Coordinator and Quality Management Development Project Coordinator both "[conduct] onsite QM program monitoring of funded services to ensure compliance with RWGA Standards of Care and QM plan" (Page 6). The Plan also states that "Annual site visits are conducted by RWGA at all agencies to ensure compliance with the standards of care" (Page 9). *Conclusion*: The AA used the Standards of Care as part of the contract monitoring process and clearly indicated this in its quality management policies, procedures, and plans.	Confirmation of use of adopted SOC in contract monitoring activities	Part A and MAI RFP issued in FY17 for FY18 contracts - Job No. 17/0278 (09/14/17) HCPH/RWGA Policy and Procedures for Performing Ryan White Part A Site Visits (Revised 03/17) HCPH/RWGA Quality Management Plan (1/17)

ADAP Eligibility Workers

See attached:

Presentation: *The Medication Jigsaw Puzzle (TRG's Pieces)*

Texas HIV Medication Program Formulary

Notice of Termination of Gilead Partnership with HarborPath

FY17/18 State Services Rebate Procurement Reports – dated 06/12/18 and 05/09/18

ADAP Enrollment Worker Service Definition – approved 06/15/17

The Medication Assistance Jigsaw Puzzle (TRG's Pieces)

Presenters:

Marcus Benoit

Patrick L. Martin

Houston HSDA
ADAP Enrollment Worker

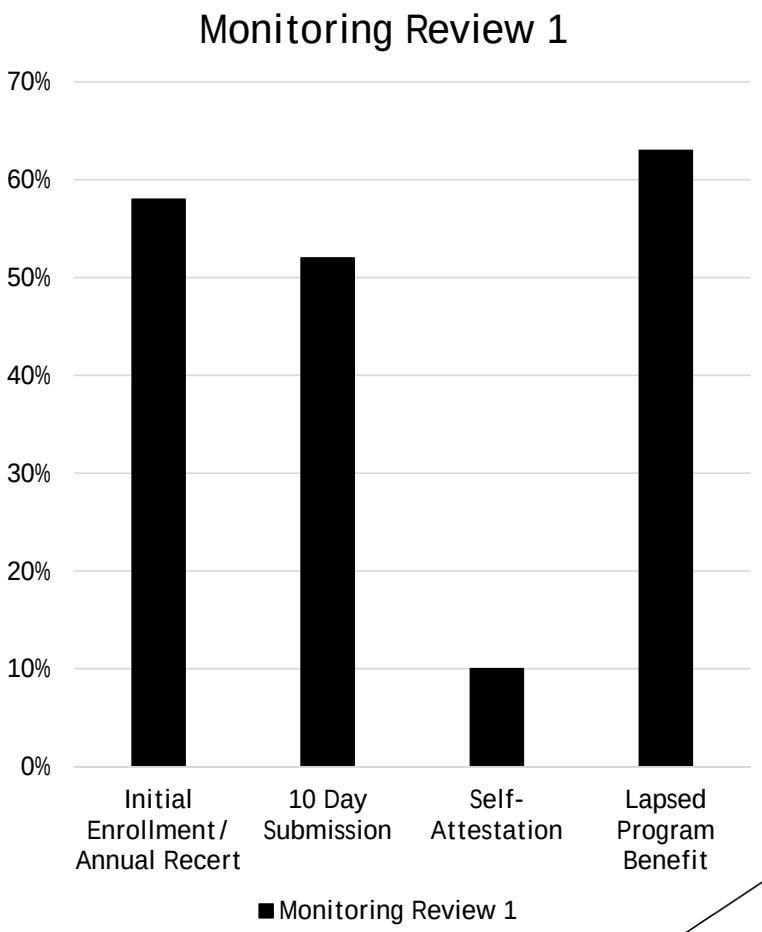
Presented by: Marcus Benoit, Ryan White Regional Liaison MSW, LBSW

The Call To Action

- In September 2016, The Houston Regional HIV/AIDS Resource Group (TRG) took on the role of monitoring, implementing, and providing technical assistance for the AIDS Drug Assistance Program in the Eastern Texas region (Rural & Houston HSDA). In January 2017, TRG added the Houston HSDA to the Ryan White ADAP Network. This included 12 none funded agencies; 7 agencies who directly assisted with ADAP applications and 4 support service;
  The areas of monitoring included:
  - Applications for Initial Enrollments
  - Annual Recertifications;
  - Self Attestation;
  - 10 days submission; and
  - Lapsed of Program Benefits.

Year 2017, for the months of March – July 31 the Houston ADAP Enrollment Pilot (HAEP) began with the 4 identified "Part A" Primary Care Providers (Houston HSDA) and 950 applications were received. These applications included Initial Enrollments, Annual Recertifications, and Self-Attestation. Data concluded that 58% of Initial Enrollments and Annual Recertifications applications were completed upon initial submission. 52% submitted within ten business days of initial contact and 10% of the Six Month Self-Attestation being complete. During this time 63% of the applications were documented as lapsed of their program benefits.

(Lapsed of Program Benefits means to be dropped from THMP due to incomplete and/or none submission of an Birthday Month Recertification, Half Birthday Month Self Attestation, or inactivity for 6 months).



Client Hold- When a client can not order medication from THMP due to outstanding items.

1. Bad Addresses (The address on file is undeliverable)
2. Client Half Birth month Self Attestation is not received and processed by due date (Due Date last day of the Half Birth month "30 days")
3. Client Birth month Recertification is not received and processed by due date (Due Date last day of the Birth month "30 days")
4. HMS Hold: Medications will be dropped due to possible insurance.
5. SPAP Coordinator will place clients on HOLD who has Medicare with an active Part D Plan.

**Holds can not be lifted until the outstanding item is received and processed*

Client Drop- When a client is removed from THMP:

1. Inactivity for 6 months of client not ordering medication
2. Market Place Insurance is gained by the client
3. Medicare Part D plan with full LIS
4. Medicaid, or Medicare is gained by client (at this point clients maybe switched to the TIAP program which pays insurance premiums).
5. Private insurance with prescription drug benefit that does not work with TIAP.
6. Client Half Birth month Self Attestation is not received and processed by the due date (Due Date is the last day of the following month "60 days")
7. Client Birth month Recertification is not received and processed. (Due Date is the last day of the following month "60 days")
8. Clients who complete their Birth Month Recertifications and exceed income guidelines (200% FPL)

CHALLENGES?

