Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, October 15, 2019
Meeting Location: 2223 W. Loop South, Room 416; 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
(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/MAI: — Carin Martin
      1. FY 2019 Procurement, dated 08/22/19
      2. FY 2019 Service Utilization, dated 09/06/19
   B. Ryan White Part B and State Services — Patrick Martin
      1. FY 19/20 Procurement Part B, dated 09/26/19
      2. FY 18/19 Procurement State Services, dated 09/26/19
      3. FY 18/19 Service Utilization State Services, dated 09/30/19
      3. FY 18/19 Health Insurance Assistance Service Utilization, dated 09/24/19

IV. FY 2020 Standards of Care and Performance Measures
   A. Ryan White Part A/MAI — Samantha Bowen
   B. Ryan White Part B/State Services — Tiffany Shepherd

V. Telehealth vs. Telemedicine

VI. Suggested Changes to Committee Reports for FY 2020 — Tori Williams

VII. Announcements

VIII. Adjourn

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, August 13, 2019
Meeting location: 2223 W. Loop South, Room 532; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Denis Kelly, Co-Chair	Rosalind Belcher	Patrick Martin, TRG
Gloria Sierra, Co-Chair	Ahmier Gibson	Heather Keizman, RWGA
Tony Crawford, via phone	Gregory Hamilton, excused	Samantha Bowen, RWGA
Ronnie Galley	Daphne L. Jones, excused	Tori Williams, Ofc of Support
Tom Lindstrom, via phone	Robert Noble	Amber Harbolt, Ofc of Support
Pete Rodriguez	John Poole, excused	Diane Beck, Ofc of Support
Crystal Starr, via phone	Carol Suazo, excused	
Ma'Janae Chambers, via phone	Kevin Aloysius, excused	
Daniel Impastato	Ashley Barnes , excused	
Marcely Macias	Billy Ray Grant, Jr	
Deondre Moore	Cecilia Oshingbade	
Tracy Sandles		
Donte Smith		
Kent Tillison		

Call to Order: Denis Kelly, Co-Chair, called the meeting to order at 2:09 p.m. and asked for a moment of reflection. He then asked everyone to introduce themselves.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Galley, Tillison) to adopt the agenda.* **Motion carried**. Abstention: Aloysius

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Tillison, Galley) to approve the June 18, 2019 committee meeting minutes.* **Motion carried**. Abstentions: Lindstrom, Rodriguez, Starr, Chambers, Impastato, Macias, Moore, Smith, Tillison.

Public Comment: None.

Reports from the Administrative Agents

Ryan White Part A and MAI: Keizman presented the following attached reports:

- FY19 Service Utilization, dated 08/07/19
- FY19 RW Part A and MAI Procurement Report, dated 08/07/19

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

- FY19/20 Part B Procurement Report, dated 07/24/19
- FY19/20 Part B Service Utilization Report, dated 07/31/19
- FY18/19 DSHS State Services Procurement Report, dated 07/24/19
- FY18/19 DSHS State Services Service Utilization Report, dated 07/31/19
- Health Insurance Service Utilization Report, dated 07/29/19

New Business

FY 2019 Assessment of the RW Part A Administrative Mechanism: See attached. ***Motion #3****: it was moved and seconded (Starr, Smith) to accept the attached report for the Part A Ryan White Administrative Mechanism with no action required.* **Motion carried**.

FY 2020 How To Best Meet the Need Updates

Geriatric Primary Care: Williams said that Legacy will be opening a geriatric clinic at Montrose Center's new senior housing facility. See attached flyer.

Greater Visibility for Adult Day Treatment: P. Martin said that they are working on a brochure about all of the services they fund. It will be shared with the CQI Committee and be included in Case Management Training. Moore asked if the information would also be advertised on social media. Williams said yes, we can do anything with it.

Test and Treat: Williams said that there will be an update on Test and Treat at the September 12th Planning Council meeting.

Mental Health Services & Non-HIV Medication Williams stated that, per the recommendation of the Committee, the financial eligibility for both of these services was raised to 400% FPL.

Training: Telehealth vs Telemedicine: See attached PowerPoint from Jones and email from Miertschin. Kelly said there was a long discussion about this at the Planning Council meeting. Telemedicine is with a doctor, telehealth is everything else like mental health, etc. Bowen said it is on the agenda for the next CQI Committee meeting to find out if it was funded how they would use it and what technology would be needed. Macias said that many low income clients only have text and limited minutes but no data so they would need access to Wi-Fi. She also expressed concern about older people having sophisticated cell phone skills. Williams will continue to gather information on this topic.

Announcements: Moore said that AIDS Healthcare Foundation is opening a thrift store with a pharmacy at the same location that will also do HIV testing. Martin said that there will be a resource fair for the recently released at Montrose Center on October 23rd.

Adjourn: The meeting was adjourned at 3:35 p.m.

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

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

FY 2019 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,783,470**	**0**	**100,096**	**0**	**0**	**9,883,566**	**44.79%**	**9,883,566**	**0**		**2,615,630**	**26%**	**42%**
1.a	Primary Care - Public Clinic (a)	3,591,064	0	0	0		3,591,064	16.27%	3,591,064	0	3/1/2019	$539,566	15%	42%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	25,032	0		965,479	4.38%	965,479	0	3/1/2019	$454,862	47%	42%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	25,032	0		811,456	3.68%	811,456	0	3/1/2019	$475,726	59%	42%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,023,797	0	25,032	0		1,048,829	4.75%	1,048,829	0	3/1/2019	$284,393	27%	42%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761	0	0	0		1,149,761	5.21%	1,149,761	0	3/1/2019	$418,944	36%	42%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540	0	0			1,874,540	8.50%	1,874,540	0	3/1/2019	$273,673	15%	42%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2019	$2,400	16%	42%
1.h	Vision	402,000	0	25,000	0		427,000	1.94%	427,000	0	3/1/2019	$166,065	39%	42%
2	**Medical Case Management**	**2,535,802**	**0**	**50,000**	**0**	**0**	**2,585,802**	**11.72%**	**2,585,802**	**0**		**585,925**	**23%**	**42%**
2.a	Clinical Case Management	488,656	0	0	0		488,656	2.21%	488,656	0	3/1/2019	$201,297	41%	42%
2.b	Med CM - Public Clinic (a)	482,722	0	0	0		482,722	2.19%	482,722	0	3/1/2019	$31,958	7%	42%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	16,666	0		337,736	1.53%	337,736	0	3/1/2019	$107,480	32%	42%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	16,666	0		337,738	1.53%	337,738	0	3/1/2019	$39,935	12%	42%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	16,668	0		123,915	0.56%	123,915	0	3/1/2019	$40,093	32%	42%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.58%	348,760	0	3/1/2019	$89,692	26%	42%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.82%	180,311	0	3/1/2019	$19,416	11%	42%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.73%	160,051	0	3/1/2019	$17,499	11%	42%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.36%	80,025	0	3/1/2019	$32,469	41%	42%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2019	$6,087	13%	42%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,657,166**	**500,000**	**125,126**	**0**	**0**	**3,282,292**	**14.88%**	**3,282,292**	**0**	3/1/2019	**$487,752**	**15%**	**42%**
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.75%**	**166,404**	**0**	3/1/2019	**70,400**	**42%**	**42%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.75%	166,404	0	3/1/2019	$70,400	42%	42%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,173,070**	**166,000**	**0**	**0**	**0**	**1,339,070**	**6.07%**	**1,339,239**	**-169**	3/1/2019	**$535,467**	**40%**	**42%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.21%**	**45,677**	**0**	3/1/2019	**$9,138**	**20%**	**42%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.55%**	**341,395**	**0**	3/1/2019	**$135,426**	**40%**	**42%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.90%**	**420,000**	**0**	**3/1/2019**	**$70,575**	**17%**	**42%**
13	**Emergency Financial Assistance**	**450,000**	**0**	**0**	**0**	**0**	**450,000**	**2.04%**	**450,000**	**0**	**3/1/2019**	**$120,778**	**27%**	**42%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
15	**Non-Medical Case Management**	**1,231,002**	**0**	**100,000**	**0**	**0**	**1,331,002**	**6.03%**	**1,331,002**	**0**		**431,851**	**32%**	**42%**
15.a	Service Linkage targeted to Youth	110,793	0	0			110,793	0.50%	110,793	0	3/1/2019	$23,976	22%	42%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0		0		100,000	0.45%	100,000	0	3/1/2019	$29,922	30%	42%
15.c	Service Linkage at Public Clinic (a)	427,000	0	0	0		427,000	1.94%	427,000	0	3/1/2019	$86,014	20%	42%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209	0	100,000	0		693,209	3.14%	693,209	0	3/1/2019	$291,938	42%	42%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.93%**	**424,911**	**0**		**147,132**	**35%**	**42%**
16.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.15%	252,680	0	3/1/2019	$124,934	49%	42%
16.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.44%	97,185	0	3/1/2019	$22,198	23%	42%
16.c	Transportation vouchering (bus passes & gas cards)	75,046	0	0	0		75,046	0.34%	75,046	0	3/1/2019	$0	0%	0%
17	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
BES27515	**Total Service Dollars**	**19,228,897**	**666,000**	**375,222**	**0**	**0**	**20,270,119**	**89.96%**	**20,270,288**	**-169**		**5,210,072**	**26%**	**42%**
	Grant Administration	**1,675,047**	**119,600**	**0**	**0**	**0**	**1,794,647**	**8.13%**	**1,794,647**	**0**	**N/A**	**627,328**	**35%**	**42%**
BES27517	HCPHES/RWGA Section	1,183,084	119,600	0		0	1,302,684	5.90%	1,302,684	0	N/A	$462,731	36%	42%
PC	RWPC Support*	491,963			0	0	491,963	2.23%	491,963	0	N/A	164,598	33%	42%

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

FY 2019 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
BE627521	**Quality Management**	495,000	-119,600	0	0	0	375,400	1.70%	375,400	0	N/A	$84,702	23%	42%
		21,398,944	666,000	375,222	0	0	22,440,166	99.79%	22,440,335	-169		5,922,102	26%	42%
								Unallocated	Unobligated					
	Part A Grant Award:	22,065,113	*Carry Over:*	465		*Total Part A:*	22,065,578	-374,588	-169					

		Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent
	Core (must not be less than 75% of total service dollars)	16,702,984	666,000	275,222	0	0	17,644,206	87.05%	4,439,737	85.21%
	Non-Core (may not exceed 25% of total service dollars)	2,525,913	0	100,000	0	0	2,625,913	12.95%	770,335	14.79%
	Total Service Dollars (does not include Admin and QM)	19,228,897	666,000	375,222	0	0	20,270,119		5,210,072	
	Total Admin (must be ≤ 10% of total Part A + MAI)	1,675,047	119,600	0	0	0	1,794,647	8.13%		
	Total QM (must be ≤ 5% of total Part A + MAI)	495,000	-119,600	0	0	0	375,400	1.70%		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	1,846,845	40,438	18,861	0	0	1,906,144	85.62%	1,906,144	0		824,725	43%	42%
1.b (MAI)	Primary Care - CBO Targeted to African American	934,693	20,219	9,430	0	0	964,342	43.32%	964,342	0	3/1/2019	$506,000	52%	42%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	912,152	20,219	9,431	0	0	941,802	42.30%	941,802	0	3/1/2019	$318,725	34%	42%
2	**Medical Case Management**	320,100	0	0	0	0	320,100	14.38%	320,100	0		$92,080	29%	42%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	7.19%	160,050	0	3/1/2019	$60,882	38%	42%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	7.19%	160,050	0	3/1/2019	$31,198	19%	42%
	Total MAI Service Funds	2,166,945	40,438	18,861	0	0	2,226,244	100.00%	2,226,244	0		916,805	41%	42%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
BE027516	**Total MAI Funds**	2,166,945	40,438	18,861	0	0	2,226,244	100.00%	2,226,244	0		916,805	41%	42%
	MAI Grant Award	2,207,383	*Carry Over:*	0		*Total MAI:*	2,207,383							
	Combined Part A and MAI Orginial Allocation Total	23,565,889												

Footnotes:

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

Prepared by: Ryan White Grant Administration

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 1st Quarter (3/1-5/31)																		
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**4,210**	**71%**	**27%**	**1%**	**41%**	**15%**	**3%**	**41%**	**0%**	**0%**	**4%**	**24%**	**27%**	**14%**	**28%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,098	68%	31%	1%	47%	10%	2%	41%	0%	0%	2%	15%	26%	16%	37%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	611	62%	35%	4%	100%	0%	0%	0%	0%	0%	6%	39%	28%	11%	14%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	737	82%	16%	1%	0%	0%	0%	100%	0%	1%	8%	30%	31%	13%	18%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	391	87%	13%	1%	0%	85%	15%	0%	0%	1%	4%	28%	21%	18%	27%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	413	69%	30%	1%	42%	25%	1%	31%	0%	0%	7%	31%	27%	12%	21%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	656	0%	100%	0%	58%	7%	2%	33%	0%	0%	1%	11%	29%	19%	35%	5%
1.g	Primary Care - Pediatric (a)	7	4	100%	0%	0%	25%	0%	0%	75%	25%	25%	50%	0%	0%	0%	0%	0%
1.h	Vision	1,600	747	73%	25%	1%	48%	12%	3%	37%	0%	0%	4%	23%	23%	14%	31%	5%
2	**Medical Case Management (f)**	**3,075**	**2,287**															
2.a	Clinical Case Management	600	494	77%	20%	2%	53%	15%	2%	31%	0%	1%	3%	29%	24%	9%	30%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	279	95%	4%	1%	67%	8%	2%	23%	0%	0%	1%	31%	22%	13%	30%	3%
2.c	Med CM - Targeted to AA (a)	550	536	66%	31%	2%	100%	0%	0%	0%	0%	0%	6%	36%	26%	11%	18%	2%
2.d	Med CM - Targeted to H/L(a)	550	180	79%	18%	3%	0%	0%	0%	100%	0%	1%	8%	28%	36%	7%	18%	1%
2.e	Med CM - Targeted to White and/or MSM (a)	260	187	83%	16%	1%	0%	92%	8%	0%	0%	0%	2%	22%	18%	20%	35%	4%
2.f	Med CM - Targeted to Rural (a)	150	327	68%	31%	0%	47%	29%	3%	20%	0%	0%	5%	26%	19%	11%	34%	4%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	116	0%	100%	0%	71%	8%	3%	19%	0%	0%	0%	12%	30%	17%	37%	3%
2.h	Med CM - Targeted to Pedi (a)	125	56	59%	41%	0%	70%	5%	2%	23%	55%	34%	11%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	108	94%	6%	0%	71%	20%	1%	7%	0%	0%	0%	0%	5%	3%	61%	31%
2.j	Med CM - Targeted to Youth	120	4	75%	25%	0%	50%	25%	0%	25%	0%	0%	100%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**2,149**	**74%**	**23%**	**3%**	**46%**	**15%**	**2%**	**37%**	**0%**	**0%**	**4%**	**25%**	**27%**	**16%**	**26%**	**2%**
4	**Oral Health**	**200**	**162**	**67%**	**33%**	**0%**	**44%**	**33%**	**2%**	**21%**	**0%**	**0%**	**4%**	**17%**	**28%**	**12%**	**33%**	**5%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	162	67%	33%	0%	44%	33%	2%	21%	0%	0%	4%	17%	28%	12%	33%	5%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,101**	**78%**	**21%**	**1%**	**44%**	**26%**	**3%**	**27%**	**0%**	**0%**	**1%**	**14%**	**17%**	**14%**	**44%**	**10%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**8**	**88%**	**13%**	**0%**	**25%**	**38%**	**13%**	**25%**	**0%**	**0%**	**0%**	**13%**	**38%**	**38%**	**13%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**289**	**78%**	**21%**	**0%**	**35%**	**26%**	**3%**	**36%**	**0%**	**0%**	**1%**	**10%**	**14%**	**15%**	**49%**	**11%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**180**	**76%**	**22%**	**2%**	**59%**	**8%**	**1%**	**32%**	**0%**	**1%**	**8%**	**26%**	**22%**	**14%**	**27%**	**2%**
13	**Non-Medical Case Management**	**7,045**	**2,854**															
13.a	Service Linkage Targeted to Youth	320	74	78%	20%	1%	53%	4%	3%	41%	0%	19%	81%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	47	77%	23%	0%	53%	11%	6%	30%	0%	0%	0%	47%	28%	6%	11%	9%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	1,489	66%	33%	1%	62%	10%	2%	27%	0%	0%	0%	16%	25%	14%	40%	4%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	1,244	72%	26%	2%	50%	14%	2%	35%	1%	1%	6%	27%	26%	10%	25%	3%
14	**Transportation**	**2,850**	**962**															
14.a	Transportation Services - Urban	170	252	66%	33%	1%	61%	10%	3%	26%	0%	1%	3%	31%	23%	14%	25%	3%
14.b	Transportation Services - Rural	130	64	75%	23%	2%	39%	39%	2%	20%	0%	0%	3%	16%	22%	9%	47%	3%
14.c	Transportation vouchering	2,550	646															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**150**	**75%**	**23%**	**3%**	**46%**	**7%**	**2%**	**45%**	**0%**	**1%**	**3%**	**24%**	**31%**	**13%**	**26%**	**2%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**8,782**	**73%**	**26%**	**1%**	**48%**	**15%**	**2%**	**33%**	**0%**	**1%**	**4%**	**22%**	**24%**	**13%**	**32%**	**4%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 18 App) (b)		**NA**	**28,225**	**60%**	**21%**		**39%**	**18%**	**3%**	**20%**	**0%**	**5%**		**15%**	**22%**	**25%**	**15%**	

Available Data As Of: 9/6/2019

Prepared by: Ryan White Grant Administration

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 1st Quarter (03/01 -05/31)

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	808	71%	27%	3%	100%	0%	0%	0%	0%	0%	7%	39%	25%	10%	17%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	492	84%	14%	1%	0%	0%	0%	100%	0%	1%	7%	27%	35%	13%	16%	1%
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	443	62%	36%	2%	52%	14%	4%	30%	0%	2%	4%	40%	26%	12%	13%	2%
2.d	Med CM - Targeted to H/L(a)	960	238	82%	12%	6%	45%	15%	3%	36%	0%	6%	9%	30%	33%	6%	15%	0%

RW Part A New Client Service Utilization Report - 1st Quarter (03/01-05/31)

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/18 - 2/28/19)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**446**	**72%**	**26%**	**2%**	**52%**	**12%**	**3%**	**33%**	**0%**	**2%**	**11%**	**31%**	**27%**	**12%**	**2%**	**15%**
2	**LPAP**	**1,200**	**99**	**62%**	**36%**	**2%**	**52%**	**14%**	**4%**	**30%**	**0%**	**2%**	**4%**	**40%**	**26%**	**12%**	**2%**	**13%**
3.a	Clinical Case Management	400	33	82%	12%	6%	45%	15%	3%	36%	0%	6%	9%	30%	**33%**	**6%**	0%	**15%**
3.b-3.h	Medical Case Management	1,600	270	71%	27%	1%	61%	11%	2%	26%	1%	3%	6%	33%	**26%**	**13%**	1%	**17%**
3.i	Medical Case Manangement - Targeted to Veterans	60	15	100%	0%	0%	60%	33%	7%	0%	0%	0%	0%	0%	**13%**	**0%**	40%	**47%**
4	**Oral Health**	**40**	**7**	**57%**	**43%**	0%	**43%**	**29%**	0%	**29%**	0%	0%	**14%**	**29%**	**14%**	**0%**	**14%**	**29%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**559**	70%	**29%**	1%	**55%**	**15%**	2%	**28%**	0%	2%	7%	**24%**	**26%**	**12%**	**27%**	3%
12.b	**Service Linkage at Testing Sites**	**260**	**36**	**83%**	**17%**	**0%**	**50%**	**11%**	**6%**	**33%**	**0%**	**0%**	**19%**	**39%**	**19%**	**6%**	**11%**	**6%**

Footnotes:

(a) Bundled Category

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

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

(e) Total MCM served does not include Clinical Case Management

(f) CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

Available Data As Of: 9/6/2019

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1920 Ryan White Part B

Procurement Report

April 1, 2019 - March 31, 2020

Reflects spending through August 2019

Spending Target: 41.7%

Revised 9/26/19

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care	$2,186,905	65%	$31,973	$2,218,878	$0	$2,218,878	4/1/2019	$879,609	40%
5	Health Insurance Premiums and Cost Sharing (1)	$1,040,351	31%	$0	$1,040,351	$0	$1,040,351	4/1/2019	$0	0%
8	Home and Community Based Health Services	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2019	$54,000	48%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	-$31,973	$0					
	Total Houston HSDA	3,340,571	100%	0	3,372,544	$0	$3,372,544		933,609	28%

Note: Spending variances of 10% of target will be addressed:

-1 HIP - Funded by Part A, B and State Services. Provider spends grant funds by ending dates Part A- 2/28; B-3/31; SS-8/31.
No expenditures submitted - Focusing on spending State Services funds.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1819 DSHS State Services

Procurement Report

September 1, 2018- August 31, 2019

Chart reflects spending through August 2019

Spending Target: 100.%

Revised 9/26/2019

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing**	$979,694	52%	**$142,285**	$1,121,979	$100,000	$1,221,979	9/1/2018	$1,158,880	95%
6	**Mental Health Services (1)**	$300,000	16%	**$0**	$300,000	-$100,000	$200,000	9/1/2018	$162,969	81%
7	**EIS - Incarcerated**	$166,211	9%	**$0**	$166,211	$0	$166,211	9/1/2018	$165,924	100%
11	**Hospice (2)**	$359,832	19%		$359,832	$0	$359,832	9/1/2018	$252,120	70%
15	**Linguistic Services (3)**	$68,000	4%		$68,000	$0	$68,000	9/1/2018	$52,513	77%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	**-$142,285**						
	Total Houston HSDA	**1,873,737**	**100%**	**$0**	$2,016,022	$0	$2,016,022		1,792,405	89%

(1) Mental Health Services are under utilized. 2nd provider has been slow to increase service utilization.

(2) Hospice care has had lower than expected client turn out and agency has other grant funding. Service category has been reduced for next grant cycle during P&A

(3) Linguistic has slow billing but there has been lower than expected client utilization.

(a) Reflect increase in State Services award and RWPC approval of increasing HIP category

* Final numbers will be presented after closeout period. TRG will move funds to other HSDAs to expend all grant funds to met the required 95% spent threshold.

2018 - 2019 DSHS State Services Service Utilization Report
9/1/2018 thru 8/31/2019 Houston HSDA
3rd Quarter

Revised 9/30/2019

Funded Service	UDC		Gender				Race				Age Group						
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Early Intervention Services	871	712	84.97%	15.03%	0.00%	2.39%	68.96%	16.15%	13.76%	1.13%	0.00%	0.99%	6.04%	32.16%	24.43%	23.17%	12.22%	0.98%
Health Insurance Premiums	1,600	2,345	80.64%	18.77%	0.01%	0.55%	25.37%	25.58%	43.33%	2.72%	0.00%	0.24%	2.43%	17.69%	19.40%	27.67%	24.13%	8.44%
Hospice	38	33	87.87%	12.13%	0.00%	0.00%	45.45%	42.42%	12.13%	0.00%	0.00%	0.00%	3.03%	3.03%	21.22%	18.18%	39.39%	15.15%
Linguistic Services	150	53	48.01%	50.01%	0.00%	1.88%	56.60%	3.77%	7.53%	32.08%	0.00%	0.00%	5.68%	22.64%	24.56%	35.84%	7.56%	3.77%
Mental Health Services	305	215	85.12%	11.63%	0.00%	3.25%	36.23%	41.86%	19.51%	2.33%	0.00%	0.00%	0.00%	20.46%	21.39%	28.83%	24.13%	5.14%
Unduplicated Clients Served By State Services Funds:	N/A	3,358	77.34%	21.51%	0.01%	1.14%	50.58%	25.96%	15.86%	7.65%	0.00%	0.25%	3.45%	19.20%	22.20%	26.74%	21.49%	6.70%

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2018-8/31/19

Revised: 9/24/2019

Request by Type	Assisted			NOT Assisted		
	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1883	$188,882.45	820			*0*
Medical Deductible	468	$179,877.18	284			*0*
Medical Premium	7065	$2,762,145.91	833			*0*
Pharmacy Co-Payment	9012	$659,869.49	1600			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	10	$3,751.00	8	*NA*	*NA*	*NA*
Totals:	18439	$3,787,524.03	3546	0	$0.00	

Comments: This report represents services provided under all grants.

Umair A. Shah, M.D., M.P.H.
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Building a Healthy Community

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2020-2021 Houston EMA: RWGA Part A
Standards of Care for HIV Services
Ryan White Grant Administration Section
SUMMARY OF CHANGES
AS OF 10/3/2019

*= Initiated based on feedback received from RWPC

ISSUE	LOCATION	CURRENT	PROPOSED
Clarify requirements of Initial Training	General Standards 1.2 Page 4	"Initial training includes eight (8) hours of HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers..."	"Initial training includes eight (8) hours of: HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers **(e.g. job description)**..."
Clarify expectations for annual review of staff guidelines	General Standards 2.3 Page 4	"...reviewed annually."	"... **staff should review these guidelines** annually."
***Grievance Procedure Protection from retaliation**	General Standard 3.5 Page 8		"Grievance procedure includes but is not limited to... • **Language outlining that clients cannot be retaliated against for filing grievances.**"
***Wait Lists**	General Standard 4.12	"It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding."	"It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied ~~due to funding~~."

