Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax

Memorandum

To:	Members, Quality Improvement Committee	
	Denis Kelly, Co-Chair	*Daniel Impastato*
	Pete Rodriguez, Co- Chair	*Marcely Macias*
	Kevin Aloysius	*Karla Mills*
	Ahmier Gibson	*Angela Rubio*
	Gregory Hamilton	*Deborah Somoye*
	Tom Lindstrom	*Cecilia Oshingbade*
	Gloria Sierra	*Nancy Miertschin*
	Crystal Starr	
	Andrew Wilson	
Copy:	Carin Martin	Amber Harbolt
	Heather Keizman	Diane Beck
	Tiffany Shepherd	Ann Robison
	Patrick Martin	Gary Grier
From:	Tori Williams	
Date:	Tuesday, March 10, 2020	
Re:	Meeting Notice	

Please note the following meeting information:

Tuesday, March 17, 2020
2:00 p.m. – Joint Meeting to Determine Criteria Used to Select the FY 2021 Ryan White Services

2:30 p.m. – Quality Improvement Committee Meeting

2223 West Loop South, Room 416
Houston, Texas 77027
Snacks will be provided

Please RSVP to Rod, even if you cannot attend the meeting. She can be reached at: Rodriga.Avila@cjo.hctx.net or by telephone at 832 927-7926. And, if you have questions for your committee mentor, do not hesitate to contact her at:

- Crystal Starr, crystalstarr2015@gmail.com

We look forward to seeing you next week.

DRAFT

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Houston, Texas 77027

Joint Meeting of the Affected Community,
Quality Improvement and Priority and Allocations Committees

2:00 p.m., Tuesday, March 17, 2020
2223 W. Loop South, Room 416; Houston, Texas 77027

Agenda

Purpose of the Joint Meeting: To determine the criteria used to select the FY 2021 Service Categories.

I. Call to Order — Denis Kelly & Pete Rodriguez, Co-Chairs, Quality Improvement Committee
   A. Moment of Reflection
   B. Adoption of the Agenda

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 yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. HRSA Service Categories — Tori Williams, Office of Support
   A. Review HRSA service definitions
   B. HRSA Defined Core Services
   C. Review list of FY 2020 Houston Part A, B and State Service-funded services

VI. Justification Tools — Denis Kelly & Pete Rodriguez
   A. FY 2021 Justification Chart

VII. Next Meeting (if necessary)
   A. Date and time
   B. Agenda items

VIII. Adjournment

THE QUALITY IMPROVEMENT COMMITTEE MEETING WILL BEGIN IMMEDIATELY AFTER THE JOINT MEETING ADJOURNS.

Appendix

RWHAP Legislation: Core Medical Services

Outpatient/Ambulatory Health Services

Description:
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Program Guidance:
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program
See Early Intervention Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must conduct a cost effectiveness analysis to ensure that purchasing health insurance is cost effective compared to the cost of medications in the aggregate.

Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Program Guidance:
See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance; and

PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance
Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.

1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

   RWHAP Part A or 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 minimum of every six months
   - Coordination with the state's RWHAP Part B ADAP
     - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
   - Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV primary care medications not otherwise available to the client
- Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program

Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See Ryan White HIV/AIDS Program Part A and B National Monitoring Standards
See also LPAP Policy Clarification Memo
See also AIDS Drug Assistance Program Treatments and Emergency Financial Assistance

Oral Health Care
Description:
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.

Program Guidance:
None at this time.

Early Intervention Services (EIS)
Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
    - Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

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 RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core

antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services

- RWHAP Part recipients 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 outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying cost-sharing on behalf of the client

Program Guidance:
Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective and sustainable.

See PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance;
PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid; and
PCN 14-01: Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

Home Health Care
Description:
Home Health Care is the 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 (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:

The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Medical Nutrition Therapy

Description:

Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:

All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

See Food-Bank/Home Delivered Meals

Hospice Services

Description:

Hospice Services are 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

Program Guidance:

Services may be provided 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 services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Home and Community-Based Health Services

Description:
Home and Community-Based Health Services are 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, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
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.

Mental Health Services

Description:
Mental Health Services are the 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.

Program Guidance:
Mental Health Services are allowable only for HIV-infected clients.

See Psychosocial Support Services

Substance Abuse Outpatient Care

Description:
Substance Abuse Outpatient Care is the 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, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

See Substance Abuse Services (residential)

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the 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. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

RWHAP Legislation: Support Services

Non-Medical Case Management Services

Description:
Non-Medical Case Management Services (NMCM) 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 clients 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 including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Child Care Services

Description:
The RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care

- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories

Food Bank/Home Delivered Meals
Description:
Food Bank/Home Delivered Meals refers to the 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 the following:
- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP.

Health Education/Risk Reduction

Description:

Health Education/Risk Reduction is the 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. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:

Health Education/Risk Reduction services cannot be delivered anonymously.

See Early Intervention Services

Housing

Description:

Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation.

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Program Guidance:

RWHAP Part recipients must have mechanisms in place to allow newly identified clients access to housing services. Upon request, RWHAP recipients must provide HAB with an individualized written housing plan, consistent with RWHAP Housing

Policy 11-01, covering each client receiving short term, transitional and emergency housing services. RWHAP recipients and local decision making planning bodies, (i.e., Part A and Part B) are strongly encouraged to institute duration limits to provide transitional and emergency housing services. The US Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients consider using HUD's definition as their standard.

Housing services funds cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

See PCN 11-01 The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services 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.

Program Guidance:
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle

- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Unallowable costs include:
- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Other Professional Services
Description:
Other Professional Services allow for the 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, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- 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, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- 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

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services
Description:
Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services

Program Guidance:
Outreach programs must be:

- Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior
- Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

Funds may not be used to pay for HIV counseling or testing under this service category.

See Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

See Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support (RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups

- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

See Respite Care Services

Referral for Health Care and Support Services
Description:
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 and 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).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Rehabilitation Services
Description:
Rehabilitation Services are 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.

Program Guidance:

Examples of allowable services under this category are physical and occupational therapy.

Respite Care

Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

Program Guidance:

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 HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

See Psychosocial Support Services

Substance Abuse Services (residential)

Description:

Substance Abuse Services (residential) is the 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
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:

Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP.

Substance Abuse Services (residential) are not allowable services under RWHAP Parts C and D.

Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP.

RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Frequently Asked Questions

GENERAL:

1. Are practitioners who provide RWHAP services required to have a professional license?

   When licensure/certification is required by state and/or local regulations, providers must be appropriately licensed and in compliance with those regulations.

2. Do subrecipients have to adhere to the service category descriptions?

   Yes, subrecipients must adhere to the service category descriptions. RWHAP recipients must ensure that subrecipients adhere to the service categories descriptions when developing contracts or memorandums of understanding and through their monitoring processes and procedures.

CORE MEDICAL SERVICES:

3. Which service categories can be used to purchase medications?

   Purchasing of medications can be done through many service categories. To determine the appropriate category, review the program guidance under: AIDS Drug Assistance Program (ADAP) Treatments, Outpatient Ambulatory Health Services (OAHS), Emergency Financial Assistance (EFA), AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program (LPAP), Community Pharmaceutical Assistance), Substance Abuse Outpatient Care, Substance Abuse Services (residential), and/or Hospice Services.

4. During a medical care visit, there are immediate needs by the client to obtain a medication. Can a provider dispense this medication as part of that medical care visit and have the service categorized under Outpatient Ambulatory Health Services or EFA?

   RWHAP recipients should not make the dispensing of medications a standard practice. When this does occur, on a rare occasion, the recipient should document such service under EFA. If EFA is not available (due to lack of contract or processes in place), the service can be documented under OAHS if the medication is dispensed as part of a medical visit and there is an immediate and urgent medical need.

5. As a direct medical care provider funded by Part C, which category should be used to capture the dispensing of medication?

   Depending on the model of care, a direct provider of care could provide services under three different categories: AIDS Pharmaceutical Assistance (Community Pharmaceutical

Assistance), OAHS (prescription and management of prescription therapy), or EFA. Availability of pharmaceutical resources will influence which category is used.

6. Under OAHS, does prescription and management of medication include dispensing?

   When the medications are not funded by any other source (such as ADAP or LPAP as part of AIDS Pharmaceutical Assistance), OAHS is an option if resources are available until such time that the client can be enrolled in other programs to pay for medications. The dispensing of medication should be in the context of a medical visit. This should be on a short term basis until recipients enroll clients in ADAP, AIDS Pharmaceutical Assistance or EFA.

7. What is the difference between a local pharmaceutical assistance program for indigent populations that is run and funded by a state or local government and the AIDS Pharmaceutical Assistance/LPAP service category described by HRSA/HAB?

   HAB's use of the term LPAP is intended to differentiate this service from the state ADAP. It is a supplemental means of providing medication assistance for people living with HIV (PLWH) where there are various limits on the state ADAP; it is created and supported by the RWHAP recipient, although, in some instances, the RWHAP-supported LPAP may also receive state or local funding. HAB recognizes that many governments fund and provide, with their own generated resources, more general pharmaceutical assistance to a wide range of indigent populations within their jurisdiction, some of which are called local pharmaceutical assistance programs. To the extent that such programs are available to PLWH, they should be utilized, but the term "LPAP" under RWHAP does not constitute a reference to such programs.

8. Can I provide targeted HIV testing and referral services under Early Intervention Services (EIS)?

   Yes, in conjunction with the other required components of EIS. RWHAP Parts A and B EIS must include the following four components: targeted HIV testing, referral services, access and linkage to HIV care and treatment services, and health education/risk reduction related to HIV diagnosis. Part C EIS services must include the following four components: counseling individuals with respect to HIV, high risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency), referral and linkage to care of HIV-infected clients, and other clinical and diagnostic services related to HIV diagnosis.

9. I am a Part C recipient. Can I use the Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals service category?

   Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-

sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective. Equitable is a systematic approach that is fair.

10. How are medical case management and non-medical case management services different?

    Medical Case Management (MCM) services help clients improve health care outcomes. MCM providers should be able to analyze the care that a client receives to ensure that the client is obtaining the services necessary to improve his/her health outcomes. Non-Medical Case Management (NMCM) services provide guidance and assistance to clients to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

    Both MCM and NMCM services may also include assisting eligible clients 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.

    Both service categories include several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient.

11. How do I know which service category should be used for treatment adherence?

    Treatment adherence services are provided conjointly with many service categories such as OAHS, MCM, or ADAP. As such, recipients may choose to record treatment adherence within the service category during which the adherence service was given. In addition, if treatment adherence services are provided as a stand-alone activity, it can be reported under Health Education/Risk Reduction.

12. Who are authorized to provide Home Health Care services to RWHAP clients?

    Home health care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals, such as physicians, mid-level providers, nurses, and certified medical assistants. This does not include non-licensed, in-home care providers.

SUPPORT SERVICES:

13. If there is another professional service that clients need, can I include it under other professional services?

Other Professional Services allow for the 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, permanency planning, and income tax preparation services. Recipients should work with their project officer to discuss other allowable professional services that may fall within this category.

14. Can I include vocational therapy under the rehabilitation services category?

    Yes, this is an allowable activity, but a recipient should establish policies regarding the use of this service, and ensure it is cost effective.

15. How do recipients define the length of life expectancy an individual must have in order to receive hospice care?

    Recipients have the flexibility to define life expectancy, but must establish that criterion and implement it consistently.

16. Can a RWHAP recipient support intermittent child care services for the children living in the house of HIV-infected clients?

    Recipients may use funds to cover child care services for HIV-infected clients to enable their attendance at medical visits, related appointments, and/or RWHAP and HIV-related meetings, groups, or training sessions. Direct cash payments to clients are not permitted. Funds used for this service should be limited and carefully monitored.

17. Should EFA funds that are used for allowable services (food, housing, transportation, etc.) be accounted under the corresponding service category or the specific category of EFA?

    The funds should be counted under EFA regardless of how the funds were used.

18. Is transitional housing an allowable service under the RWHAP?

    Yes. Recipients and local decision making planning bodies are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HAB recommends that recipients consider using the U.S. Department of Housing and Urban Development's definition of transitional housing as 24 months.

19. Can linguistic services be used to pay for translating printed materials such as ADAP application?

    Yes, this activity would facilitate discussion between the provider and client regarding their service needs through a language that is understood.

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Standalone Dental Insurance Frequently Asked Questions

1. Can recipients offer both standalone dental insurance premiums and/or cost sharing assistance under the service category Health Insurance Premiums and Cost Sharing Assistance **and** RWHAP Oral Health Care services in their program?

   Recipients and subrecipients are able to provide both service categories within their programs as long as the standalone dental insurance premium and/or cost sharing assistance and Oral Health Care services are provided in compliance with the requirements for each described in *PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*.

2. Can recipients/subrecipients use RWHAP funds to pay for oral health care services that exceed annual expenditure caps established by standalone dental insurance plans?

   RWHAP recipients and subrecipients are in the best position to understand the unique needs of their client populations, determine which costs are cost-effective to pay, and ensure availability of the resources equitably for eligible clients. It is up to the recipient and subrecipient to identify which costs they will cover related to standalone dental insurance, which can include: premiums, deductibles, co-payments, and/or costs above the cap. The recipient or subrecipient must have policies and procedures in place to ensure these services are available to all eligible RWHAP clients.

3. Can ADAP funds or pharmaceutical rebates be used to purchase standalone dental insurance premiums and/or cost sharing assistance?