While conducting site visits, TRG identified the following challenges within the Houston HSDA agencies:

- No official application review process internally at agencies.
  - Caused barriers for clients as their Initial Enrollment, Recertification or Self Attestation were denied due to being incomplete and they were placed on HOLD or rejected.
- No official process to track the status of clients who were place on HOLD
  - Caused barriers for clients who needed refills of medications
- No official process to track clients Self Attestation or Annual Recertifications due dates
  - Caused barriers for clients who solely depended on the Texas HIV Medication Program for their Medications to be placed on HOLD and/or DROPPED
- Late follow up on clients applications submissions.
  - Caused barriers for clients who were approved but continue to order from the Patient Assistance Program (PAP).

Overall Identified Problems

A multitude of staff in various positions were responsible for completing and submitting applications. It was identified that the majority of staff had no review or follow process in place. No official structure or training was provided to staff who completed any parts of the ADAP process; One particular agency had 17 different staff members completing and submitting applications.

Resolution

After site visits were conducted and challenges were identified;

- TRG identified an ADAP point of contact at each agency while establishing a Memorandum of Understanding.
- TRG and DSHS also conducted multiple ADAP trainings and meetings with those individuals who were identified to create the Ryan White ADAP Network (RWAN). During these meetings and trainings, Technical Assistance and Updates were provided to assist agencies with bettering their ADAP processes.
- During the implementation of agencies ADAP processes, TRG performed monthly site visits, pilots, and monitoring in efforts to capture the agency's strengths and inefficacy's.

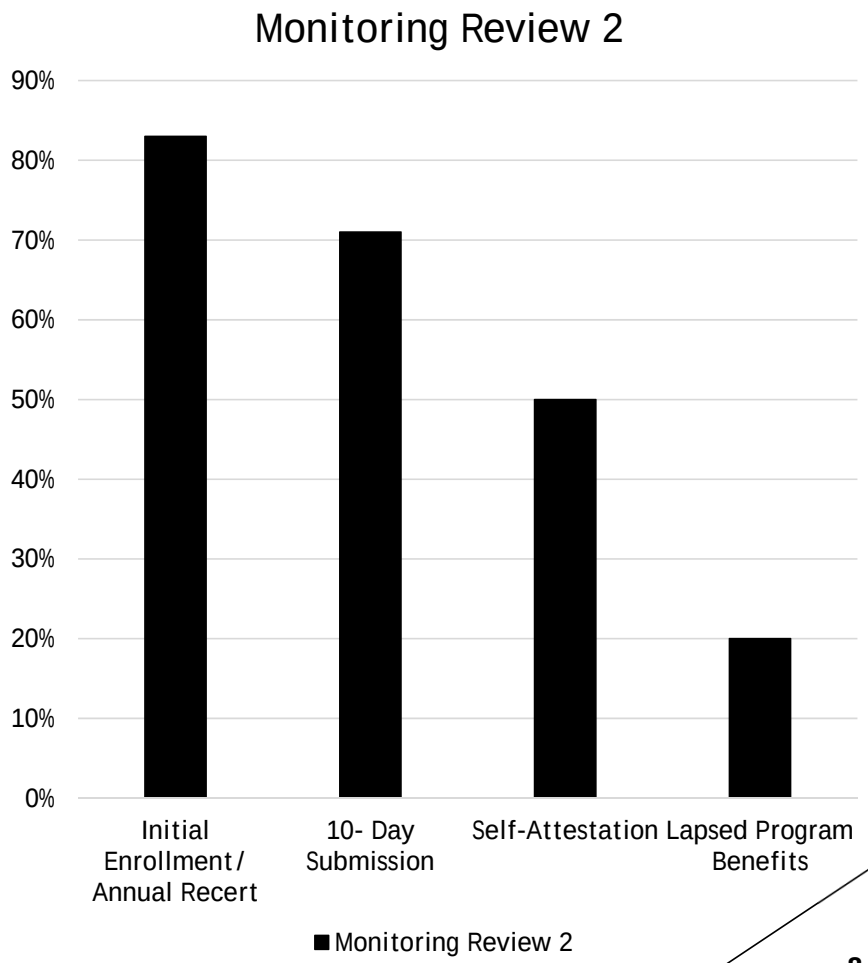
TRG GOAL

Provide and personalize recommendations and work one on one with agencies administrative and direct service staff to assist with their ADAP process internally. This would result in fewer clients Lapsing their Program Benefits and being place on HOLD or DROPPED from THMP.

Year 2017, for the months August, *September*, October, and November data concluded that the Houston HSDA area processed 1,100 applications. Overall, **83%** of Initial Enrollments and Annual Recertifications were completed and processed, reflecting a **25%** progression, with a **19%** progress for applications being submitted within ten business days of initial contact. **50% of the S**elf Attestations were identified complete and processed which showed a **40%** progression rate. Clients who Lapsed Program Benefits Decreased by **43%** which showed a all time low of only **20%** of clients lapsing.

September 1, 2017- AEW were funded in the Houston HSDA.

(Lapsed of Program benefits means to be dropped from THMP due to incomplete and/or none submission of an Birthday Month Recertification, Half Birthday Month Attestation, or inactivity for 6 months).