Acknowledge that providing emotionally supportive counseling is within the scope of case management services	Case Management description p. 19	"Case management services in HIV care facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of People Living with HIV (PLWH)."	"Case management services in HIV care facilitate client access to health care services, assist clients to navigate through the wide array of health care programs, **provide emotional support**, ensure coordination of services to meet the unique needs of People Living with HIV (PLWH)."
Increase licensure requirements for clinical case management	Clinical Case Management 1.1	All clinical case managers must have a current and in good standing State of Texas license (LBSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A).	All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LPC-I, LMFT, LMFT-A) **Staff providing Clinical Case Management services with LBSW or LMSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification or training. LMSWs receiving clinical supervision hours towards LCSW requirements may provide Clinical Case Management services under a waiver agreement."**
Increase income requirements for LPAP	Local Pharmacy Assistance Program 1.1 P. 38	"Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 300% of the Federal poverty level for HIV-related medications."	"Income no greater than 500% of the Federal poverty level for HIV medications and no greater than **400%** of the Federal poverty level for HIV-related medications."
Adjust meeting requirements for Outreach Workers	Outreach 1.3 P. 45	"The Outreach Workers are required to attend a minimum	The Outreach Workers are required to attend a minimum of **five (5)**

		of eleven (11) of the (12) Outreach Worker meetings within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & COH."	**of the six (6) Outreach Worker meetings and five (5) of the six (6) bi-monthly networking meeting facilitated by RWGA** within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & ~~COH~~. HHD
Clarify that progress notes need to be documented with 72 business hours	Case Management 2.2 p. 19 Outreach 2.1 P. 46	"...documented in the client record within 72 hours of the occurrence."	"...documented in the client record within 72 **business** hours of the occurrence."

Consumer Only SOC Workgroup
September 23rd, 2019

✔ Standard exists
◉ Standard partially exists, consider reviewing/revising
✗ Standard does not exist

Theme: Continuity of Care and Communication	
• Clients should be informed of the range of services that are available to them.	✔ General Standard 4.10
• Providers should be able to communicate and share information with other providers and members of the care team to coordinate care and prevent the client from needing to repeat their history and background unnecessarily.	✔ General Standard 3.4
• Progress notes including social and medical history should be detailed enough to prevent the client from needing to repeat their social and medical history unnecessarily.	✔ Clinical Case Management 2.4 Medical Case Management 2.2 Oral Health 2.3 Vision Services 2.2 Primary Medical Care 1.6 Substance Use Services 1.1, 1.2
• When a provider or staff member leaves the organization, there should be a plan for continuing services and communicating any reassignment to the client.	✔ Case Management 2.4 Primary Care 3.4
Theme: Wait Lists	
• Wait lists for services based on limited access (different from limited funding) should be monitored with a policy in place for how a roster will be developed and maintained.	◉ General standard 4.12 is about Wait Lists, but is specific to wait list rosters developed out of lack of funding, not availability.
• Clients should be informed of outside referrals that are available to them when the service cannot be provided within a reasonable time frame at the home agency.	✔ Case Management 2.3
Theme: Case Management and Mental Health Access	
• Newly diagnosed individuals should have access to case management or peer navigators.	✔ Medical Case Management 2.1
• If a case manager is assigned to a work on a client's case, the client should know who their case manager is and how to get in contact with them.	✔ Case Management 2.1

• Clients should be regularly assessed for mental health needs (at intake and beyond) and have access to staff who can provide emotionally supportive counseling.	✔ Clinical Case Management 2.4 Non-Medical Case Management 2.2 Medical Case Management 2.2 ◉ Consider adding language to include "emotionally supportive counseling" in Scope of Services
Miscellaneous:	
• Agencies should be encouraged to align any of their program-specific eligibility dates with birth month.	✗ Outside of the scope of RWGA to dictate

2019-2020 Houston Eligible Metropolitan Area: Ryan White CARE Act Part A
Standards of Care For HIV Services
Ryan White Grant Administration Section
Harris County Public Health (HCPH)

TABLE OF CONTENTS

Introduction

According to the Joint Commission (2008)[1], a standard is a "statement that defines performance expectations, structures, or processes that must be in place for an organization to provide safe, high-quality care, treatment, and services". Standards are developed by subject experts and are usually the minimal acceptable level of quality in service delivery. The Houston EMA Ryan White Grant Administration (RWGA) Standards of Care (SOCs) are based on multiple sources including RWGA on-site program monitoring results, consumer input, the US Public Health Services guidelines, Centers for Medicare and Medicaid Conditions of Participation (COP) for health care facilities, Joint Commission accreditation standards, the Texas Administrative Code, Center for Substance Abuse and Treatment (CSAT) guidelines and other federal, state and local regulations.

Purpose
The purpose of the Ryan White Part A SOCs is to determine the minimal acceptable levels of quality in service delivery and to provide a measurement of the effectiveness of services.

Scope
The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2019-2020:

- *Primary Medical Care*
- *Vision Care*
- *Medical Case Management*
- *Clinical Case Management*
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Oral Health*
- ***Health Insurance Assistance***
- Hospice Care
- Mental Health Services
- *Substance Abuse services*
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- *Medical Nutrition Supplement*
- *Outreach*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services
- *Emergency Financial Assistance*
- Referral for Healthcare & Support Services

Part A funded services
Combination of Parts A, B, and/or Services funding

Standards Development
The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make

[1] The Joint Commission (formerly known as Joint Commission on Accreditation of Healthcare Organization (2008)). Comprehensive accreditation manual for ambulatory care; Glossary

applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

Organization of the SOCs
The standards cover all aspect of service delivery for all funded service categories. Some standards are consistent across all service categories and therefore are classified under general standards.
These include:

- Staff requirements, training and supervision
- Client rights and confidentiality
- Agency and staff licensure
- Emergency Management

The RWGA funds three case management models. Unique requirements for all three case management service categories have been classified under Service Specific SOCs "Case Management (All Service Categories)". Specific service requirements have been discussed under each service category.
All new and/or revised standards are effective at the beginning of the fiscal year.

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing serviees to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written applieation Criminal baekground checks, if required by Agency Policy, must be eonducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indieates complianee • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours HIV basics, safety issues (fire & emergeney preparedness, hazard communication, infeetion control, universal preeautions), eonfidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy) and eustomer servicc training must be completed within 60 days of hire. https://www.train.org/texas/course/1078713/	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 year with their current employer must receive four (4) hours of eultural eompetency training to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an	• Documentation of training is maintained by the agency in the personnel file

	additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
1.5	Staff education on eligibility determination and fee schedule Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; reviewed annually	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures

2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in suffieient supply • Staff interviews indicate compliance
2.5	Staff Supervision Staff services are supervised by a paid eoordinator or manager.	• Review of personnel files indicates eompliance • Review of Agency's Policies and Procedures Manual indicates compliance
2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel files indieates complianee • Review of agency's complaint and grievance files
2.7	Communieation Therc are proccdures in plaee rcgarding regular communication with staff about the program and general agency issues.	• Review of Ageney's Polieies and Procedures Manual indicates compliance • Documentation of regular staff meetings • Staff interviews indicate compliance
2.8	Accountability There is a system in place to document staff work time.	• Staff time sheets or other documentation indicate compliance
2.9	Staff Availability Staff are present to answer incoming ealls during agency's normal operating hours.	• Published documentation of agency operating hours • Staff time sheets or other documentation indicate compliance
3.0	**Clients Rights and Responsibilities**	

3.1	Clients Rights and Responsibilities Ageney reviews Client Rights and Responsibilities Statement with eaeh elient in a language and format the elient understands. Ageney provides elient with written copy of elient rights and responsibilities, including: • Informed consent • Confidentiality • Grievanee procedures • Duty to warn or report certain behaviors • Scope of serviee • Criteria for end of services	• Doeumentation in elient's reeord
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client eonfidentiality form signed by each employee and ineluded in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance • Agency's struetural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record
3.4	Up to date Release of Information Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exehange consent form must contain: • Name of the person or entity permitted to make the disclosure	• Current Release of Information form with all the required elements signed by client or authorized person in client's reeord

	• Name of the client • The purpose of the diselosure • The types of information to be diselosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the elient/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it Release/exchange of information forms must be complcted entirely in the presence of the client. Any unused lines must have a line erossed through the space.	
3.5	Grievance Procedure Agency has Policy and Procedure regarding client grievances that is reviewed with eaeh client in a language and format the client can understand and a written copy of which is provided to eaeh elient. Grievance proeedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • time lines and steps taken by the agency to resolve the grievanee • documentation by the agency of the process, ineluding a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form • resolution of eaeh grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources	• Signed receipt of agency Grievance Procedure, filed in elient ehart • Review of Agency's Policies and Proeedures Manual indieates eompliance • Review of Ageney's Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Aeeess to Care #2

3.6	Conditions Under Which Discharge/Closure May Occur A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the elient's or legal guardian request • Changes in client's need which indicates services from another ageney • Fraudulent claims or doeumentation about HIV diagnosis by the client • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a elient is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail or cannot be eontaeted for sixty (60) days. Ageney must document three (3) attempts to eontact clients by more than one method (e.g. phone, mail, email, text message, in person via home visit). • Client service plan is coinpleted and no additional needs are identified. Client must be provided a written notiee prior to involuntary termination of serviees (e.g. due to dangerous behavior, fraudulent claims or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System • A copy of written notiee and a certified mail receipt for involuntary termination
3.7	Client Closure A summary progress note is eompleted in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/elosure • Summary of all serviees reeeived by the client and the client's response to services • Referrals made and/or • Instructions given to the individual at discharge (when applicable)	• Documentation in client record and in the Centralized Patient Care Data Management System
3.8	Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have struetured and ongoing efforts to obtain input from clients (or client earegivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaetion surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a	• Doeumentation of clients' evaluation of services is maintained • Documentation of CAB and public meeting minutes • Documentation of existence and appropriateness of a suggestion box or other client input mechanism

	file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance
4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients

		• Availability of interpretive serviees, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Ageney demonstrates a commitment to assisting individuals with special needs	• Ageney compliance with the Amcrieams with Disabilitics Act (ADA). • Review of Policics and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for low-Income Individuals Agency must ensurc that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation serviees if facility is not accessible by public transportation. Agency should not have policies that dietate a dress eode or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Ageney's Policies and Proecdures Manual indicates complianee • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Doeumentation of the client's HIV status is obtained at or prior to the initiation of services or registration serviees.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03

	An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that clients living with HIV are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Agency conducts six (6) month re-certification of eligibility for all clients. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. At one of the two required re-certifications during a year, agency may accept client self-attestation for verifying that an individual's income, residency, and insuranee status complics with the RWGA eligibility requirements. Appropriate documentation is required for changes in status and at least onee a year (defined as a 12-month period) with renewed eligibility with the CPCDMS.	• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every six (6) months • Review of Policies and Procedures indicates compliance • Information in client's files that includes proof of screening for insurance coverage (i.e. hard/scanned copy of results)

	Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured elients into Medieare, Medieaid, private health insurance and other programs. Ageney policy must also address eoordination of benefits, billing and collection. Clients eligible for Departinent of Veterans Affairs (VA) benefits are duly eligible for Ryan White scrviees and therefore exempted from the payer of last resort requirement. • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent)	• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Sereening #1 and #2 • Souree Citation: HIV/AIDS Bureau (HAB) Poliey Clarifieation Notiee #13-02
4.9	Charges for Services Ageney must institute Polieics and Proeedures for cost sharing ineluding enrollment fees, premiums, deduetibles, eo-payments, eo-insuranee, sliding fee diseount, ete. and an annual eap on these eharges. Agency should not eharge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross ineome level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as doeumented in the CPCDMS for any services provided. Clients whose gross ineome is between 101-300% may be eharged annual aggregate fees in accordanee with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, ageney must implement the following: • Six (6) month evaluation of elients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Traeking of charges • A process for alerting the billing system when the eap is reached so client will not be charged for the rest of the ealendar year. • Documentation of fees	• Review of Policies and Proeedures indicates compliance • Review of system for traeking patient charges and payments indicate compliance • Review of charges and payments in client records indieate compliance with annual eap • Sliding fee application forms on elient record is consistent with Federal guidelines
4.10	Information on Program and Eligibility/Sliding Fee Schedule Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing serviees must be provided with a clear deseription of their sliding fee charges in a simple understandablc format at intake and annually at registration update. Agency should maintain a file documenting promotion aetivities including eopics of HIV program materials and information on eligibility requirements.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout servicc area (as applicable to specific service category).

	Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	Linkage Into Core Services Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record • Review of agency's policies & procedures' manual indicates compliance
4.12	Wait Lists It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method.	• Review of Agency's Policies and Procedures Manual indicates complianee • Documentation that agency notified their Administrative Ageney when funds for services were either low or exhausted

	The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of serviee. The Agency's plan must addrcss: • Action steps to bc taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward eompleting the plan for resumption of service. • A revised plan for resumption of service, if necessary.	
4.13	Intake Thc agcncy conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identificrs for entry into CPCDMS. Intake proeess is flexiblc and responsive, accommodating disabilitics and health conditions. In addition to offiec visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when nccessary. Agency has establishcd procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indieates compliance
5.0	**Quality Management**	
5.1	Continuous Quality Improvement (CQI) Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicablc) • Project specific CQI Plans • Root Causc Analysis & Improvement Plans • Data collection methods and analysis • Work products	• Review of Agency's Polieics and Procedures Manual indicates compliance • Up to date QM Manual • Souree Citation: HAB Univcrsal Standards; Section F: #2

	• QM program evaluation • Materials necessary for QM activities	
5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Supervisors log on record reviews signed and dated • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Serviees policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of formal agreements with appropriate Points of Entry • Doeumentation of referrals and their follow-up
7.0	**Emergency Management**	
7.1	Emergency Preparedness Ageney leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other publie health threats, terrorist attacks, eivil disturbances and eollapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergeney. The agency shall communicate hazards identified with its community emergency	• Emergency Preparedness Plan • Review of Agency's Policies and Proeedures Manual indieates compliance

	response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	Emergency Management Training In accordance with the Department of Human Serviees reeommendations, all applicable ageney staff (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: • IS -100.HC – Introduction to the Incident command system for healthcare/hospitals • IS-200.HC- Applying ICS to Healthcare organization • IS-700.A-National Incident Management System (NIMS) Introduction • IS-800.B National Response Framework (management) The above courses may be aceessed at: www.training.fema.gov . Agencies providing support services only may complete alternate courses listed for the above areas All applicable new employees are required to complete the courses within 90 days of hire.	• Agency criteria used to determine appropriate staff for training requirement • Documentation of all training including certificate of completion in personnel file
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity • Patient clinical and support activities during emergency situations. (www.jointcommission.org)	• Emergency Preparedness Plan
7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

Case management services in HIV care facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of People Living with HIV (PLWH). It also involves client assessment to determine client's needs and the development of individualized service plans in collaboration with the client to mitigate clients' needs. Ryan White Grant Administration funds three case management models i.e. one psychosocial and two clinical/medical models depending on the type of ambulatory service within which the case management service is located. The scope of these three case management models namely, Non-Medical, Clinical and Medical case management services are based on Ryan White HIV/AIDS Treatment Modernization Act of 2006 (HRSA)[2] definition for non-medical and medical case management services. Other resources utilized include the current *National Association of Social Workers (NASW) Standards for Social Work Case Management*[3]. Specific requirements for each of the models are described under each case management service category.

1.0	**Staff Training**	
1.1	Required Meetings Case Managers and Service Linkage Workers Case managers and Service Linkage Workers will attend on an annual basis a minimum of four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA. Case Managers and Service Linkage Workers will attend the "Joint Prevention and Care Coordination Meeting" held annually and facilitated by the RWGA and the City of Houston STD/HIV Bureau. Medical Case Management (MCM), Clinical Case Management (CCM) and Service Linkage Worker Supervisors will attend on an annual basis a minimum of five (5) of the six (6) bi-monthly Supervisor meetings facilitated by RWGA (in the event a MCM or CCM supervises SLW staff the MCM or CCM must attend the Supervisor meetings and may, as an option, attend the networking meetings)	• Agency will maintain verification of attendance (RWGA will also maintain sign-in logs)

[2] US Department of Health and Human Services, Health Resources and Services Administration HIV or AIDS Bureau (2009). Ryan White HIV or AIDS Treatment Modernization Act of 2006: Definitions for eligible services

[3] National Association of Social Workers (2013). NASW staudards for social work case management. Retrieved 12/28/2018 from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlc%3d&portalid=0

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the ease management system, case managers will successfully complete HIV Case Management 101 2013 Update, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, ease managers will complete at least four (4) hours review of Community resources, and at lcast four (4) hours cultural competency training offered by RWGA. For cultural competency training only, Agency may request a waiver for agency based training altemative that meets or exceeds the RWGA requirements for the first year training for case management staff.	• Certificates of completion for applicable trainings in thc case manager's file • Sign-in sheets for ageney based trainings maintained by Agency • RWGA Waiver is approved prior to Ageney utilizing agency-based training currieulum
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, case managers will successfully complete CAC training. Applicable case management staff must maintain CAC certification by their Certificated Application Counselor Designated Organization employer annually. RWGA expects CAC training completion to take no longer than 6 hours.	• Certifieates of completion in case manager's file
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance
1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for dctermining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient intcraction.	• Documentation of staff training
1.6	Warm Handoff Procedure Agcncy must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the hcalth care team nccds to take place, i.e.	• Agency has a warm handoff policy to specify procedurcs and appropriate patient population(s) for conducting a warm handoff

	medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	
2.0	**Timeliness of Services**	
2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record
2.2	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes
2.3	Client Referral and Tracking Agency will have policies and proeedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager • Work with the Client to determine barriers to referrals and facilitate access to referrals • Utilize a tracking mechanism to monitor completion of all case management referrals	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking aetivities in clients records • A current list of agencies that provide services including availability of the Blue Book
2.4	Client Notification of Service Provider Turnover Client must be provided notice of assigned service provider's cessation of employment within 30 days of the employee's departure.	• Documentation in client record
2.5	Client Transfers between Agencies: Open or Closed less than One Year	• Documentation in client record

	The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a "consent for transfer and release/exchange of information" form be completed and signed by the client, the client's record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and kept on file with the receiving agency.	
2.6	Caseload Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.	• Review of the agency's policies and procedures for Staffing ratios

Clinical Case Management Services

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines medical case management as "a range of client-centered services that link clients with health care, psychosocial, and other services" including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments". The definition outlines the functions of the medical case manager as including assessments and reassessments, individualized comprehensive service planning, service plan implementation and periodic evaluation, client advocacy and services utilization review. The Ryan White Grant Administration categorizes medical case management services co-located in a Mental Health treatment/counseling and/or Substance Abuse treatment services as Clinical Case Management (CCM) services.
CCM services may be targeted to underserved populations such as Hispanics, African Americans, MSM, etc.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications All clinical case managers must have a current and in good standing State of Texas license (LBSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A).	• A file will be maintained on each clinical case manager • Supportive documentation of credentials and job description is maintained by the agency in each clinical case manager file. Documentation should include transcripts and/or diplomas and proof of licensure
1.2	Scope of Services The clinical case management services will include at a minimum, comprehensive assessment including mental health and substance abuse/use; development, implementation and evaluation of care plans; follow-up; advocacy; direction of clients through the entire spectrum of health and support services and peer support. Other functions include facilitation and coordination of services from one service provider to another including mental health, substance abuse and primary medical care providers.	• Review of client records indicates compliance • Agency Policy and Procedures indicates compliance
1.3	Ongoing Education/Training for Clinical Case Managers After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	• Certificates of completion are maintained by the agency • Current License on case manager's file
2.0	**Timeliness of Services/Documentation**	

2.1	Client Eligibility In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: • Individual living with HIV in mental health treatment/counseling and/or substance abuse treatment services or whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. • Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record
2.2	Discharge/Closure from Clinical Case Management Services In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence. ➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	• Documentation in client record.
2. 3	Coordination with Primary Medical Care and Medical Case Management Provider Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs.	• Review of Agency's Policies and Procedures Manual indicates compliance

	Clinical Case Management services provided to clients accessing primary medical eare from a Ryan White Part A funded primary medical care provider other than Agency will require Ageney and Primary Medieal Care/Medieal Case Management provider to conduct regular inulti-disciplinary ease eonferenees to ensure effective eoordination of clinical and psyehosoeial interventions. Case eonferences must at a miniinum inelude the elinical case manager; mental health/counselor and/or medieal case inanager and occur at least every three (3) months for the duration of Clinieal Case Manageinent services. Client refusal to provide consent for the elinieal ease manager to participate in multi-disciplinary case eonferenees with their Primary Medieal Care provider must be documented in the client record.	• Case conferences are documented in the client record
2.4	Assessment Assessment begins at intake. The ease manager will provide client, and if appropriate, his/her support system information regarding the range of serviees offered by the case management program during intake/assessment. The comprehensive client assessmcnt will inelude an evaluation of the elient's medical and psychosocial needs, strengths, resourees (including financial and medical coverage status), limitations, beliefs, eoncems and projected barriers to service. Other areas of assessment inelude demographic information, health history, sexual history, mental history/status, substance abuse history, medieation adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be eompleted within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool inay include Agency specific enhanceinents tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	• Documentation in elient reeord on the eomprehensive client assessment form, signed and dated, or ageney's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual ehild abuse and reporting is evident in case management records, when appropriate
2.5	Reassessment Clients will be reassessed at six (6) month intcrvals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, inereased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support systeiu). A RWGA approved reassessinent form as applicable must be utilizcd.	• Documentation in client record on the eomprehensive client reassessment form or agency's equivalent form signed and dated

2.6	Service Plan Service planning begins at admission to clinical case management services and is based upon assessment. The clinical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved serviec plan form will be eompleted no later than ten (10) working days following the eomprehensive client asscssment. A temporary eare plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to erises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is eompleted. Serviee plans reflect the needs and ehoices of the client based on their health and related needs (ineluding support services) and are consistent with the progress notes. A new serviee plan is eompleted at each six (6) month reassessment or each reassessment. The ease manager and client will update the eare plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must refleet an ongoing diseussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherenee and other client education per client need.	• Documentation in client record on the clinical case management service plan or agency's equivalent form • Service plan signed by elient and the ease manager
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The clinical case manager must receive supervision in accordance with their licensure requirements. Agcney policies and procedures should account for elinieal supervision and coverage of cascload in the absence of the clinical ease manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Non-Medical Case Management Services (Service Linkage Worker)

Non-medical case management services (Service Linkage Worker (SLW) is co-located in ambulatory/outpatient medical care eenters. HRSA defines Non-Medical case management services as the "provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services" and does not include coordination and follow-up of medical treatment. The Ryan White Part A/B SLW provides services to clients who do not require intensive case management services and these include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients to develop and utilize independent living skills and strategies.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications Service Linkage Worker – unlicensed community case manager Service linkage workers must have 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 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). Service linkage workers must have a minimum of 1 year paid work experience with PLWH. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish. Agency will provide Service Linkage Worker a written job description upon hiring.	• A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.
2.0	**Timeliness of Services/Documentation**	
2.1	Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (COH Only) In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services: • Clients not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of "not in care" status through the CPCDMS

	• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS	
2.2	Serviee Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide elient and, if appropriate, his/her personal support system information regarding the range of serviees offered by the case management program during intake/assessment. The service linkage worker will eomplete RWGA -approved brief assessment tool within five (5) working days, on all elients to idcntify those who need comprehensive assessment. Clients with mental health, substanee abuse and/or housings issues should reeeive eomprehensive assessment. Clients needing eomprehensive assessment should be referred to a licensed ease manager. **Low-need, non-primary care clients who have only an intermittent need for information about services may receive brief SLW services without being placed on open status.**	• Documentation in client record on the brief assessment form, signed and dated • A completed DSHS eheeklist for screening of suspected sexual ehild abuse and reporting is evident in case management reeords, when appropriate
2.3	Serviee Linkage Worker Reassessment Clients on **open status** will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applieable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (COH Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed elients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medieal care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services. Those elients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage serviees from provider or from a Ryan White-funded Clinic or Medieal Case Management provider.	• Documentation in client record and in the CPCDMS
2.5	Primary Care Newly Diagnosed and Lost to Care Clients Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum:	• Review of Agency's Policies and Procedures Manual indicates compliance.

	• Methods of routine communieation with testing sites regarding newly diagnosis and referred individuals • Description of service linkage worker job duties conducted in the field • Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	
3.0	**Supervision and Caseload**	
3.1	Service Linkage Worker Supervision A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record
3.2	Caseload Coverage – Service Linkage Workers Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System
3.3	Case Reviews – Service Linkage Workers. Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of ease reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW

Medical Case Management

Similarly to nonmedical case management services, medical case management (MCM) services are co-located in ambulatory/outpatient medical care centers (see clinical case management for HRSA definition of medieal case management services). The Houston RWPA/B medical case management visit includes assessment, education and consultation by a licensed soeial worker within a system of information, referral, case management, and/or social services and includes social services/case coordination". In addition to general eligibility criteria for case management services, providers are required to screen clients for complex medical and psychosocial issues that will require medical case management serviees (see MCM SOC 2.1).

