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

1:00 p.m., Tuesday, March 16, 2021

Use the following link to join the Zoom meeting
https://us02web.zoom.us/j/86882221703?pwd=cCtKeXh6a3JlVEN2WnZmMERYN28wdz09
Meeting ID: 868 8222 1703
Passcode: 327913
Or, call to participate by telephone: 346 248-7799

Agenda

Purpose of the Joint Meeting: To determine the criteria used to select the FY 2022 Service Categories.

I. Call to Order — Kevin Aloysius and Steven Vargas, 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 2021 Houston Part A, B and State Service-funded services

VI. Justification Tools — Kevin Aloysius and Steven Vargas
   A. FY 2022 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 2021 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

1:00 p.m., Tuesday, March 16, 2021

Join the meeting via Zoom, please do not come to the meeting in person
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 815 1992 9661
Passcode: 367752

Or, use your cell phone to dial in at: 346 248 7799

Agenda

* = Handout to be distributed at the meeting

I. Call to Order — Kevin Aloysius and Steven Vargas, Co-Chairs
   A. Welcoming Remarks and Moment of Reflection
   B. Introductions
   C. Adoption of Agenda
   D. Approval of Minutes
   E. Nuts, Bolts, Petty Cash and Open Meetings Act Training — Tori Williams
   F. 2021 Meeting Day and Time – see calendar — Tori Williams
   G. Approve Criteria for Selecting FY 2022 Service Categories

II. Public Comments and Announcements

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

III. Committee Orientation
   A. Review Committee Description
   B. Conflict of Interest and Voting Policy
   C. Table? Approve 2021 Committee Goals
   D. Table? Review the Timeline of Critical 2021 Council Activities

IV. Training in How to Read Reports from the Administrative Agents
   A. Part B and State Services (SS) Reports — Patrick Martin
      1. How to Read TRG Reports 2021
      2. Approve 2021-22 Part B/SS Standards of Care
   B. Part A and MAI reports — Carin Martin
      1. How to Read Part A & MAI Reports
      2. Part A: Clinical Quality Mgmt. Committee Report, 2/1/21 — Heather Keizman
      3. Chart Reviews:
         a) Case Management, 2019-2020
         b) Primary Care, 2019
         c) Oral Health, 2019
         d) Vision Care, 2019

VI. New Business
A. Elect a Committee Vice Chair

VII. Announcements
No Committee meeting in April so that members can attend the How To Best Meet the Need Workgroup meetings

VIII. Adjourn

Optional: New members meet with committee mentor Tana Pradia

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, November 17, 2020
Meeting location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Denis Kelly, Co-Chair	Kevin Aloysius	Carin Martin, RWGA
Pete Rodriguez, Co-Chair	Ahmier Gibson	Rebecca Edwards, RWGA
Oscar Perez	Gregory Hamilton	Tiffany Shepherd, TRG
Crystal Starr	Daniel Impastato	Tori Williams, Ofc of Support
Marcely Macias	Tom Lindstrom	Diane Beck, Ofc of Support
Deborah Somoye	Nancy Miertschin, excused	
	Karla Mills	
	Cecilia Oshingbade	
	Angela Rubio	
	Gloria Sierra	
	Andrew Wilson	

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

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Starr, Rodriguez) to approve the August 18, 2020 committee meeting minutes.* **Motion carried**. Abstention: Macias

Public Comment: None.

Reports from the Administrative Agents
Ryan White Part A and MAI: Martin said that the second quarter service utilization report was done last week and she will send to the Office of Support for distribution to the committee. She then presented the following attached report:

- FY20 RW Part A and MAI Procurement Report, dated 10/15/20

Ryan White Part B and State Services: Shepherd presented the following attached reports:

- TRG Steering and Council report dated September 2020
- FY19/20 DSHS State Services Procurement Report, dated 08/26/20
- FY20/21 Part B Procurement Report, dated 08/26/20
- Health Insurance Service Utilization Report, dated 09/02/20

FY 2021 Standards of Care and Performance Measures: Edwards presented the attached

changes to the Part A standards of care. ***Motion #3****: it was moved and seconded (Starr, Rodriguez) to agree with the recommended changes to the Part A Standards of Care.* **Motion carried**.

New Business

2020 Joint Committee Meeting: Williams said that we normally hold a joint meeting to discuss any changes that you would like to see on the reports that are provided to the committee. If there is something you want to see added or changed on any of the reports please let her know.

Announcements: Williams said that this is the last meeting of the year and she appreciated all the work that the committee did especially considering the unusual circumstances. Kelly said that the numbers are going up again and encouraged everyone to stay safe.

Adjourn: ***Motion #4****: it was moved and seconded (Starr, Rodriguez) to adjourn the meeting at 2:54 p.m.* **Motion carried**.

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

Scribe: D. Beck

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

2020 Quality Improvement Meeting Voting Record for Meeting Date 11/17/20

MEMBERS:	**Motion #1** Agenda				**Motion #2** Committee Meeting Minutes				**Motion #3** Part A Standards of Care			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Denis Kelly, Co-Chair				**C**				**C**				**C**
Pete Rodriguez, Co- Chair		**X**				**X**				**X**		
Kevin Aloysius	**X**				**X**				**X**			
Ahmier Gibson	**X**				**X**				**X**			
Gregory Hamilton	**X**				**X**				**X**			
Tom Lindstrom	**X**				**X**				**X**			
Oscar Perez		**X**				**X**				**X**		
Gloria Sierra	**X**				**X**				**X**			
Crystal Starr		**X**				**X**				**X**		
Andrew Wilson	**X**				**X**				**X**			
Daniel Impastato	**X**				**X**				**X**			
Marcely Macias		**X**						**X**		**X**		
Nancy Miertschin	**X**				**X**				**X**			
Karla Mills	**X**				**X**				**X**			
Cecilia Oshingbade	**X**				**X**				**X**			
Angela Rubio	**X**				**X**				**X**			
Deborah Somoye ja 2:24 pm	**X**				**X**					**X**		

Nuts and Bolts for New Members

Please take into account that some of the procedures described below have been changed due to stay at home orders because of COVID-19.

Staff will mail meeting packets a week in advance; if they do not arrive in a timely manner, please contact Rod in the Office of Support. In the meantime, most reminder emails will include an electronic copy of the meeting packet.

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

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

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

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

Due to County budgeting policy, there may be no petty cash reimbursements in March and April. Please turn in your receipts to Rod but be prepared to receive a reimbursement check in late April.

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

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

MEMORANDUM

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

Copy: Carin Martin

From: Tori Williams, Director, Office of Support

Date: January 21, 2021

Re: End of Year Petty Cash Procedures

The fiscal year for Ryan White Part A funding ends on February 28, 2021. Due to procedures in the Harris County Auditor's Office, it is important that all volunteers are aware of the following end-of-year procedures:

1.) Council and Affiliate Committee members must turn in all requests for petty cash reimbursements **at or before 2 p.m. on Friday, February 12, 2021.**

2.) Requests for petty cash reimbursements for childcare, food and/or transportation to meetings before March 1, 2021 **will not be reimbursed at all if they are turned in after March 31, 2021.**

3.) The Office of Support may not have access to petty cash funds between March 1 and May 31, 2021. If meetings are held in person during this time, then volunteers should give Rod the usual reimbursement request forms for transportation, food and childcare expenses incurred after March 1, 2021 but the Office may not be able to reimburse volunteers for these expenses until mid to late May 2021.

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

(OVER FOR TIMELINE)

March 1	**Feb 12**	**Feb 28**	**March 31**
2020……..	**2021……**	**2021……**	**2021**
Beginning of fiscal year 2020	Turn in all receipts	End of fiscal year 2020. No money available to write checks until possibly the end of May	Turn in all remaining receipts for fiscal year 2020 or you will not be reimbursed for those expenses incurred between March 1, 2020 and Feb. 28, 2021

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

Memorandum

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

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

Date: January 21, 2021

Re: Open Meetings Act Training

Please note that all Council members, and Affiliate Committee members, are required to take the Open Meetings Act training at least once in their lifetime. If you have never taken the training, or if you do not have a certificate of completion on file in our office, you must take the training and submit the certificate to the Office of Support before March 31, 2021. The training takes 60 minutes and can be accessed through the following link (if you have difficulty with the link, copy and paste it into Google and it should lead you to the correct area of the Attorney General's website):

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

If you do not have high-speed internet access, you are welcome to contact Rod in the Office of Support and we will see if we can help you access the information.

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

Print it from the Attorney General web link at:
https://www.texasattorneygeneral.gov/forms/openrec/og_certificates.php

Or, call the Office of Support with the validation code and the staff will print it for you.

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

2021 Ryan White Planning Council Committee Schedule - DRAFT

(as of 01/25/21)

AFFECTED COMMUNITY

TENTATIVE: Meetings are on the Monday after Council meets starting at 12 noon**.**

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

COMPREHENSIVE HIV PLANNING

Meetings are the second Thursday of the month starting at 2:00 pm:

February 11	August 12
March 11	September 9
April 8	October 14
May 13	November 11
June 10	December – no mting
July 8	

OPERATIONS

Meetings are Tuesdays following the Council meeting starting at 11:00 am:

February 16	August 17
March 16	September 14
April 13	October 19
May 18	November 16
June 15	December 14
July 13	

PLANNING COUNCIL

Meetings are the second Thursday of the month starting at 12 noon:

February 11	August 12
March 11	September 9
April 8 – HRSA site visit	October 14
May 13	Nov 11 – LEAP presents
June 10	December 9
July 8	

PRIORITY & ALLOCATIONS

Meetings are the fourth Thursday of the month at 12 pm:

February 25	July 22
March 16*	August 26
March 25	September 23
April 22	October 28
May 27	November - no mtg
June 24	December - no mtg

QUALITY IMPROVEMENT

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

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

STEERING

Meetings are the first Thursday of the month starting at 12 noon:

February 4	August 5
March 4	September 2
April 1	October 7
May 6	November 4
June 3	December 2
July 1	

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

BOLD = Special meeting date, time or place

Houston Area HIV Services Ryan White Planning Council
Standing Committee Structure

(Reviewed 01-14-20)

1. Affected Community Committee

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

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

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

2. Comprehensive HIV Planning Committee

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

3. Operations Committee

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

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

4. Priority and Allocations Committee

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

5. Quality Improvement Committee

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

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

Ryan White Definition of Conflict of Interest

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

DRAFT

Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2021 Council Activities

(Revised 01-28-21)

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

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

General Information: The following is a list of significant activities regarding the 2021 Houston Ryan White Planning Council. Consumers, providers and members of the general public are encouraged to attend and provide public comment at any of the meetings described below. For more information on Planning Council processes or to receive monthly calendars and/or review meeting agendas and support documents, please contact the Office of Support at 832 927-7926 or visit our website at: www.rwpchouston.org.

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

Thurs. Jan. 21	Council Orientation. 2021 Committee meeting dates will be established at this meeting.
Thurs. Feb. 4	12 noon. First Steering Committee meeting for the 2021 planning year.
Tues. Feb. 9	11 am, Orientation for new 2021 Affiliate Committee Members.
Thurs. Feb. 11	12 noon. First Council meeting for the 2021 planning year.
Mon. Feb. 15	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. The Council is currently funding, or recommending funding, for 17 of the 28 allowable HRSA service categories. The Idea Form is used to ask the Council to make a change to a funded service or reconsider funding a service that is not currently being funded in the Greater Houston area with Ryan White Part A, Part B or State Services dollars. The form requires documentation for why dollars should be used to fund a particular service and why it is not a duplication of a service already being offered through another funding source. Anyone can submit an Idea Form. Contact the Office of Support at 832 927-7926 to request required forms
Thurs. Feb. 25	12 noon. Priority & Allocations Committee meets to approve the **policy on allocating FY 2021 unspent funds**, **FY 2022 priority setting process** and more.
TBD in March	EIIHA Workgroup meeting.
Tues. March 16	1:00 pm. Joint meeting of the Quality Improvement, Priority & Allocations and Affected Community Committees to determine the criteria to be used to select the **FY 2022 service categories** for Part A, Part B and *State Services* funding.
Mon. March 15	**Consumer Training** on the How to Best Meet the Need process.
Thurs. April 1	12 noon. Steering Committee meets.
Thurs. April 8	12 noon. Planning Council meets. 1:30 – 4:30 pm. **Council and Community Training for the How to Best Meet the Need process**. Those encouraged to attend are community members as well as individuals from the Quality Improvement, Priority & Allocations and Affected Community Committees. Call 832 927-7926 for confirmation and additional information.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2021 Council Activities

(Revised 01-28-21)

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The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

Mon. April 12	10 am – 5 pm, Special workgroup meetings. Topics to be announced.
Tues. April 20	10:30 am. **How To Best Meet the Need Workgroup #1** at which the following services for FY 2022 will be reviewed: • Ambulatory/Outpatient Medical Care (including Emergency Financial Assistance – Pharmacy Assistance, Local Pharmacy Assistance, Medical Case Management, Outreach and Service Linkage – Adult and Rural) • Ambulatory/Outpatient Medical Care (including Medical Case Management and Service Linkage – Pediatric) • Referral for Health Care and Support Services • Clinical Case Management • Non-Medical Case Management (Service Linkage at Testing Sites) • Vision Care 1:30 pm. **How To Best Meet the Need Workgroup #2** at which the following services for FY 2021 will be reviewed: • Health Insurance Premium & Co-pay Assistance • Medical Nutritional Therapy (including Nutritional Supplements) • Mental Health • Substance Abuse Treatment/Counseling • Non-Medical Case Management (Substance Use) • Oral Health – Untargeted & Rural Call 832 927-7926 for confirmation and to receive meeting packets.
Wed. April 21	3:00 pm – 5:00 pm. **How To Best Meet the Need Workgroup #3** at which the following services will be reviewed: • Early Intervention Services • Emergency Financial Assistance - Other • Home & Community-based Health Services (Adult Day Treatment) • Hospice • Linguistic Services • Transportation (van-based - Untargeted & Rural) Call 832 927-7926 for confirmation and additional information.
Thurs. April 22	12 noon. Priority & Allocations Committee meets to allocate **Part A unspent funds.**
Mon. May 3	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 15 for a description of this process.) Please contact the Office of Support at 832 927-7926 to request a copy of the required forms.
Tues. May 18	11 am. **How to Best Meet the Need Workgroup** meets for recommendations on the **Blue Book**. The Operations Committee reviews the FY 2022 Council Support Budget.
Tues. May 18	1 pm. Quality Improvement Committee meets to approve the **FY 2022 How to Best Meet the Need results** and review **subcategory allocation requests**. Draft copies are forwarded to the Priority & Allocations Committee.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2021 Council Activities

(Revised 01-28-21)

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

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

Tues. May 25	7:00 pm., Public Hearing on the **FY 2022 How To Best Meet the Need results**.
Wed. May 26	Time TBD. Special Quality Improvement Committee meeting to review public comments regarding **FY 2022 How To Best Meet the Need results**.
Thurs. May 27	12 noon. Priority & Allocations Committee meets to recommend the **FY 2022 service priorities** for Ryan White Parts A and B and *State Services* funding.
Thurs. June 3	12 noon. Steering Committee meets to approve the **FY 2022 How to Best Meet the Need results**.
Thurs. June 10	12 noon. Council approves the **FY 2022 How to Best Meet the Need results**.
Week of June 14-18	Dates and times TBD. Special Priority & Allocations Committee meetings to draft the **FY 2022 allocations for RW Part A and B and *State Services* funding**.
In June or Aug.	1 pm. Quality Improvement Committee reviews the results of the Assessment of the Administrative Mechanism and hosts Standards of Care training.
Thurs. June 24	12 noon. Priority & Allocations Committee meets to approve the **FY 2022 allocations for RW Part A and B and *State Services* funding**.
Mon. June 28	7 pm. Public Hearing on the **FY 2022 service priorities and allocations**.
Tues. June 29	Time TBD. Special meeting of the Priority & Allocations Committee to review public comments regarding the **FY 2022 service priorities and allocations**.
July/Aug.	Workgroup meets to complete the proposed **FY 2022 EIIHA Plan**.
Thurs. July 1	12 noon. Steering Committee approves the **FY 2022 service priorities and allocations**.
Thurs. July 8	12 noon. Council approves the **FY 2022 service priorities and allocations**.
Fri. July 9	5 pm. Deadline for submitting a Project LEAP application form. See July 28 for description of Project LEAP. Call 832 927-7926 for an application form.
Thurs. July 22	12 noon. If necessary, the Priority & Allocations Committee meets to address problems Council sends back regarding the **FY 2022 priority & allocations**. They also allocate **FY 2020 carryover funds**. (**Allocate even though dollar amount will not be avail. until Aug.**)
Wed. July 28	**Project LEAP** classes begin. Project LEAP is a free 17-week training course for individuals living with and affected by HIV to gain the knowledge and skills they need to help plan HIV prevention and care services in the Houston Area. To apply, call 832 927-7926.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2021 Council Activities

(Revised 01-28-21)

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

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

Thurs. Aug. 5	12 noon. ALL ITEMS MUST BE REVIEWED BEFORE BEING SENT TO COUNCIL – THIS STEERING COMMITTEE MEETING IS THE **LAST CHANCE TO APPROVE ANYTHING NEEDED FOR THE FY 2022 GRANT**. (Mail out date for the August Steering Committee meeting is July 22, 2021.)
TBD in Aug.	Time TBD. **Consumer Training** on Standards of Care and Performance Measures.
Fri. Sept. 3	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 15 for a description of this process.) Please contact the Office of Support at 832 927-7926 to request a copy of the required forms.
Tues, Sept. 14	1 pm. Joint meeting of the Quality Improvement, Priority & Allocations and all Committees to review data reports and make suggested changes.
TBD in Sept.	Time TBD. **Consumer-Only Workgroup** meeting to review FY 2022 Standards of Care and Performance Measures.
Tues, Oct. 19	11 am. Review and possibly update the Memorandum of Understanding between all Part A stakeholders and the Letter of Agreement between Part B stakeholders.
October or November	Date & time TBD. Community Workgroup meeting to review **FY 2022 Standards of Care & Performance Measures** for all service categories.
Thurs. Oct. 28	12 noon. Priority & Allocations Committee meets to allocate FY 2022 unspent funds.
Tues. Nov. 9 or 30	9:30 am. Commissioners Court to receive the World AIDS Day Resolution.
Thurs. Nov. 11	12 noon. Council recognizes all Affiliate Committee Members.
Wed. Dec. 1	**World AIDS Day**.
Thurs. Dec. 9	12 noon. Election of Officers for the 2022 Ryan White Planning Council.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2021 Ryan White Part B

Procurement Report

April 1, 2020 - March 31, 2021

Reflects spending through September 2020

Spending Target: 50%

Revised 11/24/20

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care (1)	$1,758,878	52%	$0	$1,758,878	$0	$1,758,878	4/1/2020	$484,000	28%
	Oral Health Care -Prosthodontics	$460,000	14%	$0	$460,000	$0	$460,000	4/1/2020	$197,055	43%
5	Health Insurance Premiums and Cost Sharing (2)	$1,028,433	31%	$0	$1,028,433	$0	$1,028,433	4/1/2020	$325,390	32%
8	Home and Community Based Health Services (3)	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2020	$36,880	33%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	$0	$0					
	Total Houston HSDA	3,360,626	100%	0	3,360,626	$0	$2,900,626		1,043,325	36%

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

(1) OHC- Service utilization has decreased due to the interruption of COVID-19.
(2) HIP- Funded by Part A, B and State Services/. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31
(3) HCB- Service utilization has decreased due to the interruption of COVID-19.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1920 DSHS State Services

Procurement Report

September 1, 2020- August 31, 2021

Chart reflects spending through September 2020

Spending Target: 8.33%

Revised 11/24/2020

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$864,506	43%	**$0**	$864,506	$0	$864,506	9/1/2020	$0	0%
6	**Mental Health Services**	$300,000	15%	**$0**	$300,000	$0	$300,000	9/1/2020	$9,273	3%
7	**EIS - Incarcerated**	$175,000	9%	**$0**	$175,000	$0	$175,000	9/1/2020	$10,185	6%
11	**Hospice**	$259,832	13%	**$0**	$259,832	$0	$259,832	9/1/2020	$20,460	8%
	Non Medical Case Management (2)	$350,000	17%	**$0**	$350,000	$0	$350,000	9/1/2020	$4,153	1%
15	**Linguistic Services (3)**	$68,000	3%	**$0**	$68,000	$0	$68,000	9/1/2020	$1,838	3%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	**$0**						
	Total Houston HSDA	**2,017,338**	**100%**	**$0**	$2,017,338	$0	$2,017,338		45,909	2%

Note

(1) HIP- Funded by Part A, B and State Services/. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31

(2) N-Medical Case Management servicee is behind one month of submitting billing.

(3) Linguistic- Service utilization has decreased due to the interruption of COVID-19.