   ADAP funds cannot be used to purchase standalone dental insurance premiums and cost sharing assistance because standalone dental insurance does not cover the cost of medications necessary in treatment for people living with HIV. See *PCN #13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost Sharing Assistance for Private Health Insurance* for requirements for ADAPs to pay for Health Insurance Premiums and Cost Sharing Assistance for Individuals.

   However, as *PCN #15-04 Utilization and Reporting of Pharmaceutical Rebates* explains, "the RWHAP legislation requires that rebates collected on ADAP medication purchases be applied to the RWHAP Part B Program with a priority, but not a requirement, that the rebates be placed back into ADAP. These rebates must be used for the statutorily permitted purposes under the RWHAP Part B Program which are limited to core medical services including ADAP, support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with

HIV." Pharmaceutical rebates earned by the RWHAP Part B Program may be used to pay for standalone dental insurance premiums and/or cost sharing assistance.

4. When does the addition of standalone dental insurance to the Health Insurance Premiums and Cost Sharing Assistance for Low-Income Individuals service category take effect?

   PCN #16-02 is in effect for all awards made on or after October 1, 2016, including competing continuations, noncompeting continuations, supplements, and new awards.

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Housing Services Frequently Asked Questions

1. What service category should be used if the housing service is a one-time payment for a utility bill? Is a housing assessment required for this one-time payment?

   The housing service category covers transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that extends beyond a one-time service. If a RWHAP recipient makes a one-time payment for a client's utility or housing bill, this should be categorized as emergency financial assistance. A housing assessment and individualized housing plan would not be required for a one-time housing payment provided under emergency financial assistance.

2. A client comes in to receive services and it is determined that their housing needs extend beyond a one-time payment. If the client's housing needs were previously assessed, would that client need an additional assessment?

   If a RWHAP client's housing needs extend beyond a one-time payment, and there is a need for additional housing services, this service should be categorized as housing. Clients receiving housing services must have their housing needs assessed annually and an individualized written housing plan developed to determine if there is a need for new or additional housing services.

3. Can RWHAP funds be used for rental deposits?

   No, RWHAP funds may not be used for rental deposits. Because rental deposits are typically returned to clients as cash, this would violate the prohibition on providing cash payments to clients. In some instances, deposits may be retained as payment (e.g., damage to the property). As such costs would additionally be unallowable, recipients cannot pay for a rental deposit using federal funds, program income generated from federal funds, or pharmaceutical rebates generated from federal funds.

Service Categories

CORE MEDICAL SERVICES	SUPPORT SERVICES
Outpatient/Ambulatory Health Services	Non-Medical Case Management Services
AIDS Drug Assistance Program Treatments	Child Care Services
AIDS Pharmaceutical Assistance	Emergency Financial Assistance
Oral Health Care	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Health Education/Risk Reduction
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	Housing
Home Health Care	Other Professional Services
Home and Community-Based Health Services	Linguistic Services
Hospice Services	Medical Transportation
Mental Health Services	Outreach Services
Medical Nutrition Therapy	Psychosocial Support Services
Medical Case Management, including Treatment Adherence Services	Referral for Health Care and Support Services
Substance Abuse Outpatient Care	Rehabilitation Services
	Respite Care
	Substance Abuse Services (residential)

FY 2020 Ryan White Part A and B and State Services
Funded Service Categories

** = HRSA-defined core service

Part A Funded Service Categories:

**Ambulatory/Outpatient Medical Care (includes Rural, Pediatrics, OB/GYN and Vision care)
**Case Management – Medical (including treatment adherence services)
Case Management – Non-medical (community based)
**Emergency Financial Assistance
**Health Insurance Assistance
**Local Pharmacy Assistance Program
**Medical Nutrition Therapy (including supplements)
**Oral Health (Rural)
Outreach Services
Program Support (Project LEAP, Case Management Training and Blue Book)
**Substance Abuse Treatment (Outpatient)
Transportation (Van-based and bus passes)

Part B Funded Service Categories:

**Health Insurance Assistance
**Home and Community based Health Services – Facility Based
**Oral Health Care (untargeted and prosthodontics)
Referral for Health Care and Support Services (ADAP Eligibility Workers)

State Services Funded Service Categories:

**Early Medical Intervention (Incarcerated)
**Health Insurance Assistance
**Hospice Services
Linguistics Services
**Mental Health

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-19-19							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ✔ Yes ___No			

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-19-19							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:*** *(Galley/Hamilton)* *Votes: Y=7; N=0; Abstentions=Andrews, Bailey, Francis, Miertschin*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support	Epi: An estimated 6,625 people in the EMA are HIV+ and unaware of their status (2017). The current estimate of unmet need in the EMA is 6,952, or 25% of all PLWH (2017). Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2018): # clients served: *Primary Care: 8,874 (5% increase v. 2017)* *LPAP: 4,639 (<1% decrease v. 2017)*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management:	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: PriCare=300%, LPAP=300% +500%, MCM=none, SLW=none.

‡ Service Category for Part B/State Services only.

The Remainder of this Packet is for the Quality Improvement Committee meeting.

DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

2:30 p.m., Tuesday, March 17, 2020

Meeting Location: 2223 W. Loop South, Room 416; Houston, Texas 77027

Agenda

* = Handout to be distributed at the meeting

I. Call to Order — Denis Kelly and Pete Rodriguez, Co-Chairs
   A. Welcoming Remarks and Moment of Reflection
   B. Adoption of Agenda
   C. Approval of Minutes
   D. Training: Reports Related to Consumer Experiences in Care — Amber Harbolt

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

III. Reports from the Administrative Agent – Part A/MAI — Carin Martin
   A. Procurement*
   B. FY 2018-19 Chart Reviews — Heather Keizman, RN
      - Primary Care
      - Case Management
      - Oral Health – Rural
      - Vision

IV. Reports from the Administrative Agent – Part B/State Services* — Patrick Martin

V. How To Best Meet the Need (HTBMN) Meeting Schedule
   A. Sign up for Training and Workgroup Meetings

VI. New Business
   A. 2020 Criteria for Proposed Idea Forms — Tori Williams
   B. 2020 Proposed Idea Form — Tori Williams

VII. Announcements
Cancelled: the April Quality Improvement Committee meeting so that members can attend HTBMN training and workgroup meetings

VIII. Adjourn

Optional: New members meet with committee mentor — Crystal Starr

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Thursday, February 18, 2020
Meeting location: 2223 W. Loop South, Room 416; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Denis Kelly, Co-Chair	Ahmier Gibson	Tana Pradia, RWPC Chair
Pete Rodriguez, Co-Chair	Gregory Hamilton, excused	Alex C. Moses
Kevin Aloysius	Tom Lindstrom, excused	Mayra Ramirez, TRG Intern
Crystal Starr	Gloria Sierra	Kim Kirchner, TRG Intern
Daniel Impastato	Andrew Wilson, excused	Sha'Terra Johnson-Fairley, TRG
Marcely Macias	Nancy Miertschin, excused	Patrick Martin, TRG
Kayla Mills	Angela Rubio	Tiffany Shepherd, TRG
Cecilia Oshingbade	Deborah Somoye, excused	Reachelian Ellison, TRG
		Carin Martin, RWGA
		Heather Keizman, RWGA
		Tori Williams, Ofc of Support
		Diane Beck, Ofc of Support

Call to Order: Denis Kelly, Co-Chair, called the meeting to order at 2:13 p.m. and asked for a moment of reflection. He then invited members to introduce themselves.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Impastato, Starr) to approve the November 19, 2019 minutes.* ***Motion carried.*** Abstentions: Macias, Mills, Oshingbade.

Committee Orientation: Williams reviewed the attached documents related to: Nuts and Bolts for New Members, End of Year Petty Cash Procedures, and the Open Meetings Act Training.

Committee Meeting Date and Time: ***Motion #3****: it was moved and seconded (Aloysius, Impastato) to keep the regular monthly committee meeting at 2:00 p.m. on the Tuesday after the Planning Council meets.* **Motion Carried.** Abstention: Oshingbade.

Public Comment: None.

Committee Orientation: Williams reviewed the attached documents: Committee Description, 2020 Committee Goals, Conflict of Interest Statement and Voting Policy, and Timeline of Critical 2020 Council Activities. Because there were two staff from Legacy present, Aloysius agreed to abstain

from voting, per Council policy. ***<u>Motion #4</u>**: it was moved and seconded (Starr, Oshingbade) to accept the 2020 Committee goals.* **Motion carried**. Abstention: Aloysius.

Training in How to Read Reports from the Administrative Agents:
C. Martin explained to Committee members how to review a Part A and MAI quarterly Service Utilization Report and a Procurement Report. See reports dated 02/18/2020.

P. Martin explained to Committee members how to review Part B and State Services Procurement, Service Utilization, Health Insurance Assistance, and Client Satisfaction reports. See attached 2020 Schedule of Reports, How to Read TRG Reports 2020, Procurement Reports Part B & SS – dated 01/21/20 and 01/24/20, Service Utilization Report SS – dated 01/08/20, and Health Insurance Program Reports – dated 01/08/20 and 02/05/20.

Williams said that the March committee meeting will be a joint meeting with the other committees and they will determine the Criteria for FY 2019 Service Categories. See attached *FY 2020 How to Best Meet the Need Justification for Each Service Category*.

Reports from Ryan White Grant Administration
Keizman presented the results of the Part A Clinical Quality Management Committee Quarterly Report. See attached dated 02/11/2020.

Reports from The Resource Group
Shepherd reviewed the FY 2019 Part B/State Services Chart Reviews for Early Intervention Services-Incarcerated, Home and Community Based Services, Hospice, Mental Health, Oral Health, and Referral for Healthcare and Support Services. See attached. Ellison reviewed the Part B/State Services Annual Consumer Involvement Report for 2019. See attached.

Elect a Vice Chair: Aloysius nominated Starr to be the committee vice chair. Starr accepted the nomination and was elected via acclamation.

Announcements: None.

Adjourn: The meeting was adjourned at 3:49 p.m.

Submitted by:		Approved by:	
Tori Williams, Director	Date	Committee Chair	Date

Scribe: Beck

ja = Just arrived at meeting
lr = Left room temporarily
lm = Left the meeting
C = Chaired the meeting

2020 Quality Improvement Meeting Voting Record for Meeting Date 02/18/20

	Motion #1 Agenda				**Motion #2** Minutes				**Motion #3** Regular Meeting Date/Time				**Motion #4** 2020 Committee Goals				**Motion #5** Elect a Vice Chair			
MEMBERS:	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Denis Kelly, Co-Chair				**C**				**C**				**C**				**C**				**C**
Pete Rodriguez, Co- Chair		**X**				**X**				**X**				**X**				**X**		
Kevin Aloysius		**X**				**X**				**X**						**X**				**X**
Ahmier Gibson	**X**				**X**				**X**				**X**				**X**			
Gregory Hamilton	**X**				**X**				**X**				**X**				**X**			
Tom Lindstrom	**X**				**X**				**X**				**X**				**X**			
Gloria Sierra	**X**				**X**				**X**				**X**				**X**			
Crystal Starr		**X**				**X**						**X**	**X**					**X**		
Andrew Wilson	**X**				**X**				**X**				**X**				**X**			
Daniel Impastato		**X**				**X**				**X**				**X**				**X**		
Marcely Macias		**X**						**X**		**X**				**X**				**X**		
Nancy Miertschin	**X**				**X**				**X**				**X**				**X**			
Karla Mills		**X**						**X**		**X**				**X**				**X**		
Cecilia Oshingbade		**X**						**X**		**X**				**X**				**X**		
Angela Rubio	**X**				**X**				**X**				**X**				**X**			
Deborah Somoye	**X**				**X**				**X**				**X**				**X**			

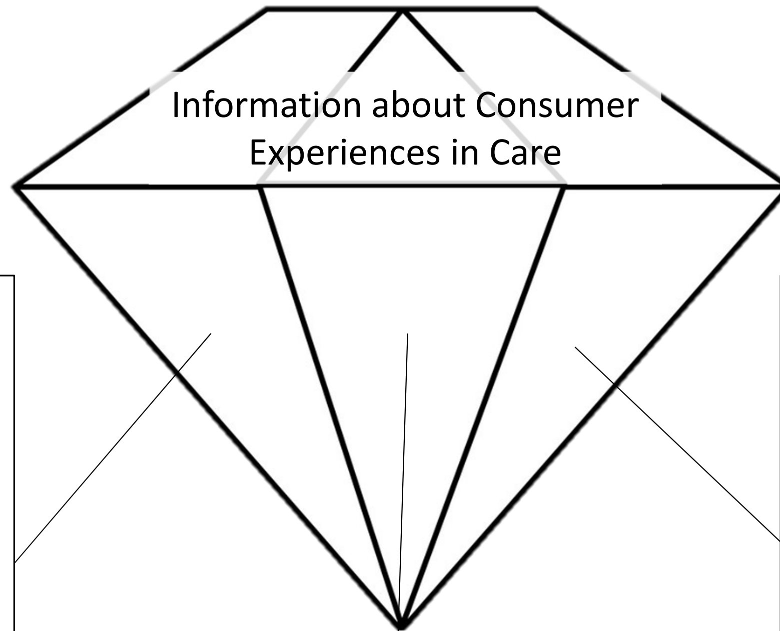


Chart reviews
- Collected by the AAs
- Gathered from a sample of medical charts
- Examines quality of care within the provision of particular services
- Answers the questions "Are RW consumers receiving services that meet Standards of Care and medical guidelines?"
- Can be tied to a specific provider, but presented to Council either de-identified or at the system level