1.0	**Staff/Training**	
1.1	Qualifications/Training Minimum Qualifications - The program must utilize a Social Worker licensed by the State of Texas to provide Medical Case Management Services. A file will be maintained on each medieal ease manager. Supportive documentation of medical case manager credentials is maintained by the agency and in each medical case manager's file. Doeumentation may include, but is not limited to, transcripts, diplomas, certifications, and/or licensure.	• Documentation of credentials and job description in medical case manager's file
1.2	Scope of Services The medical case management services will include at a minimum, screening of primary medical care patients to determine each patient's level of need for medical case management; comprehensive assessment, development, implementation and evaluation of medical case management service plan; follow-up; direction of elients through the entire spectrum of health and support serviees; facilitation and coordination of services from one service provider to another. Others inelude referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support.	• Review of clients' records indicates complianec
1.3	Ongoing Education/Training for Medical Case Managers After the first year of employment in the case management system each medical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure.	• Attendance sign-in sheets and/or certificates of completion are maintained by the ageney
2.0	**Timeliness of Service/Documentation** Medical case management for persons with HIV should reflect competence and experience in the assessment of client medical need and the development and monitoring of medical service delivery plans.	

2.1	Screening Criteria for Medical Case Management In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following: i. Newly diagnosed ii. New to ART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment ix. Housing issues x. Opportunistic infections xi. Unmanaged chronic health problems/injury/Pain xii. Lack of viral suppression xiii. Positive screening for intimate partner violence xiv. Clinician's referral Clients with one or more of these criteria would indicate need for medical case management services. Clients enrolling in medical case management services should be placed on "open" status in the CPCDMS. The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services. • Client is actively symptomatic with an axis I DSM (most current, American Psychiatrie Association approved) diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, Bipolar depression), anxiety disorders, and other psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services;	• Review of agency's screening criteria for medical case management

	• Client is in mental health counseling or chemical dependency treatment.	
2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.4	Service Plan Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive	• Documentation in client's record on the medical case management service plan or agency's equivalent form • Service Plan signed by the client and the case manager

	client assessment. A temporary care plan may be executed upon intake based upon immediate needs or eoncems). The service plan will seek timely resolution to crises, short-term and long-term needs, and may doeument erisis intervention and/or short term needs met before full serviee plan is completed. Service plans refleet the needs and ehoiees of the elient based on their health and related needs (ineluding support serviees) and are consistent with the progress notes. A new serviee plan is completed at eaeh six (6) month reassessment or each reassessment. The case manager and elient will update the eare plan upon aehievement of goals and when other issues or goals are identified and reassessed. Serviee plan must reflect an ongoing diseussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherenee and other client edueation per client need.	
2.5	Brief Interventions Clients who are not appropriate for medieal case management services may still receive brief interventions. In lieu of completing the comprehensive client re-assessment, the medical case manager should complete the brief re-assessment and service plan and doeument in the progress notes. Any referrals made should be doeumented, including their outcomes in the progress notes.	• Documentation in the progress notes refleets a brief re-assessment and plan (referral) • Documentation in client record on the brief re-assessment form • Doeumentation of referrals and their outeomes in the progress notes • Documentation of brief interventions in the progress notes.
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should aecount for clinical supervision and covcrage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, typc of supervision (e.g., group, one on one), and the content of the supervision

Emergency Financial Assistance Program

Emergency Financial Assistance (EFA) is co-located in ambulatory medieal eare eenters to provide short term (up to 30 days of medication) access to HIV pharmaceutical services to clients who have not yet eompleted eligibility determination for medications through Pharmaceutical Assistanee Programs, State ADAP, State SPAP or other sourees. EFA provides short-term (up to 30 days of medieation) payments to assist clients with an emergent need for HIV medieation. HRSA requirements for EFA include a client enrollment proeess, uniform benefits for all enrolled elients, a reeord system for dispensed medieations and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for EFA services: • Income no greater than 500% of the Federal poverty level for HIV medications	• Documentation of ineome in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	Medication Formulary RW funded prescriptions for program eligible clients shall be based on current HIV medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	**Staff HIV knowledge is based on documented training.**	

2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file • Staff interviews indieate compliance
2.3	Pharmacy Staff Experience A minimum of one year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to inelude elient care, job performance and skill development.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates complianee • Review of documentation which includes, date of supervision, eontents of discussion, duration of supervision and signatures of supervisor and all staff present

Health Insurance Assistance

The Health Insurance Premium and Cost Sharing Assistance service category is intended to help PLWH continue medical care without gaps in health insurance coverage or discretion of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Agency may provide help with client co-payments, co-insurance, deductibles, and Medicare Part D premiums.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy.

1.0	**Staff/Training**	
1.1	Ongoing Training Eight (8) hours annually of continuing education in HIV related or other specific topics including a minimum of two (2) hours training in Affordable Care Act is required as needed.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.2	Staff Experience A minimum of one year documented HIV work experience is preferred.	• Documentation of work experience in personnel file
2.0	**Client Eligibility**	
2.1	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program as needed to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health insurance marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance
2.2	Advance Premium Tax Credit Reconciliation Agency will ensure all clients receiving assistance for Marketplace QHP premiums: • Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment	• Review of client record

	• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplaee renewal periods • Submit prior year tax information no later than May 31st. Tax information must inelude: o Federal Marketplace Form 1095-A o IRS Form 8962 o IRS Form 1040 (excludes 1040EZ) • Reconciliation of APTC credits or liabilities	
3.0	**Client Access**	
3.1	Clients Referral and Tracking Agency receives referrals from a broad range of HIV serviee providers and makes appropriate referrals out when necessary.	• Documentation of referrals rceeived • Doeumentation of referrals out • Staff reports indicate compliance
3.2	Prioritization of Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistanee (in deseending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance use provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance use provider site. (i.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

Local Pharmacy Assistance Program

The Local Pharmacy Assistance Programs (LPAP) are co-located in ambulatory medical care centers and provide HIV and HIV-related pharmaceutical services to clients who are not eligible for medications through private insurance, Medicaid/Medicare, State ADAP, State SPAP or other sources. HRSA requirements for LPAP include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 300% of the Federal poverty level for HIV-related medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	LPAP Medication Formulary RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	**Staff HIV knowledge is based on documented training.**	

2.1	Orientation Initial oricntation ineludes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	Ongoing Training Sixteen (16) hours every two years of continuing edueation in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy teeh staff.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
2.3	Pharmacy Staff Experience A minimum of one year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client eare, job performanee and skill development.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates complianee • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present

Medical Nutritional Therapy/Supplements

HRSA defines core Medical Nutrition Therapy as the provision of food, nutritional services and nutritional supplements provided outside of a primary care visit by a lieensed registered dietieian based on physician's recommendation and a nutritional plan developed by a licensed registered dietician. The Houston EMA Part A/B Medical Nutrition Therapy includes nutritional counseling, provision nutritional supplements (of up to 90 day supply) for eligible people living with HIV in the Houston EMA. Clients must have a written referral or preseription from a physician or physician extender and a written nutritional plan prepared by a lieensed, registered dietieian

1.0	**Serviees are individualized and tailored to client needs.**	
1.1	Education/Counseling – Clients Reeeiving New Supplements All elients reeeiving a supplement for the first tiine will reeeive appropriate edueation/eounseling. This must inelude written information regarding supplement benefits, side effects and reeommended dosage in client's primary language.	• Client record indicates compliance
1.2	Education/Counseling – Follow-Up Clients receive education/eounseling regarding supplement(s) again at: • follow-up • when there is a change in supplements • at the discretion of the registered dietician if clinically indicated	• Client record indieates eompliance
2.0	**Services adhere to professional standards and regulations.**	
2.1	Nutritional Supplement Formulary RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Providers wishing to prescribe/order other supplements not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and proeedures must ensure that MDs and physician extenders eomply with the current clinical/Department of Health and Human Services guidelines for ART and treatment of opportunistic infections.	• Review of ageney's Polieies & Proeedures Manual indieates compliaiee • Review of billing history indicates compliance • Doeumentation in elient's record
2.2	Inventory Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.	• Review of agency's Policies & Procedures Manual indieates eompliance • Staff interviews

2.3	Licensure Providers/vendors maintain proper licensure. A physician or physician extender (PE) with prescribing privileges at a Part A/B/C and/or MAI-funded agency or qualified primary care provider must write an order for Part A-funded nutritional supplements. A licensed registered dietician must provide an individualized nutritional plan including education/counseling based on a nutritional assessment	• Documentation of current licensure • Nutritional plan in client's record
2.4	Protocols Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV including the *American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care.*	• Chart Review shows compliance • Review of agency's Policies & Procedures Manual indicates compliance

Oral Health

Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, diagnosis and treatment of HIV-related oral pathology, restorative dental services, oral surgery, root canal therapy and oral medication (including pain control) for PLWH 15 years old or older based on a comprehensive individual treatment plan. Additionally, the category includes prosthodontics services (Part B) to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Continuing Education • Sixteen (16) hours of training in HIV and clinically-related issues is required every 2 years for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
1.2	Experience – HIV A minimum of one (1) year documented work experience with PLWH is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons living with HIV. All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
2.2	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record
2.3	Health History Information	• Documentation of health history information in the client record. Reasons

	Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline (current within the last 12 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems	for missing health history information are documented
2.4	Client Health History Update An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
2.5	Comprehensive Periodontal Examination (Part B Only) Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordanee with professional standards and current US Public Health Service guidelines	• Review of agency's Policies & Procedures Manual indieates compliance • Review of client records indieate complianee
2.6	Treatment Plan • A eomprehensive, multidisciplinary Oral Health treatment plan will be developed in conjunction with the patient. • Patient's primary reason for dental visit should be addressed in treatment plan	• Treatment plan dated and signed by both the provider and patient in patient file • Updated treatment plan dated and signed by both the provider and patient in patient file

	• Patient strengths and limitations will be considered in development of treatment plan • Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions • Treatment plan will be updated as deemed necessary	
2.7	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
2.8	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record

Outreach Services

Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services.

1.0	**Staff Training**	
1.1	**Minimum/Qualifications** Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.	• Documentation of credentials and job description in outreach worker's file • Documentation includes, but is not limited to high school diploma, GED and experience
1.2	Scope of Services The OW will generate EMR reports to determine eligibility for services. Monthly, during OW-RWGA meetings OW will provide client status updates on engagement activities. Outreach workers are expected to document client's immediate needs and barriers to service in order to relink and reengage them back in to care. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a service linkage worker or medical case manager for additional assistance of the client's needs as necessary.	• Review of reporting records indicates compliance • Monthly review of spreadsheet engagement activities • Documentation of assessment will be maintained in the client file
1.3	Ongoing Education/Training for Outreach Workers The Outreach Workers are required to attend a minimum of eleven (11) of the (12) Outreach Worker meetings within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & COH.	• Documentation of attendance will be maintain by the agency. RWGA will also maintain sign-in logs • Review of reporting records indicates compliance
1.4	Documentation and Reporting Outreach Workers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with DSHS Child Abuse Screening, Documenting and Reporting Policy prior to interaction.	• Documentation of staff training in employee record
1.5	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable	• Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff.

	when a transfer of care between two members of the health care team needs to take place, i.e. Outreach worker to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	
2.0	**Timeliness of Serviee/Doeumentation**	
2.1	**Progress Notes** All Outreach Worker activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documentcd in the client record within 72 hours of the occurrence.	• Documentation of client's needs and progress notes will be maintained in client's files • Legible signed and dated in doeumentation in the client record
2.2	Eligibility Criteria for Outreach Eligibility for outreach will vary and is specific to each agency. Criteria can include but is not limited to clients: • Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks; • Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks; • Clients who have not been seen in 4 months by their primary care provider; and/or • Three missed appointments in past 12 months (do not have to be consecutive).	• Documentation of eligibility criteria will be maintained in client's files • Legible signed and dated in documentation in the client record
3.0	**Supervision**	
3.1	Outreach Worker Supervision Four (4) hours of supervision per month must be provided to each outreach worker. At least one (1) hour of supervision must be individual supervision. The remaining three (3) hours may be individual or group. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the outreach worker relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments	• Documentation in supervision notes, which must include: ➢ Date & duration of time ➢ name(s) of outreach worker(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature Supervision notes are never maintained in the client record

3.2	Case Reviews – Outreach Worker Supervisor reviews a random sample equal to 10% of unduplicated clients served by each Outreach Worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible and that services provided appropriately.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and Outreaeh Worker.

Primary Medical Care

The 2006 CARE Act defines Primary Medical Services as the "provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse speeialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting..... Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history tasking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions and referral to and provisions of specialty care".

The RW Part A primary care visit consist of a client examination by a qualified Medical Doctor, Nurse Practitioner, Clinical Nurse Specialist and/or Physician Assistant and includes all ancillary services such as eligibility screening, patient medication/treatment education, adherence education, counseling and support; medication access/linkage; and as clinically indicated, OB/GYN specialty procedures, nutritional counseling, routine laboratory and radiology. All primary care services must be provided in accordance with the current U.S. Department of Health and Human Services guidelines (HHS).

1.0	**Medical Care for persons with HIV should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published HHS treatment guidelines**	
1.1	Minimum Qualifications Medical care for persons living with HIV shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV care including fellowship.	• Credentials on file
1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 people living with HIV patients within the last year • Maintain a minimum of 30 hours of HIV-specific CME (including a minimum of 10 hours related to antiretroviral therapy) every two years in accordance with State licensure renewal dates. Agencies using	• Documentation in personnel record

	contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordanee with State licensure renewal dates • Physieian extenders must obtain this experience within six months of hire • All staff receive professional supervision • Staff show training and/or experienee with the medieal care of adults living with HIV	
1.3	Peer Review Agency/Provider will conduet peer review for all levels of licensed/eredentialed providers (i.e. MD, NP, PA).	• Provider will document peer review has occurred annually
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (http://www.aidsinfo.nih.gov/guidelines/) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines.	• Documentation in client's record • Exceptions noted in client's record
1.6	Medical Evaluation/Assessment All people living with HIV receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS	• Completed assessment in client's record

	or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client. A comprehensive reasscssment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall inelude at a minimum, general medical history, a eomprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV relatcd history shall include: • Psychosoeial history • HIV treatment history and staging • Most recent CD4 counts and VL test results • Resistanee testing and co receptor tropism assays as clinically indieated • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaceines • Psychiatric history • Transfusion/blood produets history • Past medical care • Sexual history • Substanee abuse history • Review of Systems	
1.7	Medical Records Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered • The status of routine screening procedurcs (i.e., pap smears, mammograms, colonoscopies)	• Documentation in client's record
1.8	Plan of Care	• Plan of Care documented in client's record

	A plan of care shall be developed for each identified problem and should address diagnostic, therapeutic and educational issues in accordance with the current U.S. HHS treatment guidelines.	
1.9	Follow- Up Visits All patients shall have follow –up visits every three to six months or as clinically indicated for treatment monitoring and also to detect any changes in the client's HIV status. At each clinic visit the provider will at a minimum: • Measure vital signs including height and weight • Perform physical examination and update client history • Measure CBC, CD4 and VL levels every 3-6 months or in accordance with current treatment guidelines, • Evaluate need for ART • Resistance Testing if clinical indicated • Evaluate need for prophylaxis of opportunistic infections • Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan • Update problem list • Refer client for ophthalmic examination by an ophthalmologist every six months when CD4 count falls below 50CU/MM • Refer Client for dental evaluation or care every 12 months • Incorporate HIV prevention strategies into medical care for of persons living with HIV • Screen for risk behaviors and provide education on risk reduction, including pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for negative partners, and Undetectable = Untransmittable • Assess client comprehension of treatment plan and provide education/referral as indicated • Refer for other clinical and social services where indicated	• Content of Follow-up documented in client's record • Documentation of specialist referral including dental in client's records
1.10	Yearly Surveillance Monitoring and Vaccinations • All women living with HIV–should have regular pap tests ➢ An initial negative pap test should be followed with another pap test in 6-12 months and if negative, annually thereafter.	• Documentation in client's record

	➢ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years ➢ Women 30 years old and older may have pap test and HPV co-testing, and if normal, repeated every 3 years ➢ A pap test showing abnormal results should be managed per guidelines • Sereening for anal cancer, if indicated • Resistance Testing if clinical indicated • Chem. panel with LFT and renal function test • Influcnza vaccination • Annual Mental Health Screening with standardized tool • TST or IGRA (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Servicc, Infectious Diseases Society of America. *Guidelines for preventing opportunistic infections among peaple living with HIV*) (Available at aidsinfo.nih.gov/Guidelines/) • Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated	
1.11	Preconception Care for Women Living with HIV of Child Bearing Age In accordance with the US Department of Health and Human Services recommendations (http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf), preconception care shall be a component of routine primary care for women of child bcaring age living with HIV and should include preconception counseling. In addition to the general eomponents of preconception counseling, health care providers should, at a minimum: • Assess women's pregnancy intentions on an ongoing basis and discuss reproductivc options • Offer effective and appropriate contraceptive methods to women who wish to prevent unintended prcgnancy • Counsel on safe sexual practices • Counsel on eliminating of alcohol, illicit drugs and smoking • Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, and prevention and potential effeets of HIV and treatment on pregnancy course and outcomes	• Documentation of preconception counscling and care at initial visit and annual updatcs in Client's record as applicable

	• Inform women of interventions to prevent sexual transmission of HIV when attempting conception with a partner who does not have HIV Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur • Maximum suppression of viral load prior to conception	
1.12	Obstetrical Care for Pregnant Women Living with HIV Obstetrical care for pregnant women living with HIV shall be provided by board certified obstetricians experienced in the management of high risk pregnancy and has at least two years experience in caring for pregnant women living with HIV. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines http://www.aidsinfo.nih.gov/Guidelines.	• Documentation in client's record
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of and Infants, Children and Pre-pubertal Adolescents Care and monitoring of children exposed to HIV must be done in accordance to the HHS guidelines. Treatment of infants and children living with HIV should be managed by a specialist in pediatric and adoleseent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Care (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	• Documentation in client's record

1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year paid experience in HIV care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e. initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record • Documentation of counseling in client records
1.17	Documented Non-Adherence with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-adherence with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-adherence with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care	• Review of Policies and Procedures Manual indicates compliance.

	coordination with mental health and/or substance abuse providers for clients who have mental health and substanee abuse issues.	
1.19	Intimate Partner Violence Screening Policy The agency must have in place a written poliey and proeedure regarding elient Intimate Partner Violenee (IPV) Screening that is eonsistent with the Houston EMA IPV Protoeol. The poliey and proeedure should address: • proeess for ensuring elients are sereened for IPV no less than annually • intervention procedures for patients who screen positive for IPV, ineluding referral to Medieal/Clinieal Case Management • State reporting requirements assoeiated with IPV • Description of required inedieal record documentation • Procedures for patient referral ineluding available resources, procedures for follow-up and responsible personnel Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Proeedures Manual indicates eomplianee. • Doeumentation in patient reeord
1.20	Patient Retention in Care The agency must have in place a written policy and proeedure regarding client retention in care. The policy and procedure must include: • proeess for client appointmcnt reminders (e.g. timing, frequency, position responsible) • process for contacting elients after missed appointments (e.g. timing, frequency, position responsible) • measures to promote retention in care process for re-engaging those lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates complianee •
2.0	**Psychiatric care for persons with HIV should refleet competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines.**	
2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsyeh.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.	• Documentation in patient record
3.0	**In addition to demonstrating competency in the provision of HIV specific care, HIV clinical service programs must show evidenee that their performance follows norms for ambulatory care.**	

3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be doeumented) Ageney must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mcchanisms for information/referral to: ➢ Medical sub-speeialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services ➢ Substance abuse treatment serviees ➢ Anti-retroviral eounseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	• Agency Policy and Procedure regarding continuity of care.
3.2	Continuity with Referring Providers Agency must have a formal policy for eoordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.3	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems
3.4	Client Notification of Service Provider Turnover Client must be provided notiee of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record
3.5	Recommended Format for Operational Standards Detailed standards and routines for program assessment are found in most recent Joint Commission performance standards.	• Ambulatory HIV clinical service should adopt and follow performanee standards for ambulatory care as established by the Joint Commission

3.6	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider caneellations, and a protocol for how patients will be accommodated when they do not receive notifieation in advanee of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medieation.	• Review of Agency's Policies and Procedures Manual indicates compliance

Substance Use Services

The Houston EMA Substance Abuse Trcatment/Counseling service is an outpatient service providing treatment and/or counseling to pcople living with HIV who have substance use disorders. Serviees provided must be integrated with HIV-rclated issues that triggcr rclapse and must be coordinated with local TDSHS/SAS HIV Early Intervention funded programs. All services must be provided in accordance with the Texas Department of State Health Services/Substance Abuse serviees (TDSHS/SAS) Chemical Dependency Treatment Facility Standards as well as current treatment guidelines.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Comprehensive Assessment A comprehensive assessment including the following will be completed within ten (10 days) of intake or no later than and prior to the third therapy session. • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance use history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self attitude, suicidal tendencies, perceptual disturbances, obsessions/eompulsions, phobias, panie attacks) • Cognitive assessment (level of eonseiousness, orientation, memory and language) Specific assessment tools sueh as the Addietion Severity Index(ASI) could be used for substanee use and sexual history and the Mini Mental State Examination (MMSE) for eognitive assessment.	• Completed assessment in client's record
1.2	Psychosocial History A psyehosocial history will be completed and must include: • Education and training • Employment • Military service • Legal history • Family history and constellation	• Completed assessment in elient's record

	• Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	
1.3	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in the Texas Department of State Health Services Administrative code for substance abuse including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address full range of substances the patient is abusing Treatment plans must be completed no later than five working days of admission. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance use as clinically indicated.	• Completed treatment plan in client's record • Treatment Plan review documented in client's records
1.4	Treatment Plan Review In accordance with the Texas Department of State Health Services Administrative code on Substance Abuse, the treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	• Review of agency's Policy and Procedure Manual indicates compliance • Updated treatment plan in client's record
2.0	**Services are part of the coordinated continuum of HIV services.**	
2.1	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agency must have collaboration agreements with mental health and primary care providers or demonstrate that they offer these services on-site.	• Documentation of referrals received • Documentation of referrals out • Staff interviews indicate compliance • Collaborative agreements demonstrate that these services are offered on an off-site
2.2	Facility License	• Documentation of current agency licensure

	Agency is appropriately licensed by the Texas Department of State Health Services – Substance Abuse Services (TDSHS/SAS) with outpatient treatment designations.	
2.3	Minimum Qualifications All agency staff that provides direct client services must be properly licensed per current TDSHS/SAS requirements. Non-licensed staff must meet current TDSHS/SAS requirements.	• Documentation of current licensure in personnel files
3.0	**Staff HIV knowledge is based on documented training and experience.**	
3.1	Staff Training All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance to the Texas Administrative Code, rule §448.603 (a), (c) & (d).	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines • Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b)
3.2	Experience – HIV A minimum of one (1) year documented HIV work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV work experience.	• Documentation of work experience in personnel file
4.0	**Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV Staff efforts are compassionate and sensitive to client needs.**	
4.1	Staff Supervision The agency shall ensure that each substance abuse Supervisor shall, at a minimal, be a Masters level professional (e.g. LPC, LCSW, LMSW, LMFT, Licensed Clinical Psychologist, LCDC if applicable) and licensed by the State of Texas and qualified to provide supervision per applicable TDSHS/SAS licensure requirements. Professional staff must be knowledgeable of the interaction of drug/alcohol use and HIV transmission and the interaction of prescribed medication with other drug/alcohol use.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance

Transportation Services

The 2006 Care Act classifies Medical Transportation as a support service that provides conveyance services "directly or through voucher to a client so that he or she may access health care services". The Ryan White Part A transportation services include transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. All drivers utilized by the program must have a valid Texas Driver's license and must complete a "Safe Driving" course. The contractor must ensure that each vehicle has automobile liability insurance as required by the State and all vehicles have current Texas State Inspection.