2020-2020 Ryan White Part B Service Utilization Report
4/1/2020 - 6/30/2020 Houston HSDA (4816)
1st Quarter

Revised 8/5/2020

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*1,000*	209	84.68%	15.32%	0.00%	0.00%	31.10%	32.06%	33.02%	3.82%	0.00%	0.00%	1.44%	16.75%	14.35%	32.53%	33.49%	1.44%
Home & Community Based Health Services	*30*	18	72.22%	27.78%	0.00%	0.00%	66.67%	11.11%	22.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	44.45%	44.44%	11.11%
Oral Health Care	*2,500*	1,225	71.76%	26.69%	0.00%	1.55%	51.10%	13.38%	33.55%	1.97%	0.00%	0.00%	1.22%	15.34%	22.44%	27.34%	24.57%	9.09%
Unduplicated Clients Served By RW Part B Funds:	*NA*	**1,452**	**76.22%**	**23.26%**	**0.00%**	**0.52%**	**49.62%**	**18.85%**	**29.60%**	**1.93%**	**0.00%**	**0.00%**	**0.89%**	**10.70%**	**12.26%**	**34.77%**	**34.17%**	**7.21%**

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2020-12/31/20

Revised: 2/5/2021

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	370	$37,075.31	240			*0*
Medical Deductible	0	$0.00	0			*0*
Medical Premium	2242	$762,323.63	694			*0*
Pharmacy Co-Payment	3614	$94,732.35	513			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	6227	$894,631.29	1448	0	$0.00	

Comments: This report represents services provided under all grants.

Service Category	Proposed Change
Community Based Health Services (TRG)	No Proposed Changes
Early Intervention Services for the Incarcerated (TRG)	Redesigned Standards – Should be considered new.
Health Insurance Assistance (Joint)	Clarifying Language for • Allowability of standalone dental insurance plans • Required Cost Effectiveness Assessment – has been in HIA Policy but not clearly outlined in standards • Requirement of plans to have HIV drugs • Prohibition on using fund on cost cover by Social security
Hospice (TRG)	No Proposed Changes
Linguistic Services (TRG)	No Proposed Changes
Mental Health Services (TRG)	Clarifying Language for • Allowability of telehealth
Non-Medical Case Management Targeting Substance Use Disorders (TRG)	Clarifying Language for • Allowability of telehealth
Oral Health Care (Joint)	No Proposed Changes
ADAP Enrollment Workers/RFHC (TRG)	No Proposed Changes

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
COMMUNITY-BASED HEALTH SERVICES

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

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

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

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

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

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

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

References

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

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
EARLY INTERVENTION SERVICES FOR THE INCARCERATED

Definition:
Early Intervention Services (EIS) are designed to bring HIV-positive individuals into Outpatient Ambulatory Medical Care through counseling, testing, and referral activities. Support of Early Intervention Services (EIS) that include identification of individuals at points of entry [in this case, the Harris County Jail (HCJ)] and access to services and provision of:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to have HIV (provided by other funding at HCJ),
- Referral services to improve HIV care and treatment services at key points of entry (HCJ care coordination),
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care (HCJ care coordination), and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis (HCJ care coordination).

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. EIS services are limited to counseling and HIV testing (provided by other funding at HCJ), referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system (provided through the funded care coordination services). EIS services require coordination with providers of prevention services and should be provided at specific points of entry (HCJ).

Note: All four components must be present in the EIS program.

Limitations: Funds for HIV testing must be in the budget approved in writing by TRG. Funds will only be approved by TRG for HIV testing only where existing federal, state, and local funds are not adequate and funds will supplement, not supplant, existing funds for testing. Funds cannot be used to purchase at-home testing kits.

Primary Goals of EIS for the Incarcerated:

1. The primary goals of early intervention in HIV are to prevent or delay disease progression.[1]
2. After assessing the stage of the patient, the next goal of early intervention is to minimize the risk of progression.[1]

Service Intervention Goals of EIS for the Incarcerated:

1. *DSHS Standards of Care*: To bring people living with HIV (PLWH) into Outpatient/Ambulatory Health Services (OAHS).[2]
2. *DSHS Standards of Care*: To decrease the number of underserved PLWH by increasing access to care, educating and motivating clients on the importance and benefits of getting into care, through expanding key points of entry.[2]

3. *DSHS Standards of Care*: To educate and motivate PLWH on the importance and benefits of getting into care.[2]
4. *HRSA Program Guidance*: To help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV.[3]
5. *HRSA Program Guidance*: To coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.[3]
6. To improve referral services for HIV care and treatment services at key points of entry. [3]
7. To provided Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.[3]

Intervention-Specific Performance Measures:

1. Percentage of newly diagnosed PLWH offered EIS Touch as part of results counseling.
2. Percentage of PLWH returning to the community who were linked to outpatient/ambulatory health services in the measurement year.
3. Percentage of PLWH returning to the community who attended a routine HIV medical care visit within three (3) months of HIV diagnosis.
4. Percentage of PLWH who achieve one or more benchmarks for the applicable tier.

For additional EIS Performance Measures, see 2021 EIS Attachment A: Performance Measures.

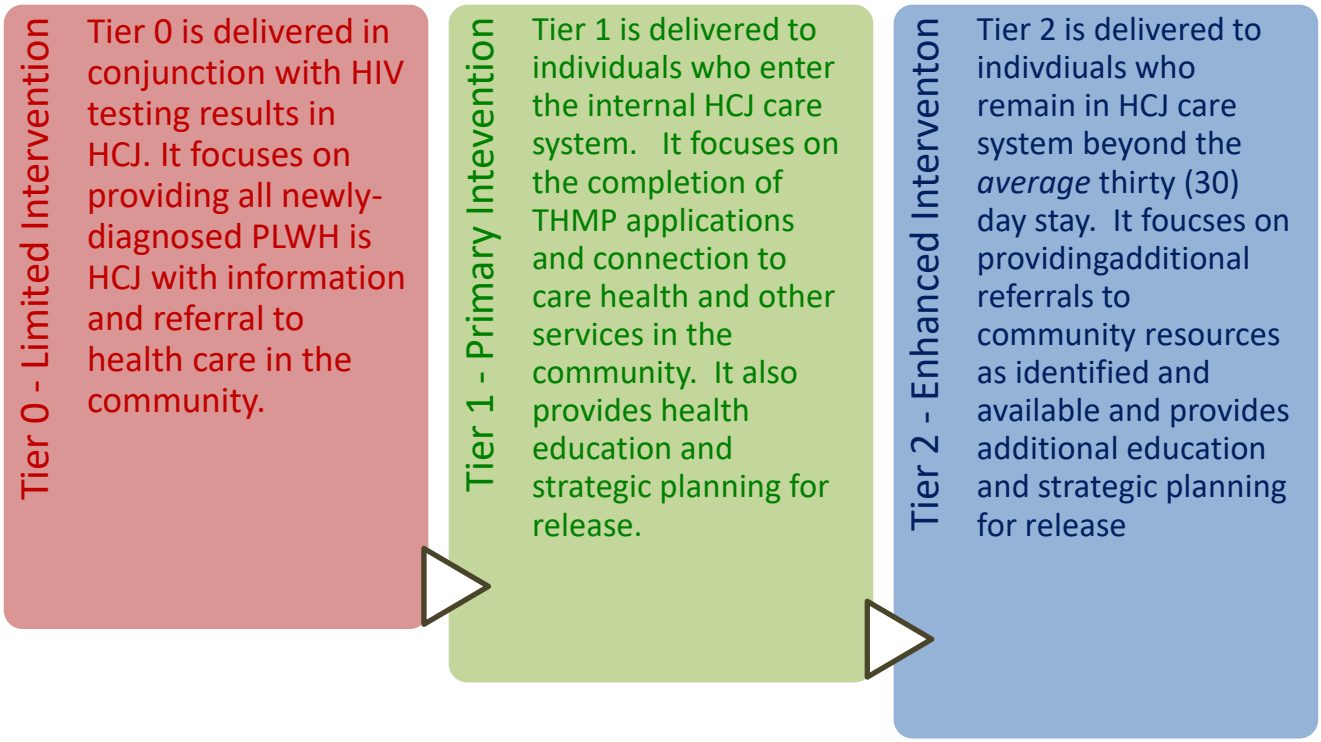
Tier-Concept for EIS for the Incarcerated:

EIS for the Incarcerated is provided at Harris County Jail. HCJ's population includes both individuals who are actively progressing through the criminal justice system (toward a determination of guilt or innocence), individuals who are serving that sentence in HCJ, and individuals who are awaiting transfer to Texas Department of Criminal Justice (TDCJ). The complexity of this population has proven a challenge in service delivery. Some individuals in HCJ have a firm release date. Others may attend and be released directly from court.

Therefore, EIS for the Incarcerated has been redesigned to consider the uncertain nature of length of stay in the service delivery. Three tiers of service provision haven been designated. They are:

- **Tier 0:** The individuals in this tier do **not** stay in HCJ long enough to receive a clinical appointment while incarcerated. The use of zero for this tier's designation reinforces the understanding that the interaction with funded staff will be minimal. The length of stay in this tier is traditionally less than 14 days.
- **Tier 1:** The individuals in this tier stay in HCJ long enough to receive a clinical appointment while incarcerated. This clinical appointment triggers the ability of staff to conduct sufficient interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days.
- **Tier 2:** The individuals in this tier remain in HCJ long enough to get additional interactions and potentially multiple clinical appointments. The length of stay in this tier is traditionally 30 or more days.

Service provision builds on the activities of the previous tier if the individual remains in HCJ. Each tier helps the staff to focus interactions to address the highest priority needs of the individual. Each interaction is conducted as if it is the only opportunity to conduct the intervention with the individual.



Guiding Principles for EIS Intervention:

1. Touch – Touch are the face-to-face opportunity for the EIS Team to implement the goals of the intervention. The term was chosen to remind the EIS Team of the intimate nature of the intervention and its goals.
2. Starting the Intervention "Where the PLWH Is At" – This phrase is often used in the provision of HIV services. It is extremely important for the EIS Team to assess those being served to ensure that EIS interventions are most effective for that PLWH. The intervention is designed with flexibility in mind. If the PLWH is receiving results from the testing team, the EIS Team may need to focus the initial touch assisting the PLWH to process their diagnosis. For PLWH returning to HCJ, the intervention may be focused on assessing follow-through with medical care and medications referrals in the "freeworld" and strategizing to improving compliance/adherence.
3. Trauma-Informed Approach - A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — in order to provide effective health care services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness.

0.0	<u>Client Eligibility</u> In order to be eligible for services, PLWH at any tier must meet the following: • Documentation of HIV Diagnosis • Language(s) spoken and Literacy level (client self-report) *Due to client's state of incarceration, this intervention is excluded from the requirement to document income and residency.*	• Documentation of HIV diagnosis is present in the primary client record. • Documentation in compliance with TRG Policies for Client Eligibility for Service.

TIER 0 – (LESS THAN 14 DAYS) – LIMITED INTERVENTION		
#	STANDARD	EVIDENCE
0.1	Inclusion/Exclusion Criteria: Identified PLWH released prior to initial medical appointment (i.e. visit with a provider with prescribing authority) are include in Tier 0. Note: Tier 0 individuals are excluded from the primary health outcomes for the intervention since no visit with a provider with prescribing authority occurred.	• Primary client record documents that PLWH should be included in this tier.
0.2	Benchmarks: • Notification of EIS Team by Prevention Team for "Joint" Session. • First EIS Intervention Touch. • Referral to community partners • Referral Follow-up • DIS Referral, if needed.	• Primary client record documents each benchmark obtained.
0.3	Brief Intake: Intake conducted at first EIS "Touch" with the PLWH. Intake will include but is not limited to: CPCDMS Registration/CPCDMS Consents, identify level of knowledge of HIV, provide information about availability of health care, sign consent to refer to community resources, give Mini Blue Book. • Brief Intervention to provide targeted information on the importance of engaging in medical care and medical adherence. • New Diagnosed PLWH are prioritized in this tier if the number of PLWH to be seen exceeds the availability of staff. • PLWH returning to HCJ who have self-disclosed will have their consents verified (if still current) or updated (if expired).	• Primary client record documents intake performed.
0.4	CPCDMS Update/Registration As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.	• Current registration of client is present in CPCDMS.
0.5 EISED	Education/Counseling (Newly Diagnosed) The EIS Team will reinforces prevention messaging/intervention received as part of HIV testing program. Additionally, the Team will target the following topics:	• Primary client record documents education/counseling provided.

	• Living healthy with HIV • Reinforcing Living with HIV not Dying from HIV • Role of medications in healthy living, • Resources available for medications and treatments based on PLWH's situation (i.e. Ryan White, third party payers, health insurance assistance, etc.)	
0.6 EISED	<u>Education/Counseling (All)</u> When PLWH returned to HCJ, the EIS Team will target the following topics: • Living healthy with HIV • Reinforcing Living with HIV not Dying from HIV • Role of medications in healthy living, • Provide education based on assessments of the PLWH's compliance with medical care and medication adherence.	• Primary client record documents education/counseling provided.
0.7 EISED	<u>Health Literacy</u> The EIS Team will briefly assess the PLWH to determine level of health literacy so that the messaging can be tailored to "where the PLWH is at." Health literacy education will be limited during the Tier 0 intervention to increasing the potential for linkage to care.	• Primary client record documents Health Literacy messaging provided.
0.8 EISRC	<u>Referrals</u> The EIS Team will provide PLWH with the following: • A copy of the mini blue book that contains medical and supportive services, and • Obtain consent to refer the PLWH to a community partners for follow-up, if possible.	• Primary client record contains signed consents. • Primary client record contains referral.
0.9 EISFU	<u>Referral Tracking</u> When consent has been obtained, the EIS Team will process and track the referral to community partners. All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS Team offered to the PLWH.	• Primary client record documents at least two (2) attempts at referral follow-up. • Primary client record documents referral outcome when follow-up is successful.
0.10	<u>Lost To Care/Connection with DIS</u> When no consent is obtained or referral follow-up indicates PLWH is lost to care, EIS Team will	• Primary client record documents DIS referral for case were no consent was obtained, referral follow-up indicates

	notify their local Disease Intervention Specialist (DIS) workers so that public health follow-up can occur. EIS Team should notify their DIS workers when a newly diagnosed PLWH is released from HCJ prior to initial medical appointment.	lost to care or when a newly diagnosed PLWH releases from HCJ prior to initial medical appointment.
0.11	Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of EIS intervention completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Primary client record contains a closure summary that includes narrative outlining the components of the EIS intervention completed with the PLWH and the reason for closure. • Primary client record contains supervisor signature/approval on closure summary (electronic review is acceptable).
0.12	Progress Notes The EIS Team will maintain progress notes in each primary client record with thorough and accurate documentation of the assistance the EIS Team provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Primary client record contains thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH.
TIER 1 – (14 TO 30 DAYS) – PRIMARY INTERVENTION		
#	STANDARD	EVIDENCE
1.1	Inclusion Criteria: Identified PLWH who attend initial medical appointment (i.e. visit with a provider with prescribing authority). If EIS Team could not complete Tier 0 intervention, the remaining elements will be added to the Tier 1 intervention.	• Primary client record documents that PLWH should be included in this tier.
1.2	Benchmarks: • Initial Medical Appointment • Completion of THMP Application • Second and Third EIS Touch (at a minimum) • Referral to Community Medical Care • Connection with Community Resource	• Primary client record documents each benchmark obtained.
1.3	Comprehensive Intake The EIS Team will complete an intake on PLWH who receive a medical provider visit. The intake will include: • Confirmation of identity,	• Primary Client Record contains completed intake documents. • Confirm identity/ 6mo prior to incarceration did they receive svc/ medical provider preference (assess

	• Intake form, • Signed Consents, and • Comprehensive Assessment.	healthcare)
1.4	<u>Comprehensive Assessment</u> The EIS Team will complete comprehensive assessment for PLWH who receive a medical provider visit. The assessment will include: • Medication/Treatment Readiness, • History of treatment & compliance, • Healthcare assessment should include location/accessibility • Insurance • Life Event Checklist (Trauma Assessment) • Disease Understanding/Health literacy, • Self-Care, • Mental health and substance use issues, • Housing/living situation, • Support system, • Desired community medical providers, • Assessment of challenges and roadblocks, • Assessment of resources (SSI, Food Stamp, etc.), • Free-world contact information, • Free-world support system, and • Other identified needs upon release.	• Primary Client Record contains completed comprehensive assessment.
1.5	<u>Reassessment Criteria</u> The EIS Team will reassess PLWH based on the following criteria: • If the client returns to HCJ within three (3) months of release, EIS Team assesses PLWH for any changes. If minimal changes are identified, the results should be documented in the progress notes. If significant changes are identified, the EIS assessment form should be updated. • If the EIS Team does not find evidence of medical care in the client-level data systems, then EIS Team will complete new comprehensive assessment.	• Primary client record documents reassessments completed per the established criteria.
1.6	<u>CPCDMS Update/Registration</u> As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.	• Current registration of client is present in CPCDMS.
1.7	<u>Internal Linkage to Care</u> PLWH identified through preliminary testing	• Primary Client Record documents access to medical appointments with a

	will be linked to and assisted in scheduling an appointment with a medical provider in HCJ. Successful linkage to outpatient/ambulatory health services is measured as attendance to the actual medical appointment with a prescribing provider while in HCJ.	clinical provider while in the correctional facility. • Primary Client Record documents access to medication while in the correctional facility.
1.8 EISAP	<u>Texas HIV Medication Program Applications</u> All PLWH in HCJ who have seen a medical provider will have a current application on file with the Texas HIV Medication Program (THMP). For newly diagnosed PLWH, the EIS Team will complete the THMP application as part of the first medication appointment and have the provider complete the medical certification form. When PLWH return to HCJ, the EIS Team will verify the THMP application is still current in ARIES (using birth month and half-birth month criteria). If not, an updated THMP application/attestation will be completed.	• ARIES documents upload of THMP application for newly diagnosed PLWH who have received a medical provider visit. • Primary client record documents whether returning PLWH has a current THMP application in ARIES. • ARIES documents upload of THMP application/attestation for returning PLWH based on birth month and half-birth month criteria.
1.9 EISAP	<u>ARIES Document Upload Process</u> ARIES Document Upload is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • Completed ADAP Applications (with supportive documentation) must be uploaded into ARIES for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be uploaded according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be uploaded into ARIES within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed upload to ARIES. • Upload option is only available for ADAP	• THMP application documents secondary review via appropriate signature. • THMP application is present within ARIES. • Primary client record documents receipt by THMP within (3) business days of application completion.

	applications; other benefits applications should be maintained separately and submitted according to instruction.	
1.10 EISED	<u>Education/Counseling (Newly Diagnosed)</u> The EIS Team will reinforces prevention messaging/intervention received as part of HIV testing program. Additionally, the Team will target the following topics: • Living healthy with HIV • Treatment As Prevention • Early Intervention as a strategy to reduce disease progression • Role of medications in healthy living • Maintenance of immune system • Disclosure to partners and support systems • Messages/interventions outlined in Standard 1.? below. • Additional messages/interventions as determined by assessment. Education/Counseling should be provided in manageable messages. The EIS Team should not attempt to cover all the necessary topics in one Touch. Instead, prioritization should be used to guide which messages should be delivered first. Additionally, the PLWH's lab values and readiness assessment should be used to guide the intervention	• Primary Client Record documents the delivery of education/counseling consistent with the information need for newly-diagnosed PLWH.
1.11 EISED	<u>Education/Counseling (All)</u> Based on the comprehensive assessment, the EIS Team will target the following topics for all PLWH served by the intervention: • Living healthy with HIV • Treatment As Prevention • Early Intervention as a strategy to reduce disease progression • Role of medications in healthy living • Maintenance of immune system • Medication Adherence • THMP Process • Provision of the Mini Blue Book • Disclosure to partners and support systems Education/Counseling should be provided in	• Primary Client Record documents the delivery of education/counseling consistent with the information need for PLWH's identified need.

	manageable messages. The EIS Team should not attempt to cover all the necessary topics in one Touch. Instead, prioritization should be used to guide which messages should be delivered first. Additionally, the PLWH's lab values and readiness assessment should be used to guide the intervention.	
1.12 EISED	<u>Health Literacy</u>: The EIS Team will provide the PLWH with health literacy messaging that is tailored to "where the PLWH is at" as determined by the comprehensive assessment. Examples of health literacy messaging include: • For newly diagnosed (i.e. treatment naïve), discussion about the importance of medical care, access third party payor options, and Ryan White care services. • Discussion of navigating care system • Discussion of medical home concept • Mapping out best option for community care based on future residence/work • Discussion of community support (EXCLAIM i.e. MAI Project) • Discussion about relationships (including U=U, viral suppression, and self-care) • Discussion about Hope (decreasing stigma and misinformation about living with HIV)	• Primary client record documents Health Literacy messaging provided.
1.13	<u>Coordination of Community Care</u>: The EIS Team will make a referral to community care based on the PLWH's selection of a medical home. This referral will include the arrange appointment for client prior to release to community partners. The referral process with comply with the preferred method of scheduling appointments established with the community partner.	• Primary Client Record documents the establishment of an appointment. • Where appointment scheduling is not possible, Primary Client Record documents referral to community support agency (MAI, case management, etc.) for follow-up with PLWH upon release.
1.14	<u>Medication Regimen Establishment/Maintenance</u>: The EIS Team will meet with the PLWH to assess readiness for the medication regimen. The Team will provide information about the readiness assessment as part of the MDT review.	• Medication discussions are documented in the primary client record.
1.15	<u>Transitional Multidisciplinary Team:</u> The EIS Team will be part for the multidisciplinary care team (MDT) within HCJ. The Team meet and review each PLWH's	• MDT reviews will be documented in the primary client record. • Communication with community partners documented in primary client

	information with the medical team to improve the quality of care provided while in HCJ. Additionally, the Team will act as the conduit to deliver the information from the internal MDT to community partners, as appropriate.	record.
1.16	Discharge Planning EIS Team conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a strategy plan. Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. EIS Staff, MAI, MHMR, DSHS Prevention)	• Primary client record documents the discharge planning activities conducted.
1.17	PLWH Strategy Plan: The EIS Team and the PLWH should discuss honestly the challenges with obtaining resources in the freeworld/community and develop strategies to minimizing those challenges. The Team should focus the PLWH on strengths that they have that con contribute to successes in the freeworld/community.	• Primary client record documents the strategies developed for obtaining services in the freeworld.
1.18	Consent to Release/Exchange Information The EIS Team will obtain signed consent to release and exchange information from the PLWH to assist in the process of making referrals to community resources.	• Signed consent will be documented in the primary client record.
1.19	Internal Referrals: Internal referrals: HIV care; substance use; mental health; referral to other clinic for comorbidities Referrals will be documented in the client's primary record and, at a minimum, should include referrals for services such as: • Mental Health, as applicable • Substance Use Treatment, as applicable	• Primary client record documents connection to internal care services, as applicable.
1.20 EISRC	External Referrals Referrals will be documented in the primary client record and, at a minimum, should include referrals for services such as:	• Primary Client Record documents referral to community medical care. • Primary Client Record documents referral to support services.

	• OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help maintain PLWH in medical care in the freeworld. The Team will schedule an appointment for PLWH who will be returning to the community with a medical provider of the PLWH's choosing. For PLWH who will be transferring to TDCJ, no appointments will be scheduled. If PLWH is awaiting transfer to TDCJ, EIS Team will ensure a note is placed in primary client record and external referrals will not occur.	• Primary Client Record documents any additional referrals made on behalf of the PLWH. • Primary Client record documents if the PLWH is awaiting transfer to TDCJ in place of required external referrals.
1.21 EISRC	<u>Referral Packet</u> Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral packet will include: a. A copy of the Harris County Jail Intake/Assessment Form, b. Copy of Medication Certification Form (whenever possible) or otherwise i. Proof of HIV diagnosis, ii. A list of current medications, and c. Copy of ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community.	• Primary Client record documents the provision of a referral packet to support external referrals
1.22 EISFU	<u>Referral Tracking/Follow-Up</u> All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS Team offered to the PLWH. Successful linkage to care is measured as attendance to the actual medical appointment with a provider with prescribing privileges.	• Primary client record documents the follow-up activities conducted to ensure that the external referrals were completed and the outcome of the referral.
1.23	<u>Lost To Care/Connection with DIS</u> After three unsuccessful attempts are made to contact and re-engage the client, EIS Team	• Referral to DIS is documented in the primary client record.

	should work with their local Disease Intervention Specialist (DIS) workers.	
1.24	Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of EIS intervention completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Primary client record contains a closure summary that includes narrative outlining the components of the EIS intervention completed with the PLWH and the reason for closure. • Primary client record contains supervisor signature/approval on closure summary (electronic review is acceptable).
1.25	Progress Notes The EIS Team will maintain progress notes in each primary client record with thorough and accurate documentation of the assistance the EIS Team provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Primary client record contains thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH.
TIER 2 – (MORE THAN 30 DAYS) – ENHANCED INTERVENTION		
#	**STANDARD**	**EVIDENCE**
2.1	Inclusion Criteria Identified PLWH who remain in HCJ beyond 30 days (i.e. potentially seeing a provider with prescribing authority multiple times)	• Primary client record documents that PLWH should be included in this tier.
2.2	Benchmarks: • Additional Touches as Length of Stay Permits to reinforce Messaging • Coordination of Additional Medical Appointments • Coordination of Referrals to Community Care and Resources. • Increased provision of health literacy, treatment adherence, and other education.	• Primary client record documents each benchmark obtained.
2.3	Reassessment: EIS Team will conduct reassessments at six (6) months and annually thereafter if individuals remain in HCJ long-term. These assessments can be conducted at the time of clinic appointments. If minimal changes are identified, the results should be documented in the progress notes. If significant changes are identified, the EIS assessment form should be updated.	• Primary client Record documents the reassessment of PLWH who meet the criteria.
2.4 EISED	Education/Counseling (All) Based on the comprehensive assessment, the EIS	• Primary Client Record documents the delivery of education/counseling

	Team will target the following topics for all PLWH served by the intervention: • Living healthy with HIV • Treatment As Prevention • Early Intervention as a strategy to reduce disease progression • Role of medications in healthy living • Maintenance of immune system • Medication Adherence • THMP Process (revisit the need for updated application/attestation) • Provision of the Mini Blue Book • Disclosure to partners and support systems Education/Counseling should be provided in manageable messages. The EIS Team should not attempt to cover all the necessary topics in one Touch. Instead, prioritization should be used to guide which messages should be delivered first. • Additionally, the PLWH's lab values and readiness assessment should be used to guide the intervention.	consistent with the information need for PLWH's identified need.
2.5 EISED	<u>Health Literacy</u>: The EIS Team will provide the PLWH with health literacy messaging that is tailored to "where the PLWH is at" as determined by the comprehensive assessment. Examples of health literacy messaging include: • Enhanced knowledge- accessing care; navigating care system • Discussion about the Patient/Provider relationship and the importance of developing self-efficacy for quality care • Co-morbidities and other health concerns • Continued discussion of medical home concept • Continued discussion about relationships (including U=U, viral suppression, and self-care) • Continued discussion about Hope (decreasing stigma and misinformation about living with HIV) • Discussion about navigating care system.	• Health literacy discussions documented in the primary client record.
2.6	<u>Medication Regimen Establishment/Maintenance</u>:	• Primary Client record documents

	The EIS Team will meet with the PLWH to reinforce adherence with the established medication regimen, discuss any side effects, and help strategize for taking medications in the freeworld/community. The Team will provide challenges or issues identified with the medication regimen to the MDT.	discussions to reinforcement of medication adherence.
2.7	<u>Transitional Multidisciplinary Team:</u> The EIS Team will be part for the multidisciplinary care team (MDT) within HCJ. The Team meet and review each PLWH's information with the medical team to improve the quality of care provided while in HCJ. Additionally, the Team will act as the conduit to deliver the information from the internal MDT to community partners, as appropriate.	• MDT reviews will be documented in the primary client record. • Communication with community partners documented in primary client record.
2.8	<u>Discharge/Care Planning</u> EIS Team conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a strategy plan. Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. EIS Staff, MAI, MHMR, DSHS Prevention)	•
2.9	<u>PLWH Strategy Plan</u>: The EIS Team and the PLWH should discuss honestly the challenges with obtaining resources in the freeworld/community and develop strategies to minimizing those challenges. The Team should focus the PLWH on strengths that they have that con contribute to successes in the freeworld/community.	• Primary client record documents review of the strategies developed for obtaining services in the freeworld with PLWH. • Primary Client record documents strategies a
2.10	<u>Internal Referrals:</u> Internal referrals: HIV care; substance use; mental health; referral to other clinic for comorbidities Referrals will be documented in the client's primary record and, at a minimum, should include referrals for services such as: • OAHS	•

	• MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable	
2.11 EISRC	<u>External Referrals</u> NOTE: If PLWH is awaiting transfer to TDCJ, EIS Team will ensure a note is placed in primary client record and external referrals will not occur. Referrals will be documented in the client's primary record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable Any additional services necessary to help clients engage in their medical care. The EIS Team will link PLWH to medical care in the community. The Team will schedule an appointment for PLWH who will be returning to the community with a medical provider of the PLWH's choosing. For PLWH who will be transferring to TDCJ, no appointments will be scheduled.	•
2.12 EISRC	<u>Referral Packet</u> Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral packet will include: d. A copy of the Harris County Jail Intake/Assessment Form, e. Copy of Medication Certification Form (whenever possible) or otherwise i. Proof of HIV diagnosis, ii. A list of current medications, and a. Copy of ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community.	•
2.13 EISFU	<u>Referral Tracking/Follow-Up</u> All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS	•

	Team offered to the PLWH. Successful linkage to care is measured as attendance to the actual medical appointment with a provider with prescribing privileges.	
2.14	Lost To Care/Connection with DIS After three unsuccessful attempts are made to contact and re-engage the client, EIS Team should work with their local Disease Intervention Specialist (DIS) workers.	• Referral to DIS is doumented in the primary client record.
2.15	Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of EIS intervention completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Primary client record contains a closure summary that includes narrative outlining the components of the EIS intervention completed with the PLWH and the reason for closure. • Primary client record contains supervisor signature/approval on closure summary (electronic review is acceptable).
2.16	Progress Notes The EIS Team will maintain progress notes in each primary client record with thorough and accurate documentation of the assistance the EIS Team provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Primary client record contains thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH.
ADMINISTRATIVE REQUIREMENTS		
#	**STANDARD**	**EVIDENCE**
3.1	Agency License The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.	• Review of agency
3.2	Program Policies and Procedures Agency will have a policy that: • Defines and describes EIS services (funded through Ryan White or other sources) that include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry	• Program's Policies and Procedures indicate compliance with expectations.

	• Specifies required coordination with HIV prevention efforts and programs • Requires coordination with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found • Requires monitoring of referrals into care and treatment Additionally, the EIS Program will have policies and procedures that comply with applicable DSHS Universal Standards.	
3.3	<u>Staff Qualifications</u> All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. Supervisors must possess a degree in a health/social service field or equivalent experience.	• Review of personnel files indicates compliance
3.4	<u>Continuing Education</u> Each staff will complete a minimum of (12) hours of training annually to remain current on HIV care.	• Evidence of training will be documented in the staff personnel records.
3.5	<u>Supervision</u> Agency must have and implement a written plan for supervision of EIS Team. Supervisors must review a 10 percent sample of each team member's client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Each supervisor must maintain a file on each staff supervised and hold supervisory sessions on at least a monthly basis. The file must include, at a minimum: • Date, time, and content of the supervisory sessions Results of the supervisory case review addressing at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
3.9	<u>MOUs with Core Medical Services</u>	• Review of MOUs at annual quality

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

Citations:
1. DSHS Early Intervention Services Service Standard (https://dshs.texas.gov/hivstd/taxonomy/eis.shtm)
2. Intervention In Early HIV Infection
Santangelo J., Todays OR Nurse. 1992 Jul;14(7):17-21.
PMID: 1636202

References:
DSHS HIV/STD Policy #2013.02, *"The Use of Testing Technology to Detect HIV Infection"* http://www.dshs.texas.gov/hivstd/policy/policies/2013-02.shtml
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 10-11
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. P. 10-11. Accessed February 14, 2018 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

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

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

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	Prioritization of Cost-Sharing Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agencies use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles 3. Co-payments for provider visits (e.g. physician visit and/or lab copayments) 4. Medicare Part D (Rx) premiums 5. APTC Tax Liability 6. Out of Network out-of-pocket expenses	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.9	Cost-Effectiveness Assessment The cost of insurance plans must be lower than the cost of providing health services through DSHS-funded delivery of care including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Agency must implement a methodology that incorporates the following requirement: **1. Health Insurance Premium:** Agency 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 only provide assistance when determined to be cost effective. **2. Standalone Dental Premium:** Agency must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and only provide assistance when determined to be cost effective..	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of primary client record indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.10	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental) * 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.11	Restricted Use of Funds 1. Insurance plans must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services to be eligible for premium payments under HIA. 2. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 3. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 4. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 5. Payment can never be made directly to clients. 6. HIA funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 7. Under no circumstances can funds be used to pay the fee for a client's failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 8. HIA funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price. 9. Funds cannot be used to cover costs associated with Social Security. 10. Life insurance and other elective policies are not covered.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Health Insurance Premium Assistance The following criteria must be met for a health plan to be eligible for HIA assistance: 1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 2. Health Insurance coverage must be evaluated for cost effectiveness 3. Health insurance plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 4. COBRA plans must be evaluated based on cost effectiveness and client benefit. Additional Requirements for ACA plans: 1. If a client between 100%-250% FPL, only SILVER level plans are eligible for HIA payment assistance (unless client enroll prior to November 1, 2015). 2. Clients under 100% FPL, who present with an ACA plan, are NOT eligible for HIA payment assistance (unless enroll prior to November 1, 2015). 3. All clients who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL). All clients receiving HIA assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client records indicates compliance. • Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.
9.13	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to ensure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.17	Waiver Process In order to ensure proper program delivery, a waiver from the AA is required for the following circumstances: 1. HIA payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers, 3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary, 4. Discontinuing HIA payment assistance due to client conduct or fraud, 5. Refusing HIA assistance for a client who is eligible and whom HIA provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted and; 7. Assisting an eligible client with the entire cost of a group policy that includes coverage for persons not eligible for HIA payment assistance.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of approved waiver.
9.18	Vigorous Pursuit All contracted agencies must vigorously pursue any excess premium tax credit received by the client from the IRS upon submission of the client's tax return. To meet the standard of "*vigorously pursue*", all clients receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must: 1. Designate premium tax credit be taken in advance during enrollment 2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal 3. Submit prior year tax information no later than May 31st. 4. Reconciliation of advance premium tax credits or liabilities.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.
9.19	Prescription Eyewear Agency must keep documentation from physician stating that the eye condition is related to the client's HIV infection when HIA funds are used to cover co-pays for prescription eyewear.	• Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV infection as indicated in the client's primary record

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

References

TDSHS HIV/STD Ryan White Part B Program Universal Standards (pg. 30-31)
TDSHS HIV/STD Prevention and Care Branch, Policy 260.002. Health Insurance Assistance
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 31-35.
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 07-05
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HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-06
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 14-01
TDSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001)
HRSA/HAB, Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance (PDF)

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HOSPICE SERVICES

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

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

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

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

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

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

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

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

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

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

References

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

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC INTERPRETIVE SERVICES

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

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

#	STANDARD	MEASURE
9.0	**Services are part of the coordinated continuum of HIV/AIDS and social services**	
9.3	Program Policies Agency will develop policies and procedures regarding the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and procedures to providers seeking to utilize the service.	• Review of Program Policies.

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

9.5	Timeliness of Scheduling Agency will schedule service within one (1) business day of the request.	• Review of client files indicates compliance.
9.6	Subcontractor Exclusion: Due to the nature of subcontracts under this service category, the staff training outlined in the General Standards are excluded from being required for interpreters.	• No Measure

References

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

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

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

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

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

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

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

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

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

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

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

References

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

HRSA Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18). Located at: https://hab.hrsa.gov/sites/default/files/hab/program-grantsmanagement/ServiceCategoryPCN_16-02Final.pdf

Mental health services can be delivered via telehealth. may be provided via telehealth and must follow applicable federal and State of Texas privacy laws, for more information see: January 2020 Texas Medicaid Provider Telecommunication Services Handbook, Volume 2.
http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Telecommu nication_Srvs.pdf

Mental health services that are provided via telehealth must be in accordance with State of Texas mental health provider practice requirements, see Texas Occupations Code, Title 3 Health Professions and chapter 111 for Telehealth & Telemedicine; see:
https://statutes.capitol.texas.gov/Docs/OC/htm/OC.111.htm

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING SUBSTANCE USE DISORDERS

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

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

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

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

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

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

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

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

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

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

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

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

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

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

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

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

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

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

References

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

RYAN WHITE PART B/DSHS STATE SERVICES
21-22 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
REFERRAL FOR HEALTH CARE AND SUPPORT SERVICES
ADAP ENROLLMENT WORKERS

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

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

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

#	STANDARD	MEASURE
9.5	Staff Training Requirement: • THMP Training Modules within 30 days of hire • Complete the DSHS ADAP Enrollment Worker (AEW) Regional update at earliest published date after hire • DSHS ARIES Document Upload Training (to include TRG upload observation module), completed no later than (45) days after completing ARIES certificate process • Data Security and Confidentiality Training • Complete all training required of Agency new hires, including any training required by DSHS HIV Care	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.6	AEW Placement AIDS Drug Assistance Program (ADAP) Enrollment Workers will be co-located at Ryan-White Part A funded primary care providers to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP).	
9.7	Initial Provision of Client Education The initial education to clients regarding the THMP process should include, but not limited to: • Discussion of confidentiality, specific to the THMP process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the client. • Applicants should realize that their physician and pharmacist would also be aware of their diagnosis. • Discussion outlining that approved medication assistance through THMP may require a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee. • Discussion outlining the recertification process, specific to THMP eligibility, including birth month recertification, half-birth month attestation and consequences of lapse.	• Documented evidence of education provided on other public and/or private benefit programs in the primary client record.

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

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

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

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

References

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

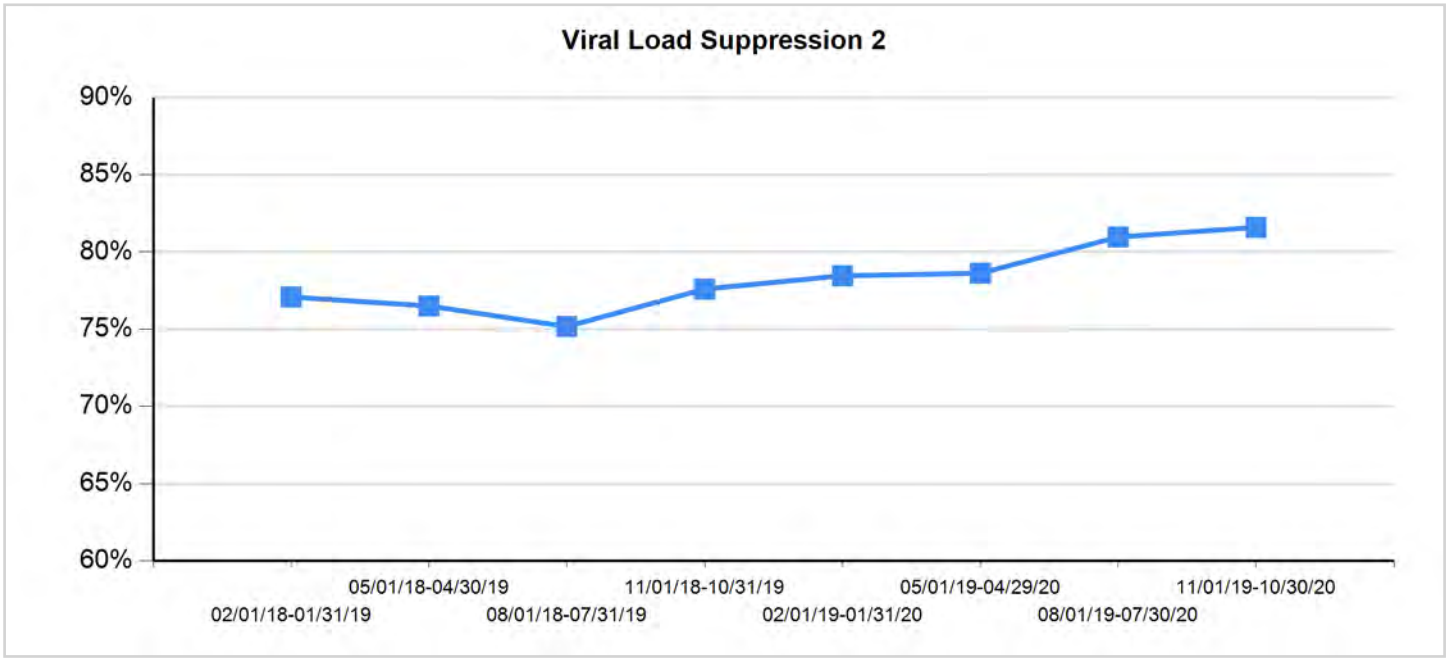
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43.
Virginia Department of Health, Division of Disease Prevention, HIV Care Services Referral for Health Care/Supportive Services (PDF)
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program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