Birth of the AEW in Houston

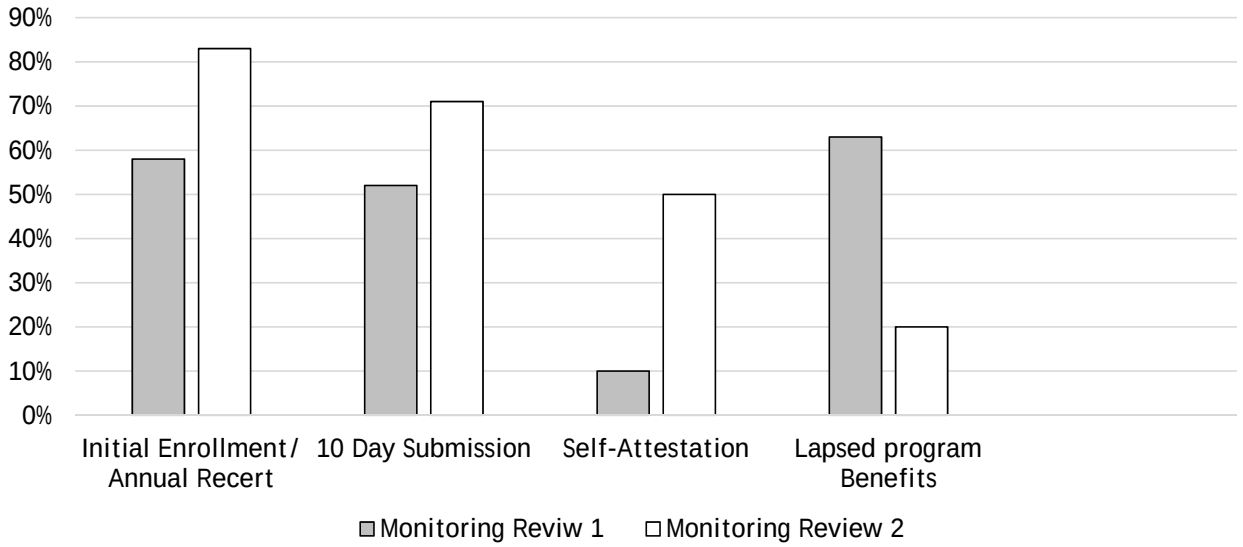
Role and Responsibilities:

ADAP Enrollment Worker:

- Assist clients with accessing ADAP services via in person, telephone, written, or other forms of communication.
- Meet with (if work flow allows) **ALL** potential and established ADAP clients and explain ADAP Program benefits/ requirement, assist with any parts of ADAP application process, and address any concerns the client my have.
- Obtain, maintain, and submit required documentation for clients ADAP applications including Residency, Income, Medical Certification Form (if applicable), and 3rd party insurance information.
- Review **ALL** submissions completed by other staff internally to ensure applications and documentation is efficient, complete, accurate, and ready to be submitted to the Texas HIV Medication Program (THMP) via the established method of submission.
- Promptly follow up with **ALL** applicants or staff regarding any incomplete, missing, or other needed information to ensure completed applications and documentation is submitted as quickly and feasible.
- Serve as the primary person to submit **ALL** ADAP related items from their agencies to THMP via the established method of submission.
- Follow up with **ALL** clients 60-90 days prior to their Birth Month Recertification and Half Birth Month Self Attestation to ensure clients are aware of their update time period.
- Ensure **ALL** clients have completed their Birth Month Recertification and Half Birth Month Self Attestation by the established deadline to ensure no Lapse or Loss of Program Benefits.
- Maintain communication with designated TMHP staff to quickly resolve any outstanding items to ensure client is not place on a Hold or Dropped.
- Track the status of **ALL** submissions to THMP via the most effective method.
- Ensure appropriate documentation is recorded into **ALL** clients primary record
- Ensure **ALL** clients Service encounters are entered into ARIES

Beginning September 01, 2017 the identified 4 Part A funded agencies received SSR funding for the AEW position.

Monitoring Review 1 VS Monitoring Review 2



Results

While having access to resources such as identifying;

- A point of contact, providing trainings, hiring an ADAP Enrollment Worker, continuous technical assistance and monitoring; the Houston HSDA has demonstrated progression related to indicators that correlate with the AIDS Drug Assistance Program.

- After the adoption of the ADAP Enrollment Worker agencies submission increased to **83% for** completed Initial Enrollment and Birth Month Recertifications applications versus **58%**.
- Previously, the Houston HSDA were only submitting **52%** of their applications within 10 business days. Now **71%** of the applications are being submitted within 10 business days which gives clients sooner access to the program and has a positive impact on Medication Adherence.
- Self-Attestation were identified as a barrier as the agencies were not completing this process which resulted in THMP not having the most current information for clients and in some cases clients being dropped. Once the Enrollment Worker was in place **50%** of Self-Attestations were being reported as complete compared to only **10%** in the past.
- **63%** of clients Lapsed Program Benefits which resulted in the client being dropped from THMP. The Houston HSDA has since decreased to **43%** of clients who Lapse in their program benefits.

The AEW is Charged with:

Achieving the program goals by ensuring at least 95% of Initial Enrollments are not only accepted but submitted within 1 business days via ARIES. Each agency and their AEW are accountable to demonstrate a minimum of 95% Birth Month Recertifications and Half Birth Month Self- Attestations before the Lapse of THMP program benefits.

ARIES Documentation Upload

Implemented in Houston HSDA 05/01/18

- Established guidelines and uniform practices for the completion and contents for the process of uploading ADAP applications into the AIDS Regional Information and Evaluation System (ARIES).
- Client-level documentation upload is established to ensure access to the Texas HIV Medication Program via online method of submission while adhering to Confidentiality requirements.
- Direct communication is achieved between the AEW and DSHS-ADAP team regarding clients status of approval or denial.
- Barriers for expediated clients as well as for all clients who are being Initially enrolled, completing their Half Birth Month Self Attestation, and Birth Month Recertification are alleviated.

The HarborPath Collaboration

Presented by:
Patrick L. Martin
Program Development Director
The Resource Group

Yes, I Know We Usually Don't Use Agency Names. . .

But this is collaboration not a traditional service category.

Genesis of the Collaboration

- The HarborPath Collaboration grew out a conversation between a RW service provider and DSHS about how DSHS could address the delay in the THMP Approval Process.
- At the time of the conversation, THMP had a backlog of applications (see previous slides in the ADAP Enrollment Worker Portion). The service provider had been utilizing HarborPath but their need far outstripped the capacity of HarborPath.
- DSHS brought together the service provider, Ryan White Grants Administration, The Resource Group and the Office of Support to discuss how funds could be used to address the capacity issue.
- A pilot project was proposed for the Houston area. Funds were targeted from State Service Rebate.

Initial Focus of the Collaboration

- The initial focus of the collaboration was to provide a low-cost alternative to utilizing other Ryan White dollars to cover the cost of medications until the patient could become eligible for THMP.
- *Caveat: The HarborPath Collaboration only covers medications that are on the THMP Formulary*.