1.0	**Transportation services are offered to eligible clients to ensure individuals most in need have access to services.**	
1.1	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/HSDA • Part A Urban Transportation limited to Harris County • Part A Rural/Part B Transportation are limited to Houston EMA/HSDA, as applicable • Income no greater than 300% of the Federal Poverty level • Proof of identification • Documentation of ineligibility for Third Party Reimbursement	• Documentation of HIV+ status, identification, residence and income in the client record
1.2	Voucher Guidelines (Distribution Sites) • Bus Card Voucher (Renewal): Eligible clients who reside in the Metro service area will be issued a Metro bus card voucher by the client's record-owning agency for an annual bus card upon new registration and annually thereafter, within 15 days of bus pass expiration • Bus Card Voucher (Value-Based): Otherwise eligible clients who are not eligible for a renewal bus card voucher may be issued a value-based bus card voucher per RWGA business rules ➢ In order for an existing bus card client to renew their bus card (i.e. obtain another bus card voucher for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV, or ➢ Documentation that the bus voucher is needed to ensure an out-of-care client is re-engaged in primary medical care	• Client record indicates guidelines were followed; if not, an explanation is documented • Documentation of the type of voucher(s) issued • Emergency neccssitating taxi voucher is documented • Ongoing current **(within the last 180 days)** medical care is documented in the CPCDMS OR • A current (within the last 180 days) copy of client's Viral Load and/or CD4 lab work (preferred) or proof client is on ART (HIV medications) for clients in medical care

	• Gas Card: Eligible clients in the rural area will receive gas cards from their Ryan White Part A/B rural ease managemcnt provider or their rural primary eare provider, if the client is not case managed, per RWGA business rules • Taxi Voucher: for emergencies, to aecess emergency shelter vouchers and to attend Social Security disability hearings only	with Ryan White or non-Ryan White funded providers in elient record OR • Engagement/re-engagement in medieal care is documented in client's case managemcnt assessment and serviee plan.
1.3	Eligibility for Van-Based Transportation (Urban Transportation Only) Written certification from the client's principal medical provider (e.g. medical care coordinator) is required to access van-based transportation and must be rcnewed every 180 days. All clients may reeeive a maximum of 4 non-certified round trips per year (includes taxi vouchers).	• Client record indicates compliance
2.0	**ACCESSIBILITY** **Transportation services are offered in such a way as to overcome barriers to access and utilization.**	
2.1	Notification of Service Availability Prospective and eurrent clients are informed of service availability, prioritization and eligibility rcquirements.	• Program information is clearly publicized • Availability of services, prioritization policy and eligibility requirements are defined in the information publicized
2.2	Access Clients must be able to initiate and coordinate their own services with the transportation providers in accordance with transportation system guidelincs. This docs not mcan an advocate (e.g. social worker) for the client cannot assist the elient in accessing transportation services. Agency must obtain a signed statement from clients regarding agreement on proper conduct of elient in the vehicle. This statement should include the consequences of violating the agreement.	• Agency's policies and procedures for transportation services describe how the client can aecess the serviee • Review of agcncy's complaint and grievances log • Signed agreement in client's records
2.3	Handicap Accessibility Transportation services are handicap accessible. Agency/Driver may refuse service to client with open sores/wounds or real exposure risk.	• Agency compliance with the Americans with Disabilities Act (ADA) • Agency documentation of reason for refusal of service • Documentation of training in personnel records

	Agency must have a policy in place regarding training for drivers on the proper boarding/unloading assistance of passengers with wheel chairs and other durable health devices.	
2.4	EMA Accessibility Services are available throughout the Houston EMA as contractually defined in the RFP.	• Review of agency's Transportation Log and Monthly Activity Reports for compliance
2.5	Service Availability The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and coverage must be available for medical and health-related appointments on Saturdays.	• Review of Transportation Logs • Transportation services shall be available on Saturdays, by pre-scheduled appointment for core services • Review of agency policy and procedure
2.6	Service Capacity Agency will notify RWGA and other Ryan White providers when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services. * Maximized means the agency will not be able to provide service to client within the next 72 hours.	• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized • Agency will document all clients who were denied transportation or a voucher
3.0	**Timeliness and Delays: Transportation services are provided in a timely manner**	
3.1	Timeliness There is minimal waiting time for vehicles and vans; appointments are kept • Waiting times longer than 2 hours will also be documented in the client record • If a cumulative incident of clients kept waiting for more than 2 hours reaches 75 clients in the contract year, this must be reported in writing within one business day to the administrative agent • Review of agency's complaint and grievance logs Client interviews and client satisfaction survey	• Waiting times longer than 60 minutes will be documented in Delay Incident Log. • Review of Delay incident log • Review of client's record
3.2	Immediate Service Problems Clients are made aware of problems immediately (e.g. vehicle breakdown) and notification documented.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievance logs

		• Client interviews and client satisfaction survey
3.3	Future Service Delays Clients and Ryan Whitc providers are notified of future serviee delays, changes in appointment or schedules as they occur.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievanee logs • Client interviews and client satisfaction survey • Documentation exists in the client record
3.4	Confirmation of Appointments Agency must allow clients to confirm appointments at least 48 hours in advance.	• Revicw of ageney's transportation policies and procedures indicates compliance • Review of agency's complaint and grievance logs • Client interviews and client satisfaction survey.
3.5	"No Shows" "No Shows" are documentcd in Transportation Log and client record. Passengers who do not cancel scheduled rides for two (2) consecutive times or who "no show" for two (2) consecutive times or three times within the contract year *may be* removed from the van/vehicle roster for 30 days. If elient is removed from the roster, he or she must be referred to other transportation serviees. One additional no show and the client can be suspended from service for one (1) year.	• Review of agency's transportation policies and procedures indicates compliance • Documentation on Transportation Log • Documentation in elient record
3.6	System Abuse If an agency has verified that a client has falsified the existence of an appointment in order to access transportation, the elient ean be removed from the agency roster. If a client cancels van/vehicle transportation appointments in excess of three (3) times per month, the client may be removed from the van/vehicle roster for 30 days. Agency must have published rules regarding the eonsequenees to the client in situations of system abuse.	• Documentation in the client record of verification that an appointment did not exist • Documentation in the client record of client eancellation of van/vehicle appointments • Availability of agency's published rules • Written documentation in the client record of specific instances of system abuse

3.7	Documentation of Service Utilization Transportation Provider must ensure: • Follow-up verification between transportation provider and destination service program confirming use of eligible service(s) or • Client provides proof of service documenting use of eligible services at destination agency on the date of transportation or • Scheduling of transportation services by receiving agency's case manager or transportation coordinator • In order to mitigate Agency exposure to clients who may fail to follow through with obtaining the required proof of service, Agency is allowed to provide one (1) one-way trip per client per year without proof of service documentation. The content of the proof of service will include: • Agency's letter head • Date/Time • CPCDMS client code • Name and signature of Agency's staff who attended to client • Agency's stamp	• Documentation of confirmation from destination agency in agency/client record • Client's original receipt from destination agency in agency/client record • Documentation in Case Manager's progress notes • Documentation in agency/client record of the one (1) allowable one-way trip per year without proof of service documentation
4.0	**Safety/Vehicle Maintenance: Transportation services are safe**	
4.1	Vehicle Maintenance and Insurance Vehicles are in good repair and equipped for adverse weather conditions. All vehicles will be equipped with both a fire extinguisher and first aid and CPR kits. A file will be maintained on each vehicle and shall include but not be limited to: description of vehicle including year, make, model, mileage, as well as general condition and integrity and service records. Inspections of vehicle should be routine, and documented not less than quarterly. Seat belts/restraint systems must be operational. When in place, child car seats must be operational and installed according to specifications. All lights and turn signals must be operational, brakes must be in good working order, tires must be in good condition and air conditioning/heating system must be fully operational.	• Inspection of First Aid/CPR kits indicates compliance • Review of vehicle file • Current vehicle State Inspection sticker. • Fire extinguisher inspection date must be current • Proof of current automobile liability and personal injury insurance in the amount of at least $300,000.00

	Driver must have radio or cell phone capability.	
4.2	Emergency Procedures Transportation emergency procedures are in place (e.g. breakdown of agency vehiele). Written procedures are developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergeneies before commencing service, and will be in-serviced annually.	• A copy of cach in-service and sign-in roster with namcs both printed and signed and maintained in the driver's personnel file
4.3	Transportation of Children Children must be transported safely. When transporting children, the agency will adhere to the Texas Transportation code 545.412 child Passenger Safety Seat Systems. Information regarding this code can be obtained at http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm. Neeessity of a ear seat should be documented on the Transportation Log by staff when appointment is scheduled. Children 15 years old or younger must be accompanied by an adult earegiver in order to be transported.	• Review of Transportation Log indicates compliance • Review of client records indicates compliance • Review of agency policies and proeedures
4.4	Staff Requirements Picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting clients Drivers must have annual proof of a safe driving record, including history of tickets, DWI/DUI, or other traffic violations Conviction on more than three (3) moving violations within the past year will disqualify the driver Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.	• Documentation in vehicle • Documentation in personnel file
5.0	**Records Administration: Transportation services are documented consistently and appropriately**	
5.1	Transportation Consent Prior to receiving transportation services, clients must read and sign the Transportation Consent.	• Review of client records indieates compliance
5.2	Van/Vehicle Transportation Agency must document daily transportation serviees on the Transportation Log.	• Review of agency files indicates compliance

		• Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.
5.3	Mileage Documentation Agency must document the mileage between Trip Origin and Trip Destination (e.g. where client is transported to access eligible service) per a standard Internet-based mapping program (e.g. Yahoo Maps, Map Quest, Google Maps) for all clients receiving Van-based transportation services.	• Map is printed out and filed in client chart

Vision Services

The Vision Services is an integral part of the Outpatient Ambulatory Medical Care Services. Primary Care Office/Clinic Vision Care consist of comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. Allowable visits with a credentialed Ophthalmic Medical Assistant include routine and preliminary tests such as musele balanee test, Ishihara color test, Near Point of Conversion (NPC), visual aeuity testing, visual field testing, Lensometry and glasses dispensing.

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Ongoing Training Four (4) hours of continuing education in vision-related or other speeific topies is required annually.	• Documentation of all training in personnel file • Staff interviews indieate compliance
1.2	Staff Experience/Qualifications Minimum of one (1) year HIV work experience for paid staff (optometry interns exempt) is preferred. Provider must have a staff Doctorate of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist, or a medical doctor who is board certified in ophthalmology.	• Documentation of work experience in personnel file
1.3	Staff Supervision Staff serviees are supervised by a paid eoordinator or manager. Supervision of clinical staff shall be provided by a practitioner with at least two (2) years experienee in vision care and treatment of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance
2.0	**Patient Care**	
2.1	Physician Contact Information Agency obtains and documents primary care physician contact information for each client. At minimum, agency should collect the physician's name and telephone number.	• Documentation of physician contact information in the client record
2.2	Client Intake Agency collects the following information for all new elients: Health history; Ocular history;	• Documentation in the client record

	Current medications; Allergies and drug sensitivities; Reason for visit (chief complaint).	
2.3	CD4/Viral Loads When clinically indicated, current (within the last 6 months) CD4 and Viral Load laboratory test results for elients are obtained.	• Documentation in the client record
2.4	Comprehensive Eye Exam The comprehensive eye exam will include documentation of the following: Visual acuity, refraction test, binocular vision musele assessment, observation of external structures, Fundus/retina Exam, Dilated Fundus Exam (DFE) when clinically indicated, Glaucoma test, findings of exam - either normal or abnormal, written diagnoses where applicable, Treatment Plan. Client may be evaluated more frequently based on clinical indications and eurrent US Public Health Scrvice guidelines.	• Documentation in the client record
2.5	Lens Prescriptions Clients who have clinical indications for corrective lens must receive prcscriptions, and referrals for such services to ensure they are able to obtain thcir eyeglass.	• Documentation in the client rceord

Appendix B

HIV Performance Measures

The following performance indicators are measured system wide to assess the impact of HIV services on the health status of the people living with HIV in the Houston EMA. These indicators are based on current HHS Guidelines for HIV health care and community input, and will be revised annually to reflect new directives.

Clinical Case Management

- A minimum of 75% of clients will utilize Part A/B/C/D primary care at least two or more times three months apart after accessing clinical case management
- 35% of clinical case management clients will utilize mental health services.
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- 85% of clinical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year.
- Percent of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment
- Less than 15% of clients will be homeless or unstably housed

Health Insurance Assistance

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Local Pharmacy Assistance

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Medical Case Management

- 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
- 15% of medical case management clients will utilize mental health services.
- 45% of clients will have 3rd party payer coverage (e.g. Medicare, Medicaid, private insurance) after accessing medical case management.
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- 50% of clients will have at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
- Less than 20% of clients will have more than a 6 month gap in medical care in the

measurement year

- 60% of medical case management clients will have a medical case management care plan developed and/or updated two or more times in the measurement year.
- Less than 15% of clients will be homeless or unstably housed

Medical Nutritional Supplements

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- 90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year

Oral Health

- 100% of oral health clients will have a dental and medical health history (initial or updated) at least once in the measurement year.
- 90% of oral health clients will have a dental treatment plan developed and/or updated at least once in the measurement year.
- 85% of oral health clients will receive oral health education at least once in the measurement year.
- 90% of oral health clients will have a periodontal screen or examination at least once in the measurement year.
- 50% of oral health clients will have a Phase 1 treatment plan that is completed within 12 months.

Outreach

- Percent of clients who attended a primary care visit within 3 months of the first Outreach visit
- Percent of Outreach clients who attended a primary care visit within 3 months of the first Outreach visit AND a subsequent visit 6-12 months thereafter
- Percent of clients who went from an unsuppressed VL (≥200 copies/ml) to a suppressed viral load (<200 copies/ml) in the project year

Primary Medical Care

- 100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible client to receive an initial appointment to enroll in outpatient/ambulatory medical care
- 100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible client to receive an appointment to receive outpatient/ambulatory medical care

- 90% of clients will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year
- Less than 20% of clients will have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care
- 100% of eligible clients, will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis
- 100% of pregnant women living with HIV will be prescribed antiretroviral therapy
- 75% percent of female clients will receive cervical cancer screening in the last three years
- 55% of clients will complete the vaccination series for Hepatitis B
- 95% of clients will have Hepatitis C (HCV) screening performed at least once since HIV diagnosis
- 85% of clients will receive HIV risk counseling within the measurement year
- 95% of clients will have been screened for substance abuse (alcohol and drugs) in the measurement year
- 90% of clients who were prescribed antiretroviral therapy and will have a fasting lipid panel during the measurement year
- 30% of clients will receive an oral exam by a dentist at least once during the measurement year
- 65% of clients at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year.
- 85% of clients will have a test for syphilis performed within the measurement year
- 75% of clients will have documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since HIV diagnosis
- 95% of clients will have been screened for Hepatitis B virus infection status at least once since HIV diagnosis
- 65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR who reported previous receipt of an influenza immunization
- 95% of clients will be screened for clinical depression using a standardized tool and follow up plan documented.
- 90% of clients will have ever received pneumococcal vaccine
- 100% of clients will be screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
- 90% of clients will have a viral load test performed at least every six months during the measurement year
- 90% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

- 35% of clients will have at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
- 95% of clients will be prescribed antiretroviral therapy during the measurement year
- Less than 20% of clients will have more than a 6 month gap in medical care in the measurement year
- 85% of clients will have an HIV drug resistance test performed before initiation of antiretroviral therapy if therapy started during the measurement year
- 75% of eligible reproductive-age women will receive reproductive health care (fertility desires assessed and client counseled on conception or contraception)
- 90% of clients will be screened for Intimate Partner Violence
- 100% of clients on ART will be screened for adherence
- 60% of new clients will be engaged in care

Non-Medical Case Management/Service Linkage

- 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)
- 60% of clients will access RW primary medical care for the first time after accessing service linkage for the first time
- Mean of less than 30 days between first ever service linkage visit and first ever primary medical care visit (Mean, Median, &/or Mode)
- 60% of newly enrolled clients will have a medical visit in each of the 4-month periods of the measurement year

Substance Abuse

- A minimum of 70% of clients will utilize Part A/B/C/D primary medical care after accessing Part A funded substance abuse treatment services
- 90% of clients will complete substance abuse treatment program
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Transportation

- A minimum of 70% of clients will utilize Part A/B/C/D primary care services after accessing Van Transportation services.
- 55% of clients will utilize Part A/B LPAP services after accessing Van Transportation services.
- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing Bus Pass services.
- A minimum of 20% of clients will utilize Part A/B LPAP services after accessing Bus

Pass services.

- A minimum of 85% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services.

Vision

- 75% of clients with diagnosed HIV related and general ocular disorders will resolve, improve, or stay the same over time
- 100% of vision clients will have a vision and medical health history (initial or updated) at least once in the measurement year.
- 100% of vision clients will have a comprehensive eye examination at least once in the measurement year

TEXAS DEPARTMENT OF STATE HEALTH SERVICES, DSHS HIV CARE SERVICES GROUP
RYAN WHITE PART B PROGRAM

UNIVERSAL STANDARDS

The Universal Standards listed below are applicable to all service categories funded under the Ryan White Part B Program for direct care service providers. These Universal Standards are taken directly from the HRSA Standards listed in the Part B HIV/AIDS Bureau (HAB) Universal National Monitoring Standards and expanded to include DSHS program requirements for all Ryan White Part B and State Service sub-recipients. HRSA/HAB "expects recipients to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV services in the State/Territory" and to report on "ongoing progress" of implementation of the National Monitoring Standards (NMS)[1].

Note: The Uniform Guidance, HHS Grants Policy Statement has not changed since January 1, 2007; Policy Clarification Notices, Program Letters, and the Notice of Grant Award are the Ryan White Part B grants management regulation and policy documents.[2]

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBLITY	LIMITATIONS	SOURCE CITATION
Section A:* ACCESS TO CARE** ***NOTE: Recipients receiving Federal financial assistance take steps to ensure that people with limited English proficiency can meaningfully access health and social services. See EO 13166, August 11, 2000; FY 2017 NOA Standard Terms #9. Providers will ensure clients have access to the language line to ensure people can meaningfully understand their treatment plans and care goals.				
1. Structured and ongoing efforts to obtain input from clients in the design and delivery of services	1. Documentation of Consumer Advisory Board and public meetings – minutes, and/or 2. Documentation of existence and appropriateness of a suggestion box or other client input mechanism, and/or 3. Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted at least annually	1. Maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes and/or; 2. Maintain visible suggestion box or other client input mechanism and/or; 3. Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented.		Universal National Monitoring Standards, Section A.1[3]; Program National Monitoring Standards (NMS), Section H.1a and H.1b; FY 2017 Part B Funding Opportunity Announcement (FOA), pp. 10-11; Part B Manual revised in 2015, p. 77; DSHS POPS 13.2. Public Health Service (PHS) Act, 42 U.S.C. sections 2602(b)(6), 2605 (a)(7)(B), 2617 (b)(5), 2617 (b)(6), 2617(b)(7)(A), 2616(c)(4).

[1] FY 2017 Part B Funding Opportunity Announcement, pp. 22-23.
[2] Ryan White Part B Manual, 2015; pp. 56-57.
[3] HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs & Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements). Accessed December 2016 on http://hab.hrsa.gov/program-grants-management/ryan-white-hivaids-program-recipient-resources. *Universal Monitoring Standards will be utilized throughout Source Citation in this document and reflects this footnoted resource.*

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section A*: ACCESS TO CARE (continued)**				
2. Provision of services regardless of an individual's ability to pay for the service	Sub-recipients billing and collection policies and procedures do ***not***: ▪ Deny services for non-payment ▪ Deny payment for inability to produce income documentation ▪ Require full payment prior to service ▪ Include any other procedure that denies services for non-payment	1. Have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay 2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of compliant review and decision reached		Universal National Monitoring Standards, Section A.2; Program Part B NMS, Section H.2b. PHS Act sections 2605(a)(7)(A)(i), and 2617(b)(7)(B)(i) DSHS Policy AA-5018 Section F.
3. Provision of services regardless of the current or past health condition of the individual to be served	Documentation of eligibility and clinical policies to ensure that they do ***not***: ▪ Permit denial of services due to pre-existing conditions ▪ Permit denial of services due to non-HIV-related conditions (primary care) ▪ Provide any other barrier to care due to a person's past or present health condition	1. Maintain files of eligibility and clinical policies 2. Maintain file of individuals refused services		Universal National Monitoring Standards, Section A.3; Program Part B NMS, Section H.2b PHS Act sections 2605(a)(7)(A) and 2617(b)(7((B)(i) DSHS Policy AA-5018
4. Provision of services in a setting accessible to low-income individuals with HIV disease	1. A facility that is handicapped accessible, accessible by public transportation 2. Policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation 3. No policies that may act as a barrier to care for low-income individuals	1. Comply with Americans with Disabilities Act (ADA) requirements 2. Ensure that the facility is accessible by public transportation or provide for transportation assistance	***NO direct cash payments to clients*** can be made for transportation needs.	Universal National Monitoring Standards, Section A.4; Program Part B NMS, Section H.2c PHS Act sections 2605(a)(7)(B), 2617(b)(7)(B)(ii), 2616(c)(4)

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section A: **ACCESS TO CARE (continued)**				
5. Efforts to inform low-income individuals of the availability of HIV-related services and how to access them	Availability of informational materials about sub-recipient's services and eligibility requirements such as: ▪ Newsletters ▪ Brochures ▪ Posters ▪ Community Bulletins ▪ Any other types of promotional materials	Maintain file documenting sub-recipient's activities for the promotion of HIV services to low-income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements		Universal National Monitoring Standards, Section A.5; Program Part B NMS, Section H.2d PHS Act sections 2605(a)(7)(C), 2617(b)(7)(B)(iii), 2616(c)(3)
Section B: **Eligibility Determination**				
1. Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction (in this case State) or ADAP: ▪ Eligibility determination of clients to determine eligibility for Ryan White services within a predetermined timeframe ▪ Reassessments of clients every 6 months to determine continued eligibility	1. Documentation of eligibility required in client records, with copies of documents (e.g., proof of HIV status, proof of residence, proof of income eligibility based on the income limit established by the State, ADAP, or local area, proof of insurance, uninsured or underinsured), using approved documentation as required by the State 2. Eligibility and Determination Enrollment forms for other third party payors such as Medicaid and Medicare 3. Eligibility policy and procedures on file 4. Documentation that all staff involved in eligibility determination has participated in required training 5. Sub-recipient client data reports are consistent with eligibility requirements specified by funder 6. Documentation of reassessment of client's eligibility status every six months 7. Training provided by the sub-recipient/ contractor to ensure understanding of the policy and procedures	1. Initial Eligibility Determination & once a year/12-month period recertification documentation requirements: ▪ HIV diagnosis (at initial determination) ▪ Proof of residence ▪ Low income (Not more than 500% of FPL) ▪ Uninsured or underinsured status (insurance verification as proof) ▪ Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare ▪ For underinsured, proof this service is **not** covered by other third party insurance programs including Medicaid and Medicare ▪ Proof of compliance with eligibility determination as defined by the State or ADAP		Universal National Monitoring Standards, Section B.1; FY 2017 FOA, pp. 15 & 43; Notice of Grant Award (NGA) dated 3/11/2016 for award #2 X07HA00054-26-00, Program Specific Terms (PST) #5; FY 2017 FOA Standard Terms #14 NMS: Frequently Asked Questions (FAQ), #35, 38-44. PHS Act sections 2616(b)(12), 2617(b)(7)(B)(iv) PCN #13-01 (rev 12/13/13), 13-02, 13-03 (rev 9/13/13), 16-02 (revised) DSHS Policy HIV/STD 220.001

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section B*: Eligibility Determination (continued)**				
1. (Continued) Eligibility Determination		2. Recertification (minimum of every six months) documentation requirements: • Proof of residence • Low income documentation (not more than 500% FPL) • Uninsured or underinsured status (insurance verification as proof) • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare **Note**: At six-month recertification, one of the following is acceptable: *full application and documentation, self-attestation of no change, or self-attestation of change with documentation.* 3. Proof of compliance with eligibility determination as defined by the State or ADAP 4. Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum of every six months 5. Document that all staff involved in eligibility determination have participated in required training 6. Sub-recipient client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services		

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section B*: Eligibility Determination (continued)**				
2. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services	Documentation that eligibility determination policies and procedures do not consider VA health benefits as the veteran's primary insurance and deny access to Ryan White services citing "payor of last resort"	Ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payor of last resort" requirement		Universal National Monitoring Standards, Section B.2; NMS FAQ #43; PCN 16-01 DSHS HIV/STD Policy 220.001
3. Payor of Last Resort: Ensure that RWHAP Part B and State Services funds distributed by DSHS are used as PoLR for eligible services and eligible clients.	Agencies have written policies and/or protocols for ensuring RWHAP Part B and State Services funds are used as PoLR for eligible services and eligible elients.	AAs will develop and assure compliance with local policies required by DSHS polieies, and monitor provider billing of third party payors to determine compliance with PoLR requirements.		Part B Program National Monitoring Standards, Section H.4c; FY 2017 FOA, pp. 14, 15, 43; PCN 07-01; PCN 16-01; PCN 16-02; Part B Manual, p. 63 PHS Act section 2617(b)(7)(F) DSHS Policy 590.001 & 220.001
***Section C*: Anti-Kickback Statute**				
1. Demonstratcd structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program	1. Employee Code of Ethics including: ▪ Conflict of Interest ▪ Prohibition on use of property, information or position without approval or to advance personal interest ▪ Fair dealing – engaged in fair and open competition ▪ Confidentiality ▪ Protection and use of company assets ▪ Compliance with laws, rules, and regulations	1. Maintain and review file documentation of: ▪ Corporate Compliance Plan (required by CMS if providing Medicare-or Medicaid-reimbursable services) ▪ Personnel Policies ▪ Code of Ethics or Standards of Conduct ▪ Bylaws and Board policies ▪ File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct		Universal National Monitoring Standards, Section C.1; NGA, Standard Terms (ST) #7 PHS Act 42 U.S.C. 1320-7b(b) AA Core Competencies

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section C*: Anti-Kickback Statute (continued)**				
1. (Continued) Demonstrated structured and ongoing efforts	1. (Continued) • Timely and truthful disclosure of significant accounting defieiencies • Timely and truthful disclosure of non-compliance	1. (Continued) • Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution 2. For not-for-profit contractors/sub-recipient organizations, ensure documentation of sub-recipient Bylaws, Board Code of Ethics, and business conduct practices		
2. Prohibition of employees (as individuals or entities), from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Any documentation required by the Compliance Plan or employee conduct standards that prohibits employees from receiving payments in kind or cash from suppliers and contractors of goods or services	1. Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: ▪ Awarding contracts ▪ Referring clients ▪ Purchasing goods or services, and/or ▪ Submitting fraudulent billings 2. Have employee policies that discourage: ▪ The hiring of persons who have a criminal record relating to or are currently being investigated for Medicaid/Medicare fraud ▪ Large signing bonuses		Universal National Monitoring Standards, Section C.2; NGA, ST #7 PHS Act 42 U.S.C. 1320-7b(b) AA Core Competencies
***Section D*: Recipient Accountability**				
1. Proper stewardship of all grant funds including compliance with programmatic requirements	Policies, procedures, and contracts that require: • Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category • Timely submission of programmatic reports • Documentation of method used to track unobligated balances and carryover funds • A documented reallocation process	Meet contracted programmatic and fiscal requirements, including: • Provide financial reports that specify expenditures by service category and use of Ryan White funds as specified by Recipient • Develop financial and sub-recipient Policies and Procedures Manual that meet federal and Ryan White program requirements • Closely monitor any sub-recipients/contractors		Universal National Monitoring Standards, Section D.1; NGA, PST #4; Part B Manual, p. 11; 45 CFR 75 - §75.300 (on compliance with regulations); 45 CFR 75 - §75.301 (Performance Measurement) AA Core Competencies

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section D: **Recipient Accountability (continued)**				
1. (Continued) Proper stewardship	Policies, procedures, and contracts that require (continued): • Report of total number of fundcd sub-rccipients/contractors • A-133 or single audit • Auditor management letter	Meet contractcd programmatic and fiscal requirements, including (continued): • Commission an independent audit; for those meeting thresholds, an audit that meet A-133 requirements • Respond to audit requcsts initiated by Recipient		
2. Recipient accountability for the expenditure of funds it shares with lead agencies (usually health departments), sub-recipients	1. A copy of each contract 2. Fiscal, program site visit reports and aetion plans 3. Audit reports 4. Documented reports that track funds by formula, supplemental, service categories 5. Documented reports that track unobligatcd balance and carryover funds 6. Documented reallocation process 7. Report of total number of funded sub-recipients/contractors 8. Sub-recipient A-133 or single audit conducted annually and made available to the State every year an audit is conductcd. (Note: State requires submission to the System Agency and Office of Inspector General within 30 calendar days of receipt of the audit reports every year an audit is conducted)* 9. Auditor management letter	Establish and implement: 1. Fiscal and general policies and proccdures that include compliance with federal and Ryan White programmatic requirements 2. Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources 3. Timely submission of independent audits (A-133 audits if required) to the State 4. Policies in place the ensure program income is documented per the Notice of Award using the "additive" method. 5. Program income must be used for the purposes for which the award was made, and may only be used for allowable costs under the award.		Universal National Monitoring Standards, Section D.2; FY 2017 FOA, pp. 22-23; Part B Manual, p. 47. *Submission of audit to State: HHSC Uniform Terms and Conditions Section 4.03 PCN 15-03 Texas Health and Human Services Commission, HHSC Uniform Terms and Conditions-Grant, Version 2.13, Section 2.08 Program Income.