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

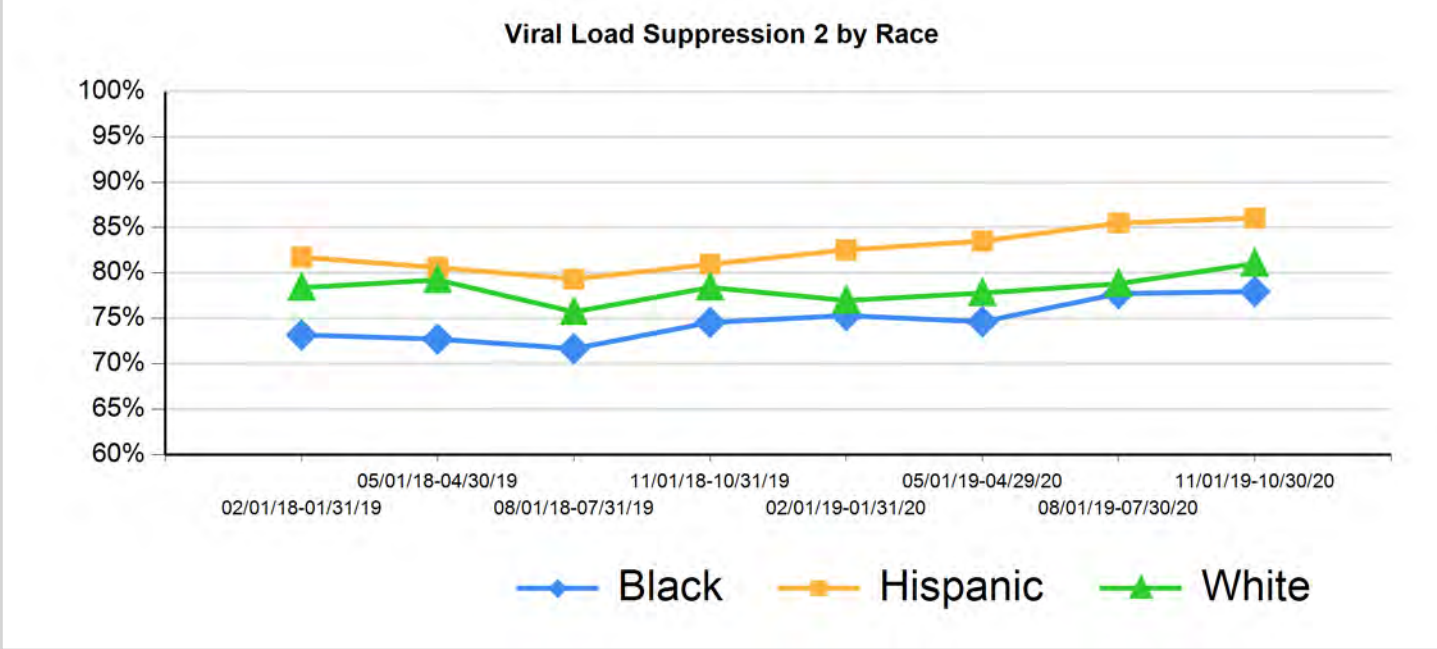
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **11/1/2019**

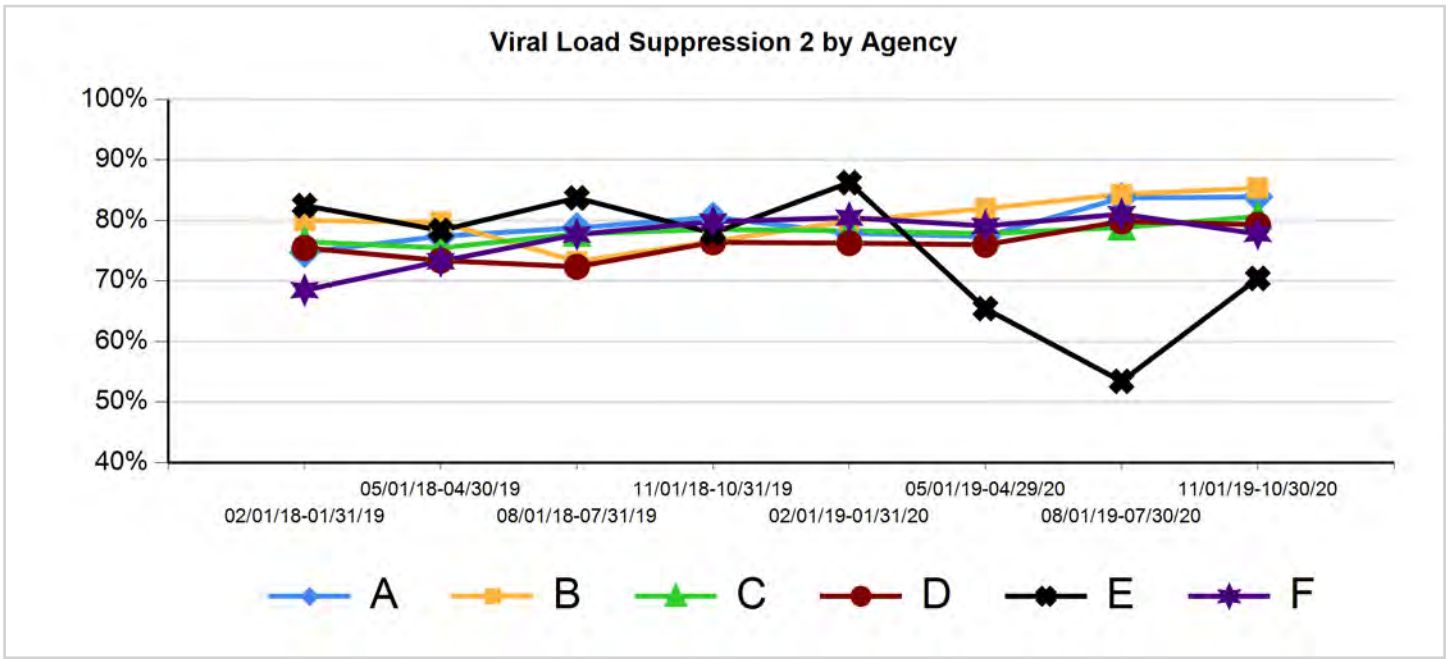
Viral Load Suppression 2- HAB Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who have a viral load of <200 copies/ml during the measurement year	6,736	6,830	6,995	6,970
Number of clients who have had at least 1 medical visit with a provider with prescribing privileges	8,585	8,687	8,639	8,542
Percentage	78.5%	78.6%	81.0%	81.6%
Change from Previous Quarter Results	0.9%	0.2%	2.3%	0.6%



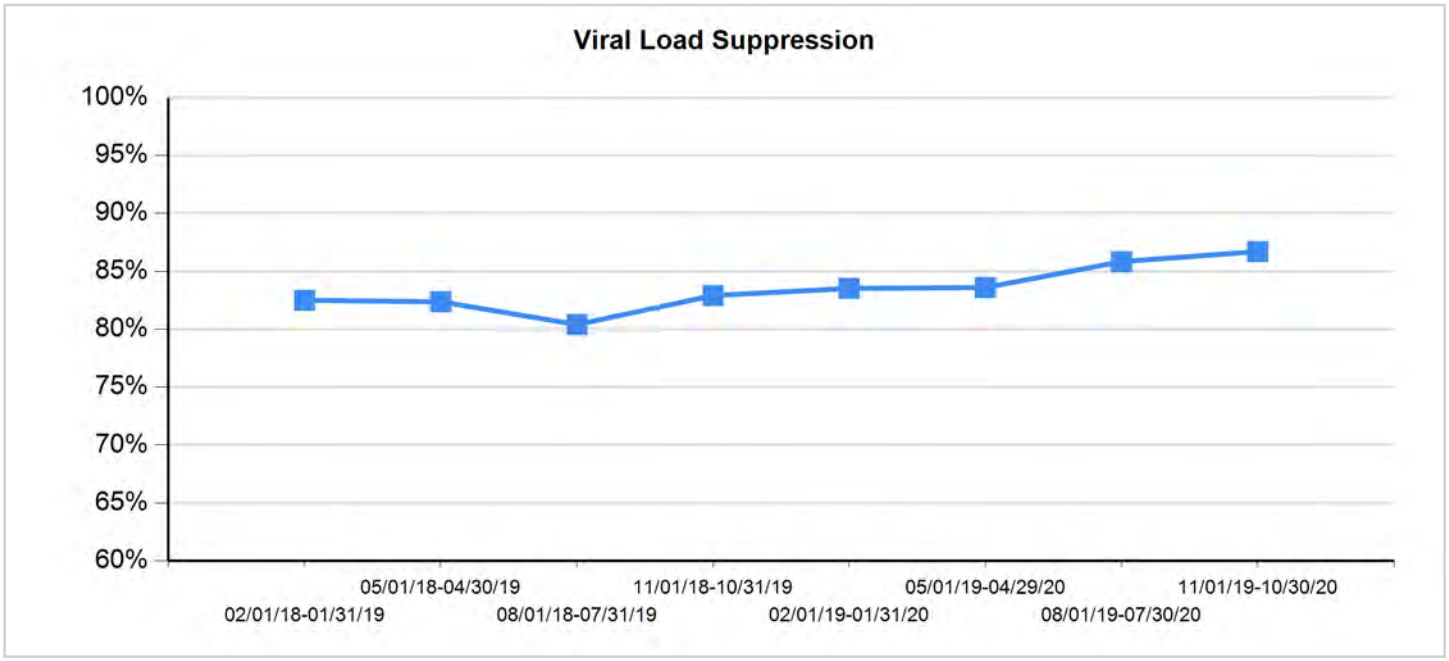
VL Suppression 2 by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	3,088	2,736	844	3,172	2,814	852	3,165	2,775	876
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,138	3,276	1,085	4,081	3,291	1,081	4,060	3,225	1,081
Percentage	74.6%	83.5%	77.8%	77.7%	85.5%	78.8%	78.0%	86.0%	81.0%
Change from Previous Quarter Results	-0.7%	1.0%	0.8%	3.1%	2.0%	1.0%	0.2%	0.5%	2.2%



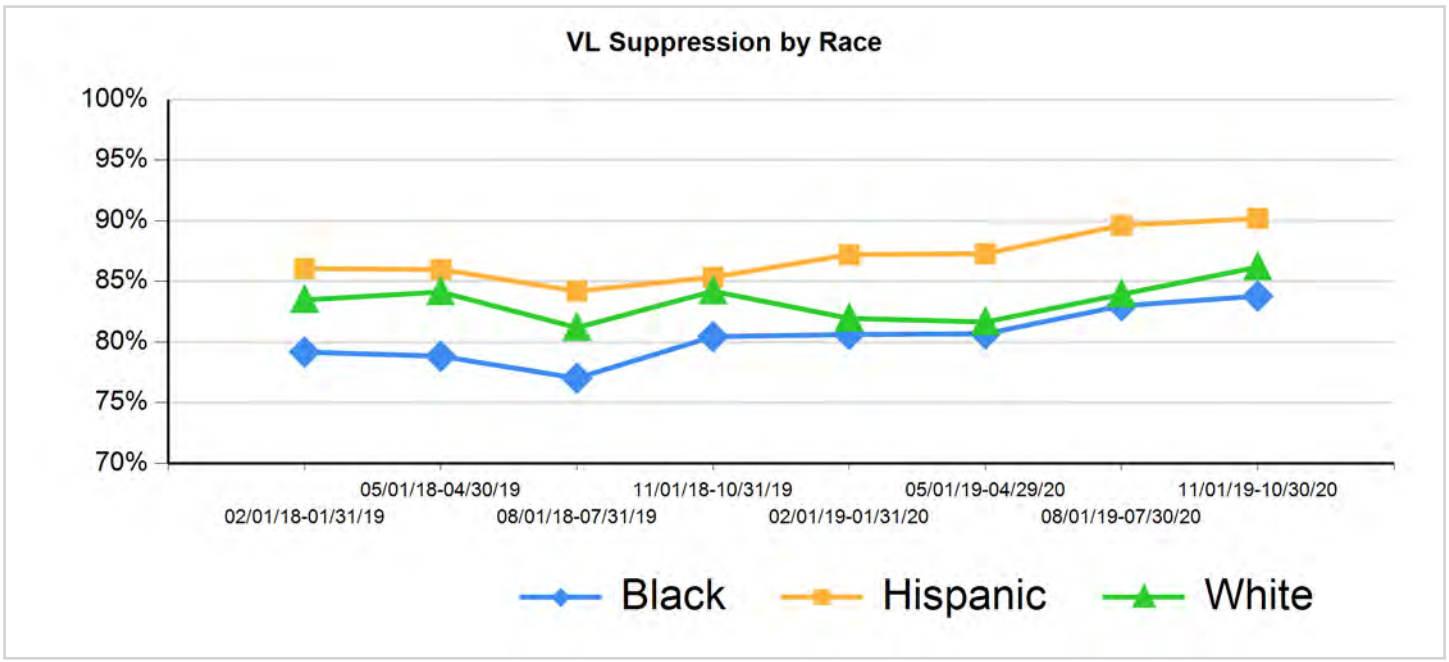
Viral Load 2 Suppression by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	561	2,213	2,220	1,677	39	398	557	2,135	2,274	1,651	50	413
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	670	2,624	2,816	2,100	73	491	664	2,501	2,819	2,082	71	531
Percentage	83.7%	84.3%	78.8%	79.9%	53.4%	81.1%	83.9%	85.4%	80.7%	79.3%	70.4%	77.8%
Change from Previous Quarter Results	6.4%	2.4%	1.0%	3.9%	-12.0%	2.0%	0.2%	1.0%	1.8%	-0.6%	17.0%	-3.3%



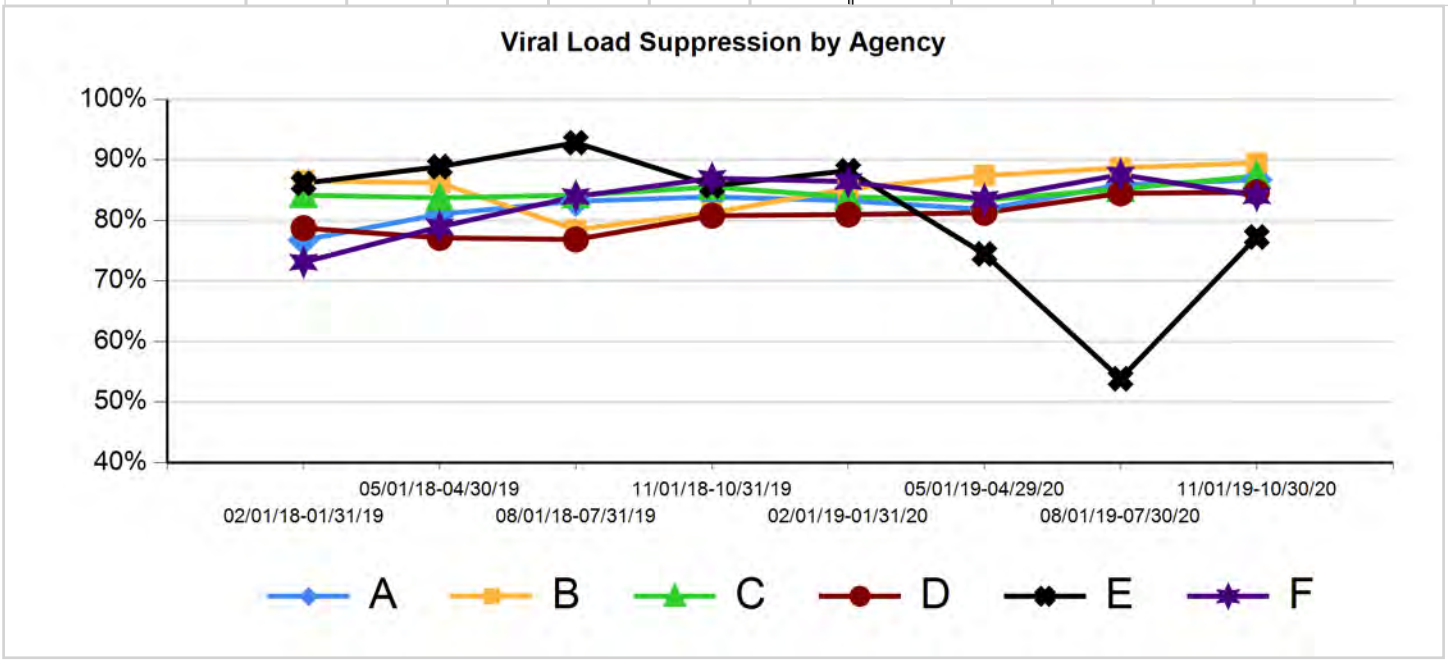
Viral Load Suppression				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who have a viral load of <200 copies/ml during the measurement year	5,130	5,162	5,150	5,073
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	6,142	6,175	6,000	5,851
Percentage	83.5%	83.6%	85.8%	86.7%
Change from Previous Quarter Results	0.6%	0.1%	2.2%	0.9%



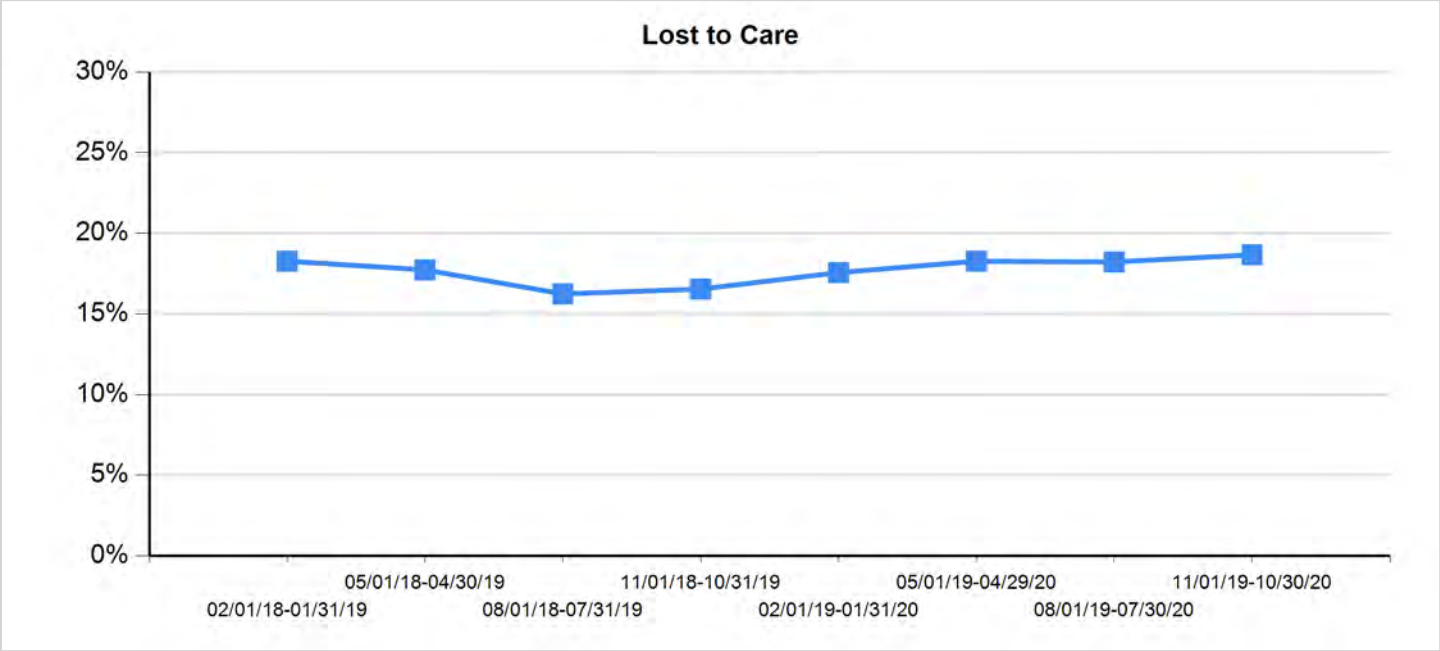
VL Suppression by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,305	2,103	623	2,312	2,107	611	2,289	2,077	605
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,857	2,409	763	2,786	2,351	728	2,732	2,303	702
Percentage	80.7%	87.3%	81.7%	83.0%	89.6%	83.9%	83.8%	90.2%	86.2%
Change from Previous Quarter Results	0.1%	0.1%	-0.3%	2.3%	2.3%	2.3%	0.8%	0.6%	2.3%



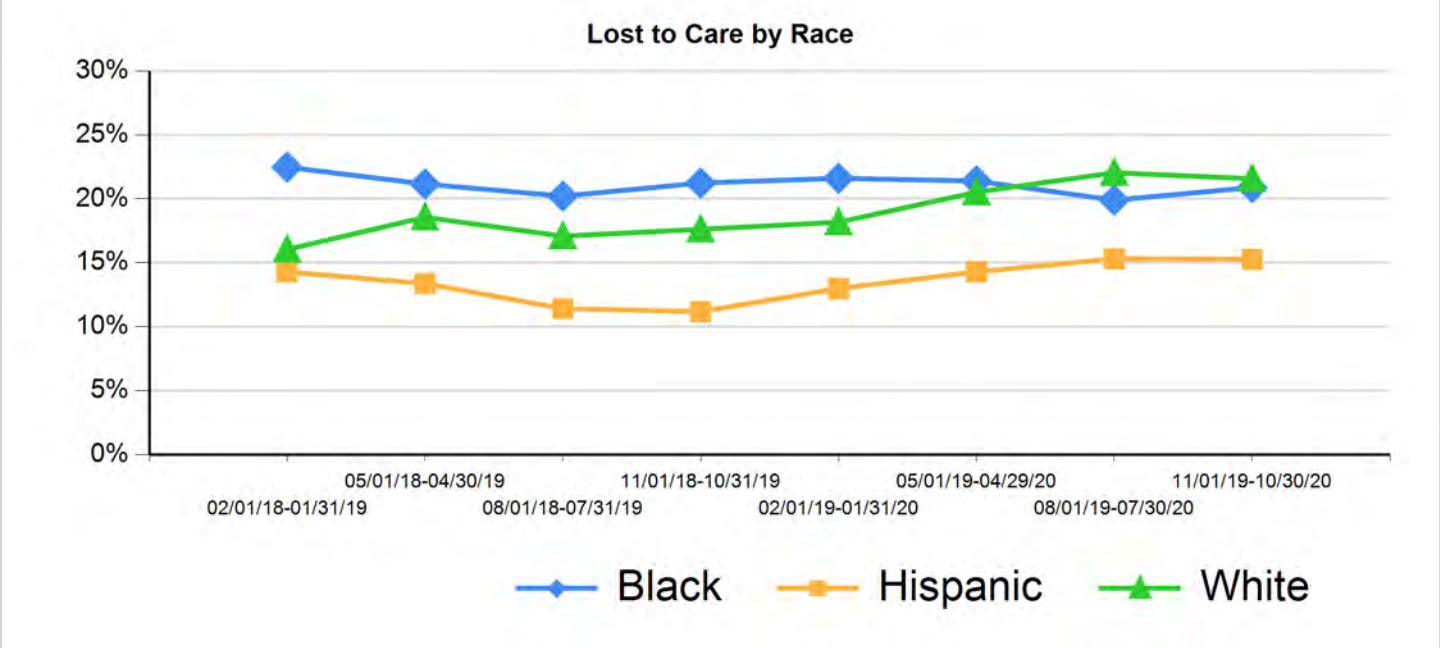
VL Suppression by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	481	1,413	1,532	1,476	21	268	483	1,324	1,506	1,481	34	280
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	560	1,593	1,798	1,747	39	306	557	1,479	1,724	1,749	44	333
Percentage	85.9%	88.7%	85.2%	84.5%	53.8%	87.6%	86.7%	89.5%	87.4%	84.7%	77.3%	84.1%
Change from Previous Quarter Results	4.1%	1.3%	1.8%	3.2%	-20.6%	4.1%	0.8%	0.8%	2.1%	0.2%	23.4%	-3.5%