Client Satisfaction Surveys
- Collected by the AAs
- Reported directly from consumer
- Examines client satisfaction within the provision of particular services
- Answer the question: "Are RW consumers satisfied with the quality of care they are receiving?"
- Can be tied to a specific provider, but presented to Council either de-identified or at the system level

Needs Assessment / Special Studies
- Collected by Office of Support
- Reported directly from consumer
- Examines the system of services in relation to need and accessibility*
- Answers the question: "What services do PLWH need to stay in medical care, and are those services accessible?"
- Not tied to any specific provider

*Also assesses service needs of those not in care

Ryan White Part A, Houston EMA FY18-19 Clinical Care Chart Review Summary of Findings

HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County

Chart Reviews Conducted

- Primary Care
- Vision
- Oral Health Care- Rural Target

- Review period was March 1, 2018 - February 28, 2019

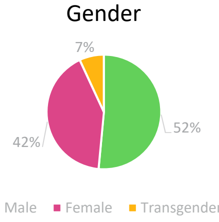
p. 5

HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County

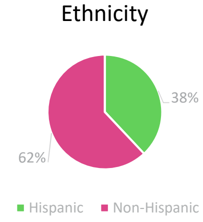
Primary Care Chart Review

- 635 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, and age demographics of each site's overall primary care population
- Female and Transgender clients were oversampled to adequately capture performance data for these populations

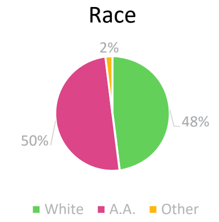
Gender



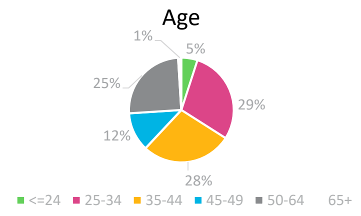
Ethnicity



Race



Age



Primary Care Measures

Performance Measures	FY17 Rate	FY18 Rate	Change	Goal
Viral Load Suppression	85.5%	87.8%	↑	90%
ART Prescription	98.7%	99.4%	–	95%
PCP Prophylaxis	93%	93.9%	–	100%
Viral Load Monitoring	98%	98.3%	–	90%
HIV Drug Resistance Testing	71.4%	75%	↑	85%
Influenza Vaccination	53.5%	62.9%	↑	65%
Lipid Screening	88.8%	89.9 %	–	90%
Tuberculosis Screening	67.2%	71%	↑	75%
Cervical Cancer	82.5%	81.6%	–	75%
STI Testing	77.6%	78.9%	–	65%
Hepatitis B Screening	87.1%	90.9%	↑	95%

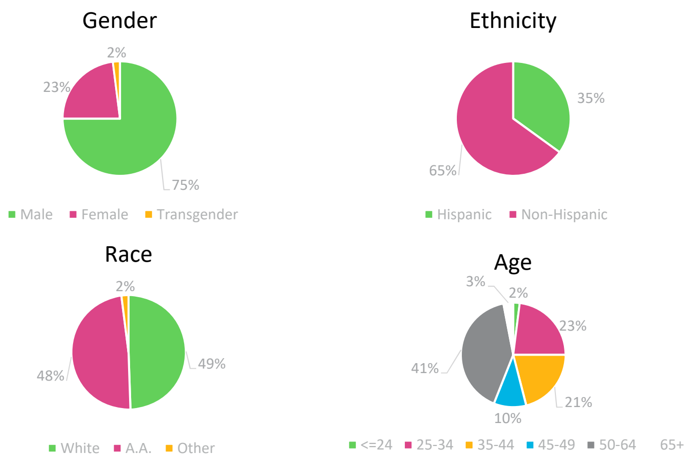
Primary Care Measures

Performance Measures	FY17 Rate	FY18 Rate	Change	Goal
Hepatitis B Vaccination	51.4%	49.3%	↓	55%
Hepatitis C Screening	92.8%	95.1%	↑	95%
HIV Risk Counseling	90.7%	83.9%	↓	85%
Pneumococcal	83.4%	83.1%	–	90%
Mental Health Screening	96.4%	98.1%	–	95%
Tobacco Screening	100%	98.7%	–	100%
Smoking Cessation Counseling	55.7%	67.8%	↑	100%
Substance Use Screening	99.1%	99.4%	–	95%
Syphilis Screening	92.4%	94.8%	↑	85%

HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County

Vision Care Chart Review

- 150 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, gender and age demographics of each site's overall vision care population



HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County

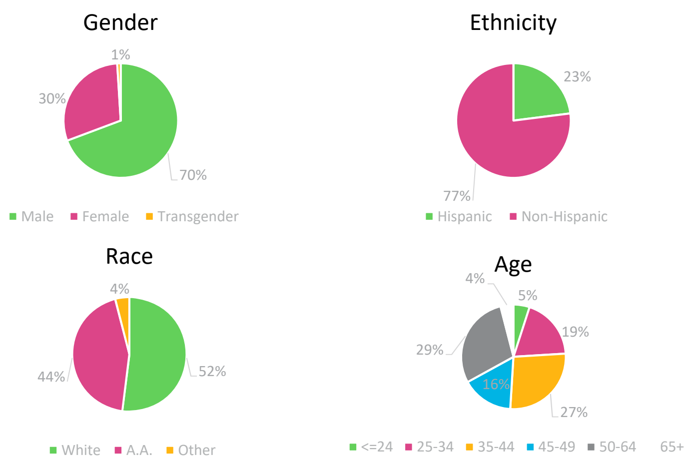
Vision Chart Review

Performance Measure	2018
CD4 & VL	83%
Primary Care Provider	87%
Medication Allergies	100%
Medical History	100%
Current Medications	100%
Reason for Visit	100%
Ocular History	100%
Complete Eye Exam	100%
Dilated Fundus Exam	94%

Performance Measure	2018
Internal Eye Exam	100%
Diagnosis Documented	100%
Treatment Plan Documented	100%
Visual Acuity Test	100%
Refraction Test	100%
External Structures Observed	100%
Glaucoma Test	100%
Cytomegalovirus (CMV) Screening	100%

Vision Care Chart Review

- 75 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, gender and age demographics of each site's overall vision care population



HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County

Oral Health-Rural Chart Review

Performance Measure	2018	Performance Measure	2018
Primary Care Provider	97%	Oral Health Education*	99%
Medical/Dental Health History*	100%	Hard Tissue Exam	96%
Medical History 6 month update	96%	Soft Tissue Exam	96%
Vital Signs	100%	Periodontal Screening*	97%
Current Medications	100%	X-Rays Present	99%
CBC Documented	92%	Treatment Plan*	99%
Antibiotic Prophylaxis Given	0%		

*HIV/AIDS Bureau (HAB) Performance Measures

Questions

Harris County Public Health Building a Healthy Community
HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County
Chronic Disease Food Safety Emergency Preparedness Environmental Health Infectious Diseases Injury Social, Mental, and Emotional Wellbeing

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

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Primary Care Chart Review Report FY 2018

Ryan White Part A Quality Management Program – Houston EMA

October 2019

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

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2018, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to five organizations. Approximately 13,000 unduplicated individuals living with HIV receive Ryan White-funded services at these organizations.

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

Introduction

On March 25, 2018, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to people living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/18 and 2/28/19. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Improvement (CQI) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, 2017* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

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

If documentation on a particular element was not found, a "no data" response was entered into the database. For some data elements, the reviewer looked for documentation that the requisite test/assessment/vaccination was performed, e.g., lipid screening or pneumococcal vaccination. Other data elements required that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was a colposcopy performed? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to evaluate quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider?

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

Tale 1. Data Collection Parameters

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

Tale 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	Viral Load Assays are recommended every 3-6 months. Clients on ART should have a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually for clients at risk
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Screening is recommended at least once since HIV diagnosis, either PPD, IGRA or chest X-ray.
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the previous three years
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV Risk Counseling	Clients are screened for behaviors associated with HIV transmission and risk reduction discussed
Pneumocystis jirovecii Pneumonia (PCP) Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis

The Sample Selection Process

The sample population was selected from a pool of 7,541 clients (adults age 18+) who accessed Part A primary care (excluding vision care) and had at least two visits, at least 90 days apart, between 3/1/18 and 2/28/19. The medical charts of 635 clients were used in this review, representing 8.4% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 41.7% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

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

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/18-2/28/19

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

Report Structure

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

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

Findings

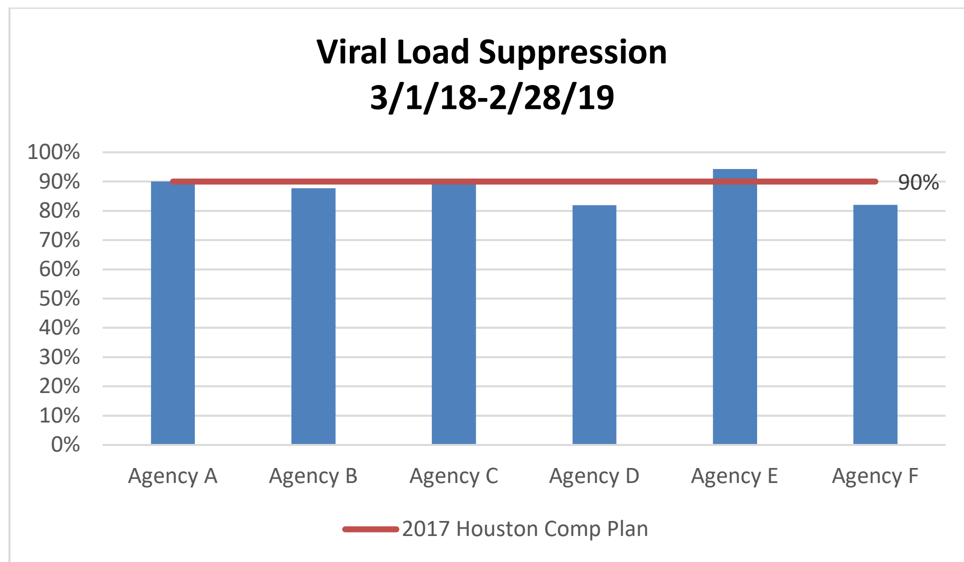
Core Performance Measures

Viral Load Suppression

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

	2016	2017	2018
Number of clients with viral load below limits of quantification at last test during the measurement year	544	535	553
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	615	626	630
Rate	**88.5%**	**85.5%**	**87.8%**
	2.1%	**-3%**	**2.3%**

2018 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	252	214	78
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	287	242	91
Rate	**87.8%**	**88.4%**	**85.7%**



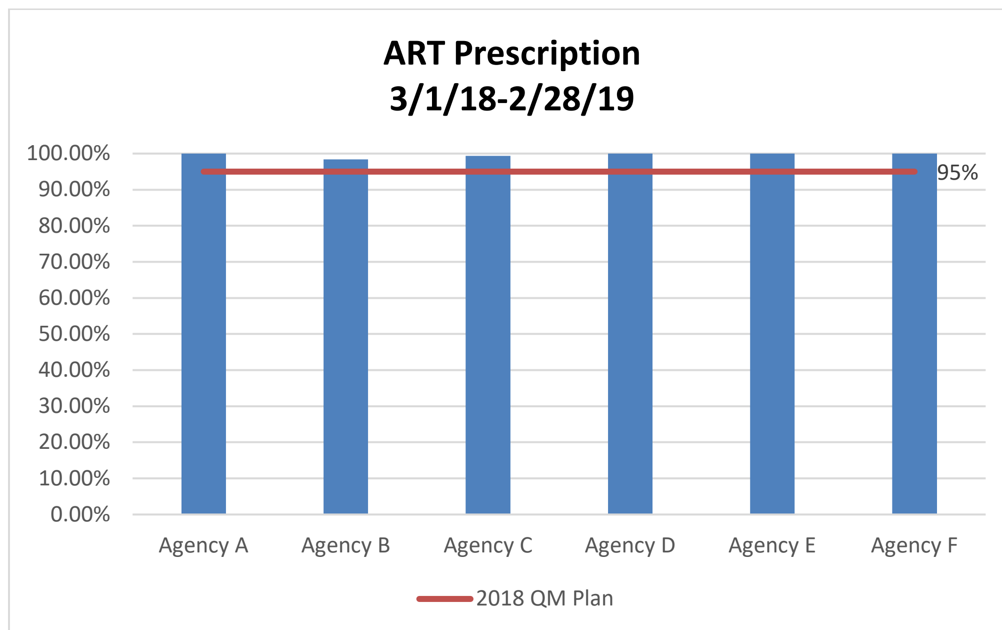
ART Prescription

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

	2016	2017	2018
Number of clients who were prescribed an ART regimen within the measurement year	620	627	631
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**97.6%**	**98.7%**	**99.4%**
Change from Previous Years Results	**1.1%**	**1.1%**	**.7%**

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

2018 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	288	242	91
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	292	242	91
Rate	**98.6%**	**100%**	**100%**