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section D*: Recipient Accountability (continued)**				
3. Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the Recipient assurances and the Notice of Grant Award	1. Review of sub-recipient contracts 2. Fiscal and program site visit reports and action plans 3. Policies and Procedures that outline compliance with federal and Ryan White programmatic requirements 4. Independent audits 5. Auditor management letter	Ensure that the following are in place: 1. Documented policies and procedures and fiscal /programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements		Universal National Monitoring Standards, Section D.3; National Part B Fiscal Monitoring Standards, Sections E & K 45 CFR 75 45 CFR 75 - §75.302 (Financial management and standards for financial management systems)
4. Responsibility for activities that are supported under the Ryan White Program as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement Program Assurances, and Notice of Grant Award (NOA) 45 CFR 75 - §75.300 (b) The non-Federal entity is responsible for complying with all requirements of the Federal award. For all Federal awards, this includes the provisions of FFATA (FFATA – NOT for Ryan White), which includes requirements on executive compensation, and also requirements implementing the Act for the non-Federal entity at 2 CRF part 25 and 2 CFR part 170. See also statutory requirements for whistleblower protections at 10 U.S.C. 2324 and 2409, and 41 U.S.C. 4304, 4310, and 4712.	Desk audits of budgets, applications, yearly expenses, programmatic reports; audit reports or on-site review when assessing compliance with fiscal and programmatic requirements	Ensure fiscal and programmatic policies and procedures are in place that comply with federal and Ryan White program requirements	Activities do NOT support Trafficking Victims	RW Part B Universal National Monitoring Standards, Section D.4; FY 2017 NOA ST #10; Part B Manual, p. 11; DSHS Statement of Work 45 CFR 75 45 CFR 75 - §75.300 (on compliance with regulations)

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section E*: Reporting**				
1. Submission of standard reports as required in circulars as well as program-specific reports as outlined in the Notice of Grant Award	Records that contain and adequately identify the source of information pertaining to: ▪ Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income, interest ▪ Client level data ▪ Aggregate data on services provided; clients served, client demographics and selected financial information	Ensure: 1. Submission of timely sub-recipient reports 2. File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with existing financial or programmatic data. Example: Test program income final FFR with calendar year RDR. 3. Submission of periodic financial reports that document the expenditure of Ryan White funds, positive and negative spending variances, and how funds have been reallocated to other line-items or service categories		Universal National Monitoring Standards, Section E.1, NGA, PST #16 & #17, and Reporting Requirements; National Part B Program Monitoring Standards, Sections I & J; National Fiscal Monitoring Standards, Section K.10; Part B Manual, Section IV 45 CFR 75
***Section F*: Monitoring**				
1. Any recipient or sub-recipient or individual receiving federal funding is required to monitor for compliance with federal requirements and programmatic expectations at least annually	Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of awards	1. Participate in and provide all material necessary to carry out monitoring activities at least annually 2. Monitor any service contractors for compliance with federal and programmatic requirements at least annually		Universal National Monitoring Standards, Section F.1; FY 2017 FOA p. 23; NGA, PST #6 and PST #22; Part B Manual, Section IV; PCN 16-02 45 CRF 75 45 CFR 75 - §75.351 and 75.352 (Sub-recipient Monitoring and Management) DSHS Statement of Work

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section F*: Monitoring (continued)**				
2. Monitoring activities expected to include annual site visits of all Provider/Sub-recipients. Note: 45 CFR 75 - §75.301 "Performance reporting frequency and content should be established to not only allow the HHS awarding agency to understand the recipient progress but also to facilitate identification of promising practices among recipients and build the evidence upon which the HHS awarding agency's program and performance decisions are made."	Review of the following program monitoring documents and actions: a. Policies and procedures b. Tools, protocols, or methodologies c. Reports d. Corrective action plans e. Progress on meeting goals of corrective action plans	1. Establish policies and procedures to ensure compliance with federal and programmatic requirements 2. Submit auditable reports 3. Provide the recipient access to financial documentation		Universal National Monitoring Standards, Section F.2; FY 2017 FOA, p. 22; NMS FAQ #25 45 CFR 75 45 CFR 75 - §75.301 (Performance Measurement)
3. Performance of fiscal monitoring activities to ensure that Ryan White funding is being used for approved purposes	Review of the following fiscal monitoring documents and actions: ▪ Fiscal monitoring policy and procedures ▪ Fiscal monitoring tool or protocol ▪ Fiscal monitoring reports ▪ Fiscal monitoring corrective action plans ▪ Compliance with goals of corrective action plans	Have documented evidence that federal funds have been used for allowable services and comply with Federal and Ryan White requirements		Universal National Monitoring Standards, Section F.3; FY 2017 FOA, p. 22; NMS FAQ #25; Part B Manual, Section V Inspector General 2004 OEI-02-01-00641 DSHS Statement of Work I. M.

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section F: **Monitoring (continued)**				
4. Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of the most current HRSA Executive Salary Level II. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts for substantive work under a HRSA grant or cooperative agreement.	1. Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Executive Salary Limit. 2. Determine whether individual staff receive additional HRSA income through other sub-awards or subcontracts.	1. Monitor staff salaries to determine whether the salary limit is being exceeded. 2. Monitor prorated salaries to ensure that the salary, when calculated at 100%, does not exceed the HRSA Executive Salary Limit 3. Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other federal sources including all parts of Ryan White do not exceed the limitation. 4. Review payroll reports, payroll allocation journals, and employee contracts.		Universal National Monitoring Standards, Section F.4; NGA, ST #11 Consolidated Appropriations Act, 2016, Division H, §202 (Limit set at $185,000 effective January 10, 2016)
5. Salary Limit Fringe Benefits: If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.	Identification of individual employee fringe benefit allocation.	Monitor to ensure that when an employee salary exceeds the salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary.		Universal National Monitoring Standards, Section F.4; NGA, ST #11 Consolidated Appropriations Act, 2016, Division H, §202 (Limit set at $185,000 effective January 10, 2016)

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section F:* Monitoring (continued)**				
6. Corrective actions taken when sub-recipient outcomes do not meet program objectives and recipient expectations, which may include: ▪ Improved oversight ▪ Redistribution of funds ▪ A "corrective action" letter ▪ Sponsored technical assistance	1. Review corrective action plans 2. Review resolution of issues identified in corrective action plan 3. Policies that describe actions to be taken when issues are not resolved in a timely manner	Prepare and submit: ▪ Timely and detailed response to monitoring findings ▪ Timely progress reports on implementation of corrective action plan		Universal National Monitoring Standards, Section F.6; FY 2017 FOA, p. 23; NMS FAQ #25; Part B Manual, Section V DSHS Program Policy 540.001
***Section G:* Quality Management**				
1. Implementation of a Clinical Quality Management (CQM) Program to: • Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent HHS guidelines for the treatment of HIV and related opportunistic infections • Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services CQM program to include: • A Quality Management Plan • Quality expectations for providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved Service Standards	1. Documentation that the Part B Program has in place a Clinical Quality Management Program that includes, at a minimum: • A Quality Management Plan • Quality expectations for providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved service category definition for each funded service 2. Review of CQM program to ensure that both the recipient and providers are carrying out necessary CQM activities and reporting CQM performance data 3. Develop and monitor own Service Standards as part of CQM Program	Participate in quality management activities as contractually required; at a minimum: • Compliance with relevant service category definitions • Collection and reporting of data for use in measuring performance		Ryan White Part B Program National Monitoring Standards, Section D.1; FY 2017 FOA pp. 2, 3, 20; NGA, PST #18; PCN 15-02, including FAQ; Part B Manual, p. 60 only. PHS Act 204(h)(5), 2618(b)(3)(E), 2664(g)(5), and 2671(f)(2) DSHS Statement of Work AA Core Competencies

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section H: **Other Service Requirements**				
1. WICY – Women, Infants, Children, and Youth: Amounts set aside for women, infants, children, and youth to be determined based on each of these population's relative percentage of the total number of persons living with HIV in the State *Note: Waiver* available if recipient can document that funds sufficient to meet the needs of these population groups are being provided through other federal or state programs	1. Documentation that the amount of Part B funding spent on services for women, infants, children, and youth is at least equal to the proportion each of these populations represents of the entire population of persons living with HIV in the State 2. If a waiver is requested, documentation that the service needs of one or more of these populations are already met through funding from another federal or state program	**Not Applicable:** DSHS will conduct all necessary documentation requirements to fulfill the State WICY report.		RW Part B Program National Monitoring Standards, Sections F.1 and H.3d; FY 2017 FOA, p. 16; NGA, PST #7 PHS Act Section 2612(e)
2. Referral relationships with key points of entry: Requirement that Part B service providers maintain appropriate referral relationships with entities that constitute key points of entry Key points of entry defined in legislation: • Emergency rooms • Substance use and mental health treatment programs • Detoxification centers, • Detention facilities • Clinics regarding sexually transmitted infections (STIs) • Homeless shelters • HIV disease counseling and testing sites • Health care points of entry specified by eligible areas • Federally Qualified Health Centers • Entities such as Ryan White Part A, C and D and F recipients	1. Documentation that written referral relationships exist between Part B service providers and key points of entry	1. Establish written referral relationships with specified points of entry 2. Doeument referrals from these points of entry		RW Part B Program National Monitoring Standards, Sections F.2 and H.2a; Part B Manual, pp. 15, 22 PHS Act 2617(b)(7)(G)

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities**				
1. Purchase of Vehicles without Approval: No use of Ryan White funds by recipients or sub-recipients for the purchase of vehicles without written approval of HRSA Grants Management Officer (GMO)	1. Implementation of measure/ method, recipient responsibility and provider/sub-recipient responsibility actions specified in I.1 above 2. Where vehicles were purchased, review of files for written permission from GMO	1. Carry out sub-recipient actions specified in I.1 above 2. If vehicle purchase is needed, seek recipient assistance in obtaining written GMO approval and maintain document in file		RW Part B Program National Monitoring Standards, Section G.2; Part B Fiscal NMS, Section B.5; NGA, PST #11 HAB Policy Notice 16-02
2. Broad Scope Awareness Activities: No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public	1. Implementation of actions specified in I.1 above 2. Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	1. Carry out sub-recipient actions specified in I.1 above 2. Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities		RW Part B Program National Monitoring Standards, Section G.3; Part B Fiscal NMS, Section B.6; FY 2017 FOA, p. 47; PCN 12-01
3. Lobbying Activities: Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel	1. Implementation of actions specified in I.1 above 2. Review of lobbying certification and disclosure forms for both the recipient and sub-recipients	1. Carry out sub-recipient actions specified in I.1 above 2. Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds		RW Part B Program National Monitoring Standards, Section G.4; Part B Fiscal NMS, Section B.8; FY 2017 FOA, p. 49 45 CFR 93 or 31. U.S.C. 1352 45 CFR 75.450 Consolidated Appropriations Act, 2016, Division H, §503

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-REICIPENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities (continued)**				
4. Direct Cash Payments: No use of Ryan White program funds to make direct payments of cash to clients	1. Implementation of actions specified in I.1 above 2. Review of Service Standards and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co-pays and deductibles, food and nutrition) 3. Review of expenditures by sub-recipients to ensure that no cash payments were made to individuals	1. Carry out sub-recipient's actions specified in I.1 above 2. Maintain documentation of policies that forbid use of Ryan White funds for cash payments to service recipients	NO direct cash payments to service recipients (clients/ consumers)	RW Part B Program National Monitoring Standards, Section g.5 and unnumbered section immediately after Section H.4b; Part B Fiscal NMS, Section B.3; NGA, PST #12; FY 2017 FOA, p. 47; PCN 16-02 PHS Act 2618(b)(6) TDSHS AA Contract SOW II. F.
5. Employment and Employment-Readiness Services: Prohibition on the use of Ryan White program funds to support employment, vocational, or employment- readiness services	Implementation of actions specified in I.1 above	Carry out sub-recipient actions specified in I.1 above		RW Part B Program National Monitoring Standards, Section G.6; PCN 16-02
6. Maintenance of Privately Owned Vehicle: No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees **Note:** This restriction does not apply to vehicles operated by organizations for program purposes	1. Implementation of actions specified in I.1 above 2. Documentation that Ryan White funds are not being used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees – except for vehicles operated by organizations for program purposes	Carry out sub-recipient actions specified in I.1 above		RW Part B Program National Monitoring Standards, Section G.7

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities (continued)**				
7. Syringe Services: No use of Ryan White funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs.	1. Implementation of actions specified in I.1 above 2. Documentation that Ryan White funds are not being used for programs related to sterile needles or syringe exchange for injection drug use.	Carry out sub-recipient actions specified in I.1 above		RW Part B Program National Monitoring Standards, Section G.8; FY 2017 FOA, p. 47; NGA, PST #10 Consolidated Appropriations Act 2016, Division H, §520
8. No use of Part B funds for construction (other than minor remodeling) or to make cash payments to clients	Documentation that no Part B funds are used for construction or to make cash payments to recipients of services	**Not Applicable:** DSHS will conduct all necessary documentation requirements.		RW Part B Program National Monitoring Standards, Section H.4b bullet 2; FY 2017 NOA PST #12 PHS Act 2618(b)
9. Additional Prohibitions: No use of Ryan White Funds for the following activities or to purchase these items: • Clothing • Funeral, burial, cremation, or related expenses • Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) • Household appliances • Pet foods or other non-essential products • Off-premise social/recreational activities or payments for a client's gym membership • Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility • Pre-exposure prophylaxis	1. Implementation of aetions specified in I.1 above 2. Review and monitoring of recipient and sub-recipient activities and expenditures to ensure that Ryan White funds are not being used for any of the prohibited activities	Carry out sub-recipient actions specified in I.1 above		RW Part B Program National Monitoring Standards, Section G.9 for all; Part B Fiscal NMS, Section B.2 for purchasing/ improvements of land/buildings/faciliti es and PrEP; PCN 16-02 for clothing, funeral, burial and property taxes PHS Act 2618(b)(6) Dr. Parham-Hopson Letter 12/2/2010 on PrEP

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESONBILITY	LIMITATIONS	SOURCE CITATION
Section J: **Minority AIDS Initiative**				
1. Reporting Submission of an Annual Plan 60 days after the budget start date or as specified on the Notice of Award that details: • The actual award amount • Anticipated number of unduplicated clients who will receive each service • Anticipated units of service • Planned client-level outcomes for each minority population served under the Minority AIDS Initiative (MAI)	Documentation that the recipient has submitted a MAI Annual Plan 60 days after the budget start date that contains required elements and meets HRSA/HAB reporting requirements	Establish and maintain a system that tracks and reports the following for MAI services: • Dollars expended • Number of clients served • Units of service overall and by race and ethnicity, women, infants, children, youth • Client-level outcomes **Not Applicable for Part B sub-recipients**: DSHS will maintain tracking and reporting for MAI services and expenditures.		RW Part B Program National Monitoring Standards, Section I; FY 2017 FOA, p. 17; NGA Reporting Requirements
2. Submission of an Annual Report following completion of the MAI fiscal year	Documentation that the recipient has submitted an Annual Report on MAI services that includes: • Expenditures • Number and demographics of clients served • Outcomes achieved	1. Maintain a system to track and report MAI expenditures, the number and demographics of clients served, and the outcomes achieved 2. Provide timely data to the Recipient for use in preparing the Annual Report **Not Applicable for Part B sub-recipients**: DSHS will maintain tracking and reporting for MAI services and expenditures.		RW Part B Program National Monitoring Standards, Section I; FY 2017 FOA, p. 17; NGA, Reporting Requirements

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section K*: Data Reporting Requirements**				
1. Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR).	Documentation that all service providers have submitted their sections of the online service providers report.	1. Report all the Ryan White Services the provider offers to clients during the funding year. 2. Submit both interim and final reports by the specified deadlines.		RW Part B Program National Monitoring Standards, Section J; NGA, PST #17 and Reporting Requirements 2016 Annual Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual DSHS Statement of Work
2. Submission of the online client report	Documentation that all service providers have submitted their sections of the online client report	1. Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client Identifier 2. Submit this report online as an electronic file upload using the standard format 3. Submit both interim and final reports by the specified deadlines		RW Part B Program National Monitoring Standards, Section J; NGA, PST #17 and Reporting Requirements 2016 Annual Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual DSHS Statement of Work

STATEWIDE PROGRAMMATIC STANDARDS

The following programmatic standards are identified for ease in determining program compliance specific to services provided in the Ryan White Part B Program for the State of Texas.

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section L: General HIV Policies & Procedures				
Grievance Policies: All contractors are required to have a written client complaint proeedure in place to meet the minimum requirements for client complaints.	Agencies have a policy and/or procedure for handling client grievances.	AAs will ensure all subcontractors and vendors will have a policy and/or procedure for handling client grievances.		PHS Act Section 2602(b) DSHS Policy 530.002 section 5.5
Delivery of Client Services: Maintain client relations of the highest possible quality.	Agencies **must** have written procedures to deal with clients who may be disruptive or uncooperative. Agencies **must have** written procedures to deal with clients who are violent or exhibit threatening behavior.	AAs will ensure all subcontractors and vendors have written procedures to deal with clients who may be disruptive or uncooperative. AAs will ensure all subcontractors and vendors have written proeedures to deal with clients who are violent or exhibit threatening behavior.		DSHS Policy 530.002 section 6.0 DSHS Policy 530.003
Non-Discrimination Policy: Written non-discrimination policies and procedures are in place that addresses protected classes and persons with disabilities, including prohibiting discrimination against sexual orientation and gender identity.	Agencies shall have eomprehensive non-discrimination policies, which prohibits discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, age, or disability, gender identity, and any other non-discrimination provision in speeific statures under which application for federal or state assistance is being made.	AAs will ensure all subcontractors have comprehensive non-discrimination policies and procedures in place.		NGA, PST #12 Title VI of Civil Rights Act of 1964, P.L. 88-352 as amended 45 CFR 75.300 DSHS Policy AA-5018

DSHS STANDARD	PERFORMANCE MEASAURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section L: General HIV Policies and Procedures (continued)				
Confidentiality regarding Patient Information: It is the policy of the DSHS THSVH Unit that information collected to prevent, treat, and control the spread of TB, HIV, STDs and Viral Hepatitis will be protected and maintained to ensure patient confidentiality.	All staff, management, and volunteers must complete a signed confidentiality agreement affirming the individuals' responsibility for keeping client information and data confidential. All staff, management, and volunteers must successfully complete confidentiality and security training.	AAs are to ensure that all vendors, subcontractors, and subrecipient staff, management and volunteers have completed signed confidentiality agreements annually. AAs are to ensure that all vendors, subcontractors, and subrecipient staff, management and volunteers have completed confidentiality and security training.		NGA, PST #21 DSHS Policy 2011.01
Breach of Confidentiality: All subcontractors and subrecipient agencies must have policies that outline how to address negligent or purposeful release of confidential client information.	Agencies will have detailed policies outlining how to address negligent or purposeful release of confidential client information in accordance with the Texas Health and Safety Code and HIPAA regulations	AAs are to ensure that all subcontractors, vendors, and subrecipient agencies have detailed policies outlining how to address negligent or purposeful release of confidential information in accordance with the Texas Health and Safety Code and HIPAA regulations.		DSHS Policy 2011.04 https://www.hhs.gov/hipaa/for-professionals/index.html
Child Abuse Reporting: HIV and STD contractors who provide clinical and/or case management services or are required to review these services if provided by subcontractors are required to monitor for compliance with Texas child abuse reporting laws and for compliance with DSHS policy referenced relating to the reporting of child abuse and the use of the DSHS "Checklist for DSHS Monitoring."	Agencies will have detailed policies outlining how to address suspected child abuse in accordance with Texas law and the DSHS policy, including the use of the DSHS "Checklist for DSHS Monitoring." Agencies have documented evidence of training provided to all staff on reporting child abuse.	All contracting agencies are required to ensure their staff is trained on Texas child abuse reporting laws and that suspected cases of child abuse are being reported as prescribed by Texas law. Note: The Child Abuse Reporting Form can be accessed on the Texas DSHS website at the following web address: http://www.dshs.texas.gov/childabusereporting/checklist.shtm		DSHS Policy 530.001

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONISIBLITY	LIMITATIONS	SOURCE CITATION
Section L: General HIV Policies and Procedures (continued)				
Incarcerated Persons in Community Facilities: Ryan White and State Services funds may not be used to pay for medical care or medications for any person incarcerated in a state or federal prison, or a local jail.	Agencies will have policies ensuring RWHAP and State Services funds are not utilized to pay for medical care or medications when incarcerated persons in community facilities are receiving services in local service provider locations.	All contracting agencies have policies in place ensuring RWHAP and State Services funding is not utilized in paying for medical care or medications when incarcerated persons in community facilities are receiving services in local service provider locations.	RWHAP and State Services funds are NOT utilized to pay for services rendered to incarcerated individuals	PCN 07-04 DSHS Policy 591.000
Conflict of Interest: Services will be provided without interference by any conflict of interest.	Agencies will have policies ensuring services will be provided without interference by any conflict of interest.	All contracting agencies have written conflict of interest policies and procedures. All employees and board members of any agency are required to complete and sign a Conflict of Interest Disclosure Form, which contains, at a minimum, the content in the sample provided by DSHS.		DSHS Policy 241.005 DSHS Conflict of Interest Statement Form AA Core Competencies
Personnel Policies and Procedures: Personnel and human resources policies are available that address new staff orientation, ongoing training plan and development, employee performance evaluations, and employee/staff grievances.	Agencies have personnel policies and procedures in place that address all items as indicated.	Agencies have personnel policies and procedures that are in compliance with local, state, and federal program requirements.		DSHS POPS 13.2 Ryan White Service Delivery Statement of Work
Required Training: Personnel and human resource departments required trainings, conferences, and meetings are documented and attended as indicated in the staff development plan, and/or in accordance with licensure requirements for direct care service providers.	Staff will attend required trainings, conferences, and meetings as indicated in the staff development plan and/or as directed by DSHS Program Staff.	Agencies will maintain documented evidence of staff trainings, conferences, and meetings to ensure program compliance. Providers shall complete cultural competency training to include cultural awareness of youth and the aging population and/or relevant local priority populations based on epidemiological data and service priorities.		PCN 11-04 Ryan White Service Delivery Statement of Work

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section M: ARIES				
ARIES Security Policy: Policies are in place to ensure that ARIES and the information collected in ARIES is protected and maintained to ensure client confidentiality.	Policies are in place at all agency locations that are funded in the state of Texas with RWHAP Part B and State Services funds that ensure ARIES information is protected and maintained to ensure client confidentiality.	Agencies will maintain policies and procedures to ensure ARIES information is protected and maintained to ensure client confidentiality.		DSHS Policy 231.001
ARIES Data Managers Core Competencies: Data managers are required to perform certain activities and possess certain knowledge, skills, and abilities, which includes but is not limited to managing and overseeing data collecting, reporting, and the Uniform Reporting System ARIES.	Data managers develop and implement local policy and procedures relating to ARIES and the data collected through ARIES.	Agencies have local policies and procedures in place relating to ARIES and the data collected through ARIES.		DSHS Policy 231.002