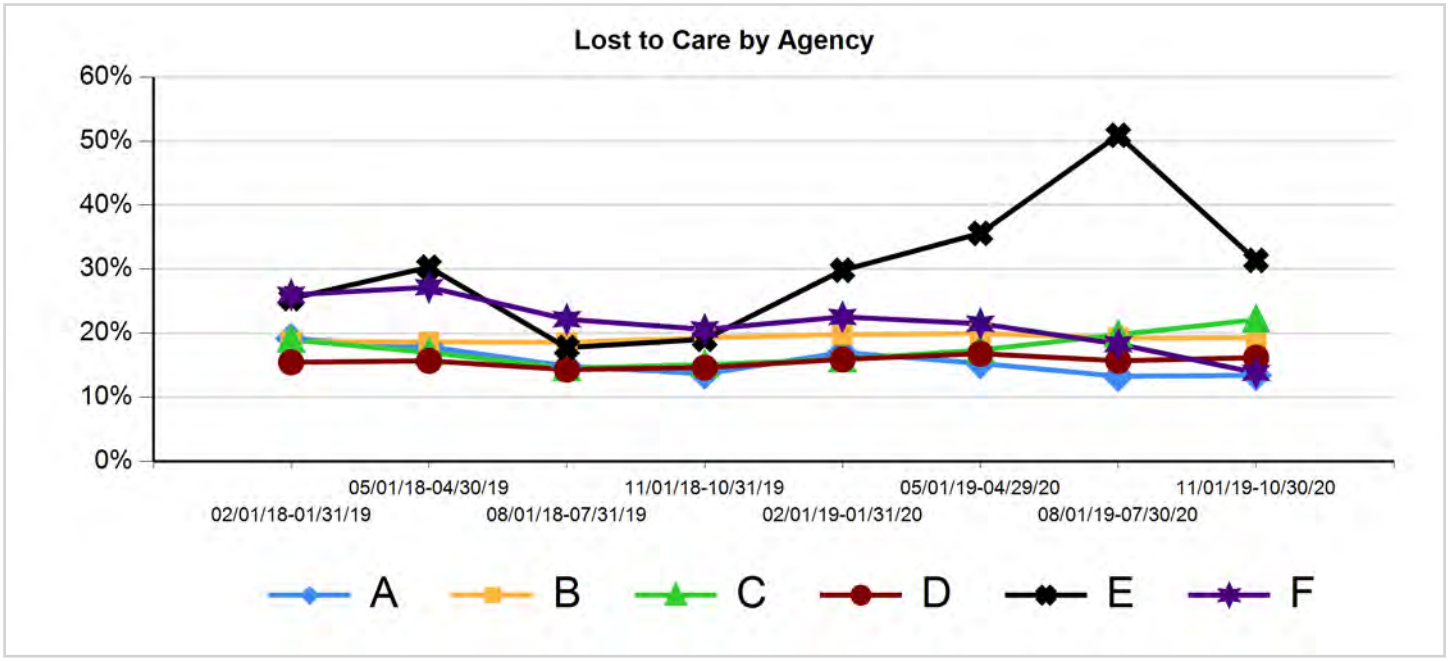
Lost to Care				
In+Care Campaign Gap Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	1,079	1,148	1,139	1,168
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	6,144	6,284	6,251	6,258
Percentage	17.6%	18.3%	18.2%	18.7%
Change from Previous Quarter Results	1.0%	0.7%	0.0%	0.4%



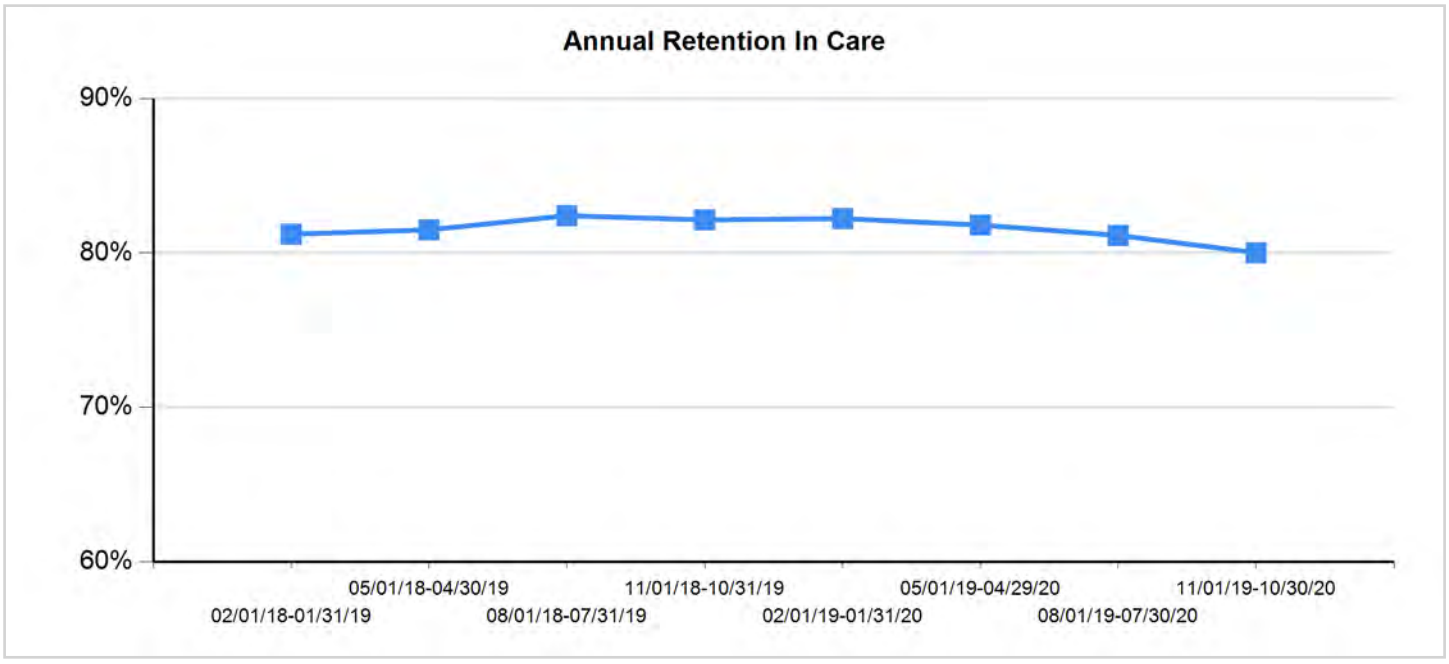
Lost to Care by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	615	355	159	560	386	171	597	382	165
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,875	2,484	775	2,815	2,522	776	2,859	2,502	765
Percentage	21.4%	14.3%	20.5%	19.9%	15.3%	22.0%	20.9%	15.3%	21.6%
Change from Previous Quarter Results	-0.2%	1.3%	2.3%	-1.5%	1.0%	1.5%	1.0%	0.0%	-0.5%



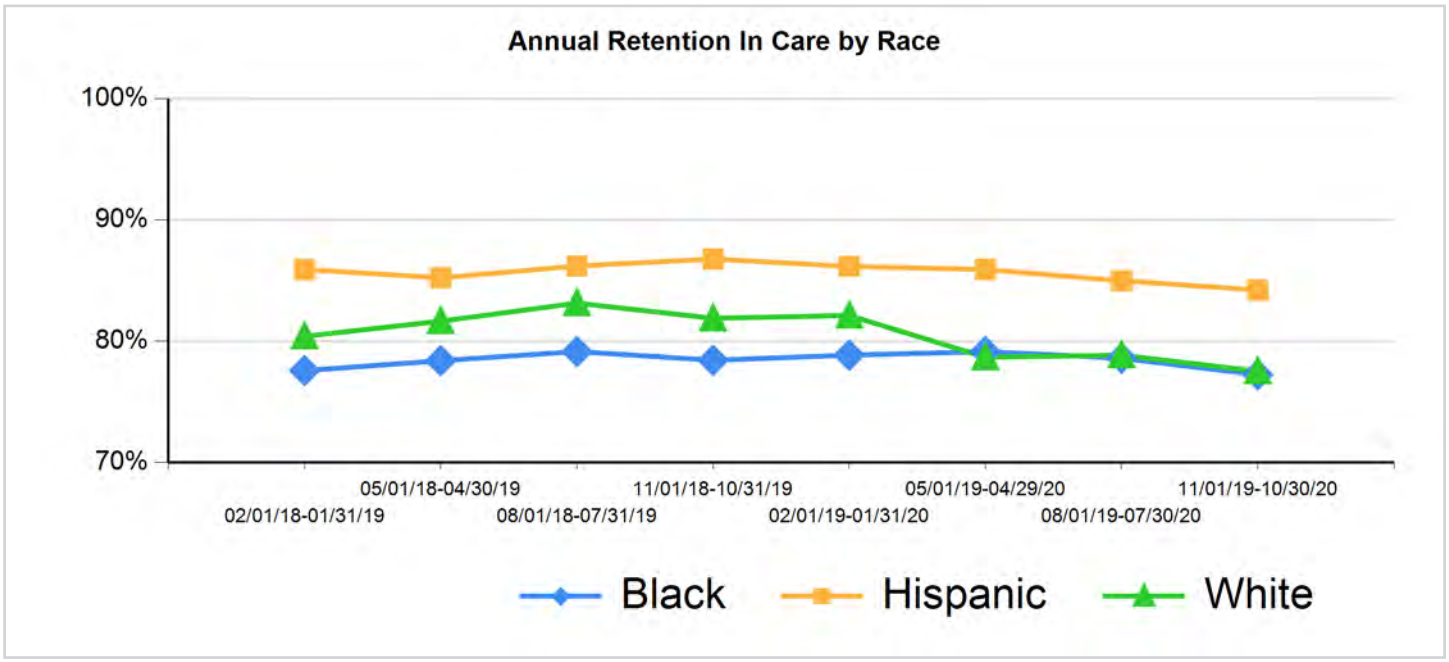
Lost to Care by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	69	367	376	251	28	58	70	357	423	264	16	46
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	520	1,909	1,902	1,601	55	317	522	1,851	1,914	1,632	51	333
Percentage	13.3%	19.2%	19.8%	15.7%	50.9%	18.3%	13.4%	19.3%	22.1%	16.2%	31.4%	13.8%
Change from Previous Quarter Results	-2.0%	-0.7%	2.4%	-1.1%	15.3%	-3.2%	0.1%	0.1%	2.3%	0.5%	-19.5%	-4.5%



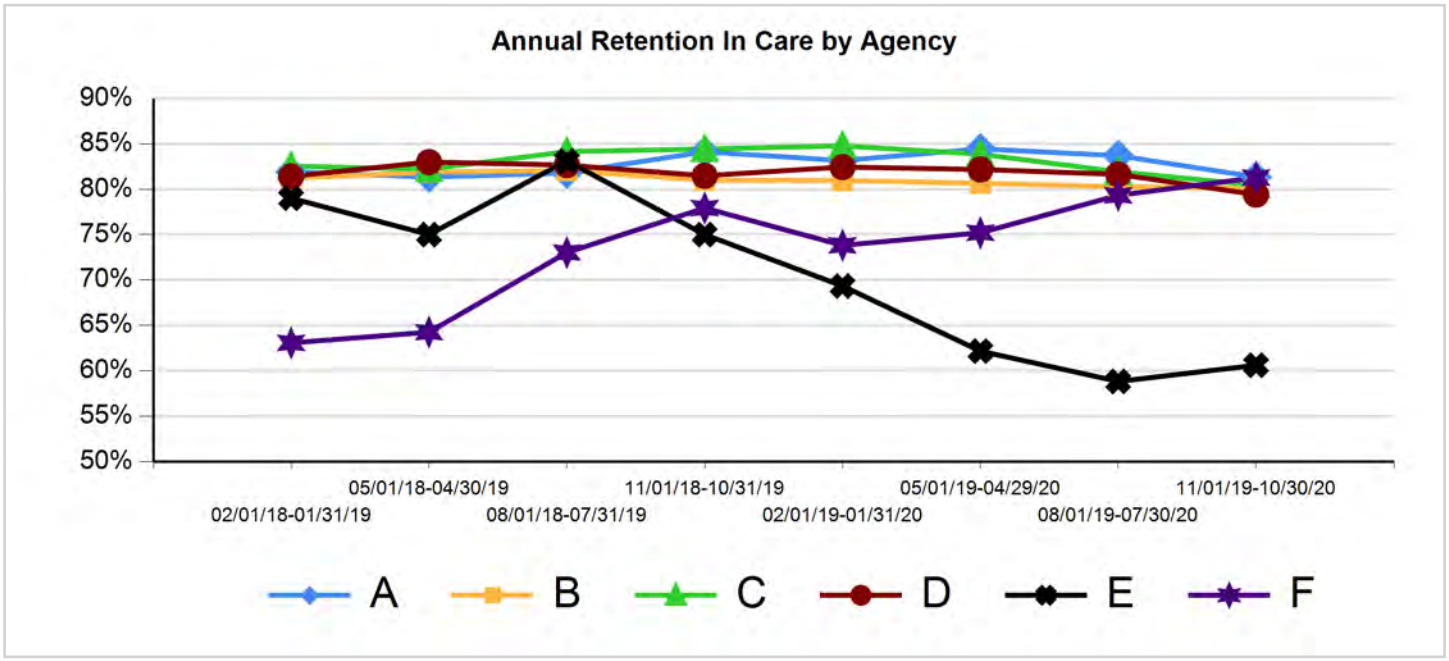
Annual Retention In Care				
Houston EMA Medical Visits Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year*	6,400	6,485	6,445	6,306
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	7,783	7,927	7,943	7,881
Percentage	82.2%	81.8%	81.1%	80.0%
Change from Previous Quarter Results	0.1%	-0.4%	-0.7%	-1.1%
* Not newly enrolled in care				



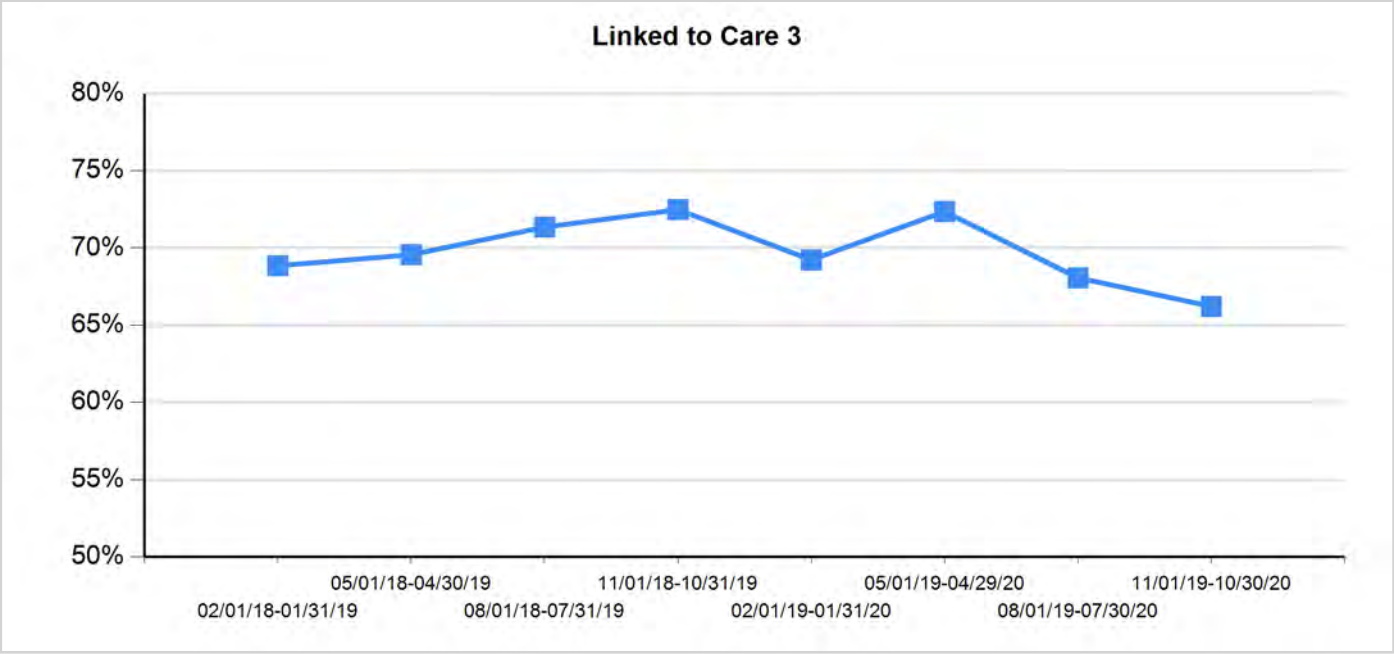
Annual Retention In Care by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	2,975	2,589	763	2,942	2,588	771	2,892	2,523	758
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	3,760	3,014	970	3,744	3,046	978	3,745	2,996	978
Percentage	79.1%	85.9%	78.7%	78.6%	85.0%	78.8%	77.2%	84.2%	77.5%
Change from Previous Quarter Results	0.3%	-0.3%	-3.4%	-0.5%	-0.9%	0.2%	-1.4%	-0.8%	-1.3%



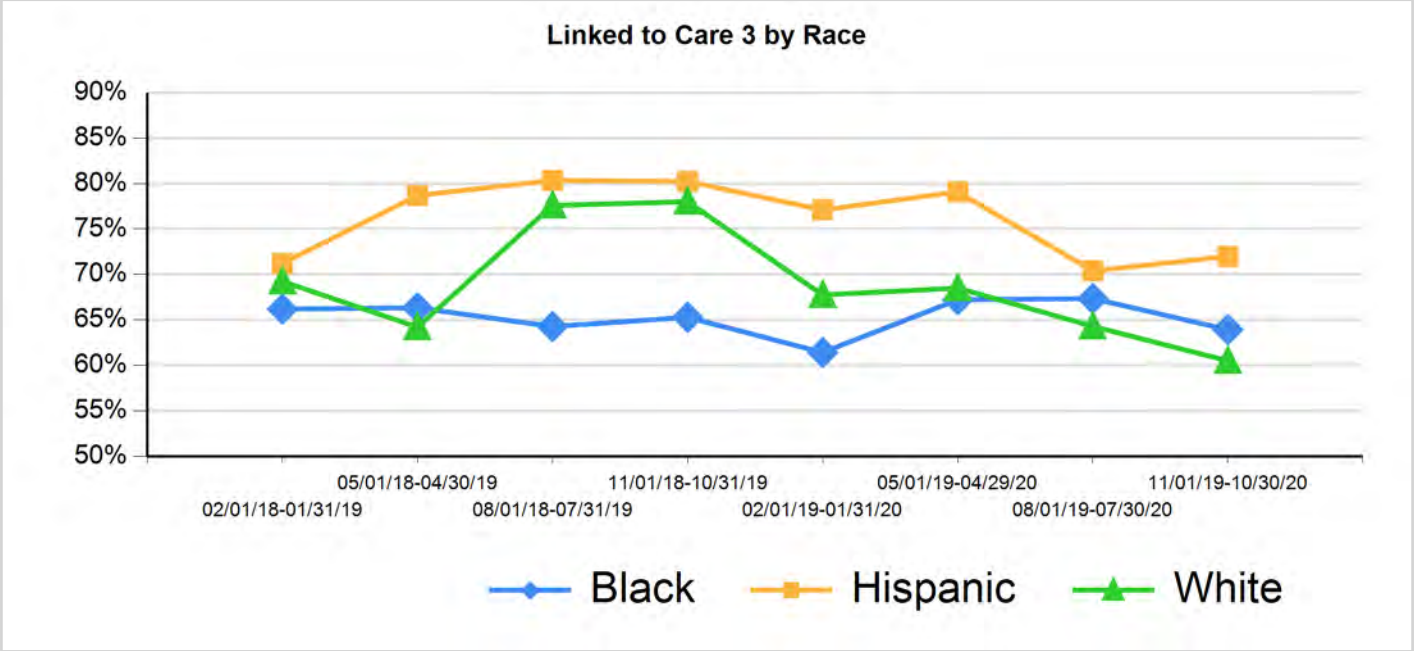
Annual Retention In Care by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	539	1,967	2,089	1,601	40	307	519	1,871	2,058	1,557	40	343
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	644	2,450	2,550	1,961	68	387	638	2,336	2,558	1,961	66	422
Percentage	83.7%	80.3%	81.9%	81.6%	58.8%	79.3%	81.3%	80.1%	80.5%	79.4%	60.6%	81.3%
Change from Previous Quarter Results	-0.8%	-0.4%	-1.9%	-0.5%	-3.3%	4.1%	-2.3%	-0.2%	-1.5%	-2.2%	1.8%	2.0%