Rollout, Success, and Expansion

- Houston Medical Providers were approached to participate in the pilot. Five providers became part of the collaboration. One provider opted not to participate.
- DSHS explored the possibility of each AA having a contract directly with HarborPath for their service area but the idea was discarded. TRG continues to serve as the "local" administrator of the funds statewide.
- DSHS decided to expand the collaboration across the entire state in 2018. HarborPath presented the collaboration as part of the Part A/B Meeting in Austin in February 2018.
- DSHS has established a "carve-out" of SS-R funds to cover the entire state.

Additional Focus of the Collaboration

- As the challenges with recertifications have become a barrier, the collaboration can be used to fill the gap in service that might occur when patients do not successfully complete the recertification process.
- This is possible since SS-R funds are not limited by RW EFA restrictions.

Service Utilization in Houston HSDA

- Between 7/1/2017–6/30/2018, the HarborPath Collaboration has provided 341 unduplicated clients in the Houston HSDA with 876 units of service.

How Does It Work?

- Clinics become partners of the collaboration.
  - HarborPath and each clinic execute a HIPAA-compliant business agreement
  - The clinic completes set-up paperwork (doctors who will be prescribing, case managers/staff who will be registering patients, etc.)

How Does It Work?

- HarborPath provides the only web-based portal with a single application, allowing healthcare professionals to efficiently apply for multiple medications on behalf of their uninsured patients living with chronic and life-threatening diseases, including HIV/AIDS and hepatitis C.
- Healthcare professionals enter patient eligibility data ONCE into HarborPath's secure, HIPAA-compliant portal to generate ONE application for multiple medications.
- A 30-day supply of a patient's medications ships directly from HarborPath's contracted mail-order pharmacy to the patient or healthcare facility. The HarborPath portal allows healthcare professionals to securely log in and track up-to-the-minute prescription refill and delivery status.

How Does It Work?

- Online PAP Application via the HarborPath portal
  - Healthcare professionals enter patient eligibility data once into fields of common application form
  - Site prompts for eligibility data and documentation
- Eligibility via HarborPath portal system:
  - Processes and provides immediate notification of eligibility for participating PAP programs
  - Auto-populates and generates hard copy application for non-participating PAP programs for healthcare professionals to submit separately

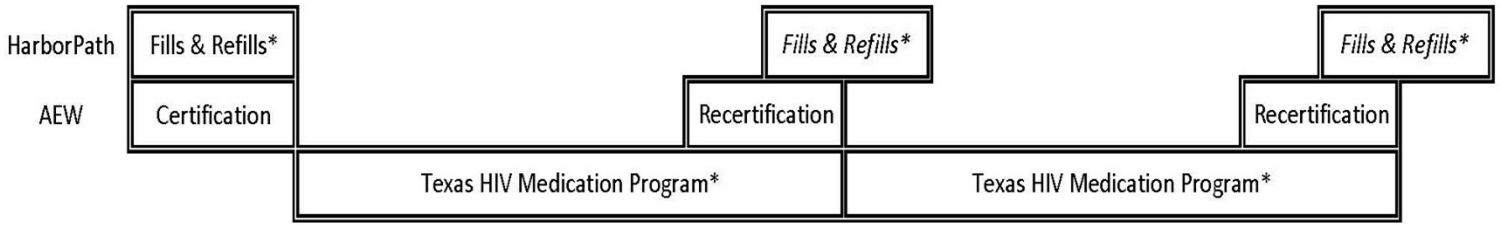
How Does It Work?

- Documentation And Portal Tracking
  - Healthcare professionals upload or fax eligibility documentation and medication script
  - Healthcare professionals can log in to the portal to view the status of an application or shipment
- Pharmacy Services
  - All medications are shipped directly to the patient or healthcare facility
- Medication Adherence
  - Online refills, IVR and personal customer service help healthcare professionals provide prompt refills

Changes In the Collaboration

- Gilead has decided to focus its support on its own Advancing Access Program (AAP).
  - No new patient enrolled in HarborPath as of July 1st.
  - Existing patients will be transferred to AAP by September 30th.
- HarborPath is adding new one-pill regimens.

How Do TRG's Pieces Fit Together?



*Only covers medications on the approved THMP Formulary

Questions??

TEXAS HIV MEDICATION PROGRAM FORMULARY

Antiretroviral Medications

Reverse Transcriptase Inhibitors (RTIs)
didanosine (generic of Videx, DDI)
stavudine (generic of Zerit, D4T)
zidovudine (generic of Retrovir, AZT)
lamivudine (generic of Epivir, 3TC)
abacavir (generic of Ziagen 300)
Emtriva (emtricitabine)
Combivir (AZT 300/3TC 150)*
Epzicom (3TC 300/abacavir 600)
Trizivir (AZT 300/3TC 150/abacavir 300)
Truvada (tenofovir TDF/emtricitabine)
Descovy (tenofovir TAF/emtricitabine)

Protease & CYP3A Inhibitors
Invirase (saquinavir)
Norvir (ritonavir)
Crixivan (indinavir)
Viracept (nelfinavir)
Kaletra (lopinavir/ritonavir)
Reyataz (atazanavir)
Lexiva (fosamprenavir)
Aptivus (tipranavir)
Prezista (darunavir)
Tybost (cobicistat)
Evotaz (atazanavir/cobicistat)
Prezcobix (darunavir/cobicistat)

Non-Nucleoside RTIs
Viramune (nevirapine)*
Rescriptor (delavirdine)
Sustiva (efavirenz)
Intelence (etravirine)
Edurant (rilpivirine)

Nucleotide RTI
Viread (tenofovir TDF)

Integrase Inhibitors
Isentress (raltegravir)
Isentress HD (raltegravir 600 mg)
Tivicay (dolutegravir)
Vitekta (elvitegravir)

Entry & Fusion Inhibitors
Fuzeon (enfuvirtide)
Selzentry (maraviroc)

Single Tablet ARV Regimens
Atripla (efavirenz/emtricitabine/tenofovir TDF)
Complera (emtricitabine/rilpivirine/tenofovir TDF)
Stribild (tenofovir TDF/emtricitabine/elvitegravir/cobicistat)
Triumeq (abacavir/dolutegravir/lamivudine)
Genvoya (tenofovir TAF/emtricitabine/elvitegravir/cobicistat)
Odefsey (emtricitabine/rilpivirine/tenofovir TAF)
Juluca (dolutegravir/rilpivirine)
Biktarvy (Bictegravir/emtricitabine/tenofovir alafenamide