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures				
Outpatient/Ambulatory Health Services: OAHS are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting.	Documentation of the following: • Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting • Only allowable services are provided • Services are provided as part of the treatment of HIV infection • Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects • Services are consistent with HHS guidelines Please refer to the following link for additional information on Peer Review: **https://www.dshs.texas.gov/hivstd/taxonomy/oamcfaq.shtm** *For information regarding determining "experience" in HIV care, please review the HIV Medical Association notes **http://www.hivma.org/Defining-HIV-Expertise.aspx**	1. Ensure that client medical records document services provided, the dates and frequency of services provided, that services are for the treatment of HIV infection. 2. Include clinician notes in client records that are signed by the licensed provider of services. 3. Maintain professional certifications and licensure documents and make them available to the Recipient on request. 4. Standing Delegation Orders are available to staff and are reviewed annually, dated and signed. 5. Peer review will be conducted and documented annually for all levels of licensed/credentialed providers (e.g. MD, NP, PA). 6. Service providers shall employ clinical staff with experience* regarding their area of clinical practice as well as knowledgeable in the area of HIV clinical practice, and personnel records/resumes/applications for employment will reflect requisite experience/education. 7. All staff with less than one (1) year experience working with HIV must be supervised by an employee with at least one (1) year of experience.	Service is NOT being provided in an emergency room, urgent care, hospital or any other type of inpatient treatment center	RWHAP Part B Program National Monitoring Standards, Section B.1 PCN 13-04; PCN 16-02; PCN 16-02 FAQ General #1, 11 22 Texas Administrative Code §193.2

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Local AIDS Pharmaceutical Assistance Program (LPAP): RWHAP Part B recipients using the LPAP service category must establish the following: • Uniform benefits for all enrolled clients throughout the service area; • A recordkeeping system for distributed medications; • An LPAP advisory board; • A drug formulary approved by the local advisory committee/board; • A drug distribution system; • A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at a minimum of every six months; • Coordination with the state's RWHAP Part B ADAP (Statement of Need) • Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program	Documentation that the LPAP program's drug distribution system has: • A client enrollment and eligibility determination process that includes ADAP and LPAP eligibility with rescreening every six months • An LPAP advisory board • Uniform benefits for all enrolled clients through the region(s) • Compliance with RWHAP requirement of payor of last resort • A recordkeeping system for distributed medications • A drug distribution system that includes a drug formulary approved by the local advisory committee/ board • Medications are secured and locked/stored appropriately • System for drug therapy management • Policy for timeliness of services • MOUs with local pharmacies to ensure cost efficiency with established dispensing fees.	1. Provide to the Recipient upon request, documentation that the LPAP program meets HRSA/HAB requirements. 2. Maintain documentation, and make available to the Recipient upon request, proof of client LPAP eligibility. 3. Only authorized personnel dispense/ provide prescription medication. 4. Medications and supplies are secured in a locked area and stored appropriately. 5. Agency has a system for drug therapy management. 6. Policy for timeliness of services. 7. MOUs ensuring cost efficient methods are in place 8. MOUs ensure dispensing fees are established and implemented. 9. Active pharmacy license is onsite and is renewed every two years. 10. Pharmacies and pharmacy staff will adhere to the Texas State Board of Pharmacy rules and regulations. 11. Documentation on file that pharmacy owner if not a Texas licensed pharmacist, is consulting with a pharmacist in charge (PIC) or with another licensed pharmacist. 12. Pharmacy technicians and other personnel authorized to dispense medications are under the supervision of a licensed pharmacist. 13. A licensed nurse or practitioner designated by the pharmacist in charge (PIC) as supportive personnel may provide unit of use-packaged medications. 14. Prescriptions are filled with most cost-effective medications as evidenced by receipts.	Only Part B Base award funds may be used to support an LPAP. LPAP are not to be used for EFA. Medications are NOT dispensed with LPAP funds as: 1. A result or component of a primary medical visit 2. A single occurrence of short duration (an emergency) without arrangements for longer term access to medications 3. Vouchers to clients on a single occurrence without arrangements for longer-term access to medications	RWHAP Part B Program National Monitoring Standards, Section B.4 PCN 16-02 LPAP Policy Clarification Memo FY 2017 FOA, p. 19

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Oral Health Care: Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.	Documentation that: 1. Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines. 2. Oral health professionals providing the services have appropriate and valid licensure and certification, based on State and local laws. 3. Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations on the procedures, or a combination of any of the above, as determined by the State and/or local communities.	1. Maintain dental files for all clients. 2. Maintain and provide to Recipient upon request, copies of professional licensure and certification. 3. X-rays are taken by dental assistants who are registered with the State Board of Dental Examiners. 4. OH caps are documented at the regional level and are tracked for each client in the service area that receives OH services. 5. If cost of dental care exceeded regional caps set, documentation of reason is in the client record.		PHS ACT 2612(b)(3)(D); RWHAP Part B Program National Monitoring Standards, Section B.5; PCN 16-02 FAQ General #1 22 Texas Administrative Code §108.11; 22 Texas Administrative Code §114.2

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Early Intervention Services: includes identification of individuals at points of entry and access to services and provisions of: • HIV Testing and Targeted counseling to help unaware • Referral services to improve HIV care at key points of entry • Linkage to care such as OAHS, MCM, and Substance Abuse Care • Outreach and Health Education/Risk Reduction related to HIV diagnosis *NOTE: All 4 components MUST be present, but Part B funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding*	Documentation that: 1. Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and RW funds will supplement, and not supplant, existing funds for testing 2. Individuals who test positive are referred for and linked to health care and supportive services 3. Health education and literacy training is provided that enables clients to navigate the HIV system 4. EIS is provided at or in coordination with documented key points of entry 5. EIS services are coordinated with HIV prevention efforts and programs	1. MOUs are in place with key points of entry into care 2. All four required EIS service components are documented in the RWHAP Part B EIS program policies both at local and regional systems of care 3. Document that HIV testing activities and methods meet CDC and state requirements, including licensure to conduct phlebotomy services where applicable. 4. Establish linkage agreements with testing sites where Part B is not funding testing but is funding referral and access to care 5. Ensure agencies have capacity and training to document number of tests (if applicable), number of referrals, and results of testing. 6. Documentation that EIS program funds will supplement, not supplant, other funds available to the entity for the provision of providing EIS services in the fiscal year involved.		RWHAP Part B Program National Monitoring Standards, Section B.6 PCN 16-02; PCN 16-02 #8 PHS Act section 2612(d)(2)

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Health Insurance Premium and Cost-sharing Assistance: Provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RHWAP Part recipient must implement a methodology that incorporates the following requirements: • Ensure clients are buying health coverage that, at a minimum, includes at least one drug in each class of core ART from the HHS treatment guidelines along with appropriate HIV OAHS • Must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV OAHS, and allocate funding to HIPCSA only when determined to be cost effective. • HIV insurance continuation funds will only be used for payment of insurance premiums, deductibles, co-insurance payments, copayments, and related administrative costs. HIV insurance assistance shall be provided directly to the insurance carrier, insurance administrator, or health provider, rather than to the client. Insurance premiums may be prepaid, including that part of the coverage period, which extends beyond the Contract term.	Documentation that: • Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications • Assurance that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by RW • Assurance that RW funds are not being used to cover costs associated with Social Security • Documentation of clients' low income status • Documentation that HIV insurance continuation funds will only be used for payment of insurance premiums, deductibles, co-insurance payments, copayments, and related administrative costs. HIV insurance assistance shall be provided directly to the insurance carrier, insurance administrator, or health provider, rather than to the client.	1. Provide upon request: • Where premiums are covered by RW funds, provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications • Maintain proof of low-income status • Provide documentation that demonstrates that funds were not used to cover costs associated with the creation, capitalization, or administration of a liability risk pool, or social security costs 2. Agency has policy that outlines caps on assistance/payment limits and adheres to DSHS Policy. 3. Agency has policy that details the expectation for client contribution and tracks these contributions under client charges. 4. Agency has policy that requires referral relationships with organizations or individuals who can provide expert assistance to clients on their health insurance coverage options and available cost reductions. 5. Agency has policy that ensures referral relationships with organizations or individuals who can provide income tax preparation assistance for clients. 6. Agency has policies and procedures detailing process to make premium and out-of-pocket payments. 7. Documentation is maintained at the agency level as to number of clients served by: (1) Premium assistance/out of pocket costs; (2) IRS payments.		RWHAP Part B Program National Monitoring Standards, Section B.7 PCN 07-05; PCN 13-04; PCN 13-05; PCN 13-06; PCN 14-01 revised 4/3/2015; PCN 16-02 DSHS Policy 260.002 DSHS Policy 270.001 (Calculation of Estimated Expenditures on Covered Clinical Services)

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Home Health Care: Provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include: • Administration of prescribed therapeutics • Preventive and specialty care • Wound care • Routine diagnostics testing administered in the home • Other medical therapies The provision of Home Health Care is limited to clients that are homebound.	Assurance that: • Services are limited to medical therapies in the home and exclude personal care services • Services are provided by home health care workers with appropriate licensure as required by State and local laws	1. Maintain on file and provide to the recipient upon request, copies of the licenses of home health care workers. 2. Agency policy on operation and procedures to contact agency after hours for urgent and/or emergency care is current and evident.	Home settings do NOT include nursing facilities or inpatient mental health/substance abuse treatment facilities	RWHAP Part B Program National Monitoring Standards, Section B.8 PCN 16-02; PCN 16-02 FAQ General #1, 12 40 Texas Administrative Code §97.211

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Home and Community-based Health Services: Provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include: • Appropriate mental health, development, and rehabilitation services • Day treatment or other partial hospitalization services • Durable medical equipment • Home health aide services and personal care services in the home	1. Provide assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community based health services. 2. Documentation of appropriate licensure and certifications for individuals providing the services, as required by local and state laws.	Assurance of: 1. Services are being provided in an HIV-positive client's home, and/or a day treatment or other partial hospitalization services program as licensed by the State. 2. Maintain, and make available to recipient, copies of appropriate licenses and certifications for professionals providing services. 3. Documented policy on operation and procedures to contact agency after hours for urgent and/or emergency care. 4. The agency shall have policies/procedures for the following: • Referral resources and procedures that ensure access to a continuum of services • All appropriate consent forms (e.g., consent to share information, shared client data/registration system (ARIES), HIPAA requirements) • Consent to treatment signed by the client annually • Data collection procedures and forms, including data reporting • Quality assurance/quality improvement • Guidelines for language accessibility 5. All agency professional staff, contractors, and consultants who provide direct-care services, and who require licensure, shall be properly licensed by the State of Texas, or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act (or in the case of a nurse, the Nursing Practice Act), including satisfactory arrangements for malpractice insurance with evidence of such in the personnel file. 6. Provider will document provision of in-service education to staff regarding current treatment methodologies and promising practices.	Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.	RWHAP Part B Program National Monitoring Standards, Section B.9 PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Hospice Services: End of life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are: • Mental health counseling • Nursing care • Palliative therapeutics • Physician services • Room and board. Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that is designated and staffed to providc hospice care. Physician must certify that a client is terminally ill and has a defined life expectancy as established by recipient.	Documentation including: 1. Physician certification that the client's illness is terminal as defined under Medicaid hospice regulations. 2. Appropriate and valid licensure of provider as required by the State in which hospice care is delivered. 3. Types of services provided, and assurance that they include only allowable services. 4. Locations where hospice services are provided, and assurance that they are limited to a home or other residential setting or a non-acute care section of a hospital designated and staffed as a hospice setting. 5. Assurance that services meet Medicaid or other applicable requirements.	1. Obtain and have available for inspection appropriate and valid licensure to provide hospice care. 2. Maintain and provide the recipient access to program files and client records. 3. Documentation that staff attended continuing education on HIV and end of life issues. 4. Documentation that supervisory provider or registered nurse providcd supervision to staff. 5. Agency has a policy detailing the reasons the Agency may rely upon for refusal of referral. 6. Agency has a policy for client discharge.	Does NOT extend to skilled nursing facilities or nursing homes.	RWHAP Part B Program National Monitoring Standards, Section B.10 PCN 16-02; PCN 16-02 FAQ General #1 40 Tcxas Administrative Code §97.211
Mental Health Services: Provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.	1. Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State, including supervision of licensed staff. 2. Documentation of the existence of a detailed treatment plan for each eligible client. 3. MOUs to provide services if specific service is not available. 4. Agency has emergency/crisis intervention plan.	1. Obtain and have on file and available for recipient review appropriate and valid licensure and certification of mental health professionals, including supervision of licensed staff. 2. Maintain client records that include detailed treatment plans and documentation of services provided. 3. MOUs are available for referral needs. 4. Agency has policies/procedures in place for emergency/crisis intervention plan. 5. Agency has a policy for clinical supervision per licensure standards. 6. Agency/Provider has a discharge policy and procedure. 7. Agency/Provider has a policy/procedure documenting how clients are introduced to program services either in writing or orally.	Only for HIV clients.	RWHAP Part B Program National Monitoring Standards, Section B.11 PCN 16-02; PCN 16-02 FAQ General #1

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Medical Nutrition Therapy (MNT): MNT includes nutrition assessment and screening, dietary/nutritional evaluation, food and/or nutritional supplements per medical provider's recommendation, and nutrition education and/or counseling. These services can be provided in individual and/or group settings and outside of HIV OAHS. All services performed must be pursuant to a medical provider's referral and based on nutritional plan developed by the registered dietitian or other licensed nutrition professional.	Documentation of: 1. Licensure and registration of the dietitian as required by the State 2. Staff has the knowledge, skills and experienee appropriate to providing food or nutritional counseling/education services. 3. Licensed Registered Dietitians will maintain current professional education (CPE) units/hours, including HIV nutrition and other related medical topics approved by the Commission of Dietetic Registration.	1. Maintain and make available to the recipient copies of the dietitian's lieense and registration 2. Personnel records/resumes/ applications for employment will reflect requisite education, skills and experience. 3. Documentation in personnel records of professional education. 4. Agency has a policy and procedure for determining frequency of contact with the licensed Registered Dietitian based on the level of care needed. 5. Agency has a policy and procedure on obtaining, tracking inventory, storing, and distributing supplemental nutrition products if applicable. 6. Agency has a policy and procedures on discharging a client from medical nutrition therapy and the process for discharge/referral.		RWHAP Part B Program National Monitoring Standards, Section B.12 PCN 16-02; PCN 16-02 FAQ General #1

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Medical Case Management (MCM), including Treatment Adherence: Provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. ***Please reference DSHS MCM service standard for full complement of key activities.***	1. Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team. 2. Documentation that all activities are being carried out for all clients. 3. Documentation of case management services and encounters. 4. Documentation in client records of services provided. 5. Minimum qualifications are established regionally by the Administrative Agencies. DSHS preferred qualifications for staff: a degree in health, human or education services and one year of case management experience with people living with HIV and/or persons with a history of mental illness, homelessness, or substance use. 6. Minimum qualifications for Medical Case Management supervisors: degreed or licensed in the fields of health, social services, mental health or a related area (preferably Masters' level). Additionally, case manager supervisors must have 3 years' experience providing case management services, or other similar experience in a health or social services related field (preferably with 1 year of supervisory or clinical experience). 7. Mandatory agency training should include the provision of agency's policy and procedure manual and employee handbook to familiarize new staff with the internal workings and processes of their new work environment.	1. Maintain documentation showing that MCM services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team. 2. Maintain client records that include all required elements for compliance with contractual and RW programmatic requirements. 3. Policies and procedures are in place for conducting MCM services, including the following: • Data collection procedures and forms, including data reporting • Initial Comprehensive Assessment • MCM Case Management Acuity Level and Client contact • Care Planning • Viral Suppression/Treatment Adherence • Referral and follow-Up • Case Closure/Graduation • Case Conferencing • Caseload Management • Case Closure and Graduation • Case Transfer (internal/external) • Probationary Period (new hire) • Staff Supervision • Staff Training, including agency specific training 4. All MCM staff must meet the minimum training requirements established in this document. Training expectations for newly hired case managers can be found at: http://www.dshs.texas.gov/hivstd/contractor/cm.shtm		RWHAP Part B Program National Monitoring Standards, Section B.13 PCN 16-02; PCN 16-02 FAQ #10, 11

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Medical Case Management, including Treatment Adherence (continued)	8. Supervisors should expect to expend more time in providing such training to staff during their probationary period of employment. During the probationary period, new case managers should be monitored for satisfactory completion of core, case management specific tasks (e.g. assessments, care planning and interventions). These aetivities should be monitored in person by appropriate supervisory staff -- or qualified designees -- at least once weekly for the entire probationary period before the case manager is approved to provide services independently. 9. New Medical Case Managers must complete all components of the MCM Competency Training Course within six (6) months of hire. This course addresses the following core compctencies: • STD Facts & Fallacies: Chlamydia, Gonorrhea & Pelvic Inflammatory Disease (PID)* • STD Facts & Fallacies: Syphilis* • Perinatal HIV Prevention Online Program* *These courses are all available through the TRAIN (Training Finder Real-time Affiliate Integrated Network) Texas learning management system (www.tx.train.org). 10. Core training of staff, using supportive supervision techniques (e.g. job shadowing, performance evaluation, and immediate (responsive) job counseling/training) should be provided on an ongoing basis -- frequency based on staff experience and performance -- by supervisors.	5. Each agency is responsible for providing new staff members and supervisors with job-related training that commences within 15 working days of hire and is completed no later than 90 days following hire. 6. All staff at agencies receiving Ryan White Part B or State Services case management funds (both medical and non-medical) must complete (or have completed prior) the required MCM training within six (6) months of hire.		

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Medical Case Management, including Treatment Adherence (continued)		7. Staff performing MCM at agencies recciving Ryan White Part B or State Services case management funds must fulfill the below training requirements. 8. All case management staff must complete a minimum of 12 hours of continuing education annually in relevant topics. Relevant topics include, but are not limited to: • HIV Confidentiality and the Law • Working with Special Populations (undocumented, LGBT, Women, African-American/Black, Latino/a, aging population, youth) • Domestic Violence/Family Violence/Intimate Partner Violence • Assessment • Monitoring/Outcomes • Records Management • Resources Development/Use • Safety • Care Planning and Implementation • Ethics and HIV • Hepatitis A, B, C • Screening Tools (Substance Use, Mental Health, Sexual Health) • HIV disclosure, Partner Notification Services • Sexual Health • Harm Reduction		

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Substance Abuse Outpatient Care: Provision of outpatient services for the treatment of drug or alcohol use disorders. Services include: • Screening • Assessment • Diagnosis, and/or • Treatment of substance use disorder	1. Documentation that services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State. 2. Documentation through program files that services provided meet the service category definition. 3. All services provided are allowable under RW 4. Assurance that RW funds are used to expand HIV-specific capacity of programs only if timely access would not otherwise be available to treatment and counseling. 5. Assurance that services provided include a treatment plan that calls for only allowable activities 6. Facilities providing substance abuse treatment services will be licensed by the Texas Department of State Health Services (Department) or be registered as a faith-based exempt program. 7. Supervisors' files reflect notes of weekly supervisory conferences.	Maintain and provide: 1. Provider licensure or certifications as required by the State 2. Staffing structure showing supervision by a physician or other qualified personnel 3. Evidence that all services are provided on an outpatient basis 4. Program files and client records that include treatment plans 5. Agency will have documentation on site that license is current for the physical location of the treatment facility, if applicable. 6. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS). 7. Each staff member will have documentation of minimum experience to include: • Two years of experience in HIV or other catastrophic illness and continuing education in HIV • One year of experience in family counseling as pertaining to substance use • Non-violent crisis intervention training • Training in mental health issues and knowing when to refer a client to a mental health program/counselor. 8. Documentation of professional liability for all staff and agency.	Syringe access services are allowable, to the extent that they comport with appropriate law and applicable HHS guidance, including HRSA- or HAB-specific guidance.	RWHAP Part B Program National Monitoring Standards, Section B.14 PCN 16-02; PCN 16-02 General #1

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Substance Abuse Outpatient Care (continued)		9. Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months. Case Conference documentation, signed by the supervisor, in client record will include: • Date, name of participants and name of client • Issues and concerns • Follow-up plan • Clinical guidance provided 10. Provider agency must have and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following: • Verbal Intervention • Non-violent physical intervention • Emergency medical contact information • Incident reporting • Voluntary and involuntary client admission • Follow-up contacts • Continuity of services in the event of a facility emergency 11. Agency will have a policy and procedure for clients to follow if they need after-hours assistance. This procedure will be included in the client orientation process. 12. Written policies and procedures for staff to follow in psychiatric or medical emergencies. 13. Policies and procedures define emergency situations, and the responsibilities of key staff are identified.		

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures ***NOTE: Use of Part B funds only to support "Support Services that are needed by individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS-related clinical status" and Support Services approved by the Secretary of Health and Human Services; see Part B Program National Monitoring Standards, Section A.1 bullet #2 and Section C.1; FY 2017 FOA, p. 2***				
Non-Medical Case Management (NMCM): Provides guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. ***Please reference DSHS NMCM service standard for full complement of key activities.***	1. Documentation that scope of activity includes advice and assistance to clients in obtaining medical, social, community, legal, finaneial, and other needed services. 2. Services cover all types of encounters and communications. 3. Where transitional case management for incarcerated persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correction system for a brief period. 4. Supervisor signature and date, signifying review and approval of initial comprehensive assessment, for case managers during their probationary period.	1. Maintain client records that include the required elements as detailed by the Reeipicnt. 2. Provide assurances that any transitional case management for incarcerated persons meets contract requirements. 3. Policies and procedures are in place for conducting NMCM services. 4. Non-medical case managers will completc annual trainings per DSHS		RWHAP Part B Program National Monitoring Standards, Section C.2 PCN 16-02; PCN 16-02 FAQ #10
Child Care Services: RWHAP supports intermittent child care services for thc children living in the household of HIV clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.	1. Documentation of parent's eligibility as defined by the State. 2. Appropriate and valid licensure and registration of child care providers under applicable State and local laws where services are provided in a day care setting.	1. Maintain documentation of child care services provided. 2. Maintain valid licensure and registration of child care providers. 3. Informal child care arrangements are in compliance with Recipient requirements. 4. Agency will establish a policy and procedure to address liability issues addressed through liability release forms designed to protect the client, provider and the RW program.	No cash to clients or primary caregivers to pay for thcse servicc.s.	RWHAP Part B Program National Monitoring Standards, Section C.3 PCN 16-02; PCN 16-02 FAQ #16

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Emergency Financial Assistance: Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and medication. Services must be for limited amounts, uses, and periods of time.	1. Documentation of services and payments to verify that EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the Recipient. 2. Documentation ensuring assistance is provided only for the following essential services: utilities, housing, food, or medications through a voucher program or short-term payments to the service entity. 3. Emergency funds are allocated, tracked, and reported by type of assistance. 4. No more than a 30-day supply of medications are purchased at a time.	1. Maintain client records that document client eligibility, types of EFA provided, dates of EFA, and method of providing EFA. 2. Maintain and provide documentation of assistance provided to clients. 3. Provide assurance to State that all EFA was for allowable types of assistance, was used where RW was payor of last resort, met State or local specified limitations on amount and frequency of assistance to an individual, and provided through allowable payment methods. 4. Policies include medication purchase limitations. 5. Agencies providing EFA medications must have policies and procedures to pursue all feasible alternative revenues systems (e.g., pharmaceutical company patient assistance programs) before requesting reimbursement through EFA. 6. Agency may reimburse the pharmacy a minimal dispensing fee per prescription as outlined in a MOU.	Must be a direct payment to an agency or through a voucher program. Continuous provision of an allowable service to a client should not be funded through EFA. Grocery/Food vouchers cannot be used for the purchase of alcohol and/or tobacco products.	RWHAP Part B Program National Monitoring Standards, Section C.4 PCN 16-02; PCN 16-02 FAQ #4, 17

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Food Bank/Home-Delivered Meals: Provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to: • Personal hygiene products • Household cleaning supplies • Water filtration/purification systems in communities where issues of water safety exist	1. Documentation that services supported are limited to food bank, home-delivered meals, and/or food voucher programs. 2. Documentation of types of non-food times provided. If water filtration/ purifieation systems are provided, community has documented water purity issues. 3. Assurance of compliance with federal, state, and local regulations including any required licensure or certification for the provision of food banks and/or home-delivered meals. 4. Monitoring of providers to document actual services provided, client eligibility, number of clients served, and level of services. 5. Food pantry program will meet regulations on Food Service Sanitation as set forth by Texas Department of State Health Services, Regulatory Licensing Unit and/or local city or county health regulating agencies.	1. Maintain documentation of: • Services provided by type • Amount and use of funds for purchase of non-food items • Compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certifications (displayed on site). • Assurance that RW funds were used only for allowable purposes and RW was the payor of last resort. • Records of local health department food handling/food safety inspection are maintained on file. 2. Agency will be licensed for non-profit salvage by the Texas Department of State Health Services Regulatory Licensing Unit and/or local city, or county health regulating agencies. 3. Food Pantry must display "And Justice for All" posters that inform people how to report discrimination. 4. There must be a method to regularly obtain client input about food preference and satisfaction. Such input shall be used to make program changes. 5. Director of meal program must complete and pass Service Safety certification every three (3) years. 6. An application form is completed for each volunteer. 7. Each staff and volunteer position has written job descriptions. 8. Personnel files reflect completion of applicable trainings and orientation.	Unallowable costs include household appliances, pet foods, and other non-essential products.	RWHAP Part B Program National Monitoring Standards, Section C.5 PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Health Education/Risk Reduction: Provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.	Documentation that: 1. Clients are educated about HIV transmission and how to reduce the risk of HIV transmission to others. 2. Clients receive information about available medical and psychosocial support services.	1. Maintain records of services provided. 2. Document in client files client eligibility, information provided on available services, education about HIV transmission, counseling on how to improve their health status and reduce risk of HIV transmission. 3. Documentation that staff has visited collaborating service agencies/has knowledge of local resources. 4. Documentation that supervisors reviewed 10 percent of each HE/RR staff client records each month. 5. Documentation that supervisor/program manager has reviewed pre-post tests and program evaluations.	HE/RR services cannot be delivered anonymously.	RWHAP Part B Program National Monitoring Standards, Section C.6 PCN 16-02
Housing Services: Provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain OAHS services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.	1. Must have mechanisms in place to allow newly identified clients access to housing services. 2. Documentation that funds are used only for allowable purposes. 3. Services are provided by case managers or other housing professionals. 4. Policies and procedures to provide individualized written housing plans, consistent with Housing Policy, covering each client receiving short term, transitional, and emergency housing services. 5. Agency established payment methodology to issue direct payment to housing vendor or voucher system.	1. Maintain documentation of services provided. 2. Ensure staff providing housing services are case managers or other professionals who possess knowledge of local, state, and federal housing programs and how to access those programs. 3. Policies and procedures are written ensuring individualized written housing plans are consistent with Housing Policy.	Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.	RWHAP Part B Program National Monitoring Standards, Section C.7 PCN 16-02; PCN 16-02 FAQ #18

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Housing Services (continued)		4. Ageney will establish payment methodology to include either direct payment to a housing vendor or a voucher system with no direct payments to clients. Payment process will include documentation of lease/mortgage, utility bill, fees (late fees, legal), utility bill, IRS Form W-9. 5. Documentation of required initial training by staff as outlined in the Standards of Care for Housing Services completed within three (3) months of hire is located in the personnel file. All professional housing providers must complete the following within three (3) months of hire: • Effective Communication • Texas HIV Medication Program • HIV Case Management • HIV and Behavioral Risk • Substance Use and HIV • Mental Health and HIV • Local, state, and federal housing program rules and regulations • How to access housing programs 6. Client eligibility for services, actual services provided by type of service, number of clients served, and level of services will be collected.		