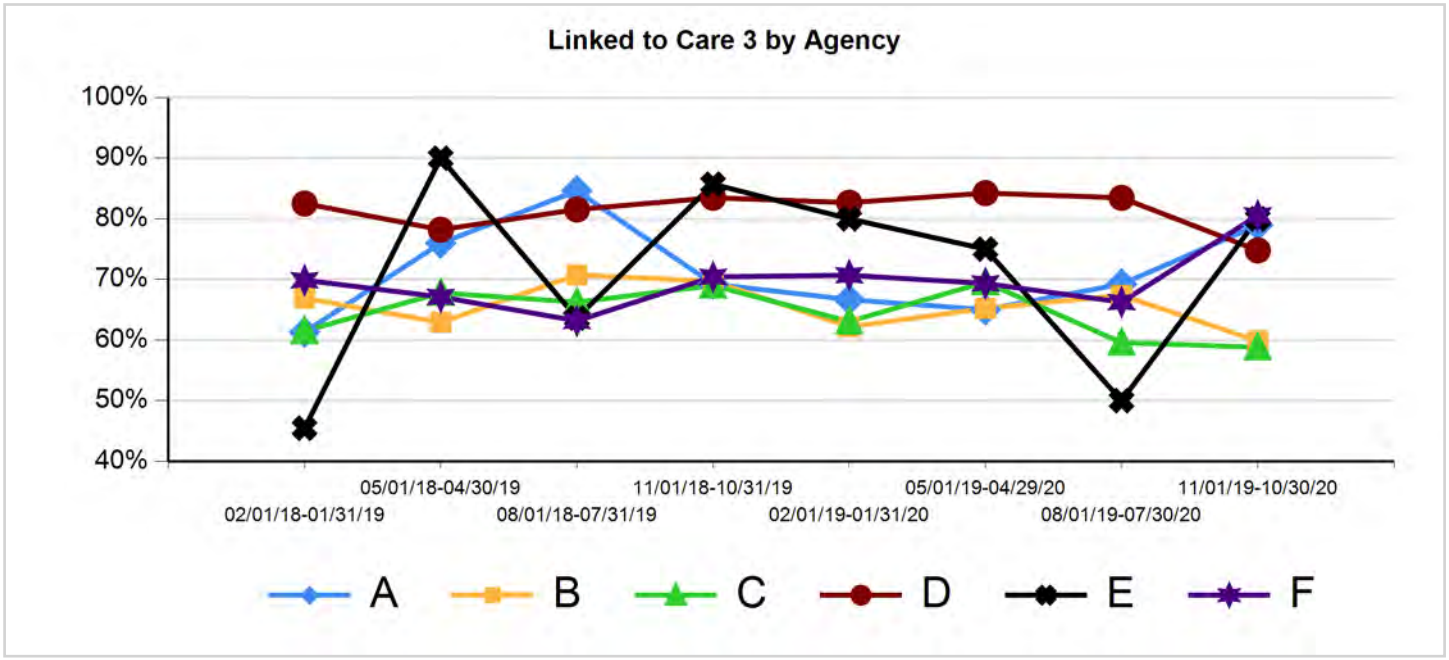
Linked to Care 3				
Medical Visits for Newly Enrolled Clients				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	378	411	373	345
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	546	568	548	521
Percentage	69.2%	72.4%	68.1%	66.2%
Change from Previous Quarter Results	-3.3%	3.1%	-4.3%	-1.8%



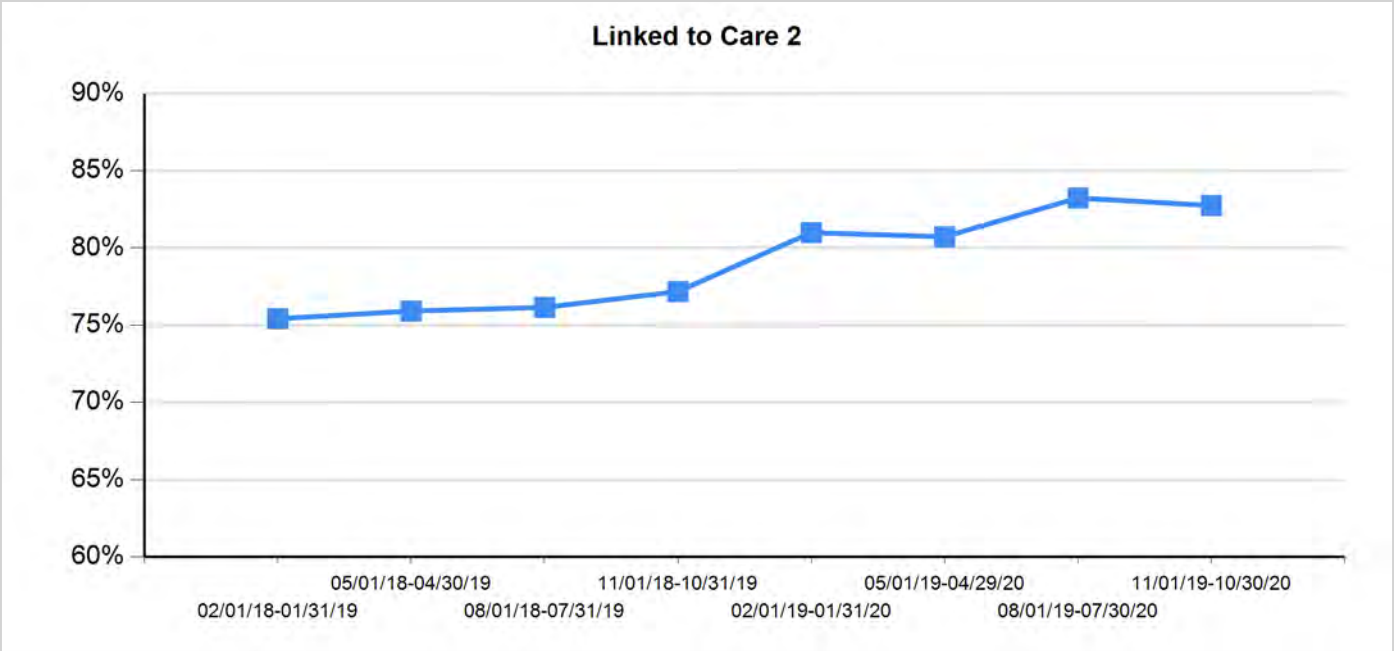
Linked to Care 3 by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	164	189	50	167	145	54	163	131	49
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	244	239	73	248	206	84	255	182	81
Percentage	67.2%	79.1%	68.5%	67.3%	70.4%	64.3%	63.9%	72.0%	60.5%
Change from Previous Quarter Results	5.8%	2.0%	0.8%	0.1%	-8.7%	-4.2%	-3.4%	1.6%	-3.8%



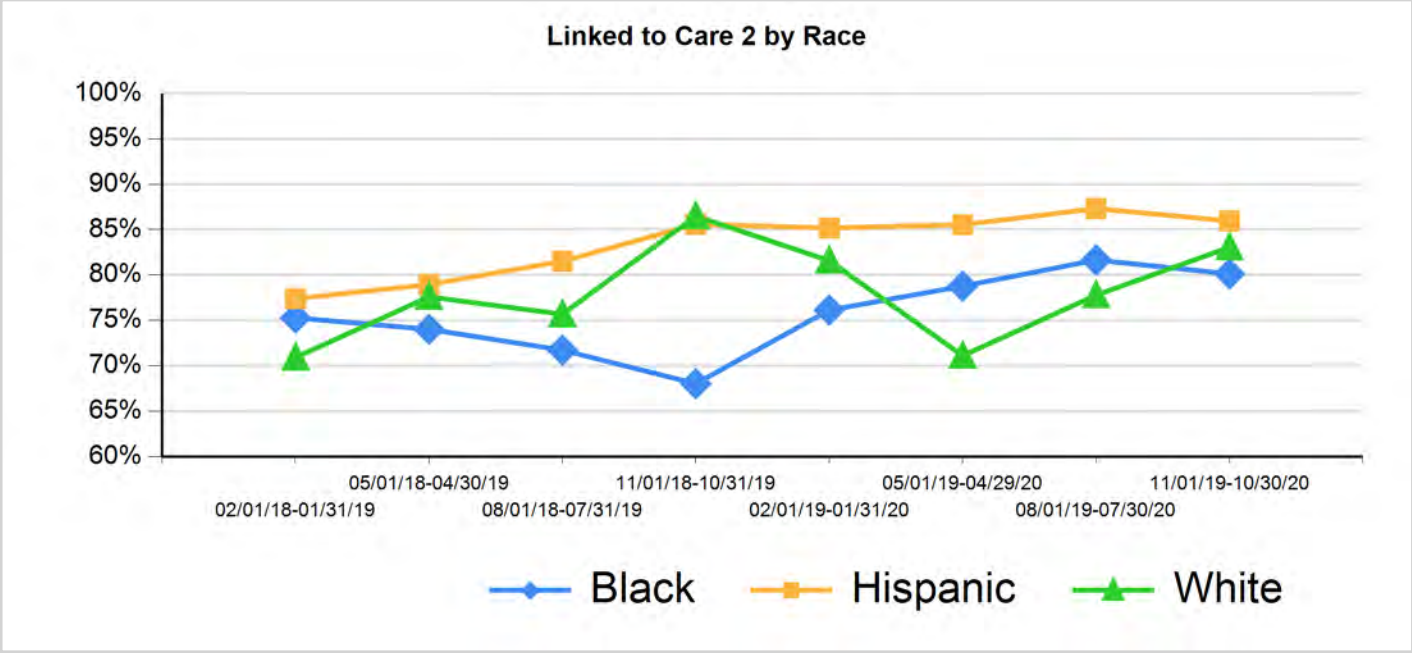
Linked to Care 3 by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	9	95	112	106	2	53	15	79	107	86	4	58
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	13	141	188	127	4	80	19	132	182	115	5	72
Percentage	69.2%	67.4%	59.6%	83.5%	50.0%	66.3%	78.9%	59.8%	58.8%	74.8%	80.0%	80.6%
Change from Previous Quarter Results	4.2%	2.2%	-10.0%	-0.8%	-25.0%	-3.1%	9.7%	-7.5%	-0.8%	-8.7%	30.0%	14.3%



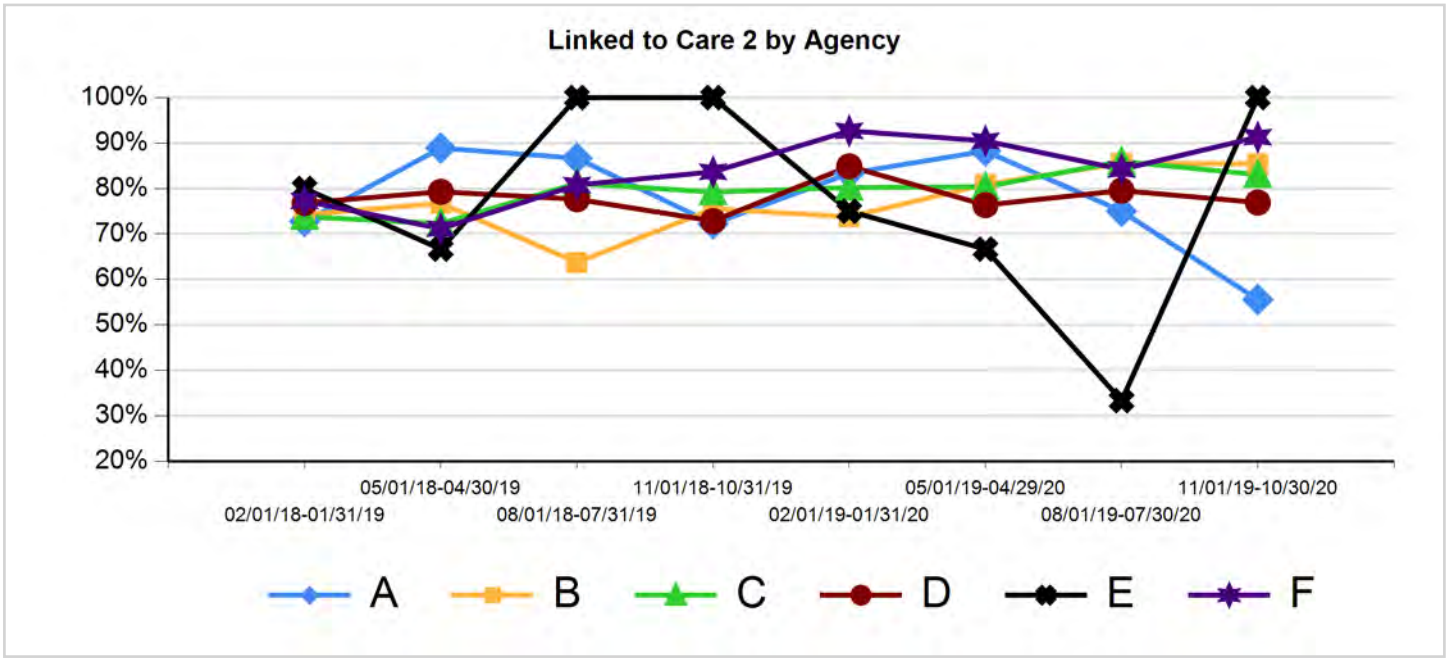
Linked to Care 2				
Viral Load Suppression Measure for Newly Enrolled Clients				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	277	289	288	283
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	342	358	346	342
Percentage	81.0%	80.7%	83.2%	82.7%
Change from Previous Quarter Results	3.8%	-0.3%	2.5%	-0.5%



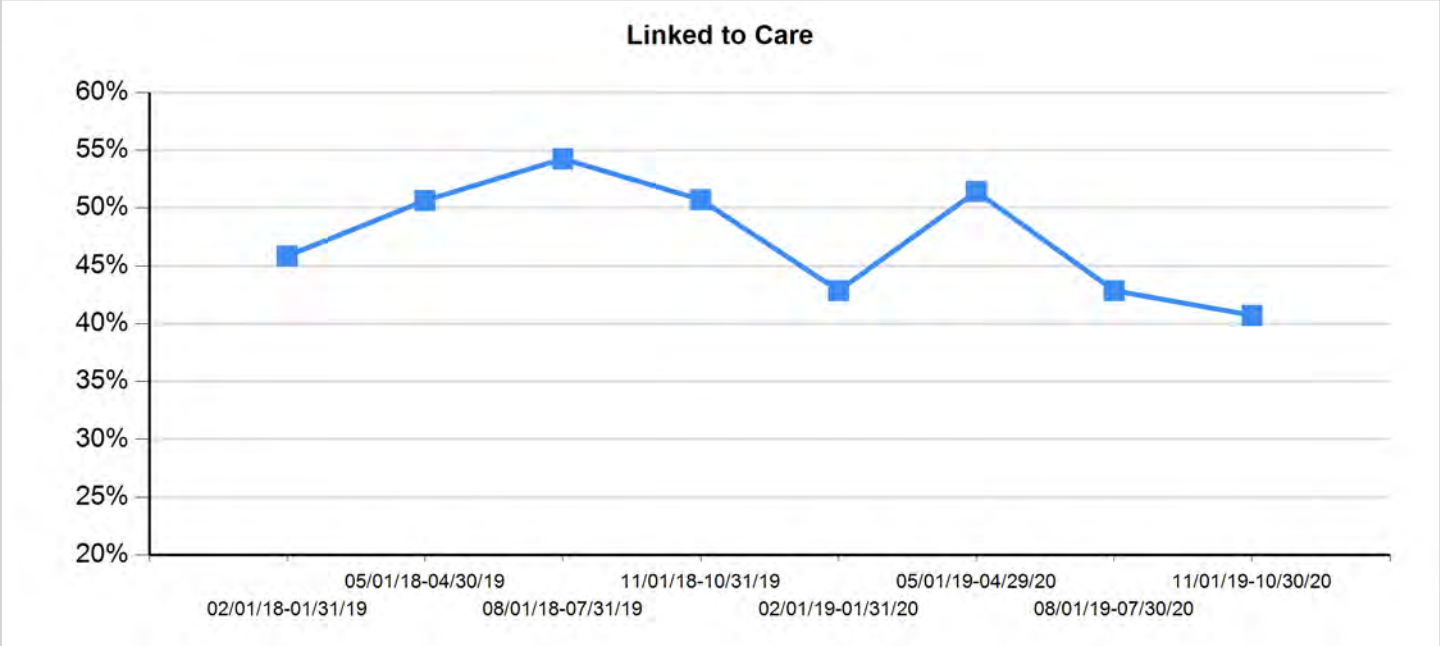
Linked to Care 2 by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	115	136	32	129	117	35	129	104	49
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	146	159	45	158	134	45	161	121	59
Percentage	78.8%	85.5%	71.1%	81.6%	87.3%	77.8%	80.1%	86.0%	83.1%
Change from Previous Quarter Results	2.6%	0.3%	-10.5%	2.9%	1.8%	6.7%	-1.5%	-1.4%	5.3%



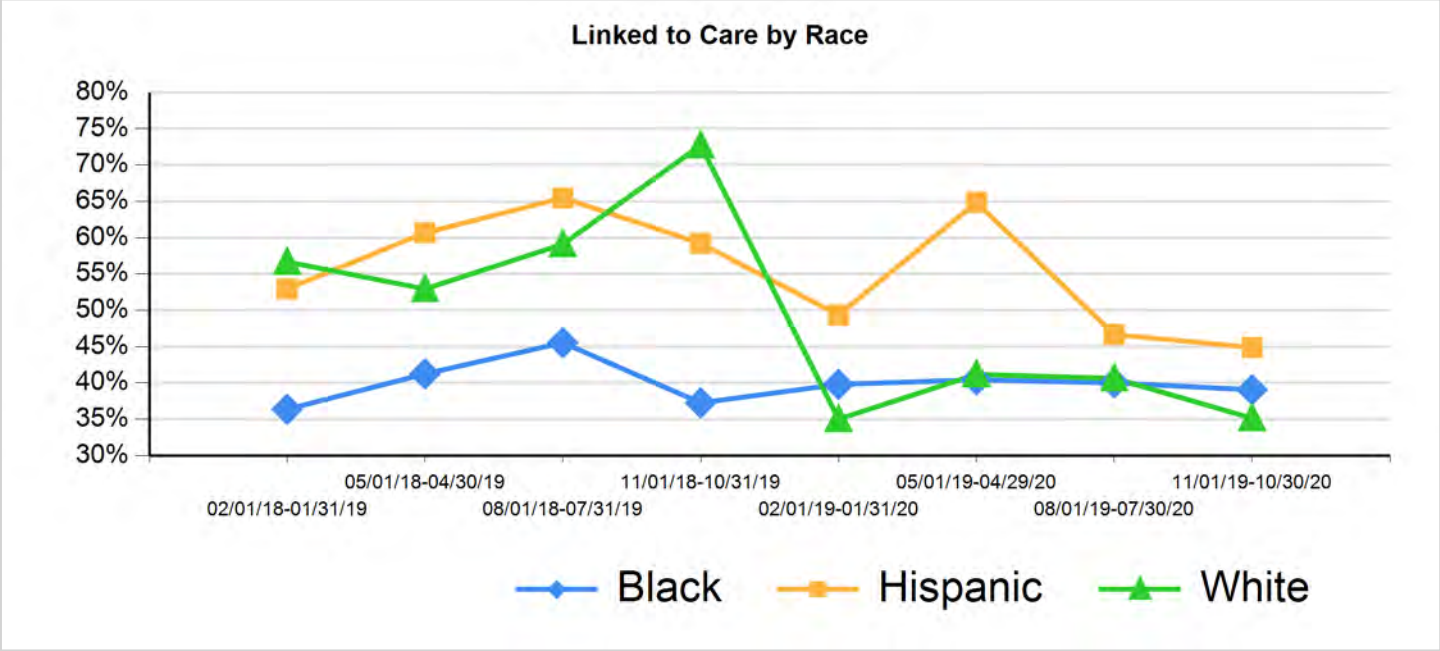
Linked to Care 2 by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	3	71	98	70	1	48	5	82	93	60	3	42
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	4	83	114	88	3	57	9	96	112	78	3	46
Percentage	75.0%	85.5%	86.0%	79.5%	33.3%	84.2%	55.6%	85.4%	83.0%	76.9%	100.0 %	91.3%
Change from Previous Quarter Results	-13.2%	4.6%	5.6%	3.2%	-33.3%	-6.3%	-19.4%	-0.1%	-2.9%	-2.6%	66.7%	7.1%