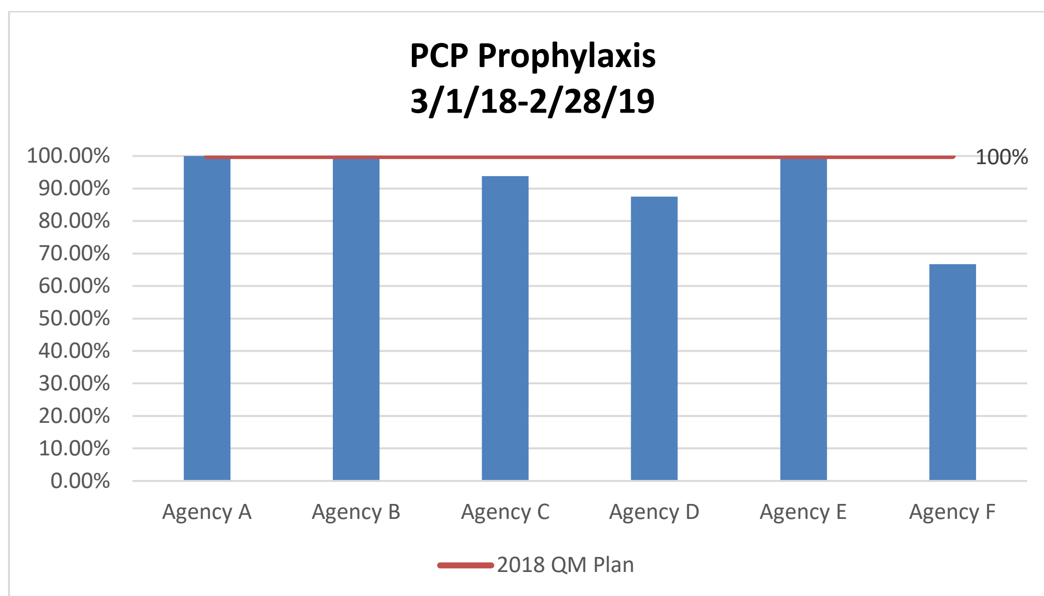


PCP Prophylaxis

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

	2016	2017	2018
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	48	53	62
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	48	57	66
Rate	**100%**	**93%**	**93.9%**
Change from Previous Years Results	**7%**	**-7%**	**.9%**

2018 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	30	21	11
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	33	22	11
Rate	**90.9%**	**95.5%**	**100%**



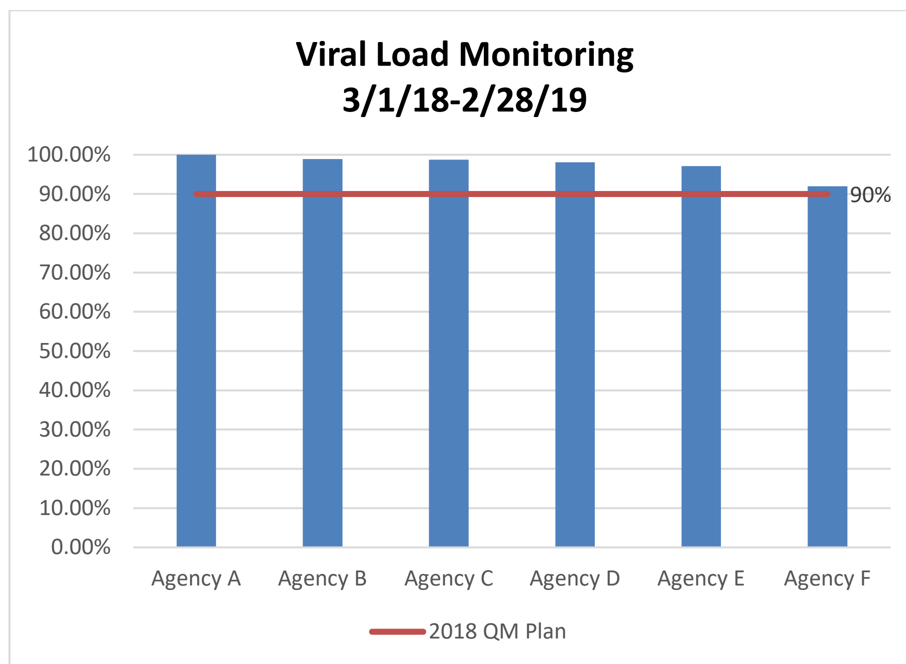
All Ages Performance Measures

Viral Load Monitoring

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

	2016	2017	2018
Number of clients who had a viral load test performed at least every six months during the measurement year	601	622	624
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**94.6%**	**98%**	**98.3%**
Change from Previous Years Results	**1.7%**	**3.4%**	**.3%**

2018 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	284	239	91
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	292	242	91
Rate	**97.3%**	**98.8%**	**100%**



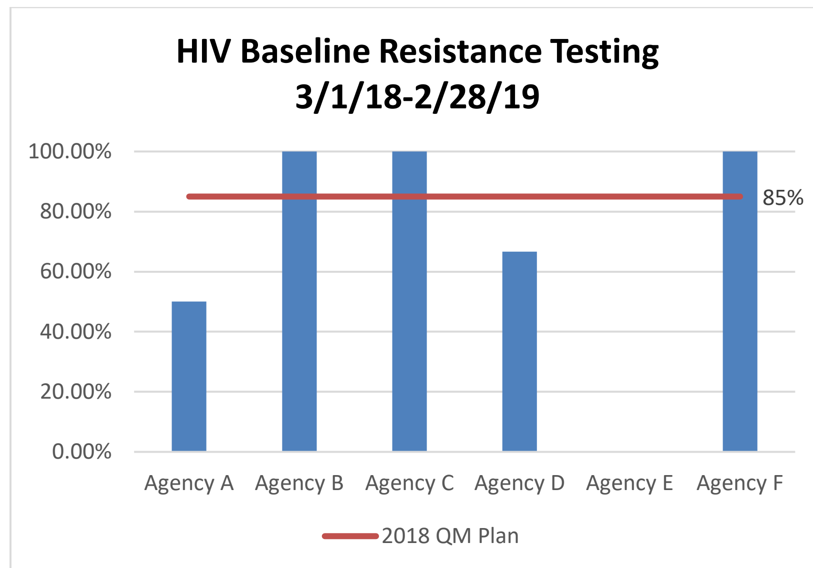
HIV Drug Resistance Testing Before Initiation of Therapy

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

	2016	2017	2018
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	9	5	6
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	13	7	8
Rate	**69.2%**	**71.4%**	**75%**
Change from Previous Years Results	**-.8%**	**2.2%**	**3.6%**

2018 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	1	2	3
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	2	3	3
Rate	**50%**	**66.7%**	**100%**

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



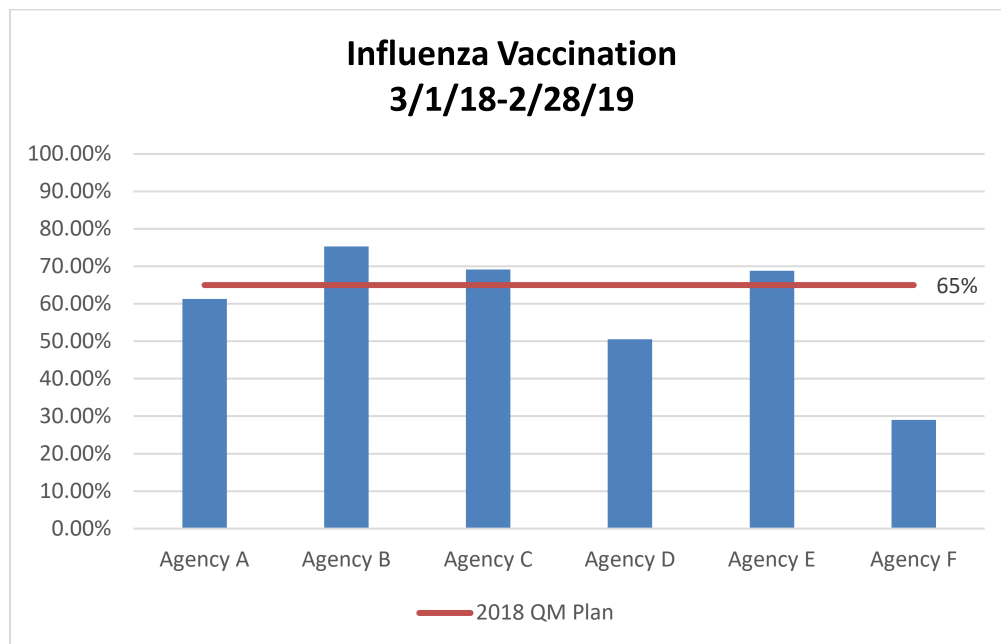
Influenza Vaccination

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

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

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

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

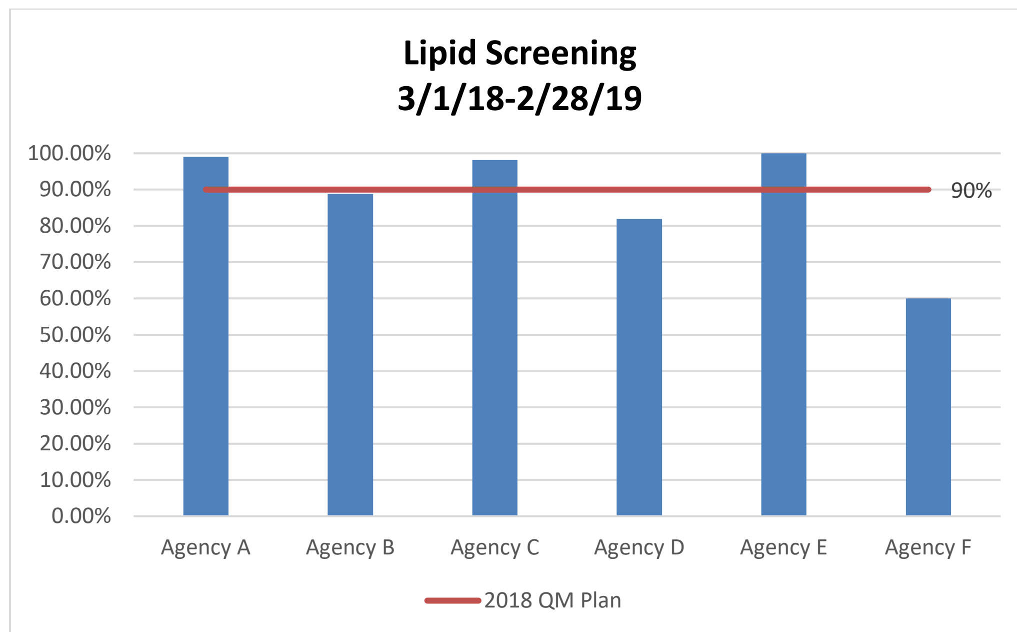


Lipid Screening

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

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

2018 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	256	219	82
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	288	242	91
Rate	**88.9%**	**90.5%**	**90.1%**

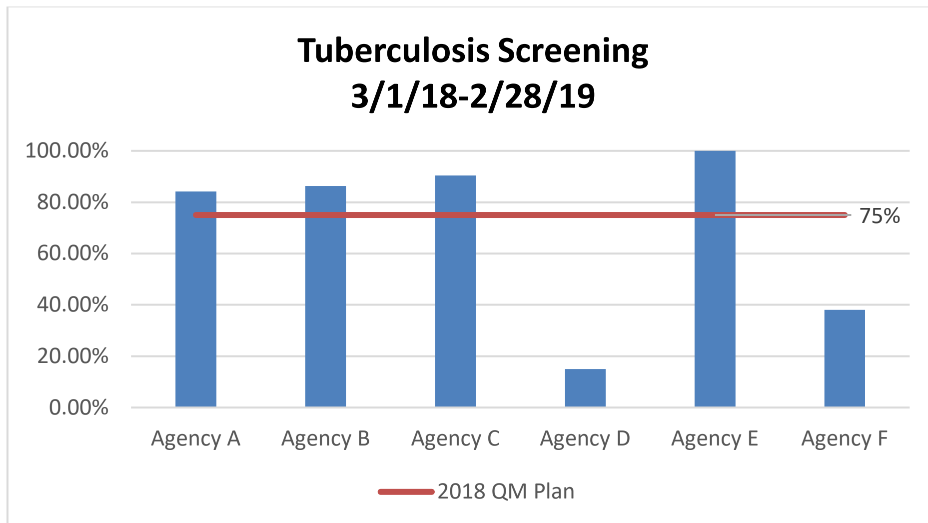


Tuberculosis Screening

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

	2016	2017	2018
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	382	375	401
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	571	558	565
Rate	**66.9%**	**67.2%**	**71%**
Change from Previous Years Results	**-.2%**	**.3%**	**3.8%**

2018 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	177	164	57
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	269	208	84
Rate	**65.8%**	**78.8%**	**67.9%**