Other Medications

acyclovir (generic of Zovirax)
atovaquone (Mepron)
azithromycin (generic of Zithromax)
clarithromycin (generic of Biaxin)
Dapsone
ethambutol (generic of Myambutol)
fluconazole (generic of Diflucan)
itraconazole (generic of Sporanox)
leucovorin calcium
megesterol acetate OS (generic of Megace)
pentamidine (Nebupent)
pyrimethamine (Daraprim)
rifabutin (generic of Mycobutin)
sulfamethoxazole/trimethoprim (SMZ/TMP DS)
valacyclovir (generic of Valtrex)
Egrifta (tesamorelin acetate P/F)

clindamycin
clotrimazole troche
famciclovir (generic of Famvir)
Gynazole (butoconazole) topical cream
isoniazid
Monistat (tioconazole) topical cream
Mytesi (crofelemer)
nystatin oral suspension
Oravig (miconazole) buccal tablets
prednisone
primaquine phosphate
rifampin
sulfadiazine
terconazole topical cream
voriconazole
valganciclovir (Valcyte)

HCV Direct-Acting Antiviral Pilot Program

Zepatier (elbasvir/grazoprevir)
Viekira XR (ombitasvir/paritrprevir/ritonavir/dasaburvir)
Ribavirin
Daklinza (daclatasvir)
Epclusa (sofosbuvir/velpatasvir)

Harvoni (ledipasvir/sofosbuvir)
Mavyret (glecaprevir/pibrentasvir)
Sovaldi (sofosbuvir)
Technivie (ombitasvir/paritaprevir/ritonavir)
Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

*Please note that the THMP provides the generic versions of formulary medications for specific strengths & formulations when consistently available. Due to stocking and purchasing limitations the THMP cannot provide brand name equivalents upon demand once generic equivalents of a formulary item are readily available and currently stocked by the program. Certain items may not be obtainable on the formulary at all times due to manufacturer production shortages.

Revised April 2018

NOTICE OF TERMINATION OF GILEAD PARTNERSHIP WITH HARBORPATH

Dear

Gilead Sciences has notified HarborPath that the company is ending its participation in the HarborPath program. Effective July 1, 2018, Gilead will no longer provide products to NEW patients through the HarborPath program. Currently enrolled patients will be able to order refills through September 30, 2018. Therefore, please note that no Gilead products will be made available through the HarborPath program after September 30, 2018.

Gilead's Advancing Access Program is available to your eligible patients. Please contact Gilead directly with any questions at 1-800-226-2056 or via www.gileadadvancingaccess.com.

Our mission remains steadfast, and since 2012, we have helped patients living with chronic illnesses obtain their life-saving medicines. We want to assure you that HarborPath, along with our other pharmaceutical company partners, are committed to continue to serve your uninsured patients with their medication needs.

Sincerely,

Ken Trogdon
President

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1718 DSHS State Services Rebate

Procurement Report

September 1, 2017- August 31, 2018

Chart reflects spending through April 2018

Spending Target: 67%

Revised 6/12/2018

Priority	Service Category	Original Allocation per	% of Grant	Amendment	Contractual Amount	% of Grant	Date of Original	Expended YTD	Percent YTD
6	ADAP Eligibility Worker (1)	$375,000	38%		$375,000	38%	9/1/2017	$102,987	27%
7	Emergency Financial Assistance (2)	$600,000	62%		$600,000	62%	9/1/2017	$156,521	26%
	Total Houston HSDA	**975,000**	**100%**	$0	$975,000	100%		259,507	27%

Note: Spending variances of 10% will be addressed

1 2 of 5 positions are unfilled; This is a start-up project and all positions were new hires.

2 Contract was implemented late; The public clinic has yet to utilize services, however, DSHS has expanded statewide. Expenditures has increased.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1718 DSHS State Services Rebate

Procurement Report

September 1, 2017- August 31, 2018

Chart reflects spending through March 2018

Spending Target: 58%

Revised 5/9/2018

Priority	Service Category	Original Allocation per	% of Grant	Amendment	Contractual Amount	% of Grant	Date of Original	Expended YTD	Percent YTD
6	ADAP Eligibility Worker	$375,000	38%		$375,000	38%	9/1/2017	$199,361	53%
7	Emergency Financial Assistance**	$600,000	62%		$600,000	62%	9/1/2017	$123,976	21%
	Total Houston HSDA	975,000	100%	$0	$975,000	100%		323,337	33%

Note: Spending variances of 10% will be addressed

** The public clinic is yet to utilize services, however, DSHS has expanded statewide.

Service Category Definition - DSHS State Services-R

FY 2017 Houston EMA/HSDA State Services-R Service Definition **AIDS Drug Assistance Program Enrollment Worker at RW Care Sites** (Created Date: 4/5/2017)	
DSHS Service Category Title: **TRG Only**	Referral For Health Care/Support Services
Local Service Category Title:	A. Clinic-Based ADAP Enrollment Service Linkage Worker
Budget Type: **TRG Only**	Categorical: 1 FTE per RW Care Site; unless advised otherwise
Budget Requirements or Restrictions: **TRG Only**	Maximum of 10% of budget for Administrative Costs. A Full-Time Equivalent must be proposed at each clinic.
DSHS Service Category Definition: **TRG Only**	***ADAP Enrollment Worker*** Direct a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	C. **PROPOSED:** AIDS Drug Assistance Program (ADAP) Enrollment Service Linkage Workers (SLWs) are collocated at Ryan-White Part A funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment SLWs will meet with new potential and established ADAP enrollees, explain ADAP program benefits and requirements, assist clients and or staff with the submission of complete, accurate ADAP applications. ADAP enrollment SLWs will ensure all annual Re-Certifications are submitted by the last day of the client's birth month and semi-annual Attestations are completed six months later to ensure there is no lapse in ADAP eligibility and loss of benefits. Other responsibilities will include: • Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible; • Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible; ADAP Enrollment workers will maintain relationships through the Ryan White ADAP Network (RWAN). Guidelines and or instructions will vary according to agency internal processes and as agreed upon by the AA.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Meet with new potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist clients and or staff with the submission of complete, accurate ADAP applications, including but not limited to: • Identifying and screening clients including screening for third party payer and potential abuse; completing the comprehensive THMP intake including determination of client eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI).