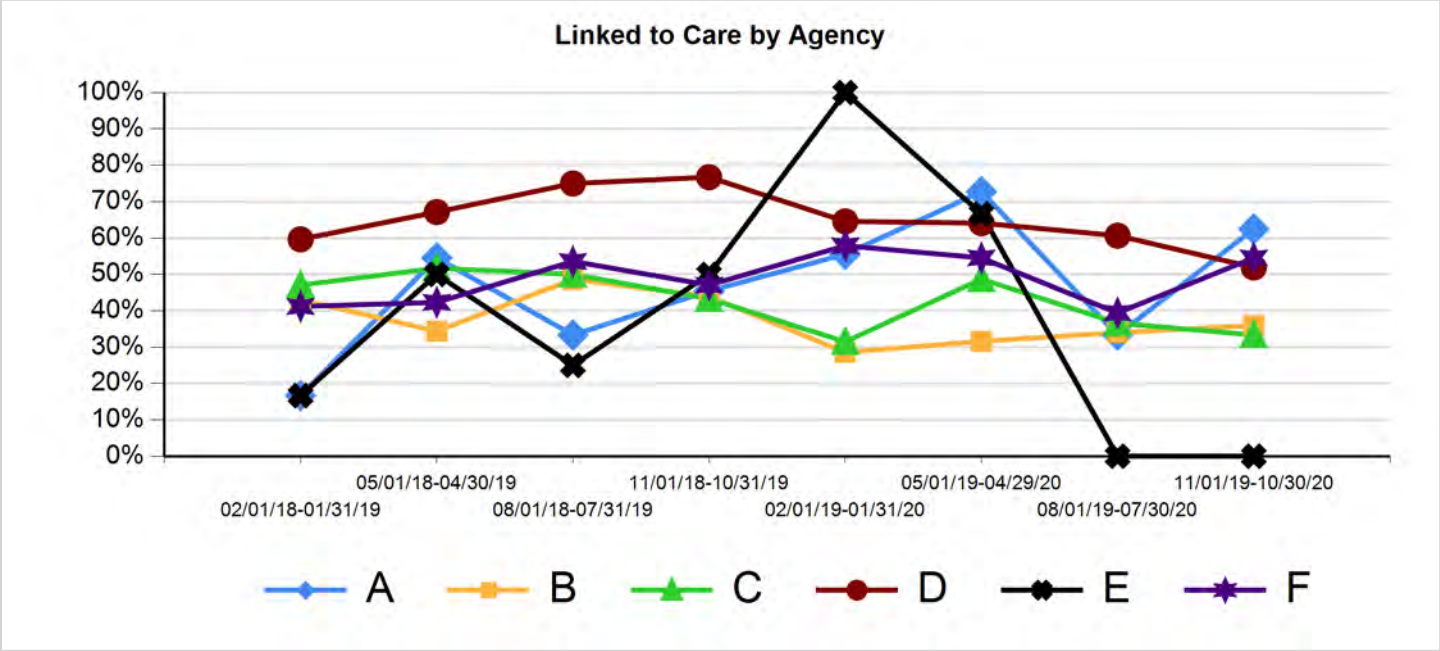
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	87	126	93	90
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	203	245	217	221
Percentage	42.9%	51.4%	42.9%	40.7%
Change from Previous Quarter Results	-7.9%	8.6%	-8.6%	-2.1%
* exclude if vl<200 in 1st 4 months				



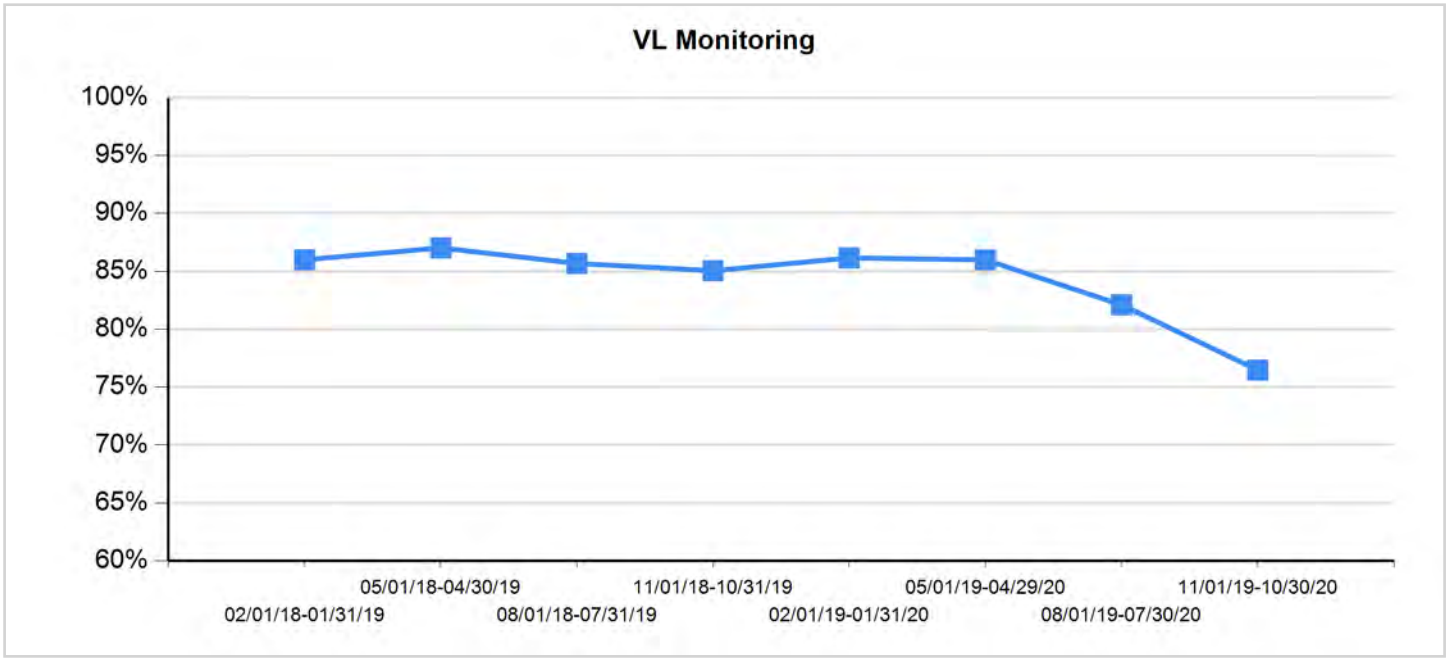
Linked to Care by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	38	72	14	36	42	13	41	35	13
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	94	111	34	90	90	32	105	78	37
Percentage	40.4%	64.9%	41.2%	40.0%	46.7%	40.6%	39.0%	44.9%	35.1%
Change from Previous Quarter Results	0.6%	15.5%	6.2%	-0.4%	-18.2%	-0.6%	-1.0%	-1.8%	-5.5%
* exclude if vl<200 in 1st 4 months									



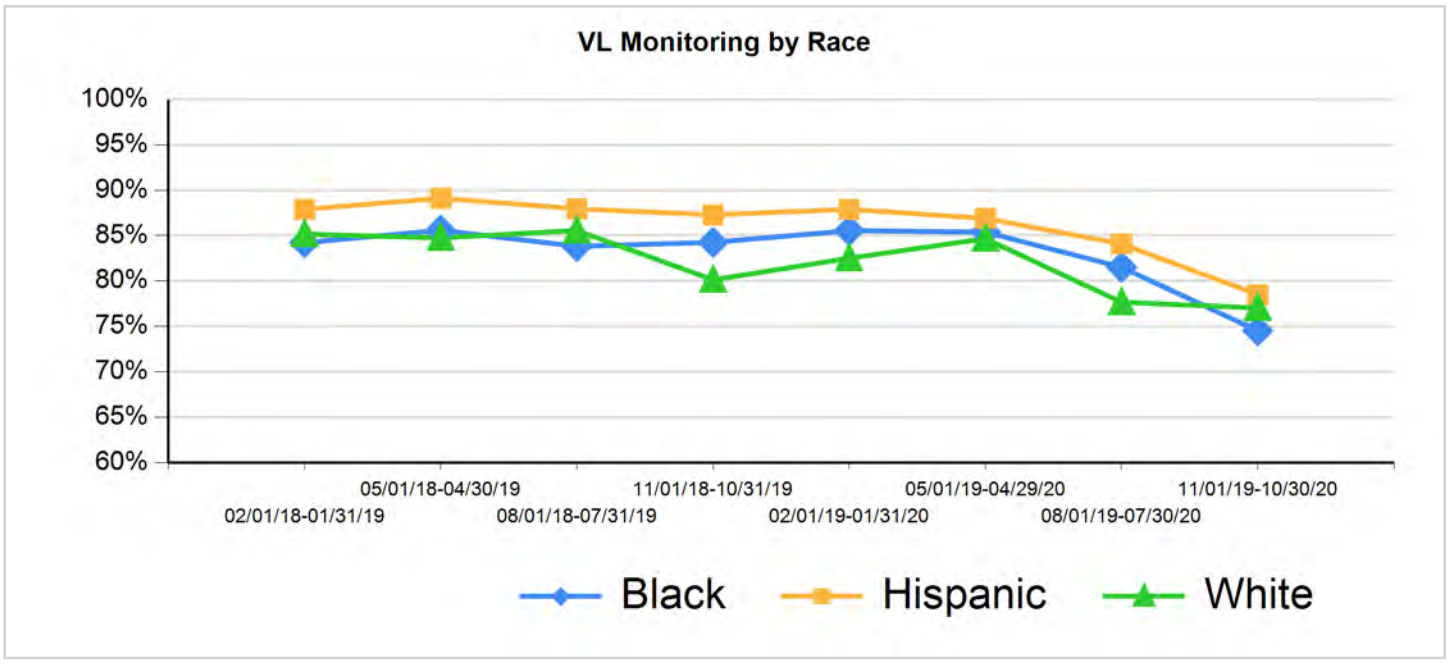
Linked to Care by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	1	17	26	37	0	13	5	23	25	27	0	12
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	3	50	71	61	1	33	8	64	75	52	2	22
Percentage	33.3%	34.0%	36.6%	60.7%	0.0%	39.4%	62.5%	35.9%	33.3%	51.9%	0.0%	54.5%
Change from Previous Quarter Results	-39.4%	2.4%	-12.1%	-3.4%	-66.7%	-15.2%	29.2%	1.9%	-3.3%	-8.7%	0.0%	15.2%
* exclude if vl<200 in 1st 4 months												



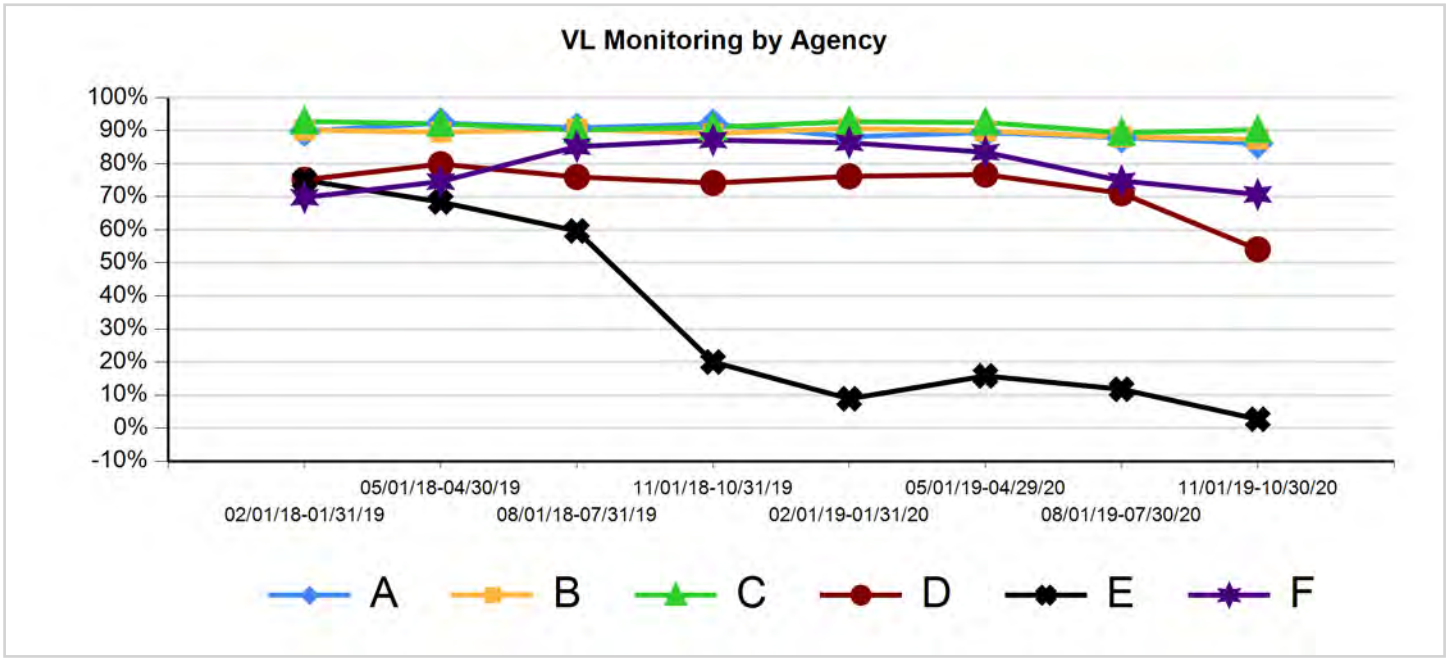
Viral Load Monitoring				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	4,598	4,597	4,233	3,802
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	5,337	5,346	5,156	4,972
Percentage	86.2%	86.0%	82.1%	76.5%
Change from Previous Quarter Results	1.1%	-0.2%	-3.9%	-5.6%



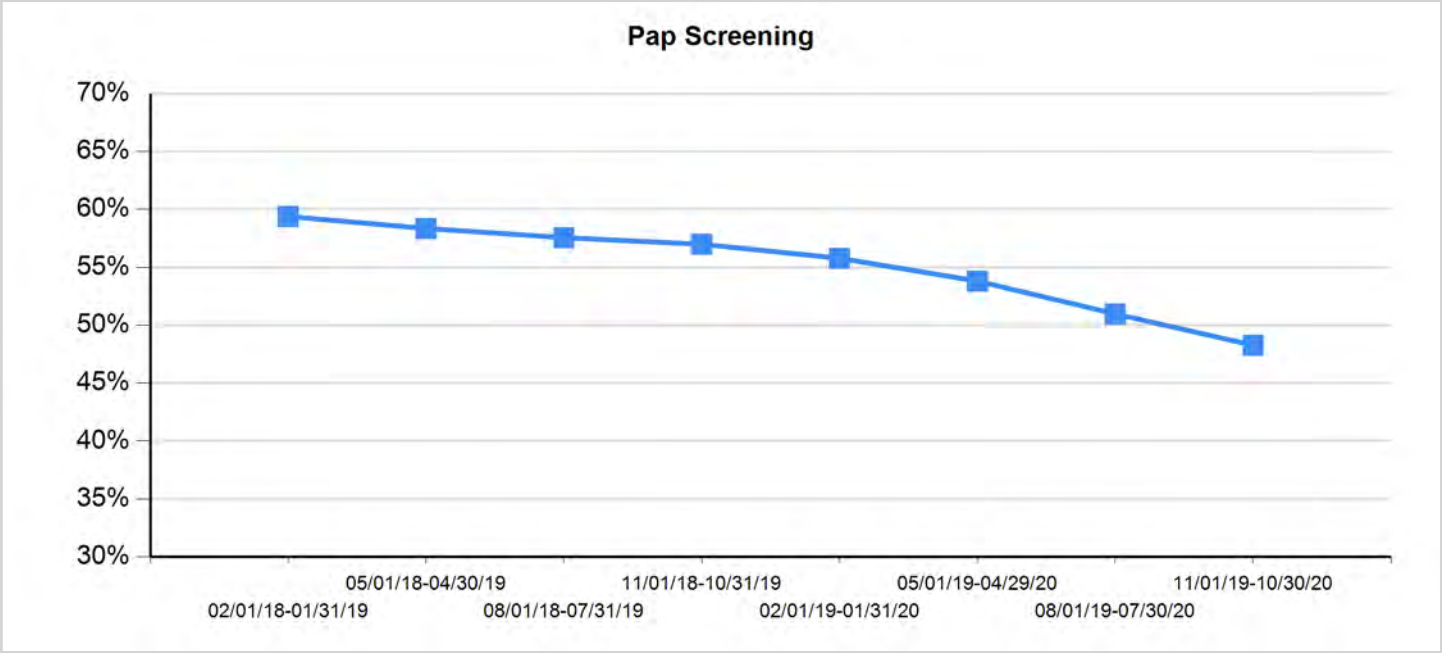
VL Monitoring Data by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	2,045	1,896	541	1,896	1,754	483	1,670	1,610	446
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	2,395	2,182	639	2,326	2,086	622	2,241	2,051	579
Percentage	85.4%	86.9%	84.7%	81.5%	84.1%	77.7%	74.5%	78.5%	77.0%
Change from Previous Quarter Results	-0.2%	-1.0%	2.2%	-3.9%	-2.8%	-7.0%	-7.0%	-5.6%	-0.6%



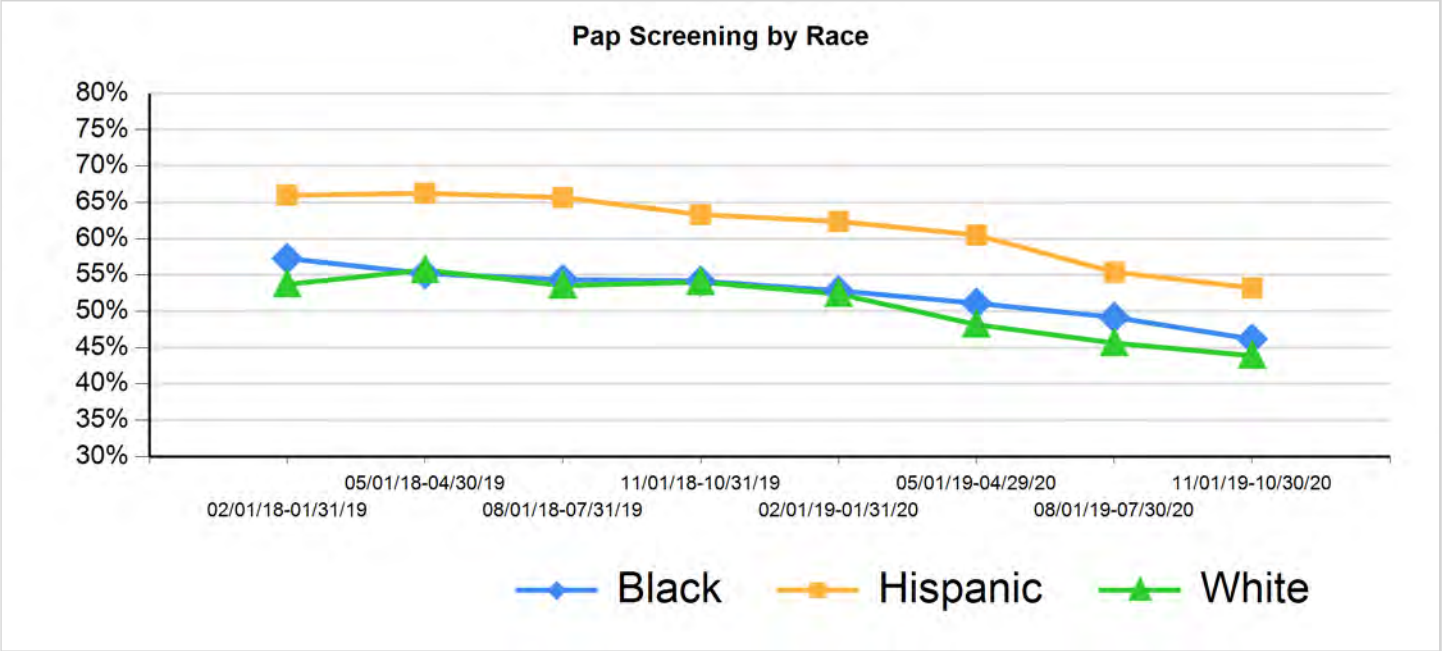
VL Monitoring by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	419	1,136	1,381	1,078	4	202	404	1,042	1,329	801	1	210
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	477	1,290	1,545	1,517	34	270	469	1,191	1,473	1,481	37	297
Percentage	87.8%	88.1%	89.4%	71.1%	11.8%	74.8%	86.1%	87.5%	90.2%	54.1%	2.7%	70.7%
Change from Previous Quarter Results	-1.6%	-1.8%	-3.1%	-5.6%	-4.0%	-8.7%	-1.7%	-0.6%	0.8%	-17.0%	-9.1%	-4.1%