Adolescent/Adult Performance Measures

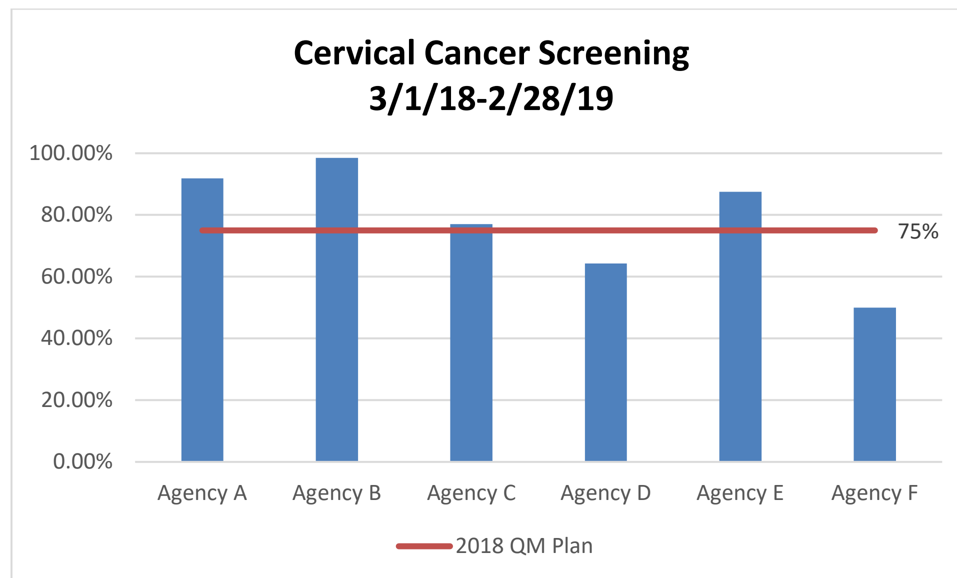
Cervical Cancer Screening

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

	2016	2017	2018
Number of female clients who had Pap screen results documented in the previous three years	229	226	199
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	286	274	244
Rate	**80.1%**	**82.5%**	**81.6%**
Change from Previous Years Results	**11.9%**	**2.4%**	**-.9%**

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

2018 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	97	94	8
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	115	112	15
Rate	**84.3%**	**83.9%**	**53.3%**



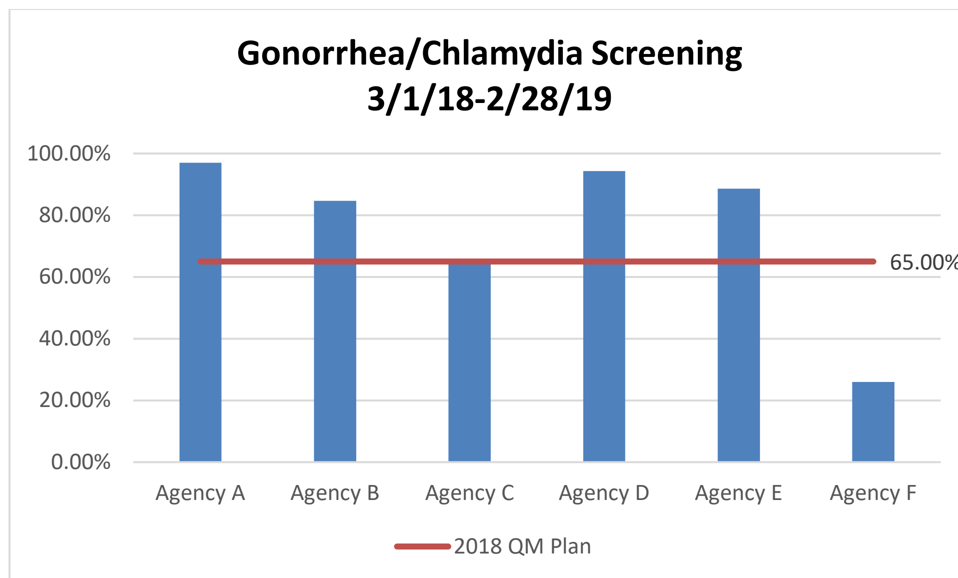
Gonorrhea/Chlamydia Screening

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

	2016	2017	2018
Number of clients who had a test for Gonorrhea/Chlamydia	463	493	501
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**72.9%**	**77.6%**	**78.9%**
Change from Previous Years Results	**3.3%**	**4.7%**	**1.3%**

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

2018 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	232	199	61
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**79.5%**	**82.2%**	**67%**



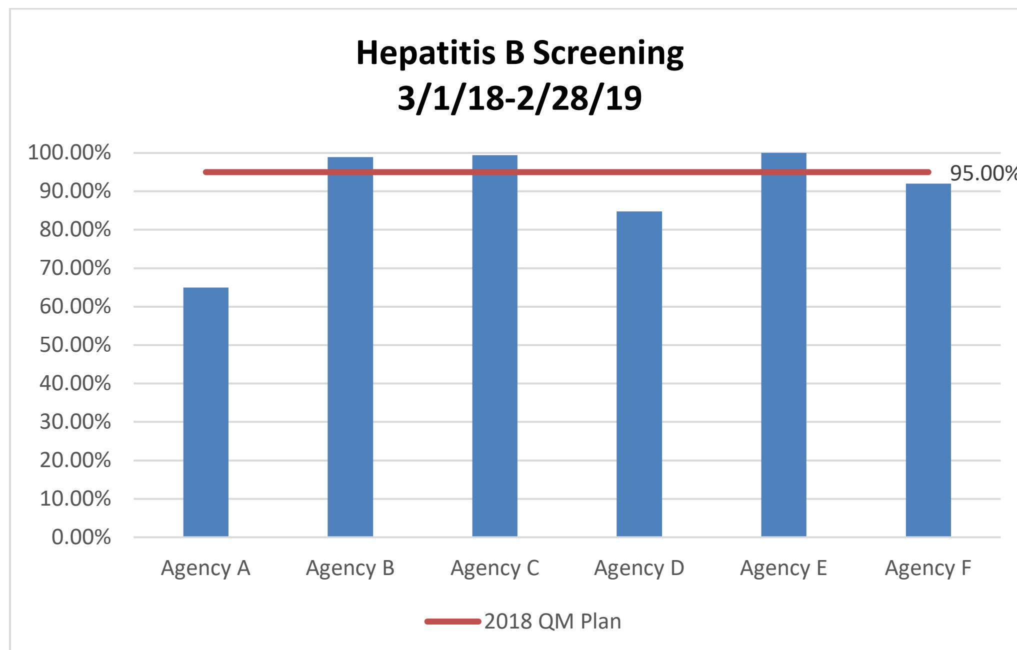
Hepatitis B Screening

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

	2016	2017	2018
Number of clients who have documented Hepatitis B infection status in the health record	610	553	577
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**96.1%**	**87.1%**	**90.9%**
Change from Previous Years Results	**-3.7%**	**-9%**	**3.8%**

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

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

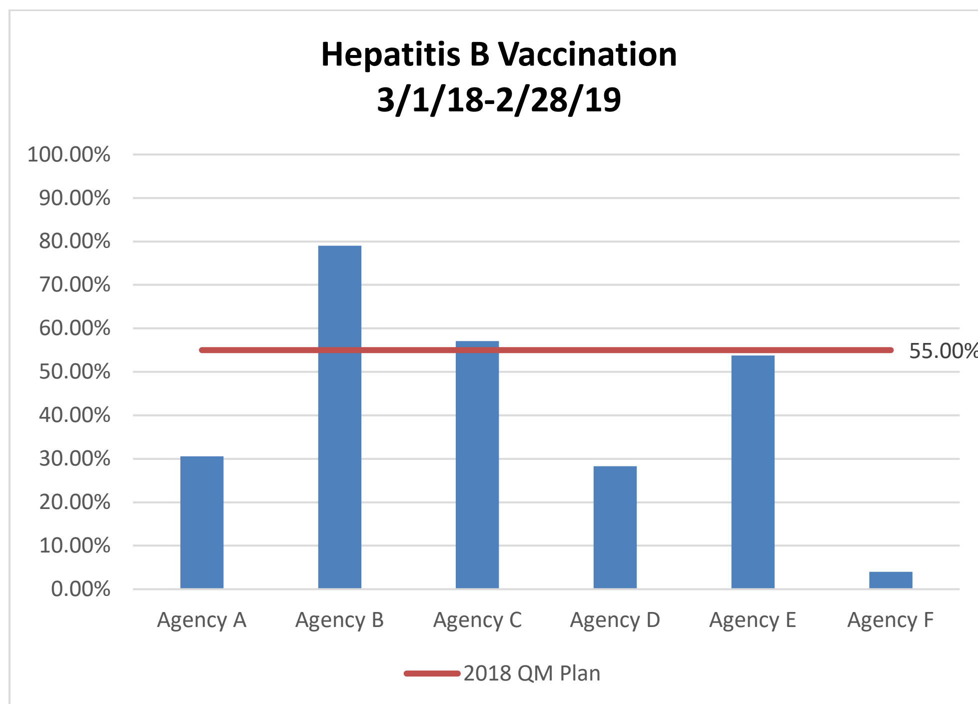


Hepatitis B Vaccination

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

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

2018 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	60	89	21
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	136	160	50
Rate	**44.1%**	**55.6%**	**42%**



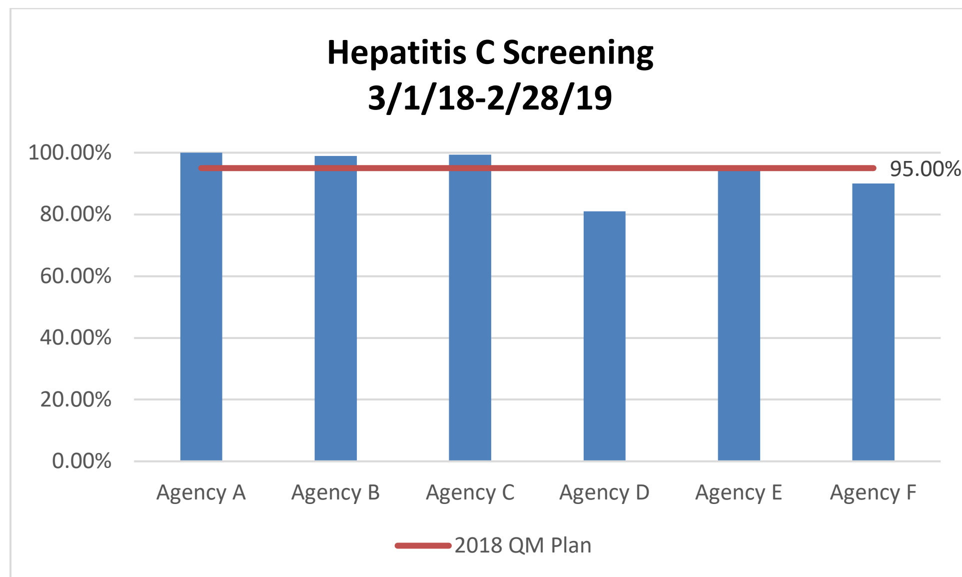
Hepatitis C Screening

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

	2016	2017	2018
Number of clients who have documented HCV status in chart	629	589	604
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**99.1%**	**92.8%**	**95.1%**
Change from Previous Years Results	**-.6%**	**-6.3%**	**2.3%**

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

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

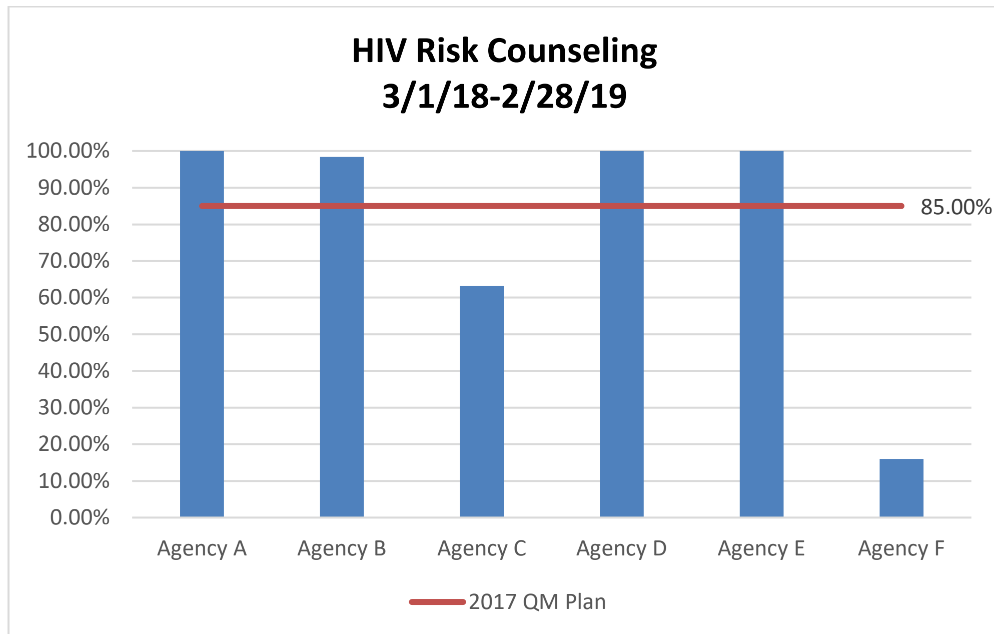


HIV Risk Counseling

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

	2016	2017	2018
Number of clients, as part of their primary care, who received HIV risk counseling	441	576	533
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**69.4%**	**90.7%**	**83.9%**
Change from Previous Years Results	**-1.9%**	**21.3%**	**-6.8%**