	• Obtain, maintain, and submit the required documentation for client application including residency, income, and the THMP Medical Certification Form (MCF). • Conduct the 6-month attestations for all enrolled clients in accordance with THMP policies. Obtain, maintain, and submit to THMP all updated eligibility documentation. • Conduct annual Re-Certifications for enrolled clients in accordance with THMP policies. Obtain, maintain, and submit to THMP all updated eligibility documentation. • Proactively contact current ADAP enrollees 60-90 days prior to the enrollee's re-certification or attestation deadline to ensure all necessary documentation is gathered to complete the re-certification/attestation on or before the deadline. • Ensure annual Re-certifications are submitted by the last day of client's birth month and semi-annual Attestations are completed six months later to ensure there is no lapse in ADAP eligibility and loss of benefits. Provide initial education to applicants about the THMP including, but not limited to: • Discuss the confidentiality of the process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the client. Applicants should realize that their physician and pharmacist would also be aware of their diagnosis. • Discuss how applicants who have been approved by the THMP for assistance may be required to pay a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee. • Discuss how applicants who are eligible for Medicaid assistance benefits must first utilize and exhaust their monthly Medicaid pharmacy benefits in order to be eligible to receive medications from the Program. Medicaid eligible applicants shall be assigned to the nearest available participating THMP pharmacy outlet to receive medication. The pharmacy will not charge the $5.00 co-payment to the patient. • Discuss the use of participating pharmacies and the procedure for how applicants will receive medications through the program. Submit completed applications via the most efficient method available (e.g. the Public Health Information Network or PHIN), including ARIES, once the document upload capability is rolled out. Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible. Participate in ongoing training and technical assistance provide by DSHS, THMP, or the RWAN.
Service Unit Definition(s): **TRG Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Adjusted gross income less than 200% of the Federal Poverty Level* (adjusted annually).

	** A spend-down calculation is applied to applicants' gross incomes to determine an adjusted gross income for eligibility screening.* DSHS THMP Eligibility requirements https://www.dshs.texas.gov/hivstd/meds/
Client Eligibility:	Proof of Texas residency; Proof of being HIV-positive; Uninsured or underinsured for prescription drugs; and under the care of a Texas-licensed physician who prescribes the medication(s). DSHS THMP Eligibility requirements https://www.dshs.texas.gov/hivstd/meds/
Agency Requirements:	Agency will ensure documentation meets TDSHS and Agency requirements all activities performed on behalf of ADAP enrollees including re-certifications and attestations Agency will track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible. Agency will ensure that completed applications undergo secondary review by a peer ADAP Enrollment Worker or Supervisor before submission. This peer or supervisor must meet all requirements of the ADAP enrollment service linkage worker, including required training. Agency will provide aggregated data regarding ADAP enrollment service linkage worker performance measures to TRG as directed.
Staff Requirements:	**Education:** To be defined locally, but must have at minimum a high school degree or equivalency; **Experience:** • Must have documented experience (paid, internship and/or as a volunteer) working with Persons Living with HIV/AIDS or other chronic health conditions. • Experience in performing intake/eligibility, referral/linkage and/or basic assessments of client needs preferred. **Skills**: • Must demonstrate proficiency in the use of PC-based word processing and data entry to ensure ADAP applications and re-certifications are completed accurately in a timely manner; • Must demonstrate the ability to quickly establish rapport with clients in a respectful manner consistent with the health literacy, preferred language, and culture of prospective and current ADAP enrollees; • Must demonstrate general knowledge of, or the ability to learn, health care insurance literacy (third party insurance and Affordable Care Act (ACA) Marketplace plans); • Bilingual (English/Spanish) preferred; • AEWs working in care systems with a high prevalence of non-English speaking clients must be fluent in the preferred language of the high prevalence non-English speaking clients; **Training:** • Must complete all THMP ADAP training modules within 30 days of hire; • Must complete all training required of Agency new hires, including any training required by TDSHS HIV Care Services Branch Standards of Care, within established timeframes;

	• Must complete all annual or periodic training or re-certifications within established timeframes;
Special Requirements: **TRG Only**	There will be 1 FTE; unless advised otherwise, placed at each funded Part A primary care clinic. Meet the established guidance by DSHS for the ADAP Enrollment Worker. Follow the HHSC Uniform Terms and Conditions. THMP regards all information in the application as confidential. No information that could identify a client (including 11-character codes) will be released, except as allowed by law or as specifically designated by the client. THMP regards the information in the application as part of the applicant's medical record. Funded agencies should have physical security and administrative controls to safeguard the confidentiality of the applications and other means of identifying the individual. Applications can be expedited for pregnant women, post-incarcerated persons, minors, those with CD4 counts under 100, and other special circumstances. Eligibility and access to medications for newborn infants and pregnant women is considered a program priority. <u>Required Performance Measures</u> 1. Enroll all ADAP-eligible clients in Texas HIV Medication Program (THMP) within 30 days of initiation of care. 2. Recertify all existing clients in THMP without lapse in coverage. 3. Maintain 95-100% approval rate for initial application submissions 4. Maintain 100% Ryan White Eligibility for all Ryan White clients at the contracted agency. 5. Ensure that up-to-date eligibility information (in compliance with established guidance) is maintained for all clients served. 6. Maintain relationships through the Ryan White ADAP/Eligibility Network (RWAN) to ensure all clients on ADAP in the HSDA are submitting accurate application 7. Utilize CPCDMS and Texas PHIN databases.