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Linguistic Services: Provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic service providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.	1. Documentation that linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of RW-eligible services in both group and individual settings. 2. Services are provided by appropriately trained and qualified individuals holding appropriate State or local certification.	1. Document the provision of linguistic services. 2. Maintain documentation showing that interpreters and translators employed with RW funds have appropriate training and hold relevant State and/or local certification.	Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).	RWHAP Part B Program National Monitoring Standards, Section C.8 PCN 16-02; PCN 16-02 FAQ #19
Other Professional Services: Provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: • Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease. • Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them. Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.	1. Documentation that funds are used only for allowable services as indicated in Standard. 2. Assurance that program activities do not include any criminal defense or class-action suits unrelated to access to services eligible for funding under the RWHAP Part B program. 3. Maintain client files that include: client eligibility; description of how service is necessitated by individual's HIV status; types of services provided; and hours spent in provision of such services.	1. Document services provided, including specific types of services. 2. Provide assurance that funds are being used only for services directly necessitated by an individual's HIV status. 3. All licensed agency professional staff, contractors, and consultants who provide legal services shall be currently licensed by the State Bar of Texas. 4. Law students, law school graduates and other legal professionals will be supervised by a qualified licensed attorney. 5. Agency paid legal staff and contractors must complete two (2) hours of HIV-specific training annually. 6. Agency maintains system for dissemination of HIV information relevant to the legal assistance needs of PLWH to staff and volunteers.	Exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.	RWHAP Part B Program National Monitoring Standards, Section C.7 (formerly Legal Services) PCN 16-02; PCN 16-02 FAQ #13 45 CFR §75.459

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Medical Transportation Services: Provision of nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.	1. May be provided through contracts with providers of transportation services. 2. Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or support services, but should not in any case exceed the established rates for federal programs. 3. Purchase or lease of organizational vehicles for client transportation programs, provided recipient receives prior approval for the purchase of vehicle. 4. Organization and use of volunteer drivers (through reliance upon established programs that ensure auto insurance and other liability issues specifically addressed).	1. Maintain program files. 2. Maintain documentation that the provider is meeting stated contract requirements with regard to methods of providing transportation. 3. Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services. 4. Obtain HRSA and State approval prior to purchasing or leasing a vehicle(s). 5. Voucher or token systems.	No direct cash payments or reimbursements to clients. No direct maintenance expenses of a privately-owned vehicle. No costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.	RWHAP Part B Program National Monitoring Standards, Section C.9 PCN 16-02 DSHS HIV Care Services Medical Transportation Services Standard
Outreach Services: Provision of the following three activities: • Identification of people who do not know their HIV status and linkage into OAHS • Provision of additional information and education on health care coverage options Reengagement of people who know their status into OAHS	1. Conducted at times and in places where there is a high probability that individuals with HIV infection are present and/or high-risk behaviors are being exhibited 2. Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness 3. Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort. 4. Targeted to populations known, through local epidemiological data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection	1. Document the design, implementation, target areas and populations, and outcomes of outreach activities. 2. Document and provide data showing that all RFP and contract requirements are being met with regard to program design, targeting, activities, and use of funds. 3. Provide financial and program data demonstrating that no outreach funds are being used to pay for HIV counseling and testing, to support broad-scope awareness activities, or to duplicate HIV prevention outreach efforts.	Funds may not be used to pay for HIV counseling or testing. No use of Part B funds for outreach activities that have HIV prevention education as their exclusive purpose.	RWHAP Part B Program National Monitoring Standards, Section C.10; RW Part B Fiscal National Monitoring Standards, Section B.7; Part B Manual PCN 12-01; PCN 16-02; HAB Policy Notice 07-06, Policy Notice 97-01

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Outreach Services (continued)		4. Within the first (3) months of hire, 16 hours of training for new staff and volunteers shall be given which includes but not limited to: • Specific HIV-related issues • Substance use and treatment • Mental health issues • Domestic violence • Sexually transmitted infections (STIs) • Partner notification • Housing Services • Adolescent health issues • Commercial sex workers • Incarcerated/recently released • Gay/lesbian/bisexual/transgender coneerns 5. Each outreach supervisor, staff and volunteer shall hold a valid Texas driver's license and proof of liability insurance, if needed, to carry out work responsibilities.		

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Psychosocial Support Services: Provide group or individual support and counseling services to assist eligible PLWH to address behavioral and physical health concerns. Services include: • Bereavement counseling • Child abuse and neglect counseling • HIV support groups • Nutrition counseling provided by a non-registered dietitian Pastoral care/counseling services	1. Documentation that psychosocial services funds are used only to support eligible services. 2. Documentation that pastoral care/ counseling services meet the following: • Provided by an institutional pastoral care program; • Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; • Available to all individuals eligible for RW services. 3. Assurance that no funds under this service are used for the provision of nutritional supplements.	1. Document the provision of psychosocial support services. 2. Maintain documentation that demonstrates funds are used for allowable services only, no funds are used for provision of nutritional supplements, and any pastoral care/ counseling services meet all stated requirements. 3. Program staff conducting nutritional counseling will be trained to perform nutritional assessments. 4. All non-professional staff delivering support group facilitation must be supervised by a licensed professional.	Funds may not be used to provide nutritional supplements. Funds may not be used for social/ recreational activities or to pay for a client's gym membership.	RWHAP Part B Program National Monitoring Standards, Section C.11 PCN 16-02
Referral for Health Care/Supportive Services: Directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible.	1. Documentation that funds are used only for allowable services. 2. Documentation of method of client contact; method of providing referrals; and referrals and follow up provided.	1. Maintain program files. 2. Maintain client records that include required elements as detailed by the State. 3. Maintain documentation demonstrating that services and circumstances of referral services meet contract requirements.		RWHAP Part B Program National Monitoring Standards, Section C.12 PCN 16-02
Rehabilitation Services: Provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.	Documentation that services: 1. Intended to improve or maintain a client's quality of life and optimal capacity for self-care. 2. Limited to allowable activities. 3. Provided by a licensed or authorized professional. 4. Provided in accordance with an individualized plan of care that includes components specified by the State. 5. Rehabilitative services must be provided in an outpatient setting.	1. Maintain and share all program and financial records that document types of services provided, type of facility, provider licensing, use of funds only for allowable services. 2. Maintain client records that include the required elements as detailed by the State.		RWHAP Part B Program National Monitoring Standards, Section C.13 PCN 16-02; PCN 16-02 FAQ #14

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Rehabilitation Services (continued)		3. Rehabilitative services must be provided in an outpatient setting. This may include outpatient ambulatory or home setting. Contracts or Memorandums of Agreement/Understanding are in place with these agencies/individual providers to provide services in an outpatient setting. 4. Direct supervision by a licensed/certified professional during client interaction is required if assistants or students are providing care. 5. Staff participating in the direct provision of services to clients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed/ certified therapist.		
Respite Care: Provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV. Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within OAHS or satellite facilities.	1. Documentation that funds are used only for allowable services.	1. Maintain program files that include number of clients served, and settings/methods of providing care. 2. Maintain client files that include: eligibility and services provided. 3. Staff will have the skills, experience, and qualifications appropriate to providing respite care services. When the client designates a community respite caregiver who is a member of his or her personal support network, this designation suffices as the qualification. 4. All non-professional staff must be supervised by a degreed or licensed individual in the fields of health, social services, mental health, or a related area, preferably Master's Level. A person with equivalent experience may be used. 5. Supervisors must review a 10 percent sample of each staff records each month for completeness, compliance with these standards, and quality and timeliness of service delivery.	Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.	RWHAP Part B Program National Monitoring Standards, Section C.14 PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Respite Care (continued)		6. Each supervisor must maintain a file on each staff member supervised and hold supervisory sessions on at least a weekly basis. The file on the staff member must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards, and effectiveness of service. 7. Funds may be used to support informal respite care if: • Liability issues have been addressed • Appropriate releases obtained that protect the client, provider of respite care, and the Program • Payment for services (reimbursement) is made for actual costs and no cash payments are made to clients or primary caregivers • Voucher or gift card may be used as reimbursement		

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Substance Abuse Services (residential): Provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes: pretreatment/recovery readiness programs; harm reduction; behavioral health counseling associated with substance use disorder; medication assisted therapy; neuro-psychiatric pharmaceuticals; relapse prevention; and detoxification if offered in a separate licensed residential setting.	1. Documentation that services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State. 2. Documentation that services provided meet the service category definition. 3. Documentation that services are provided in accordance with a written treatment plan. 4. Assurance that services are provided only in a short-term residential setting. 5. Documentation that if provided, acupuncture services are limited through some financial cap, are provided only with a written referral from the client's primary care provider, and are offered by a provider with appropriate State license and certification, if it exists.	1. Maintain documentation of provider licensure or certifications as required by the State. This includes licensures and certifications for a provider of acupuneture services. 2. Documentation of staffing structure showing supervision by a physician or other qualified personnel. 3. Provide assurance that all services are provided in a short-term residential setting. 4. Maintain program files that document allowable services provided, and the quantity/frequency/modality of treatment services. 5. Maintain client records. 6. Ageney will have documentation on site that license is current for the physical location of the treatment facility. 7. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by DSHS. 8. Each staff member will have documentation of minimum experience to include: • Continuing Education in HIV • One (1) year of experience in family counseling as pertaining to substance use disorders • Non-violent crisis intervention training • Training in mental health issues and knowing when to refer a client to a mental health program/counselor	Funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.	RWHAP Part B Program National Monitoring Standards, Section C.15 PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Substance Abuse Services (residential) (continued)		9. All direct care staff shall maintain current Cardio Pulmonary Resuscitation (CPR) and First Aid certification. Licensed health professionals and personnel in licensed medical facilities are exempt if emergency resuscitation equipment and trained response teams are available 24 hours a day. 10. Documentation of professional liability for all staff and agency. 11. Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every six (6) months. 12. Agency shall have and implements policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following: • Verbal Intervention • Non-violent physical intervention • Emergency medical contact information • Incident reporting • Voluntary and involuntary client admission • Follow-up contacts • Continuity of services in the event of a facility emergency 13. Agency will have a policy and procedure for clients to follow if they need after-hours assistance. 14. There will be written policies and procedures for staff to follow for psychiatric or medical emergencies. 15. Policies and procedures define emergency situations, and the responsibilities of key staff are identified.		

THE RESOURCE GROUP

2020-2021 Standards of Care
Table of Contents

RYAN WHITE PART B/DSHS STATE SERVICES
2210 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
COMMUNITY-BASED HEALTH SERVICES

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

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

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

#	STANDARD	MEASURE
9.7	Initial Client Assessment A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. Client will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.	• Documentation of needs assessment completed in the client's primary record • Documented evidence of a comprehensive evaluation completed in the client's primary record.
9.8	Comprehensive Client Assessment A comprehensive client assessment, including nursing, therapeutic, and educational is completed for each client within seven (7) days of intake and every six (6) months thereafter. A measure of client acuity will be incorporated into the assessment tool to track client's increased functioning. A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of client's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine client's ability to perform activities of daily living and the level of attendant care assistance the client needs to maintain living independently.	• Review of client's primary record indicates compliance. • Acuity levels documented as part of assessment.
9.9	Nutritional Evaluation Each client shall receive a nutritional evaluation within 15 days of initiation of care.	• Documentation is completed and maintained in the client's primary record.
9.10	Meal Plan Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
9.11	Plan of Care A written plan of care is completed for each client within seven (7) days of intake and updated at least every sixty (60) calendar days thereafter. Development of plan of care incorporates a multidisciplinary team approach.	• Review of client's primary record indicates compliance

#	STANDARD	MEASURE
9.12	Implementation of Care Plan In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation. • Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services). • Monitor changes in client's physical and mental health, and level of functionality. • Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service-related needs, challenges and barriers. • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with client's self-administration of medication. • Promptly report any problems or questions regarding the client's adherence to medication. • Report any changes in the client's condition and needs. • Current assessment and needs of the client, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services • Types, quantity and length of time services are to be provided Care plan is updated at least every sixty (60) calendar days	• Documentation in the client's primary record indicates services provided were consistent with the care plan. • Documentation in the client's primary record indicates services provided were consistent with the care plan. • Percentage of clients with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the client's primary record. • Percentage of clients with documented evidence of care plans reviewed and/or updated as necessary based on changes in the client's situation at least every sixty (60) calendar days as evidenced in the client's primary record.

9.13	Provision of Services/ Progress Notes Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services. • Progress notes will be kept in the client's primary record and must be written the day services are rendered. • Progress notes will then be entered into the client record within (14) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines. • The Home and Community-Based Provider will document in the client's primary record progress notes throughout the course of the treatment, including evidence that the client is not in need of acute care.	• Documented evidence of completed progress notes in the client's primary record • Documentation of on-going communication with primary medical care provider and care coordination team as indicated in the client' primary record
9.14	Coordination of Services/Referrals If referrals are appropriate or deemed necessary, the agency will: • Ensure that service for clients will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging client access to integrated health care. • Consistently report referral and coordination updates to the multidisciplinary medical care team. • Assist clients in making informed decisions on choices of available service providers and resources.	• Documentation of referrals (as applicable) to other services as indicated, with follow-up in the client's primary record.
9.15	Refusal of referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home/community setting. The agency must document the situation in writing and immediately contact the client's primary medical care provider.	• Documentation in the client's primary record will indicate the reason for refusal

#	STANDARD	MEASURE
9.16	Completion of Services/Discharge Services will end when one or more of the following takes place: • Client acuity indicates self-sufficiency and care plan goals completed; • Client expresses desire to discontinue/transfer services; • Client is not seen for ninety (90) days or more; and • Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility) • Client is unable or unwilling to adhere to agency policies. • Client relocates out of the service delivery area • When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a client's home, in the company of an escort or not. The agency may discontinue services or refuse the client for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances (if applicable) must be accompanied by a referral to an appropriate service provider agency.	• Documentation of a discharge/transfer plan developed with client, as applicable, as indicated in the client's primary record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 14-16.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 13-15.
Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Standards of Care for HIV/AIDS Services 2009.
San Francisco EMA Home-Based Home Health Care Standards of Care February 2004.
Texas Administrative Code, Title 40, Part 1, Chapter 97, Subchapter B, Rule 97.211.
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02

RYAN WHITE PART B/DSHS STATE SERVICES
1920 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
EARLY INTERVENTION SERVICES FOR THE INCARCERATED

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

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

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

#	STANDARD	MEASURE
9.5	Continuing Education Each staff will complete a minimum of (12) hours of training annually to remain current on HIV care.	• Evidence of training will be documented in the staff personnel records.
9.6	Supervision Each agency must have and implement a written plan for supervision of all Early Intervention staff. Supervisors must review a 10 percent sample of each staff member's client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Each supervisor must maintain a file on each staff supervised and hold supervisory sessions on at least a monthly basis. The file must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
9.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV-positive status • Language(s) spoken and Literacy level (client self-report) *Due to client's state of incarceration, this service is excluded from the requirement to document income and residency.*	• Documentation of HIV status is present in the primary client record. • Documentation in compliance with TRG Policies for Documentation of HIV Status.
9.8	CPCDMS Update/Registration As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.	• Current registration of client is present in CPCDMS.
9.9	Assessment of Client Staff will complete an intake assessment form for all clients served. The assessment will include: • Mental health and substance use issues, • Housing/living situation, • Support system, • Desired community medical providers, and • Other identified needs upon release.	• Intake assessment form is present in the primary client record. •

#	STANDARD	MEASURE
9.10	Provision of Education/Counseling - All Staff provide PLWH with education regarding the disease and its management, risk reduction, medication adherence and other health-related education. The provision education will include: • Health Education regarding HIV • Risk Reduction counseling • Maintenance of immune system • Disclosure to partners and support systems • Importance of accessing medical care and medications	• Documentation of client education is present in the primary client record.
9.11	Provision of Education/Counseling – Newly-Diagnosed Staff provide newly diagnosed PLWH with additional education regarding the disease and its management, risk reduction, medication adherence and other health-related education. The provision education will include: • HIV 101 • Risk Reduction counseling • Treatment as Prevention • Importance of accessing medical care and medications	•
9.12	Increase Health Literacy Staff assesses client ability to navigate medical care systems and provides education to increase client ability to advocate for themselves in medical care systems.	• Documentation of health literacy evaluation and education is present in the primary client record.
9.13	Coordination of Care Staff assists in the coordination of client medical care while incarcerated including, but not limited to, medical appointments with a prescribing provider and medications.	• Documentation of coordination of care is present in the primary client record.
9.14	Medication Regimen Establishment/Transition Staff assists clients to become eligible for THMP/ADAP medication program prior to release through THMP Electronic Upload Process. Staff assists client with transition of medication from correctional facility to outside pharmacy.	• Documentation of THMP/ADAP application and its submission is present in primary client record. • Documentation of connection/referral to outside pharmacy.

9.15	Transitional Team Multidisciplinary (TTMD) Review Staff creates opportunities for MDT review with all involved agencies to discuss client's case.	• Schedule of available times for TTMD reviews with involved agencies available for review. • Documentation of TTMD reviews present in primary client record.
9.16	Discharge/Care Planning Staff conducts discharge planning into Houston HIV Care Continuum. Discharge/Care planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a discharge/care plan. • Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. EIS Staff, MAI, MHMR, DSHS Prevention)	• Documentation of review of services present in primary client record. • Documentation of client discharge/care plan is present in primary client record. • Documentation of applicable referrals (internal/external) with follow-up in the primary client record
9.17	Progress Note Progress notes will be maintained in each primary client record with documentation of the assistance the EIS staff provided to the client to help achieve applicable goals, including successful linkage to OAHS services.	• Documented progress notes showing assistance provided to the client in the primary client record.
9.18	HIV Testing and Targeted Counseling According to the HRSA National Monitoring Standards all four components must be present. Part B funds can only be used for HIV testing to supplement, not supplant, existing funding. • If Ryan White Part B/State Services funds are used for HIV testing, agency must submit a waiver to TRG and document the reason(s) necessary to supplement existing funding.	• Review of monthly expenses indicates compliance • Waiver are present when funds are utilized for testing

#	STANDARD	MEASURE
9.19	Referral Process Referrals will be documented in the primary client record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable Any additional services necessary to help clients engage in their medical care Referral Packet Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral will include a packet with a. A copy of the Harris County Jail Intake/Assessment Form, b. Proof of HIV diagnosis, c. A list of current medications, and d. Provide client ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community. Referral Tracking All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS staff offered to the PLWH. The following outcomes will be documented: • Initial Eligibility/Screening appointment with community clinic • Initial Medical appointment with primary care provider.	• Documentation of referral present in primary client record • Documentation of referral feedback present in primary client record. • Copy of "known to me as" letter present in primary client record.
9.20	Case Closure PLWH who are released from Harris County Jail must have their cases closed with a case closure summary narrative documenting the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM) and referral outcome summary	• Closed cases that include documentation stating the reason for closure and a closure summary in the primary client record system. • Documentation of supervisor signature/approval on closure summary (electronic review is acceptable).

	(if applicable).	
9.21	MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting PLWHs into ongoing care.	• Review of MOUs at annual quality compliance reviews. • Documentation of communication and referrals with agencies covered by MOUs is present in primary client record.

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE – DRAFT

Definition:
Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Compliance with Regional Health Insurance Assistance Policy The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Annual Review of agency shows compliance with established policy.
9.3	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary. Agencies must maintain referral relationships with organizations or individuals who can provide income tax preparation assistance.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
9.4	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required. Minimum of two (2) hours training for all relevant staff on how to identify advance premium tax credits and liabilities.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.5	Staff Experience A minimum of (1) year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
9.6	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
9.7	Program Policies Agency will develop policies and procedures regarding HIA assistance, cost-effectiveness and expenditure policy, and client contributions. Agencies must maintain policies on the assistance that can be offered for clients who are covered under a group policy. Agency must have P&P in place detailing the required process for reconciliation and documentation requirements. Agencies must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual clients, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of personnel files indicates training on the policies.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	Prioritization of Cost-Sharing Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agencies use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles 3. Co-payments for provider visits (e.g. physician visit and/or lab copayments) 4. Medicare Part D (Rx) premiums 5. APTC Tax Liability 6. Out of Network out-of-pocket expenses	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental) * 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Health Insurance Premium Assistance The following criteria must be met for a health plan to be eligible for HIA assistance: 1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 1. Health Insurance coverage must be evaluated for cost effectiveness 2. Health insurance plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 3. COBRA plans must be evaluated based on cost effectiveness and client benefit. Additional Requirements for ACA plans: 1. If a client between 100%-250% FPL, only SILVER level plans are eligible for HIA payment assistance (unless client enroll prior to November 1, 2015). 2. Clients under 100% FPL, who present with an ACA plan, are NOT eligible for HIA payment assistance (unless enroll prior to November 1, 2015). 3. All clients who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL). All clients receiving HIA assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client records indicates compliance. • Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.
9.12	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to ensure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	Client Education Education must be provided to clients specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP can assist with to ensure healthcare coverage is maintained. **Cost Sharing Education** 1. Education is provided to clients, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. 2. Clients who are not eligible for cost-sharing reductions (i.e. clients under 100% FPL or above 400% FPL; clients who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the client's health care needs. **Premium Tax Credit Education** 1. Education should be provided to the client regarding tax credits and the requirement to file income tax returns 2. Clients must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.	• Documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record. • Documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.
9.14	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.18	Prescription Eyewear Agency must keep documentation from physician stating that the eye condition is related to the client's HIV infection when HIA funds are used to cover co-pays for prescription eyewear.	• Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV infection as indicated in the client's primary record
9.19	Medical Visits Clients accessing health insurance premium and cost sharing assistance services should demonstrate adherence with their HIV medical care and have documented evidence of attendance of HIV medical appointments in the client's primary record. Note: For clients who use HIA to enable their use of medical care outside of the RW system: HIA providers are required to maintain documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months.	• Clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (for clients with applicable data in ARIES or other data system used at the provider location) • Note: For clients who use HIA to enable their use of medical care outside of the RWHAP system: Documentation of the client's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months
9.20	Viral Suppression Clients receiving Health Insurance Premium and Cost Sharing Assistance services have evidence of viral suppression as documented in viral load testing.	• For clients with applicable data in ARIES or other data system used at the provider location, percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

References

TDSHS HIV/STD Ryan White Part B Program Universal Standards (pg. 30-31)
TDSHS HIV/STD Prevention and Care Branch, Policy 260.002. Health Insurance Assistance
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 31-35.
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HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-06
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 14-01
TDSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001)
HRSA/HAB, Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance (PDF)

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HOSPICE SERVICES

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

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

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

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

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.17	Physician Certification • The attending physician must certify that a client is terminal, defined under Texas Medicaid hospice regulations as having a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification must specify that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification statement must be based on record review or consultation with the referring physician. • The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse.	• Documentation of attending physician certification of client's terminal illness documented in the client's primary record. • Documentation in the primary record of all physician orders for initiation of care.
9.18	Intake and Service Eligibility Agency will receive referrals from a broad range of HIV/AIDS service providers. Information will be obtained from the referral source and will include: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (client self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information • Documentation of insurance status • Documentation of income (including a "zero income" statement) • Documentation of state residency • Documentation of proof of HIV positivity • Photo ID or two other forms of identification • Acknowledgement of client's rights	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's primary records

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.19	Comprehensive Health Assessment A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Documentation of comprehensive health assessment completed within 48 hours of admission in the client's primary record.
9.20	Plan of Care Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. A written Plan of Care is completed for each patient within seven (7) calendar days of admission and reviewed monthly. Care Plans will be updated once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV/AIDS (http://hab.hrsa.gov/tools/palliative/contents.html) and professional guidelines. Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Documentation in client's primary record • Written care plan based on physician's orders completed within seven calendar days of admission documented in the client's primary record. • Documented evidence of monthly care plan reviews completed in the client's primary record.