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

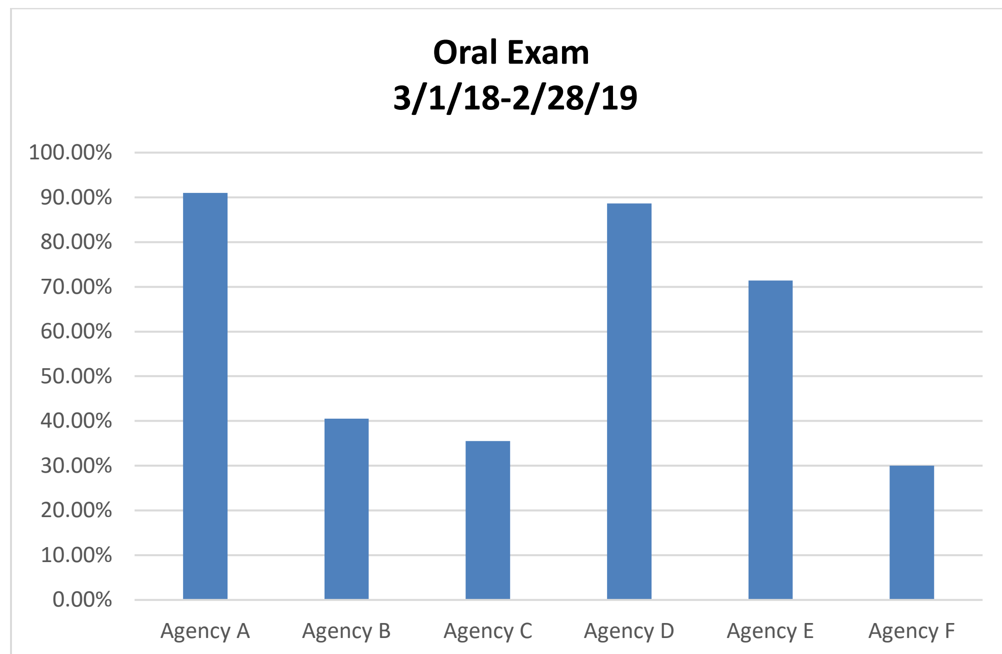


Oral Exam

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

	2016	2017	2018
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	327	272	355
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**51.5%**	**42.8%**	**55.9%**
Change from Previous Years Results	**-2%**	**-8.7%**	**13.1%**

2018 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	165	142	44
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**56.5%**	**58.7%**	**48.4%**



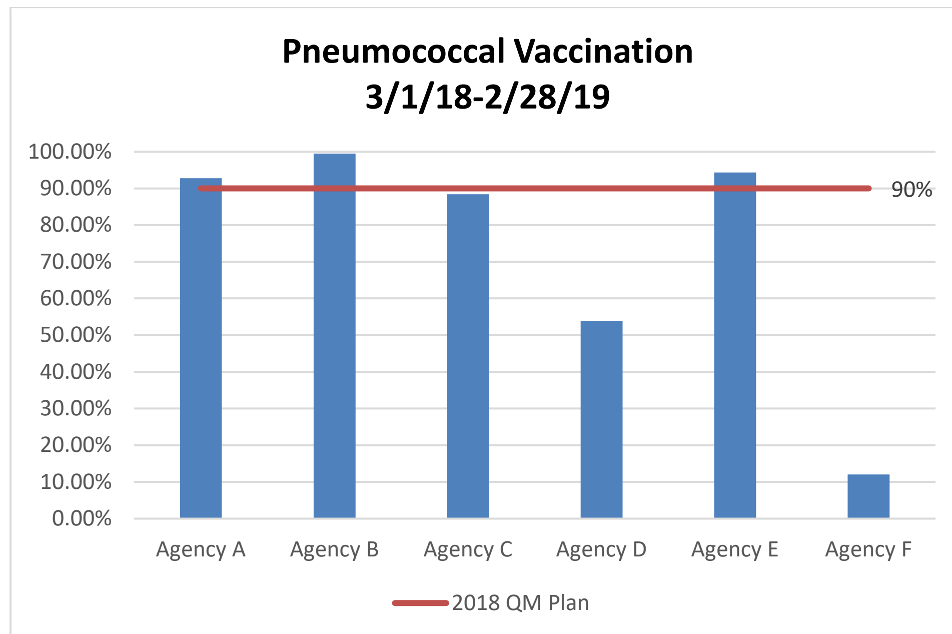
Pneumococcal Vaccination

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

	2016	2017	2018
Number of clients who received pneumococcal vaccination	534	514	507
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	616	616	610
Rate	**86.7%**	**83.4%**	**83.1%**
Change from Previous Years Results	**-1.1%**	**-3.3%**	**-.3%**

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

2018 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	224	204	70
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	282	233	85
Rate	**79.4%**	**87.6%**	**82.4%**

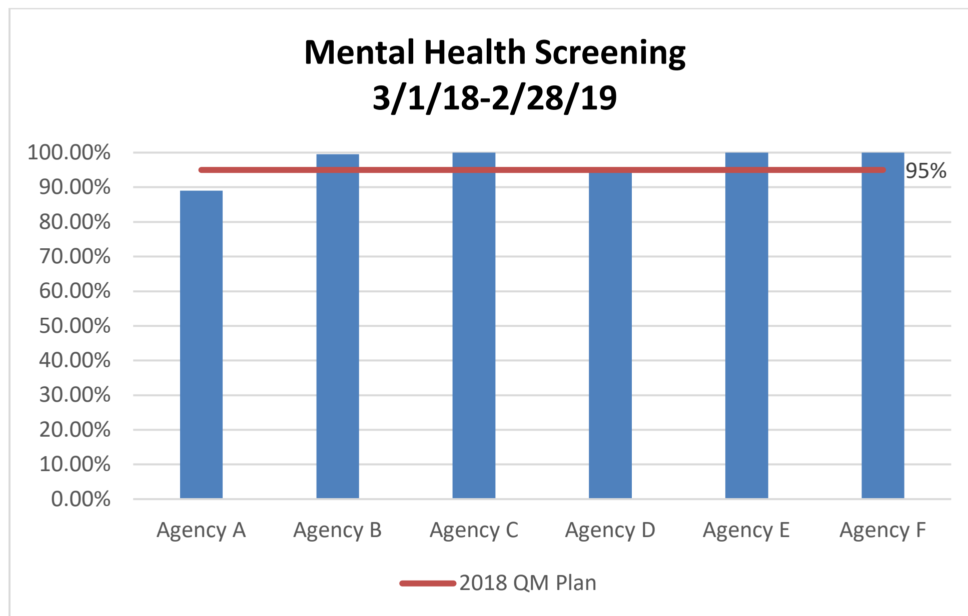


Preventative Care and Screening: Mental Health Screening

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

	2016	2017	2018
Number of clients who received a mental health screening	558	612	623
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**87.9%**	**96.4%**	**98.1%**
Change from Previous Years Results	**-4.4%**	**8.5%**	**1.7%**

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

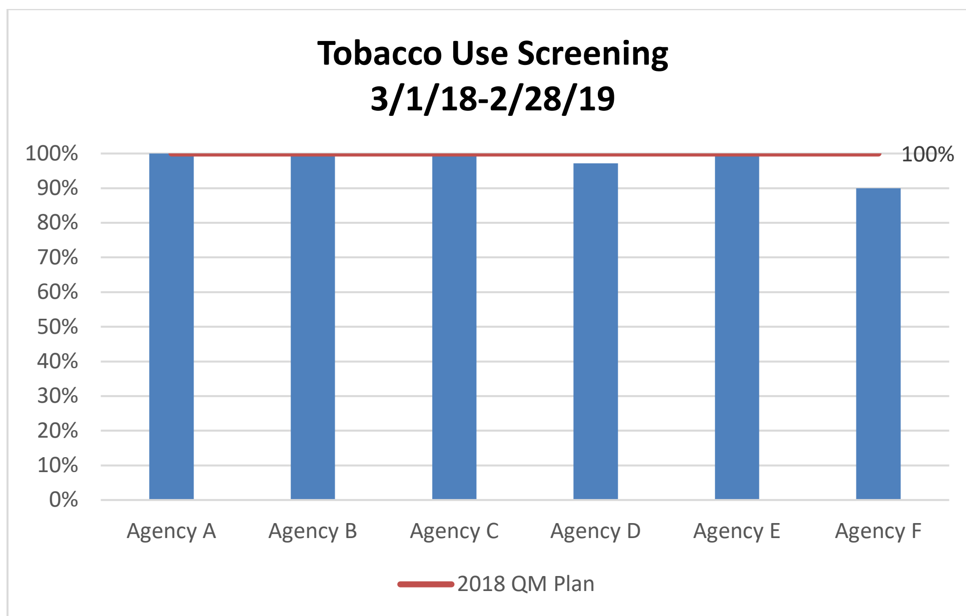


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

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

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



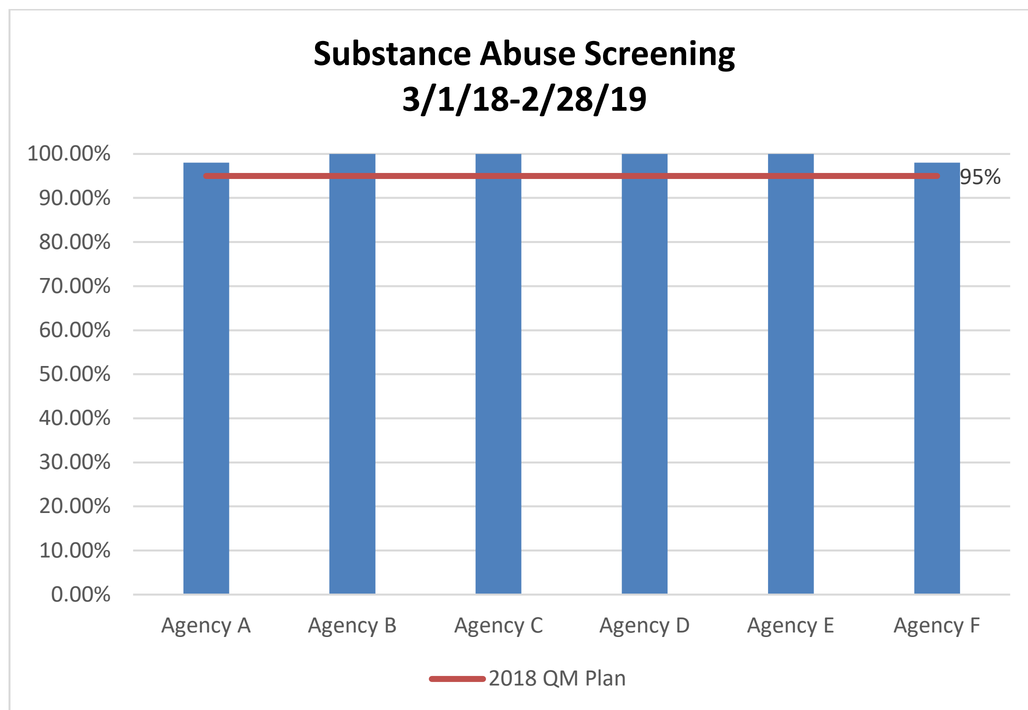
Substance Use Screening

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

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

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

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

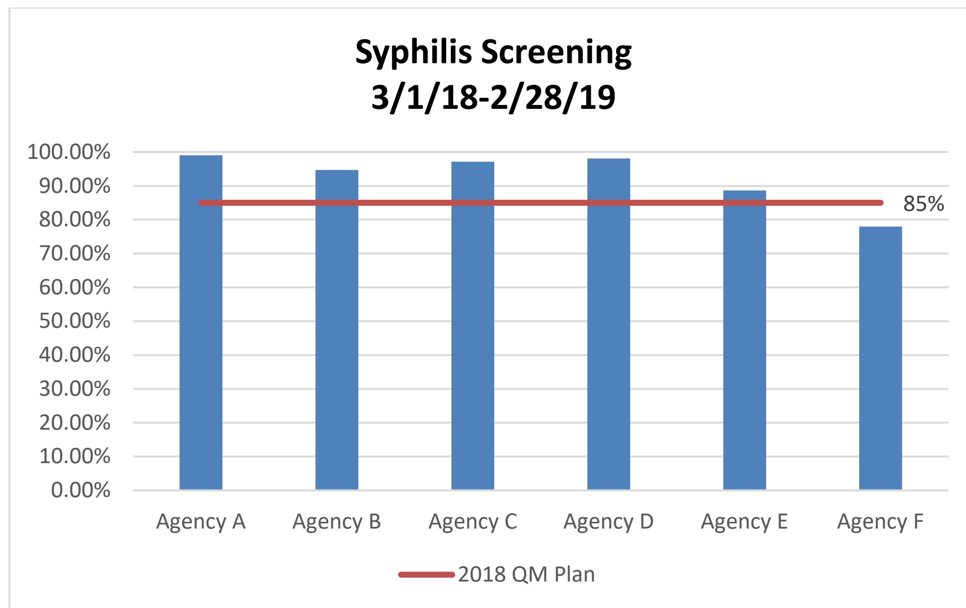


Syphilis Screening

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

	2016	2017	2018
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	597	587	602
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**94%**	**92.4%**	**94.8%**
Change from Previous Years Results	**-.3%**	**-1.6%**	**2.4%**