Service Linkage Worker Positions Related to Substance Abuse Treatment

See attached:

Public Comment – summary of the need

Public Comment – suggestions re: service definition

Public Comment – suggestions re: above suggestions

Service Linkage Worker Service Definition – DRAFT as of 06/07/18

PUBLIC COMMENT

Submitted 02-13, 2018
From email to Office of Support and Ryan White Grant Administration

Subject: Update on Substance Abuse Block Grant funds

There is legislation attached to this block grant that set aside 5% of the funding for HIV services for substance users. Due to poor wording in the enabling legislation from 1987 setting aside 5% of the block grant for HIV services, Texas has fallen under the AIDS case threshold for this set aside. (They used AIDS cases instead of HIV surveillance numbers.) The Center receives $1,332,214 for case management and outreach from this source. The set aside will end 8.31.19. We have been in conversations with the state about how this funding can be repurposed to capture the training and expertise that the staff has gained in the 22 years we have had this set aside but it will not be for HIV. We have 4 clinical case managers and part of a supervisor serving current or former substance users and those in treatment. AAMA has 1 plus part of a supervisor. We would like the council and grants administration to know this so that when the next round of allocations are done, they will understand that these positions will be lost starting 9.1.19. Please let me know what information you need to brief the council.

--

Ann J. Robison, PhD
Executive Director
The Montrose Center

PUBLIC COMMENT – as of 06/08/18

The Office of Support received the following comments regarding the proposed service definition for Service Linkage targeted to PLWHA receiving Outpatient Substance Abuse Treatment.

Under Local Service Category Title: These clients are not all in treatment or counseling. The language DSHS uses is this: Persons living with HIV disease with co-occurring substance use disorder issues. They have required consumers to be in substance use disorder support services which can include treatment, counseling, community support groups (12-step and similar), and/or recovery support services. Consumers need to be able to define their path to sobriety and treatment only is too restrictive not to mention the volume of treatment that can be done at one location. It also only last for a defined period of time and consumers eligible for this case management cannot be dropped when they finish treatment. There is an ongoing support that is needed. The target needs to be about the condition and then the workers co-located with treatment and recovery services.

"Service Linkage targeted to PLWHA receiving Outpatient Substance Abuse Treatment/Counseling in the Houston EMA/HDSA" would be better as "Service Linkage targeted to PLWHA with co-occurring substance use disorder issues receiving substance use disorder support services which can include treatment, counseling, community support groups (12-step and similar), and/or recovery support services co-located with a SUD treatment and recovery support provider in the Houston EMA/HDSA"

Under Target Population: Same edits as Local Service Category Title.

Under Agency requirements: "Service Linkage targeted to PLWHA receiving Outpatient Substance Abuse Treatment/Counseling" would be better is if said "Service Linkage targeted to PLWHA with Substance Use Disorder and receiving Outpatient Substance Abuse Treatment/Counseling and/or recovery support services"

"Substance Abuse Treatment/Counseling: Agency must be appropriately licensed by the State for substance abuse treatment/counseling. **All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse.**

Provider must provide a written plan no later than March 30th documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA." The bolded part doesn't seem right. This service category is not for the treatment itself. So referencing that the agency has to be licensed is good but the funding part is irrelevant since SLW is not funded by insurance or treatment. The italicized part references the HIV Early Intervention funded program which is the entire point of this request since the funding that is losing it's set aside is the HEI program.
Everything else seems right. Thanks for having this available for comment.

FROM: Ann Robison PhD, Executive Director, the Montrose Center

RESPONSE TO PUBLIC COMMENT RE: SLW TARGETING SUBSTANCE ABUSE TREATMENT SERVICE DEFINITION

as of 06/14/18

Just some points of clarification based on Ann's public comment today. My intent of the services definition is not to require that clients receiving this target non-medical case management be receiving substance abuse treatment/ counseling, but that the service be offered only with a providers that can offer substance abuse treatment/counseling. So **All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards...**can be changed to **All substance abuse treatment/counseling services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards.** The bolded insurance references can be omitted.

Provider must provide a written plan no later than March 30th documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA." should remain because if this funding becomes available again in our EMA, we want to be made aware.

Don't know if you want to just have me speak to this at QI or include it in materials. Probably just speak to it?

Carin

Carin Martin, MPA
Program Manager
Ryan White Grant Administration
Phone: 713.439.6041
Please note my email has changed:
Email: carin.martin@phs.hctx.net

FY 2019 Houston EMA/HSDA Ryan White Part A Service Definition **Service Linkage at Outpatient Substance Abuse Provider** (Revision Date: 060718)	
HRSA Service Category Title: **RWGA Only**	Non-medical Case Management
Local Service Category Title:	Service Linkage targeted to PLWHA receiving Outpatient Substance Abuse Treatment/Counseling in the Houston EMA/HDSA
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. Substance Abuse Treatment/Counseling cannot be billed under this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Local Service Category Definition:	**A.** ***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. **B.** ***Service Linkage:*** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with substance abuse treatment/counseling personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients

	are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Service Linkage:** Services will be available to eligible HIV-infected clients receiving co-located Outpatient Substance Abuse Treatment/Counseling residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	**Goal:** The expectation is that a single Service Linkage Worker Full Time Equivalent (FTE) targeting PLWHA receiving Outpatient Substance Abuse Treatment/Counseling can serve approximately 80 PLWHA per year. The purpose of **Service Linkage** is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. **Service Linkage** is a working

	agreement between a client and a Service Linkage Worker (SLW) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of **Service Linkage** is to assist clients who do not require the intensity of *Clinical or Medical Case Management*, as determined by RWGA Quality Management guidelines. **Service Linkage** is both office- and field-based and **may include the issuance of bus pass vouchers and gas cards per published guidelines.** Service Linkage targeted PLWHA receiving Outpatient Substance Abuse Treatment/Counseling extends the capability of existing programs with a documented track record of PLWHA receiving Outpatient Substance Abuse Treatment/Counseling by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of completion of substance abuse treatment services. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHA receiving co-located Outpatient Substance Abuse Treatment/Counseling residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPHES/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. **Service Linkage** targeted to PLWHA receiving Outpatient Substance Abuse Treatment/Counseling must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with

	men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers. **Substance Abuse Treatment/Counseling:** Agency must be appropriately licensed by the State for substance abuse treatment/counseling. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan no later than March 30th documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	*Must comply with applicable HCPHES/RWGA published Ryan White Part A/B Standards of Care:* <u>Minimum Qualifications:</u> **Service Linkage Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. <u>Supervision:</u> The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.