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.24	Mental Health Counseling Mental health counseling must be provided. Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's psychosocial assessment • The patient's acceptance of these services	• Referral and/or service provision documented. • Documented evidence of mental health counseling offered, as medically indicated, in the client's primary record.
9.25	Spiritual Counseling A hospice must provide spiritual counseling that meets the patient's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the client's and family's spiritual needs; • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a client's spiritual needs; and • Advise the client and family of the availability of spiritual counseling services.	• Referral and/or service provision documented. • Spiritual counseling, as appropriate, documented in the written care plan in the client's primary record.
9.26	Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure. Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider.	• Written care plan that documents palliative therapy as ordered by the referring provider documented in the client's primary record.
9.27	Medical Social Services Medical social services must be provided by a qualified social worker. and is based on: • The patient's and family's needs as identified in the patient's psychosocial assessment • The patient's and family's acceptance of these services.	• Assessment present in the client's primary record. • Documentation in client's primary records.

9.28	Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves, and hospice care is no longer necessary, based on attending physician's plan of care and a referral to Medical Case Management or OAHS must be documented Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's primary records. • Percentage of clients in Hospice care with documented evidence of discharge status in the client's primary record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 15-17.
Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services
Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook
HRSA Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds, June 2017

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

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

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

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

9.4	Provision of Services
	• Agencies shall provide translation/interpretation services for the date of scheduled appointment per request submitted and will document the type of linguistic service provided in the client's primary record.
	• Agency/providers will offer services to the client only in connection with other HRSA approved services (such as clinic visits).
	• Providers will deliver services to the client only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the client
	• Based on provider need, agency shall provide the following types of linguistic services in the client's preferred language:
	  • Oral interpretation
	  • Written translation
	  • Sign language
	• Agency/providers should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the client seeking assistance
	• Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area
		• Review of Program's Policies and Procedures indicate compliance.
		• Documentation that linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of RW-eligible services in both group and individual settings.
		• Documented evidence of need of linguistic services as indicated in the client's assessment.
		• Percentage of client files with documented evidence of interpretive/translation services provided for the date of service requested.

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

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 37-38.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 37-38.
Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP).
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

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

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

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

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

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

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Treatment Plan (Cont'd) Treatment plans must be completed within 30 days from the Mental Health Assessment. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals as clinically indicated. The treatment plan will be signed by the mental health professional rendering service.	
9.13	Treatment Plan Review Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated. The plan must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures.	• Review of Agency Policies and Procedures Manual indicates compliance. • Documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.
9.14	Psychiatric Referral Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	• Documentation of need for psychiatric intervention are referred to services as evidenced in the client's primary record.
9.15	Psychotropic Medication Management: Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	• Clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. • Documentation of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

9.16	Progress Notes Progress notes are completed according to the agency's standardized format, completed for each counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	• Legible, signed and dated documentation in client primary record. • Documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.
9.17	Coordination of Care Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.
9.18	Referrals As needed, mental health providers will refer clients to full range of medical/mental health services ineluding: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

	will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s).	
#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.19	Discharge Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death	• Agency will develop discharge criteria and procedures.
9.20	Discharge Summary Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	• Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record. • Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.
9.21	Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Documentation of supervisor credentials is maintained by the agency.
9.22	Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Documentation in supervision notes. • Each mental health service agency must have and implement a written policy for regular supervision of all licensed staff.

References

American Psychiatric Association. *The Practice Guideline for Treatment of Patients with HIV/AIDS*, Washington, DC, 2001.
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April, 2013, page 17-18.
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New York State Mental Health Standards of Care

RYAN WHITE PART B/DSHS STATE SERVICES
1920 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING SUBSTANCE USE DISORDERS

Definition:
Non-Medical Case Management Services (N-MCM) Targeting Substance Use Disorders (SUD) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible PLWHs to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service The purpose of Non-Medical Case Management (N-MCM) Services targeting Substance Use Disorders (SUD) is to assist people living with HIV (PLWH) who are also facing the challenges of substance use disorder to procure needed services so that the problems associated with living with HIV and/or SUD are mitigated. N-MCM targeting SUD is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is community based (i.e. both office-based and field based). N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in primary client record.

#	STANDARD	MEASURE
9.1	alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are facing the challenges of SUD. Key activities include: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Continuous monitoring to assess the efficacy of the care plan • Re-evaluation of the care plan at least every six (6) months with adaptations as necessary • Ongoing assessment of the PLWH's and other key family members' needs and personal support systems **Limitation: Direct Medical Costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.	
9.2	Agency License The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of substance use treatment/counseling.	• Review of agency
9.3	Program Policies and Procedures Agency will have a policy that: • Defines and describes N-MCM targeting SUD services (funded through Ryan White or other sources) that complies with the standards of care outlined in this document. • Specifies that services shall be provided in the office **and** in the field (i.e. community based). • Specifies required referral to and coordination with HIV medical services providers. • Requires referral to and coordination with providers of substance use treatment/counseling, as appropriate. • Requires monitoring of referrals into services.	• Program's Policies and Procedures indicate compliance with expectations.

#	STANDARD	MEASURE
9.4	Staff Qualifications Non-Medical Case Managers must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Agency will provide Non-Medical Case Manager a written job description upon hiring.	• A file will be maintained on each non-medical case manager. Supportive documentation of credentials and job description are maintained by the agency and in each non-medical case manager's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure. • Review of personnel files indicates compliance
9.5	Supervision A minimum of four (4) hours of supervision per month must be provided to each N-MCM by a master's level health professional. At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
9.6	Caseload Coverage – N-MCMs Supervisor ensures that there is coverage of the caseload in the absence of the N-MCM or when the position is vacant. N-MCM may assist PLWHs who are routinely seen by other CM team members in the absence of the PLWH's "assigned" case manager.	• Documentation of all service encounters in primary client record and in the Centralized Patient Care Data Management System
9.7	Case Reviews – N-MCMs Supervisor reviews a random sample equal to 10% of unduplicated PLWHs served by each N-MCM at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in primary client record, signed and dated by supervisor and/or quality assurance personnel and N-MCM
9.8	Client Eligibility N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder.	• Documentation of eligibility is present in the PLWH's primary record. • Documentation in compliance with TRG SR-1801 Client Eligibility for Services.

#	STANDARD	MEASURE
9.9	Initial Assessment The Initial Assessment is required for PLWHs who are enrolled in Non-Medical Case Management (N-MCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer- standing access and/or barriers to medical and/or psychosocial needs. The 30 day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: a) PLWH's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner Services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (CPS/APS referral as indicated) • Family Violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, SSDI applications) • Linguistic Services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education b) Additional information • PLWH strengths and resources • Other agencies that serve PLWH and household • Brief narrative summary of assessment session(s)	• Percentage of PLWHs who access N-MCM services that have a completed assessment within 30 calendar days of the first appointment to access N-MCM services and includes all required documentation. • Percentage of PLWHs that received at least one face-to-face meeting with the N-MCM staff that conducted the initial assessment. • Percentage of PLWHs who have documented Initial Assessment in the primary client record.

#	STANDARD	MEASURE
9.10	Care Planning The PLWH and the N-MCM will actively work together to develop and implement the care plan. Care plans include at a minimum: • Problem Statement (Need) • Goal(s) – suggest no more than three goals • Intervention o Task(s) o Assistance in accessing services (types of assistance) o Service Deliveries • Individuals responsible for the activity (N-MCM, PLWH, other team member, family) • Anticipated time for each task • PLWH acknowledgment The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every six (6) months. Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed – not at set intervals.	• Percentage of non-medical case management PLWHs, regardless of age, with a diagnosis of HIV who had a non-medical case management care plan developed and/or updated two or more times in the measurement year. • Percentage of primary client records with documented follow up for issues presented in the care plan. • Percentage of Care Plans documented in the primary client record.
9.11	Assistance in Accessing Services and Follow-Up N-MCM will work with the PLWH to determine barriers to accessing services and will provide assistance in accessing needed services. N-MCM will ensure that PLWH are accessing needed services, and will identify and resolve any barriers PLWH may have in following through with their Care Plan. When PLWHs are provided assistance for services elsewhere, the referral should be documented and tracked. Referrals will be documented in the primary client record and, at a minimum, should include referrals for services such as: OAHS, MCM, Medical transportation, Mental Health, Substance Use Treatment, and any additional services necessary to help clients engage in their medical care. Referral Tracking All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the N-MCM offered to the PLWH.	• Percentage of N-MCM PLWHs with documented types of assistance provided that was initiated upon identification of PLWH needs and with the agreement of the PLWH. Assistance denied by the PLWH should also be documented in the primary client record system • Percentage of N-MCM PLWHs with assistance provided have documentation of follow up to the type of assistance provided.

#	STANDARD	MEASURE
9.12	Increase Health Literacy N-MCM assesses PLWH ability to navigate medical care systems and provides education to increase PLWH ability to advocate for themselves in medical care systems.	• Documentation of health literacy evaluation and education is present in the primary client record.
9.13	Transtheoretical Model of Change N-MCMs shall use the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change) to promote improved health outcomes and achievement of care plan goals.	• Documentation is present in the primary client record.
9.14	Overdose Prevention & SUD Reduction N-MCMs should provide activities, strategies and education that enhance the motivation of PLWH to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors.	• Documentation of activities, strategies and education is present in the primary client record.
9.15	Substance Use Treatment N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations.	• Documentation of discussion regarding treatment or other recovery support services is present in primary client record.Documentation of referrals and follow-up is present in the primary client record. •
9.16	Harm- and Risk-Reduction N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction.	• Documentation of tools and methods is present in the primary client record. • Review of agency tools • Review of agency training

#	STANDARD	MEASURE
9.17	Case Closure/Graduation PLWH who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • PLWH is referred to another case management program • PLWH relocates outside of service area • PLWH chooses to terminate services • PLWH is no longer eligible for services due to not meeting eligibility requirements • PLWH is lost to care or does not engage in service • PLWH incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • PLWH death Graduation criteria: • PLWH completed case management goals for increased access to services/care needs • PLWH is no longer in need of case management services (e.g. PLWH is capable of resolving needs independent of case management assistance) PLWH is considered non-compliant with care if three (3) attempts to contact PLWH (via phone, e-mail and/or written correspondence) are unsuccessful and the PLWH has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure appropriate *Releases of Information and consents are signed by the PLWH and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a PLWH, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).	• Percentage of PLWH with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary). • Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). • Percentage of PLWH notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the PLWH from case management services. • Percentage of PLWH with written documentation explaining the reason(s) for discharge and the process to be followed if PLWH elects to appeal the discharge from service. • Percentage of PLWH with information about reestablishment shared with the PLWH and documented in primary client record system. • Percentage of PLWH provided with contact information and process for reestablishment as documented in primary client record system. • Percentage of PLWH with documented Case Closure/Graduation in the primary client record system.

9.18	Community-Based Service Provision N-MCM targeting SUD is a community-based service (i.e. both office-based and field based). Agency policies should support the provision of service outside of the office and/or medical clinic. Agencies should have systems in place to ensure the security of staff and the protections of PLWH information.	• Review of policies and/or procedures. • Review of primary client record indicates compliance with policies and/or procedures.

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

Definition:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants

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

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

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

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	Oral Examination Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established patient • D0120-Periodic Oral Evaluation to include bitewing x-rays, established patient, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established patient; not post-operative visit) • Comprehensive Periodontal Evaluation, new or established patient. Source: http://ada.org	• Documented oral examination completed within the measurement year in the client's primary oral health record.
9.14	Comprehensive Periodontal Examination Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines. Patient must have a periodontal screening once per year. A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants. Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the patient's dental and medical history and general health assessment. • It may include the evaluation and recording or dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. (Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. Patients with HIV may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with patients with acquired immune deficiency syndrome).	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation of periodontal screen or examination as least once in the measurement year. (HRSA HAB Measure)

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

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

References

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- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2011, page 9-10.
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 9-10.
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Rule 7.Minimal Standards of Care. located at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
REFERRAL FOR HEALTH CARE AND SUPPORT SERVICES
SERVICE STANDARD

Definition:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public or private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Services Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible clients to obtain access to other public and private programs for which they may be eligible. *AEW Benefits Counseling*: Services should facilitate a client's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting clients in identifying all available health and disability benefits supported by funding streams other than RWHAP Part B and/or State Services funds. Clients should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs. *Health Care Services:* Clients should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting client's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.2	Provision of Services Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources. ADAP Enrollment Workers (AEW) will meet with new potential and established ADAP enrollees to: 1. Explain ADAP program benefits and requirements 2. Assist clients and or staff with the submission of complete, accurate ADAP applications 3. Ensure there is no lapse in ADAP eligibility and loss of benefits, and 4. AEW will maintain relationships through the Ryan White ADAP Network (RWAN).	
9.3	Staff Qualifications All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working with Persons Living With HIV/AIDS or other chronic health conditions; • Ability to (demonstrate) or learn health care insurance literacy, (Third Party Insurance and Affordable Care Act (ACA) Marketplace plans). • Ability to perform intake/eligibility, referral/ linkage and/or basic assessments of client needs preferred. ➢ Data Entry Quickly establish rapport in respectable manner consistent with the health literacy, preferred language, and culture of prospective client.	• Personnel Qualification on file • Documentation of orientation of file
9.4	Staff Education • Education to be defined locally, but must have at minimum a high school degree or equivalency	• Documentation of education and/ or certification located in personnel file.

#	STANDARD	MEASURE
9.5	Staff Training Requirement: • THMP Training Modules within 30 days of hire • Complete the DSHS ADAP Enrollment Worker (AEW) Regional update at earliest published date after hire • DSHS ARIES Document Upload Training (to include TRG upload observation module), completed no later than (45) days after completing ARIES certificate process • Data Security and Confidentiality Training • Complete all training required of Agency new hires, including any training required by DSHS HIV Care	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.6	AEW Placement AIDS Drug Assistance Program (ADAP) Enrollment Workers will be co-located at Ryan-White Part A funded primary care providers to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP).	
9.7	Initial Provision of Client Education The initial education to clients regarding the THMP process should include, but not limited to: • Discussion of confidentiality, specific to the THMP 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. • Discussion outlining that approved medication assistance through THMP may require 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. • Discussion outlining the recertification process, specific to THMP eligibility, including birth month recertification, half-birth month attestation and consequences of lapse.	• Documented evidence of education provided on other public and/or private benefit programs in the primary client record.

9.8	Benefits Counseling Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and/or private benefits and/or resources for which they are eligible. Staff will explore the following as possible options for clients, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/ Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (SSI, SSDI, SDI) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible clients with completion of benefits application(s) as appropriate within (14) business days of the eligibility determination date. Conduct a follow-up within 90 days of completed application to determine if additional and/or ongoing needs are present.	• Documented evidence of other public and/or private benefit applications completed as appropriate within (14) business days of the eligibility determination date in the primary client record. • Eligible clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record. • Percentage of clients with documented evidence of education provided on other public and/or private benefit programs in the primary client record.

9.9	Health Care Services Clients should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. • Eligible clients will be referred to Health Insurance Premium and Cost-Sharing Assistance (HIA) to assist clients in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible clients should be referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. • Eligible clients are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Staff will follow-up within (10) business days of an applicable referral provided to HIA, any core or support service to ensure the client accessed the service(s).	• Documented evidence of assistance provided to access health insurance or Marketplace plans in the primary client record. • Clients who received a referral for other core services who have documented evidence of the education provided to the client on how to access these services in the primary client record. • Clients who received a referral for other support services who have documented evidence of the education provided to the client on how to access these services in the primary client record. • Clients with documented evidence of referrals provided for HIA assistance that had follow-up documentation within 10 business days of the referral in the primary client record. • Clients with documented evidence of referrals provided to any core services that had follow-up documentation within 10 business days of the referral in the primary client record. • Clients with documented evidence of referrals provided to any support services that had follow-up documentation within 10 business days of the referral in the primary client record.
	THMP Intake Process Staff are expected to meet with new/potential clients to complete a comprehensive THMP intake including explanation of program benefits and requirements. The intake will also include the determination of client eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI). Staff should identify and screen clients for third party payer and potential abuse Staff should obtain, maintain, and submit the required documentation for client application including residency, income, and the THMP Medical Certification Form (MCF).	• Documented evidence of THMP education provided to new/potential clients in the primary client record. • Documentation of acquisition of all required THMP application documentation (including proof of residency, income and MCF)

9.10	Benefits Continuation Process (ADAP) ADAP Enrollment Workers are expected to 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. Birth Month/Recertification • Staff should conduct annual recertifications for enrolled clients in accordance with THMP policies. Recertification should include completion of the ADAP application, obtaining and verifying all eligibility documentation and timely submission to THMP for approval. • Recertification process should include screening clients for third party payer to avoid potential abuse. • Complete ADAP application includes proof of residency, proof of income, and the THMP Medical Certification Form (MCF). • Staff must ensure Birth Month/Recertifications are submitted by the last day of client's birth month to ensure no lapse in program benefits. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's recertification deadline to ensure all necessary documentation is collected and accurate to complete the recertification process on or before the deadline. Half-Birth Month/ 6-month Self Attestation • Staff should conduct a 6-month half-birth month/self-attestation for all enrolled clients in accordance with THMP policies. Staff will obtain and submit the client's self-attestation with any applicable updated eligibility documentation. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's attestation deadline to ensure all necessary documentation is collected and accurate to complete the attestation on or before the deadline. • Half-birth/6-month self-attestations must be submitted by the last day of the client's half-birth month to ensure no lapse in program benefits.	• Documentation of lapse benefits due to non-completion of timely recertification/attestation in the client's record.

#	STANDARD	MEASURE
9.11	ARIES Document Upload Process ARIES Document Upload is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • Completed ADAP Applications (with supportive documentation) must be uploaded into ARIES for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be uploaded according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be uploaded into ARIES within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed upload to ARIES. • Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction. Houston Only: Medication Certification forms for changes to medication should be faxed to THMP for approval.	• Documentation of upload receipt by THMP within (3) business days of application completion.
9.12	Tracking ADAP Applications 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	
9.13	Case Closure Summary Clients who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the client primary record. The case closure summary must include a brief synapsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.' A supervisor must sign the case closure summary.	• Clients who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary client record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 43-44.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43.
Virginia Department of Health, Division of Disease Prevention, HIV Care Services Referral for Health Care/Supportive Services (PDF)
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
DSHS Policy 591.000, Section 5.3 regarding Transitional Social Service linkage.

Bringing Care Closer to Home

TexLa Telehealth Resource Center is a federally funded program of the Texas Tech University Health Sciences Center designed to provide technical assistance and resources to new and existing telehealth programs throughout Texas and Louisiana.

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TELEHEALTH
RESOURCE CENTERS

TexLa is a proud member of the National Consortium of Telehealth Resource Centers. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).

What is Telehealth?

Context for Framing Your Perspective

June 2019

As state and federal policymakers, government agencies, insurers, practitioners, and consumers expanded the opportunities for telehealth, a wide range of terms and definitions have emerged. Unfortunately, there are very few universal definitions and many terms are interchangeable. There are several general themes that can be used to describe your "telehealth initiative."

COMMON TELEHEALTH DEFINITIONS

AMERICAN TELEMEDICINE ASSOCIATION (ATA):

[...] is the remote delivery of health care services and clinical information using telecommunications technology[...]

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA):

[...] defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care[...]

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS):

[...] In general, these "Telehealth Services" require the use of an interactive audio and video telecommunications system for real-time communication between a provider and beneficiary who must to be located at a rural health care facility. InJuly 2018, CMS proposed new services with "Remote Communication Technology," including virtual check-ins and remote evaluation of pre-recorded patient information[...]

NATIONAL CONSORTIUM OF TELEHEALTH RESOURCE CENTERS

The NCTRC acknowledges the various definitions of telehealth. The purpose of this fact sheet is to encompass all the varying ways to interpret telehealth rather than providing a hardline definition. For instance, a payer would view telehealth differently from an insurance company, yet the two are still intertwined.

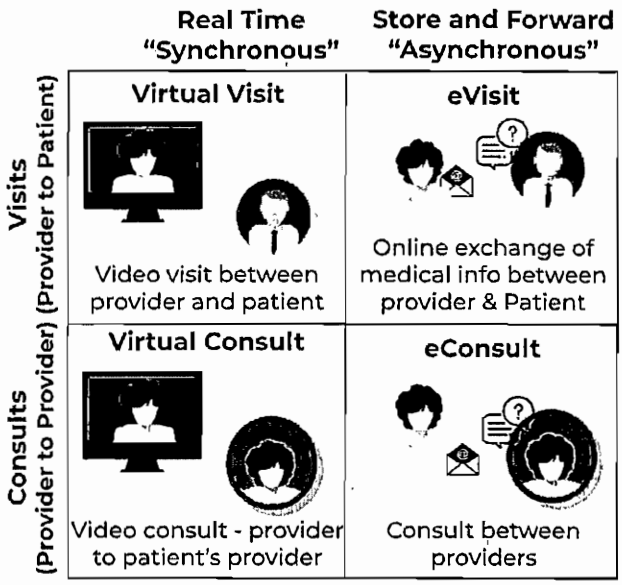
3 important contexts are outlined to expand your perspective to see telehealth as an integrative tool that connects healthcare.

Understanding telehealth from the perspective that applies to you:

1. TYPES OF TELEHEALTH TECHNOLOGY

There are four main categories of telecommunications technologies that are used for telehealth: synchronous, asynchronous, RPM*, and mHealth. What type of connection(s) will your telehealth program make?

2. WHEN AND BETWEEN WHO?**



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*Remote Patient Monitoring (RPM) is a modality that monitors physiology and behavior to maintain best function in the least restrictive, least expensive, or most preferred environment.

Telehealth can be viewed from multiple perspectives. For example, a clinician and patient might focus on convenience and clinical effectiveness, while hospitals and insurers would might be more interested in utilization and meeting needs across an entire region. Each perspective is important, but none provides the entire picture.

EACH PARTY COULD EMPHASIZE DIFFERENT ASPECTS OF TELEHEALTH IN A DEFINITION.

PATIENT HEALTH SYSTEM
HOSPITAL CLINICIAN
COMMUNITY PAYER CLINIC

We don't have to use the same definition of telehealth.

CONNECT

www.telehealthresourcecenter.org

NCTRC & TheNCTRC

KEY QUESTIONS TO ASK:

As you look to describe your telehealth initiative, consider these questions:

- Who is providing and receiving the service?
- Is it a clinical service, a professional consultation, or an education/training?
- In what context is the service being provided? Is it in a hospital, clinic, patient's home/residence, or other facilities?
- Is it synchronous or asynchronous?
- What type of technology is being used?
- How is the service funded? Is it billable to insurance or supported by some other arrangement?
- How does this service fit into any established definitions in your state laws, regulations, etc.

FOUR CRITICAL DIFFERENTIATORS:

1. Direct Patient services vs other health-related activities
2. Live vs Store and Forward (synchronous vs asynchronous)
3. Clinic or hospital-based vs direct to consumer
4. Billable (direct or monthly) vs Patient Self-pay vs unbillable value generation

The National Consortium of Telehealth Resource Centers (NCTRC) is an affiliation of the 14 Telehealth Resource Centers funded individually through cooperative agreements from the Health Resources & Services Administration, Office for the Advancement of Telehealth. The goal of the NCTRC is to increase the consistency, efficiency, and impact of federally funded telehealth technical assistance services. This Framing Telehealth fact sheet was made possible by 14 Telehealth Resource Centers and administered through grant#G22RH30365 from the Office for the Advancement of Telehealth, Federal Office of Rural Health Policy, Health Resources and Services Administration, Department of Health and Human Services.

FYI

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

August 30, 2019

Dear Health Department and CBO Grantees,

I am writing to encourage you to continue your work to spread the word about the power of viral suppression to improve the health of people with HIV and to prevent the sexual transmission of HIV. This information is important and has the power to change lives.

In July, we updated our webpage titled "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV" that features tables summarizing the latest evidence of effectiveness for the key HIV prevention strategies ART, PrEP, and condoms. For ART, the science is strong and clear; the data show that the effectiveness for ART with viral suppression is estimated to be 100% for preventing sexual transmission of HIV. In other words, for persons taking ART as prescribed and achieving and maintaining viral suppression, there is *effectively no risk* of transmitting HIV through sex.

CDC has taken a number of steps to share this information. We have sent various communications to our partners, developed technical and consumer fact sheets, and received funding from HHS to further accelerate the dissemination of this information through the development of new campaign resources for health care providers and consumers through our *Let's Stop HIV Together* (formerly *Act Against* AIDS) campaigns. We are pleased that these resources are available on our Treatment as Prevention website, and we will continue to post more as they become available.

We urge you to share this groundbreaking science with your communities. Research shows that no single message is acceptable or understandable to all audiences, so it is important to have flexibility and options when communicating about this life-saving science. You can use CDC-developed materials, as well as materials developed by community groups such as Prevention Action Campaign, the organization responsible for the U=U campaign (undetectable=untransmittable).

The bottom line – there are a lot of resources available through CDC and elsewhere. We encourage you to do all you can to share this important information in your communities. If you have specific questions related to this issue or how to best integrate CDC materials into your program, please contact your CDC project officer who can help you or link you to Division resources who are happy to assist.

Thank you,

Eugene McCray, M.D.
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