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

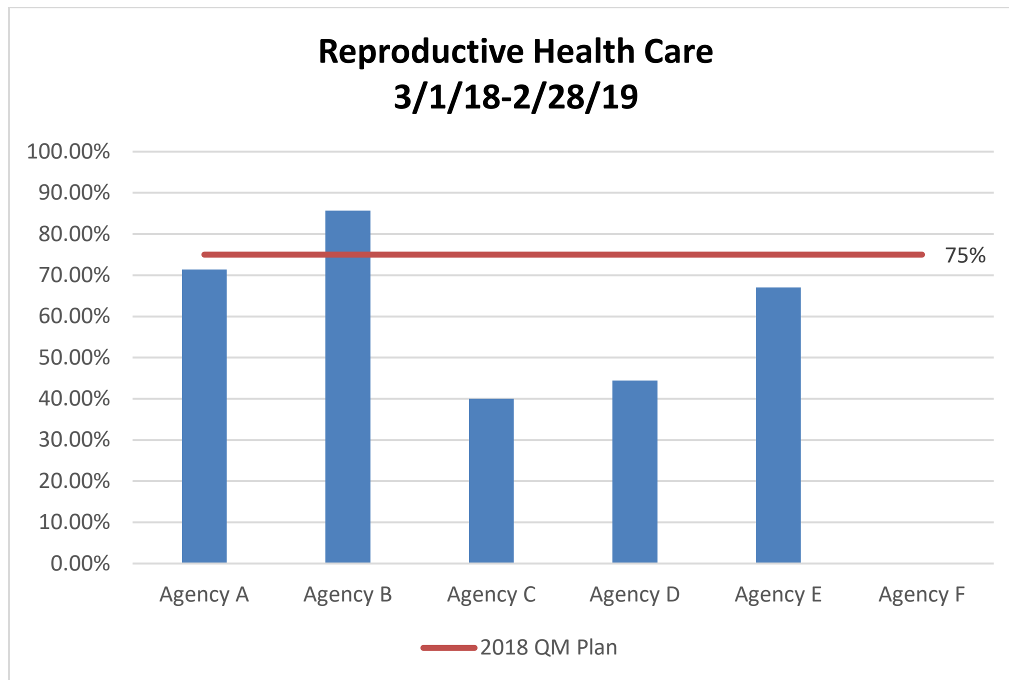


Other Measures

Reproductive Health Care

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

	2016	2017	2018
Number of reproductive-age women who received reproductive health assessment and care	34	22	29
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	63	63	54
Rate	**54%**	**34.9%**	**53.7%**
Change from Previous Years Results	**4.7%**	**-19.1%**	**18.8%**

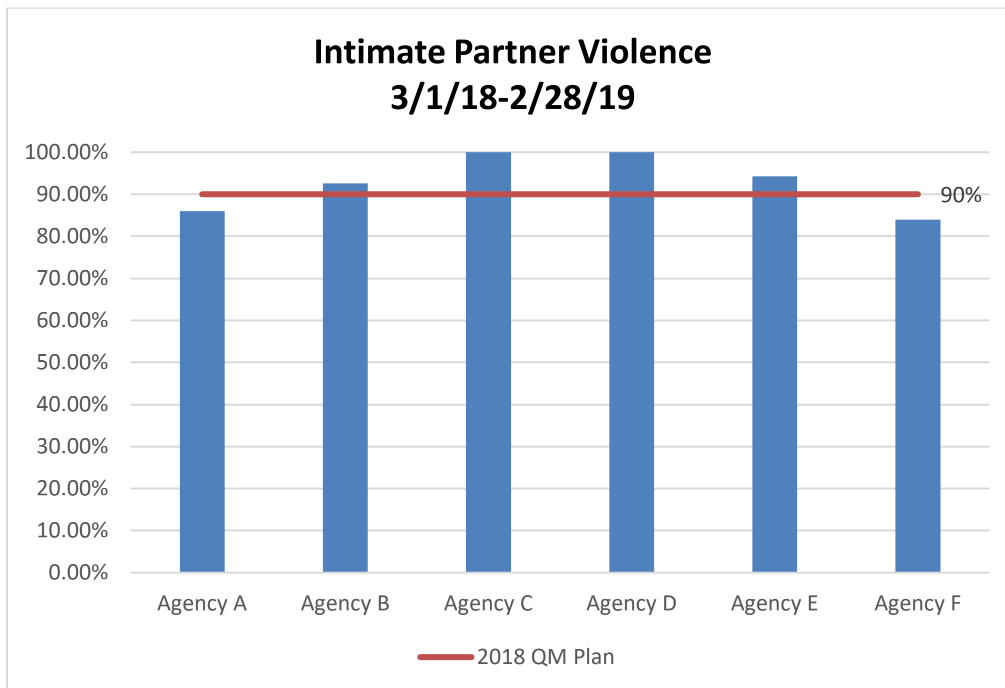


Intimate Partner Violence Screening

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

	2016	2017	2018
Number of clients who received screening for current intimate partner violence	520	499	592
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**81.9%**	**78.6%**	**93.2%**
	-7.7%	**-3.3%**	**14.6%**

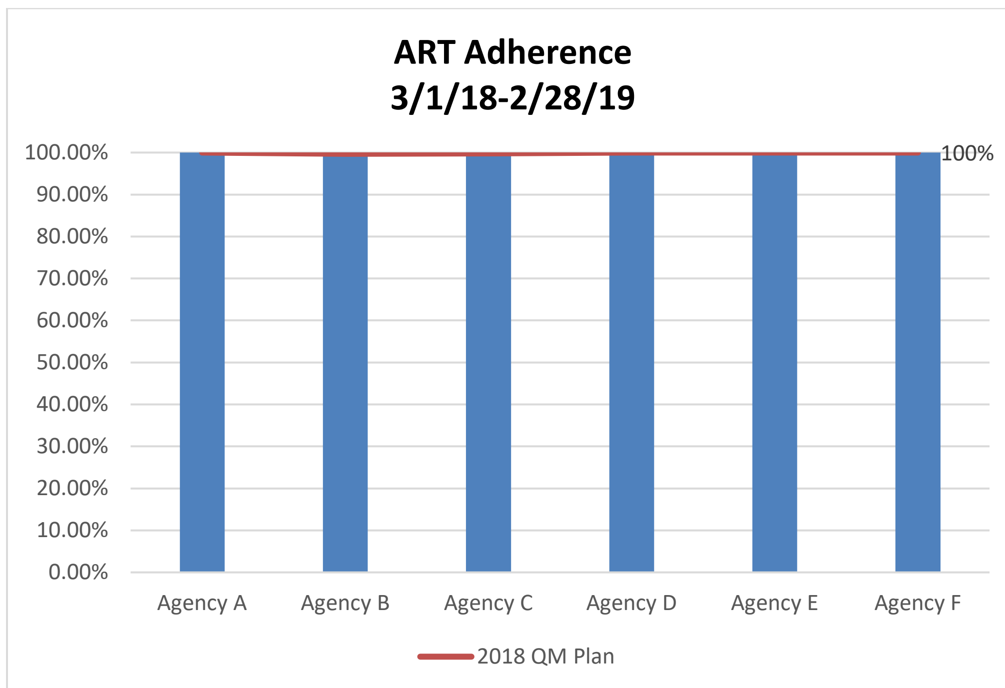
* 3/635 screened positive



Adherence Assessment & Counseling

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

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



ART for Pregnant Women

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

	2016	2017	2018
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	3	3	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	3	3	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

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

	2016	2017	2018
Number of diabetic clients whose last HbA1c in the measurement year was <8%	51	48	35
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	70	74	67
Rate	**72.9%**	**64.9%**	**52.2%**
Change from Previous Years Results	**15.5%**	**-8%**	**-12.7%**

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

Primary Care: Hypertension Control

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

	2016	2017	2018
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	133	166	145
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	206	180
Rate	**73.9%**	**80.6%**	**80.6%**
Change from Previous Years Results	**-1.8%**	**6.7%**	**0%**

- 145/635 (22.8%) of clients were diagnosed with hypertension

Primary Care: Breast Cancer Screening

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

	2016	2017	2018
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	133	150	141
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	171	164
Rate	**73.9%**	**87.7%**	**86%**
Change from Previous Years Results	**-1.8%**	**13.8%**	**-1.7%**

Primary Care: Colon Cancer Screening

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

	2016	2017	2018
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	82	93	127
Number of clients over age 50 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	152	151	160
Rate	**53.9%**	**61.6%**	**79.4%**
Change from Previous Years Results	**3.2%**	**7.7%**	**17.8%**

Conclusions

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

Harris County
Public Health
Building a Healthy Community

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

CUMMULATIVE SUMMARY, DE-IDENTIFIED

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Overview

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

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

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

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

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

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

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

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

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

The Tool

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

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

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

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

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

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

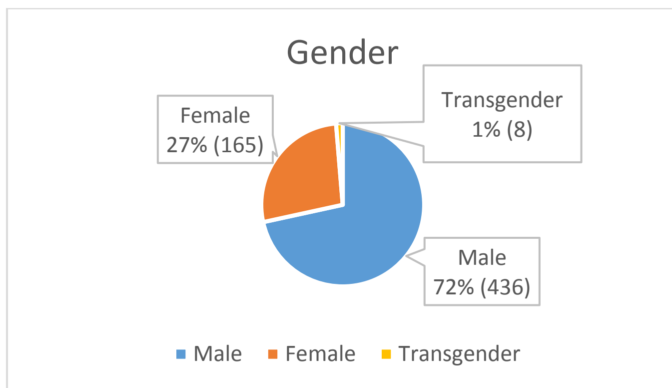
The Sample

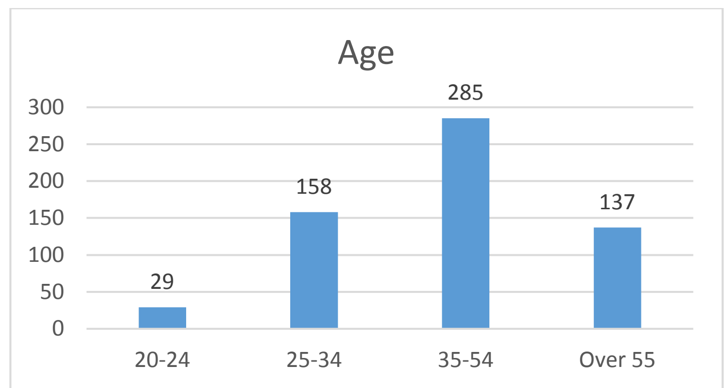
In order to conduct a thorough and comprehensive review, a total of 609 client records were reviewed across seven agencies for the 2018-2019 grant year. This included sixty (60) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated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

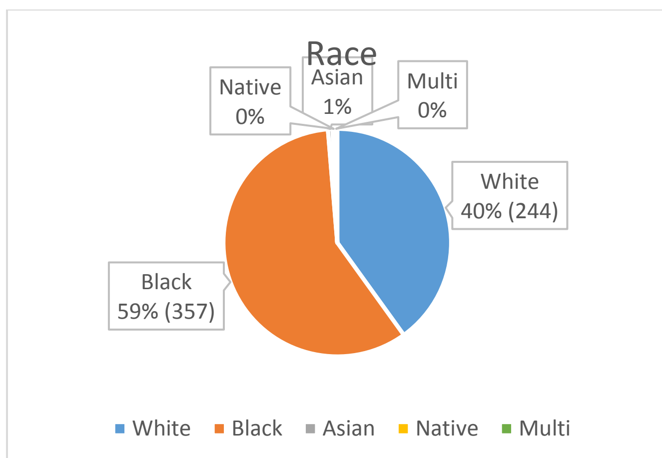
Agency	A	B	C	D	E	F	G
# of Charts Reviewed	67	105	97	70	105	105	60

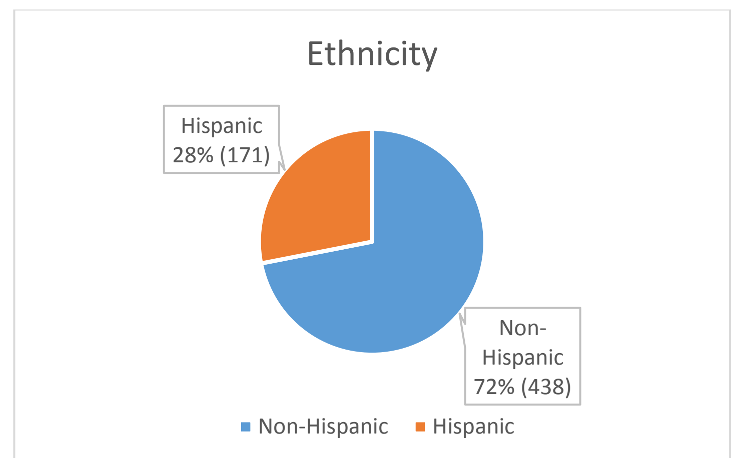
TOTAL 609 (549 excluding non-PCare site)

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









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

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

Cumulative Data Summaries

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

HIV-RELATED PRIMARY CARE APPOINTMENTS

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

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

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

CASE MANAGEMENT ENCOUNTERS

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

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

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

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

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

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

VIRAL SUPPRESSION

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

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

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

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

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

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

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

CARE STATUS

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

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

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

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

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

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

MENTAL HEALTH & SUBSTANCE ABUSE (history or active)

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

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

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

MENTAL HEALTH & SUBSTANCE ABUSE REFERRALS

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

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

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

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

MEDICAL CONDITIONS

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

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

SOCIAL CONDITIONS

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

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

CASE MANAGEMENT ROLE DELEGATION

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

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

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

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

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

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

COMPREHENSIVE ASSESSMENTS

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

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

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

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

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

SERVICE PLANS

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

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

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

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

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

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

BRIEF ASSESSMENTS

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

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

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

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

ASSESSED NEEDS

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

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

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

Conclusion

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

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

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

Case Management staff demonstrated high levels of coordination of care:

- 91% MH and SA referral rate

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

- <10% of sample was unsuppressed without intervention

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

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

Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL
Chart Review Date _____/_____/_____
Agency: ☐ AHF ☐ AH ☐ Ave360 ☐ HHS ☐ Legacy ☐ SHF

Review Period:
3/1/20__ - 2/28/20__

CLIENT INFORMATION

Pt. ID # ______________________________ Race: ____________________________

Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk. Gender: ____________________________

Last OAMC Appts:	Virally Suppressed?	← If No, linked to CM?
1.	☐ Y ☐ N ☐ Unk.	
2.	☐ Y ☐ N ☐ Unk.	
3.	☐ Y ☐ N ☐ Unk.	
☐ No appts. during review period		

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description)	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client: ☐ New to care ☐ Lost to care ☐ Re-engaged in care ☐ NA
If yes.... was there documentation of coordination of care or contact attempts? ☐ Y ☐ N ☐ NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)

☐ Alcohol abuse/dependence
☐ Other substance abuse/dependence: ____________________
☐ Depression
☐ Bipolar disorders
☐ Anxiety disorders
☐ Schizophrenia
☐ Other: ____________________

Was the client referred or already engaged with MH/SA services?
☐ N/A ☐ Yes ☐ No

Does the client have any co-morbidity?