Special Requirements: **RWGA Only**	**Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

FY 2015 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/12/2014**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/05/2014**
Recommendations:	Approved: Y: X No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/14/2014**
Recommendations:	Approved: Y: X No: _____ Approved With Changes:_____	If approved with changes list changes below:
1. Accept workgroup recommendations.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**		Date: **04/07/2014**
Recommendations:	Financial Eligibility: None	
1. Accept the service category definition as presented and keep the financial eligibility the same.		
2.		
3.		

2018 Quarterly Report
Quality Improvement Committee
(July 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

FYI

HIV Communication: Using Preferred Language to Reduce Stigma[1]

Stigmatizing	Preferred
HIV-infected person HIV or AIDS patient AIDS or HIV carrier Positives or HIVers	Person living with HIV. Do not use "infected" when referring to a person. Use *People First* language, which emphasizes the person, not their diagnosis
Died of AIDS, to die of AIDS	Died of AIDS-related illness, AIDS-related complications or end-stage HIV
AIDS virus	HIV (AIDS is a diagnosis, not a virus; it cannot be transmitted)
Full-blown AIDS	There is no medical definition for this phrase; simply use the term AIDS, or Stage 3 HIV
HIV virus	This is redundant; use HIV
Zero new infections	Zero new HIV acquisitions or transmissions
HIV infections	HIV transmissions, diagnosed with HIV, people living with HIV
HIV-infected	Living with or diagnosed with HIV; or contracted or acquired HIV
Number of infections	Number diagnosed with HIV, or number of HIV acquisitions
Became infected	Contracted, acquired, diagnosed with HIV
HIV-exposed infant	Infant exposed to HIV
Serodiscordant couple	Serodifferent, magnetic, or mixed-status couple
Mother-to-child transmission	Vertical transmission, perinatal transmission
Victim, Innocent victim, Sufferer Contaminated or infected	Person living with HIV (never use the term "infected" when referring to a person)
AIDS orphans	Children orphaned by loss of parents or guardians, who died of AIDS related complications
AIDS test	HIV test
To catch AIDS, to contract AIDS Transmit AIDS, to catch HIV	An AIDS diagnosis, developed AIDS, to contract HIV (AIDS is a diagnosis, which cannot be passed from one person to the next)
Compliant	Adherent
Prostitute or prostitution	Sex worker, sale of sexual services, transactional sex
Promiscuous	This is a value judgment and should be avoided; instead use: having multiple partners
Unprotected sex	Condomless sex with PrEP, or condomless sex without PrEP, sex not protected by condoms, sex not protected by antiretroviral prevention methods

[1] Source: *HIV is Not A Crime II National Training Academy* program booklet (May 2016). Authors are Vickie Lynn and Valerie Wojciechowicz, both women openly living with HIV.

Death sentence, fatal condition, or life threatening condition	HIV is a chronic health condition, a manageable health condition (as long as people are in care and on treatment)
"Tainted" blood, dirty needles	Blood containing HIV, shared needles
Clean, as in "I am clean. Are you?"	Referring to yourself or others as being "clean" suggests that those living with HIV are dirty. Avoid this term
"a drug that prevents HIV infection"	A drug that prevents the transmission of HIV
End HIV, End AIDS	End HIV transmission. Be specific: are we ending HIV or AIDS?

Resources Regarding the Appropriate Use of Language

Dilmitis S, Edwards O, Hull B et al (2012). Language, identity, and HIV: why do we keep talking about the responsible and responsive use of language? Language matters. Journal of the International AIDS Society, 15 (Suppl 2)

Kaiser Family Foundation. Reporting Manual on HIV/AIDS

UNAIDS (2015) Terminology Guidelines

UNESCO (2006) Guidelines on Language and Content in HIV- and AIDS-related Materials

Language of Recovery

Current Terminology	Alternative Terminology
Treatment is the goal; Treatment is the only way into Recovery	Treatment is an opportunity for initiation into recovery (one of multiple pathways into recovery)
Untreated Addict/Alcoholic	Individual not yet in Recovery
Substance Abuse	Substance Use Disorder/Addiction/ Substance Misuse
Drug of Choice / Abuse	Drug of Use
Denial	Ambivalence
Relapse Prevention	Recovery Management
Pathology Based Assessment	Strength / Asset Based Assessment
Focus is on total abstinence from all illicit and non-prescribed substances the CLINICIAN identifies	Focus on the drug CLIENT feels is creating the problems
A Drug is a Drug is a Drug	Each illicit substance has unique interactions with the brain; medication if available is appropriate.
Relapse	Recurrence/Return to Use
Relapse is part of Recovery	Recurrence/Return to Use may occur as part of the disease
Clean / Sober	Drug Free / Free from illicit and non-prescribed medications
Self Help Group	Mutual Aid Group
Drug Overdose	Drug Poisoning
Graduate from Treatment	Commence Recovery

Revised
7/16
cfd

The Most Respectful Way of Referring to People is as People

Current	Alternative	Reasoning
Clients / Patients / Consumers	The people in our program The folks we work with The people we serve	More inclusive, less stigmatizing
Alex is an addict	Alex is addicted to alcohol Alex is a person with a substance use disorder Alex is in recovery from drug addiction	Put the person first Avoid defining the person by their disease
The terms listed below, along with others, are often people's ineffective attempts to reclaim some shred of power while being treated in a system that often tries to control them. The person is trying to get their needs met, or has a perception different from the staff, or has an opinion of self not shared by others. And these efforts are not effectively bringing them to the result they want.		
Mathew is manipulative	Mathew is trying really hard to get his needs met Mathew may need to work on more effective ways of getting his needs met	Take the blame out of the statement Recognize that the person is trying to get a need met the best way they know how
Kyle is non-compliant	Kyle is choosing not to… Kyle would rather… Kyle is looking for other options	Describe what it looks like uniquely to that individual—that information is more useful than a generalization
Mary is resistant to treatment	Mary chooses not to… Mary prefers not to… Mary is unsure about…	Avoid defining the person by the behavior. Remove the blame from the statement
Jennifer is in denial	Jennifer is ambivalent about…… Jennifer hasn't internalized the seriousness of…. Jennifer doesn't understand……	Remove the blame and the stigma from the statement

Southeast (HHS Region 4)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

PhoenixCenter
Prevent · Treat · Recover

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FACES AND VOICES OF RECOVERY