☐ Opportunistic Infection
☐ Sexually Transmitted Infections (STIs) : ____________________
☐ Diabetes
☐ Cancer
☐ Hepatitis
☐ Hypertension
☐ Other: ____________________

Was the client reported to have any of the following conditions?

☐ Homelessness
☐ Pregnancy (or other pregnancy-related conditions)
☐ Recently released
☐ IPV

INSURANCE, BENEFITS, AND INCOME INFORMATION

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

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

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

CASE MANAGEMENT SERVICES

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

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

ASSESSMENTS & SERVICE PLANS

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

COMPLETED ASSESSMENTS

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

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Oral Health Care-Rural Target Chart Review FY 2018

Ryan White Part A Quality Management Program–Houston EMA

October 2019

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

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health. During FY 18, a comprehensive review of client dental records was conducted for services provided between 3/1/18 to 2/28/19. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 18 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

Table 1. Data Collection Parameters

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

The Sample Selection Process

The sample population was selected from a pool of 326 unduplicated clients who accessed Part A oral health care between 3/1/18 and 2/28/19. The medical charts of 75 of these clients were used in the review, representing 23% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/18 and 2/28/19 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 18 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	33	44%	143	43.9%
White	39	52%	176	54%
Asian	1	1.3%	3	.9%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	1	1.3%	2	.6%
Multi-Race	1	1.3%	2	.6%
	75		**326**	
Hispanic Status				
Hispanic	17	22.7%	81	25.5%
Non-Hispanic	58	77.3%	245	74.5%
	75		**326**	
Gender				
Male	52	69.3%	227	69.6%
Female	22	29.3%	97	29.8%
Transgender	1	1.3%	2	.6%
	75		**326**	
Age				
<=24	4	5.3%	15	4.6%
25 – 34	14	18.7%	63	19.3%
35 – 44	20	26.7%	96	29.5%
45 – 49	12	16%	52	16%
50 – 64	22	29.3%	86	26.4%
65+	3	4%	14	4.3%
	75		**326**	

Findings

Clinic Visits

Information gathered during the 2018 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

A complete and thorough assessment of a client's medical history is essential. Such information, such as current medications or any history of alcoholism for example, offers oral health care providers key information that may determine the appropriateness of prescriptions, oral health treatments and procedures.

Assessment of Medical History

	2016	2017	2018
Primary Care Provider	93%	100%	97%
Medical/Dental Health History*	87%	95%	100%
Medical History 6 month Update	100%	100%	96%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2016	2017	2018
Vital Signs	95%	99%	100%
CBC documented	78%	97%	92%
Antibiotic Prophylaxis Given if Indicated			0% (0/1)

Prevention and Detection of Oral Disease

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

	2016	2017	2018
Oral Health Education*	88%	99%	99%
Hard Tissue Exam	88%	88%	96%
Soft Tissue Exam	86%	88%	96%
Periodontal screening*	84%	81%	97%
X-rays present	91%	92%	99%
Treatment plan*	94%	99%	99%

*HIV/AIDS Bureau (HAB) Performance Measures

Treatment Plan Status

	2018
Treatment plan complete	34%
Dental procedures done, additional procedures needed	45%
No dental procedures needed	10%
No dental procedures done	10%

Conclusions

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

Appendix A – Resources

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

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Vision Care Chart Review Report FY 2018

Ryan White Part A Quality Management Program–Houston EMA

October 2019

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health. During FY 18, a comprehensive review of client vision records was conducted for services provided between 3/1/18 to 2/28/19.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 18 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

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

The Sample Selection Process

The sample population was selected from a pool of 2,718 unduplicated clients who accessed Part A vision care between 3/1/18 and 2/28/19. The medical charts of 150 of these clients were used in the review, representing 5.5% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/18 and 2/28/19 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 18 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		Ryan White Part A EMA	
Race/Ethnicity	Number	Percent	Number	Percent
African American	72	48%	1,346	50%
White	73	49%	1,297	48%
Asian	3	2%	39	1%
Native Hawaiian/Pacific Islander	0	0%	6	<1%
American Indian/Alaska Native	0	0%	11	<1%
Multi-Race	1	<1%	19	<1%
TOTAL	**150**		**2,718**	
Hispanic Status				
Hispanic	53	35%	924	34%
Non-Hispanic	97	65%	1,718	63%
TOTAL	**150**		**2,718**	
Gender				
Male	113	75%	2,033	75%
Female	34	23%	685	25%
Transgender Male to Female	3	2%	37	1%
Transgender Female to Male	0	0%	0	0
TOTAL	**150**		**2,718**	
Age				
<= 24	3	2%	132	5%
25 – 34	35	23%	665	24%
35 – 44	31	21%	589	22%
45 – 49	15	10%	390	14%
50 – 64	61	41%	865	32%
65+	5	3%	77	3%
TOTAL	**150**		**2,718**	

Findings

Laboratory Tests

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

Patient chart records should provide documentation of the most recent CD4 and VL information. Ideally this information should be updated in coordination with an annual complete eye exam.

	2016	2017	2018
CD4	91%	80%	83%
VL	91%	80%	83%

Client Intake Form (CIF)

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

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

	2016	2017	2018
Primary Care Provider	50%	81%	87%
Medication Allergies	100%	99%	100%
Medical History	100%	99%	100%
Current Medications	100%	99%	100%
Reason for Visit	100%	100%	100%
Ocular History	100%	99%	100%

Eye Examinations (Including CEE/DFE) and Exam Findings

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

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

	2016	2017	2018
Complete Eye Exam	100%	100%	100%
Dilated Fundus Exam	98%	98%	94%
Internal Eye Exam	100%	100%	100%
Documentation of Diagnosis	100%	100%	100%
Documentation of Treatment Plan	100%	100%	100%
Visual Acuity	100%	100%	100%
Refraction Test	100%	100%	100%
Observation of External Structures	100%	100%	100%
Glaucoma Test	100%	100%	100%
Cytomegalovirus (CMV) screening	98%	98%	94%

Ocular Disease

Eleven clients (7.3%) demonstrated ocular disease, including visual field defects, lattice degeneration of the peripheral retina, corneal ulcer, cataracts, optic atrophy, pinguecula, conjunctivitis, and strabismic amblyopia. Four clients received treatment for ocular disease, four clients were referred to a specialty eye clinic, and three clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 95% (99%-FY17) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 18 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 18-Vision Chart Review Data Collection Tool

Mar 1, 18 to Feb 28, 19

Pt. ID # ____________________________ Site Code:_________________

CLIENT INTAKE FORM (CIF)

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

CD4 & VL

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

EYE CARE:

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

Appendix B – Resources

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

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

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

4. Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed February 1, 2019.

FY 2021 *HOW TO BEST MEET THE NEED* WORKGROUP SCHEDULE *(Revised 03/10/20)*

Houston Ryan White Planning Council, 2223 W. Loop South; Houston, TX 77027

TRAINING FOR ALL PARTICIPANTS:

1:30 p.m. ~ Thursday, April 9, 2020 ~ 2223 West Loop South, Room 532

SPECIAL WORKGROUP: 10 am, Monday, April 13, 2020

Special Workgroup Meeting to Discuss: *Ryan White Part A funded services to support Ending the HIV Epidemic activities, which may include Housing Services. Also, access to medication, especially through ADAP, availability of Legal Services and services for the homeless.*

Group Leaders:

2223 West Loop South, Room 416

All workgroup packets are available online at www.rwpcHouston.org on the calendar for each date below (packets are in pdf format and are posted as they become available).

Workgroup 1	***Workgroup 2***	***Workgroup 3***	***Workgroup 4***
10:30 a.m. **Tuesday, April 21, 2020** Room #416	**1:30 p.m.** **Tuesday, April 21, 2020** Room #416	**3:00 p.m.** **Wednesday, April 22, 2020** Room #416	**11:30 a.m.** **Tuesday, May 19, 2020** Room #240
Group Leaders:	**Group Leaders:**	**Group Leaders:**	**Group Leaders:**
SERVICE CATEGORIES:	***SERVICE CATEGORIES:***	***SERVICE CATEGORIES:***	***SERVICE CATEGORIES:***
Ambulatory/Outpatient Medical Care (includes Emergency Financial Assistance, Local Pharmacy Assistance, Medical Case Management, Outreach and Service Linkage) – Adult and Rural Ambulatory/Outpatient Medical Care (includes Medical Case Management and Service Linkage) – Pediatric Case Management - Clinical Case Management - Non-Medical (Service Linkage at Test Sites) Referral for Health Care and Support Services‡ (ADAP workers) Vision Care	Health Insurance Premium & Co-pay Assistance Medical Nutritional Therapy and Supplements Mental Health Services‡ Oral Health – Rural & Untargeted‡ **Substance Abuse Treatment/ Counseling** Case Management - Non-Medical‡ (Targeting Substance Use Disorder)	Early Intervention Services‡ (for the incarcerated) Home & Community-based Health Services‡ (Adult Day Treatment) Hospice Linguistic Services‡ Transportation (Van-based -- untargeted & rural)	Blue Book

Part A categories in **BOLD** print are due to be RFP'd.

‡ Service Category for Part B/State Services (SS) only; Part B/SS categories are RFP'd every three to five years. **To confirm info for Part B/SS, call 713 526-1016.**

Quality Improvement Committee

2019 Criteria for Reviewing Ideas

In order for the Quality Improvement Committee to review a request for an idea, the idea must:

1.) Fit within the HRSA Glossary of HIV-Related Service Categories.

2.) Not duplicate a service currently being provided by Ryan White Part A or B or State Services funding.

3.) Document the need using one or more Planning Council publications.

4.) *For an emerging need only,* attach documentation from an outside source. Acceptable sources may include:
   - Letter on agency letterhead from three other agencies describing their experience related to this need.
   - Or, documentation from HIV websites or newspaper articles including a copy of the original document or study sited in the article or website.

DRAFT

2019 Proposed Idea

(Applicant must complete this two-page form as it is. Agency identifying information must be removed or the application will not be reviewed. Please read the attached documents before completing this form: 1.) HRSA HIV-Related Glossary of Service Categories to understand federal restrictions regarding each service category, 2.) Criteria for Reviewing New Ideas, and 3.) Criteria & Principles to Guide Decision Making.)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

_____________ Control Number Date Received_____________

Proposal will be reviewed by the: Quality Improvement Committee on:_____________ (date)
Priority & Allocation Committee on: _____________ (date)

THIS PAGE IS FOR THE QUALITY IMPROVEMENT COMMITTEE
(See Glossary of HIV-Related Service Categories & Criteria for Reviewing New Ideas)

1. SERVICE CATEGORY:____________________________________
(The service category must be one of the Ryan White Part A or B service categories as described in the HRSA Glossary of HIV-Related Service Categories.)

This will provide ______ clients with ________ units of service.

2. ADDRESS THE FOLLOWING:

A. DESCRIPTION OF SERVICE:

B. TARGET POPULATION (Race or ethnic group and/or geographic area):

C. SERVICES TO BE PROVIDED (including goals and objectives):

D. ANTICIPATED HEALTH OUTCOMES (Related to Knowledge, Attitudes, Practices, Health Data, Quality of Life, and Cost Effectiveness):

3. ATTACH DOCUMENTATION IN ORDER TO JUSTIFY THE NEED FOR THIS NEW IDEA. AND, DEMONSTRATE THE NEED IN AT LEAST ONE OF THE FOLLOWING PLANNING COUNCIL DOCUMENTS:

___ Current Needs Assessment (Year:___________) Page(s): ___Paragraph: ___
___ Current HIV Comprehensive Plan (Year:_____) Page(s): ___Paragraph: ___
___ Health Outcome Results: Date: _____________________ Page(s): ___Paragraph: ___
___ Other Ryan White Planning Document:
Name & Date of Document: ________________________ Page(s): ___Paragraph: ___

RECOMMENDATION OF QUALITY IMPROVEMENT COMMITTEE:
___ Recommended ___ Not Recommended ___ Sent to How To Best Meet Need

REASON FOR RECOMMENDATION:

(Continue on Page 2 of this application form)