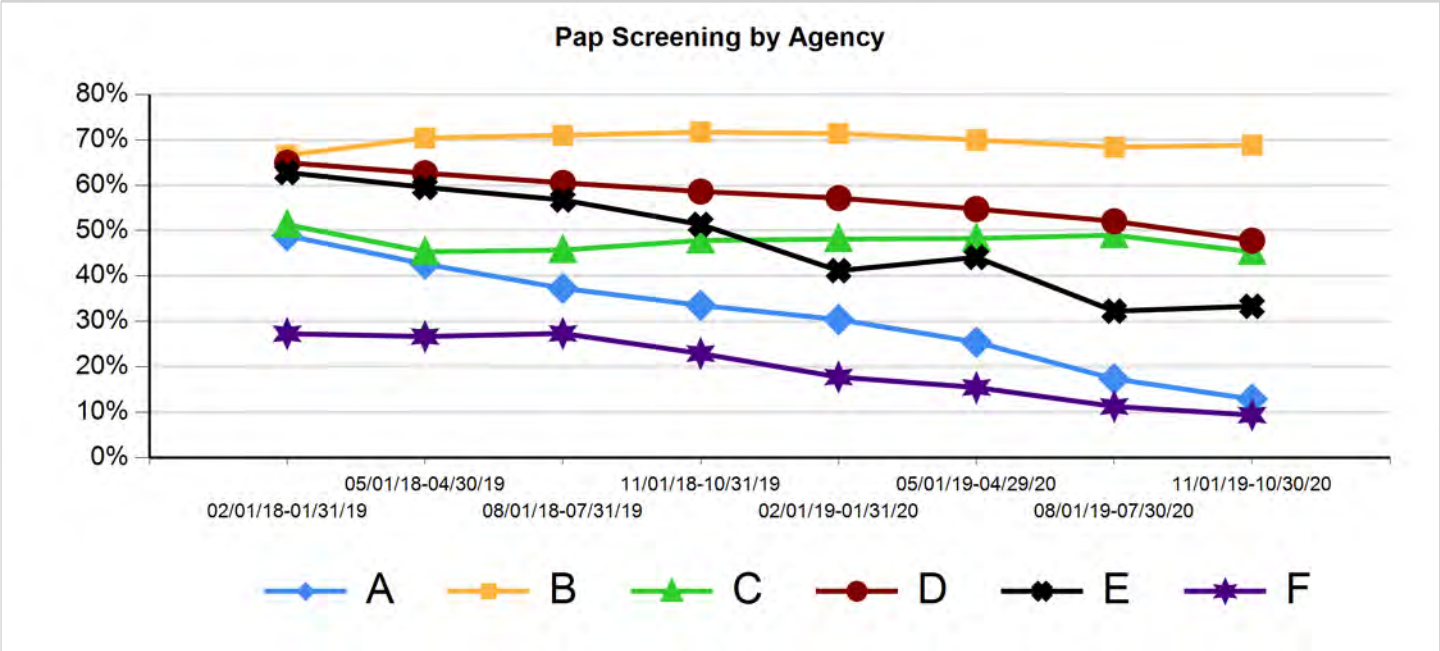
Cervical Cancer Screening				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	1,149	1,116	1,049	975
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	2,060	2,074	2,058	2,020
Percentage	55.8%	53.8%	51.0%	48.3%
Change from Previous Quarter Results	-1.2%	-2.0%	-2.8%	-2.7%



Cervical Cancer Screening Data by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	647	363	79	617	334	73	573	313	68
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,266	600	164	1,255	603	160	1,241	588	155
Percentage	51.1%	60.5%	48.2%	49.2%	55.4%	45.6%	46.2%	53.2%	43.9%
Change from Previous Quarter Results	-1.7%	-1.9%	-4.2%	-1.9%	-5.1%	-2.5%	-3.0%	-2.2%	-1.8%



Cervical Cancer Screening by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	31	563	196	563	10	18	22	530	188	241	11	16
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	179	823	400	509	31	160	171	770	415	504	33	171
Percentage	17.3%	68.4%	49.0%	52.1%	32.3%	11.3%	12.9%	68.8%	45.3%	47.8%	33.3%	9.4%
Change from Previous Quarter Results	-8.1%	-1.6%	0.7%	-2.7%	-11.9%	-4.2%	-4.5%	0.4%	-3.7%	-4.2%	1.1%	-1.9%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v5.0 5/2/19 [MAI=ALL]", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
   A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 19-20
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

Table of Contents

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 661 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, 2019- February 28, 2020. 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.

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.

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 Sample

In order to conduct a thorough and comprehensive review, a total of 661 client records were reviewed across seven agencies for the 2019-2020 grant year. This included eighty-four (84) 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	105	105	105	97	79	86	84

TOTAL 661 (577 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, 2019- February 28, 2020 grant year was queried from the Centralized Patient Care Data Management System data base. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.

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.

HIV MEDICAL # appt	A	B	C	D	E	F	TOTAL	PERCENT
0	10	10	16	16	4	14	70	**12%**
1	22	13	18	4	21	18	96	**17%**
2	39	20	16	8	20	15	118	**20%**
3	34	62	55	69	34	39	293	**51%**
Total	105	105	105	97	79	86	577	

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 (51%), followed by 20% of the clients having 2 appointments in the year.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The number 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) were also recorded.

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 (33%) within the year or more than 5 encounters (26%).

*"Overall, the average number of case management encounters for the entire sample was **three (3)**."*

CASE MGMNT # appointments	A	B	C	D	E	F	G	TOTAL	PERCENT
1	39	32	36	31	30	27	25	220	**33%**
2	24	26	19	16	15	12	11	123	**19%**
3	18	13	14	13	10	13	6	87	**13%**
4	11	8	10	12	7	6	3	57	**9%**
5	13	26	26	25	17	28	39	174	**26%**
Total	105	105	105	97	79	86	84	661	

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."

SUPPRESSION STATUS	A	B	C	D	E	F	TOTAL	PERCENT
Suppressed for all labs	69	64	68	54	51	64	370	**64%**
Mixed status	10	12	9	13	14	6	64	**11%**
Unknown (no recent labs on file)	13	10	18	18	7	13	79	**14%**
Unsuppressed for all labs	13	19	10	12	7	3	64	**11%**
Total	105	105	105	97	79	86	577	

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate of 64%. 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.

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	PERCENT
New to Care	4	2	7	4	6	5	28	5%
Lost to Care	7	12	13	3	3	8	46	8%
Re-engaged in Care	7	14	8	6	10	0	45	8%
Both New and later Lost to Care in the same review year	1	0	1	0	0	0	2	<1%
Re-engaged and later lost again	1	3	0	3	0	2	9	2%
N/A	85	77	76	80	60	71	449	78%
total	105	106	105	97	79	86	577	

Overall, 5% of the sample was considered New to Care, 8% was Lost to Care, and 8% was Re-engaged in Care.

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.

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 USE DISORDER (history or active)

Any diagnosis of a mental health disorder (MH) or substance use disorder issue (SUD) was recorded in the chart review tool, including a history of mental illness or substance use. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SUD 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 SUD, 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 SUD issues. Any conditions other than alcohol misuse, other SUD, 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.

Diagnosis or Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Alcohol abuse/dependence	5	6	3	4	3	3	11	35	**5%**
Other Substance dependence	17	18	19	16	11	4	19	104	**16%**
Depression	25	41	32	26	13	15	39	191	**29%**
Bipolar disorder	10	6	4	5	4	3	12	44	**7%**
Anxiety	4	21	11	16	8	12	29	101	**15%**
Schizophrenia	4	1	2	0	0	2	6	15	**2%**
Other	11	16	16	29	4	4	15	95	**14%**

Overall, 41% 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 SUD issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE USE DISORDER REFERRALS

For clients with an *active* diagnosis of a mental health or SUD issue, the chart abstractor recorded if they were referred or already engaged in MH/SUD 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%.

MH referral	A	B	C	D	E	F	TOTAL	PERCENT
N/A	70	54	65	56	57	63	365	**63%**
Yes	28	42	34	34	20	19	177	**31%**
No	7	9	6	7	2	4	35	**6%**
Total	105	105	105	97	79	86	577	

Overall, 63% of the sample would not have been appropriate for a MH or SUD referral based on the information available in their medical record. An additional 31% either did receive a referral or were already engaged in treatment and 6% did not receive a referral.

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 24% and 23% prevalence within the sample, respectively. Obesity was the most common co-occurring condition that was coded in the "Other" category.

Medical Condition	A	B	C	D	E	F	TOTAL	PERCENT
Smoking (hx or current)	54	31	18	12	10	5	130	**23%**
Opportunistic Infection	3	2	1	1	1	2	10	**2%**
STIs	20	37	28	19	23	9	136	**24%**
Diabetes	16	18	9	11	3	9	66	**11%**
Cancer	1	1	0	0	0	0	2	**0%**
Hepatitis	18	8	3	3	2	3	37	**6%**
Hypertension	43	24	20	22	9	17	135	**23%**
Other	8	33	21	24	11	30	127	**22%**

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.

Social Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Homelessness or housing-related issues	6	14	5	4	10	1	6	46	**7%**
Pregnancy or pregnancy-related issues	0	0	1	0	4	2	0	7	**1%**
Recently released	4	3	4	2	3	0	2	18	**3%**
Intimate Partner Violence	1	2	2	1	2	2	12	22	**3%**

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	PERCENT
0	4	13	16	31	5	21	26	116	**18%**
1	1	24	21	12	10	36	23	127	**19%**
2	1	0	3	1	0	4	6	15	**2%**
N/A	99	68	65	53	64	25	31	405	**61%**
Total	105	105	105	97	79	86	84	661	

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 above, 61% of the sample did not work with a Medical Case Manager within the year. 18% of the sample received zero comprehensive assessments, 19% received one, and 2% received two.

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, 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	PERCENT
0	4	22	26	33	6	29	29	149	**23%**
1	2	15	11	10	9	29	20	96	**15%**
2	0	0	3	1	0	3	6	13	**2%**
N/A	99	68	65	53	64	25	31	405	**61%**
Total	105	105	105	97	79	86	84	661	

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.

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	PERCENT
0	20	33	53	63	5	52	226	**39%**
1	50	43	31	12	47	13	196	**34%**
2	8	1	4	0	4	1	18	**3%**
N/A	27	28	17	22	23	20	137	**24%**
Total	105	105	105	97	79	86	577	

Completion of brief assessments were recorded, along with any justification of why an assessment was not completed if one would have been expected. 24% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 39% of the sample received zero brief assessments, 34% received one, and 3% received two.

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 most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Medication Adherence Counseling, 5) Mental Health, and (6) Insurance. 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. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" and "Medication Adherence Counseling" 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	A	B	C	D	E	F	G	TOTAL	PERCENT
Medical/Medication	30	17	25	10	38	18	9	147	22%
Vaccinations	5	1	2	0	2	1	0	11	2%
Nutrition/Food Pantry	0	13	4	1	21	4	5	48	7%
Dental	13	22	11	2	30	10	8	96	15%
Vision	13	18	10	3	28	13	3	88	13%
Hearing Care	0	1	0	0	5	1	3	10	2%
Home Health Care	0	1	0	1	4	0	2	8	1%
Basic Necessities/Life Skills	2	11	1	1	8	2	1	26	4%
Mental Health	5	19	9	8	23	13	12	89	13%
Substance Use Disorder	1	8	2	3	8	2	1	25	4%
Abuse	0	0	3	1	4	1	1	10	2%
Housing/Living Situation	3	12	6	5	18	6	18	68	10%
Support Systems	1	5	2	3	14	1	6	32	5%
Child Care	0	0	0	0	0	1	1	2	0%
Insurance	8	6	14	4	33	10	9	84	13%
Transportation	25	12	6	7	17	7	2	76	11%
HIV-Related Legal Assistance	0	2	2	2	2	0	3	11	2%
Cultural/Linguistic	0	0	0	2	1	4	0	7	1%
Self-Efficacy	0	0	0	2	4	2	2	10	2%
HIV Education/Prevention	3	4	3	4	11	1	1	27	4%
Family Planning/ Safer Sex	2	6	4	1	10	1	1	25	4%
Employment	0	3	4	4	9	4	3	27	4%
Education/Vocation	0	0	0	2	7	0	5	14	2%
Financial Assistance	1	5	3	0	16	6	6	37	6%
Medication Adherence Counseling	7	18	18	8	37	19	6	113	17%
Client Strengths	0	1	0	0	3	0	3	7	1%

Conclusion

The 2019-2020 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 most common co-occurring conditions were: Sexually Transmitted Infections (24%), Depression (29%), and Hypertension (23%). Diabetes and Obesity were also relatively common and providing overview information on nutrition counseling may be a useful topic for future frontline case management trainings. The prevalence of complex co-morbidities 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 (51%) of the clients in the sample had at least three HIV-related primary care appointments within the review year. Case Management staff demonstrated a high level of coordination of care in many areas. For example, 88% 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. 87% 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.

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

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

ASSESSMENTS & SERVICE PLANS

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

Domain	MOST RECENT ASSESSMENT TYPE (circle one)		Comprehensive		Brief	NEXT MOST RECENT ASSESSMENT TYPE (circle one)		Comprehensive		Brief
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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Primary Care Chart Review Report FY 2019

Ryan White Part A Quality Management Program – Houston EMA

November 2020

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2019, 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 30, 2019, 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 3/1/19 and 2/29/20. 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 most current *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* 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 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 8,174 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 3/1/19 and 2/29/20. The medical charts of 635 clients were used in this review, representing 7.8% 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 42.7% 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 3/1/19-2/28/20

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	334	52.6%	6,046	74%
Female	271	42.7%	1,976	24.2%
Transgender Male to Female	30	4.7%	151	1.9%
Transgender Female to Male	0	0%	1	.01%
TOTAL	**635**		**8,174**	
Race				
Asian	9	1.4%	111	1.4%
African-Amer.	302	47.6%	4,002	49%
Pacific Islander	0	0%	7	.1%
Multi-Race	2	.3%	65	.8%
Native Amer.	2	.3%	28	.3%
White	320	50.4%	3,961	48.5%
TOTAL	**635**		**8,174**	
Hispanic				
Non-Hispanic	388	61.1%	5,105	62.5%
Hispanic	247	38.9%	3,069	37.6%
TOTAL	**635**		**8,174**	
Age				
<=24	24	3.8%	420	5.1%
25-34	177	27.9%	2,385	29.2%
35-44	160	25.2%	2,290	28%
45-49	82	12.9%	981	12%
50-64	184	29%	1,982	24.2%
65 and older	8	1.3%	116	1.4%
Total	**635**		**8,174**	

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

Findings

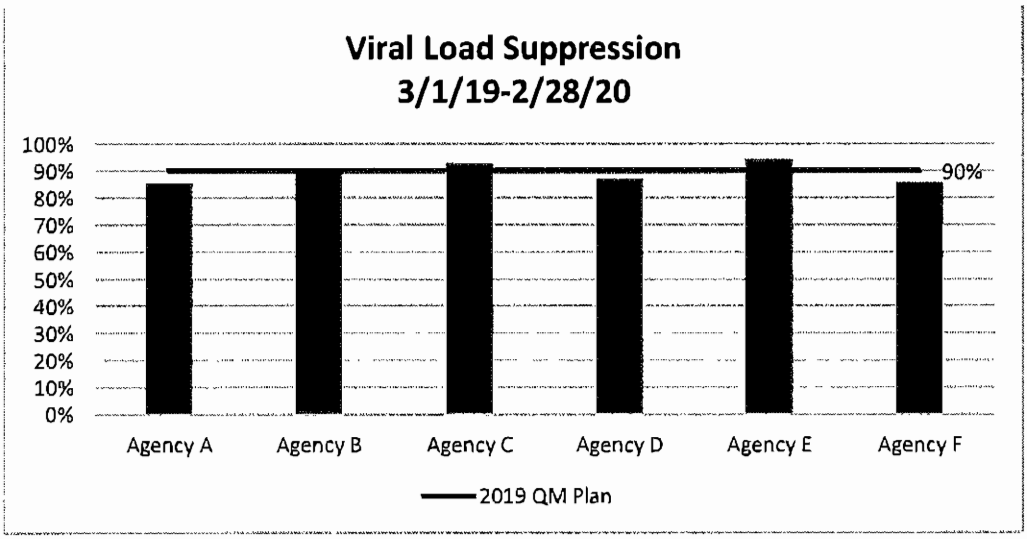
Core Performance Measures

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

	2017	2018	2019
Number of clients with viral load below limits of quantification at last test during the measurement year	535	553	559
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	626	630	625
Rate	**85.5%**	**87.8%**	**89.4%**
	-3%	**2.3%**	**1.6%**

2019 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	230	227	92
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	266	246	102
Rate	**86.5%**	**92.3%**	**90.2%**



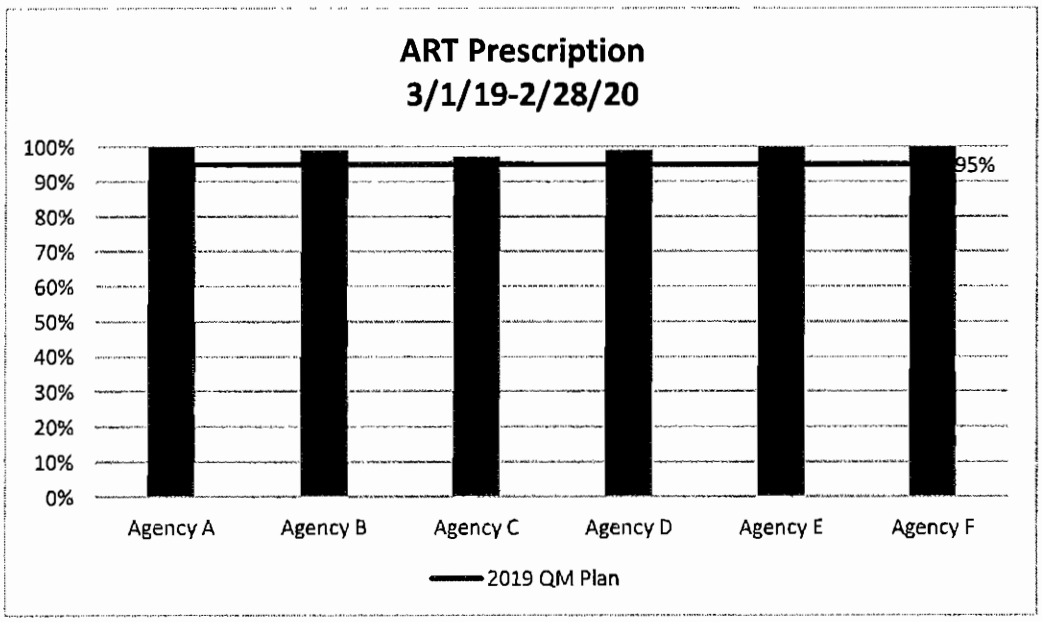
ART Prescription

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

	2017	2018	2019
Number of clients who were prescribed an ART regimen within the measurement year	627	631	627
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	**98.7%**	**99.4%**	**98.7%**
Change from Previous Years Results	**1.1%**	**.7%**	**-.7%**

- Of the 8 clients not on ART, none had a CD4 <200, 5 were elite controllers/long-term non-progressors, and 3 refused

2019 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	267	247	102
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	272	247	105
Rate	**98.2%**	**100%**	**97.1%**

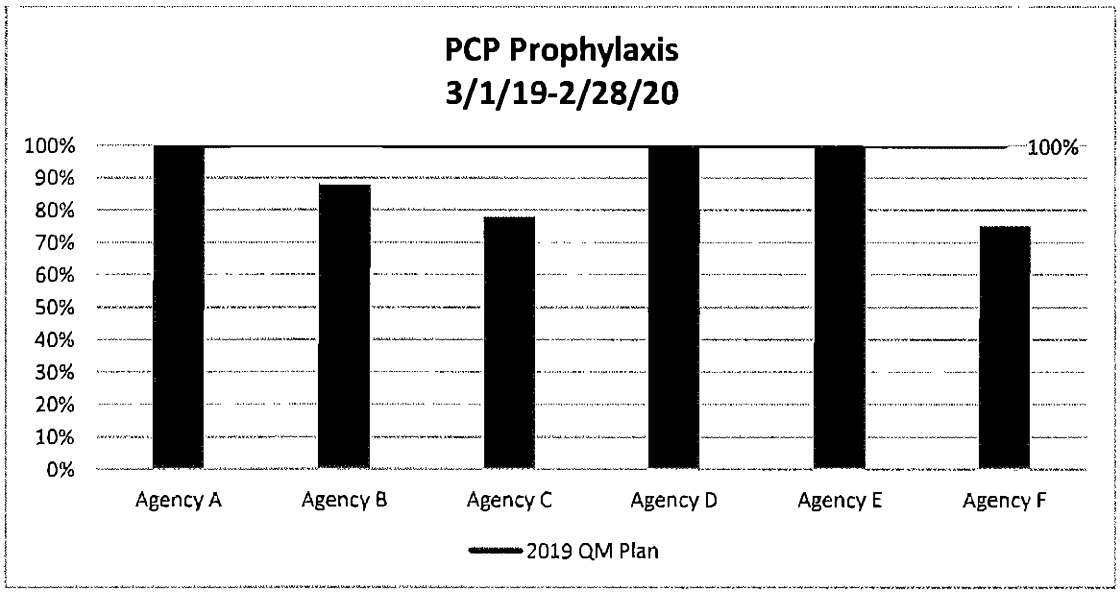


PCP Prophylaxis

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

	2017	2018	2019
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	53	62	34
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	57	66	38
Rate	**93%**	**93.9%**	**89.5%**
Change from Previous Years Results	**-7%**	**.9%**	**-4.4%**

2019 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	11	14	6
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	12	17	6
Rate	**91.7%**	**82.4%**	**100%**



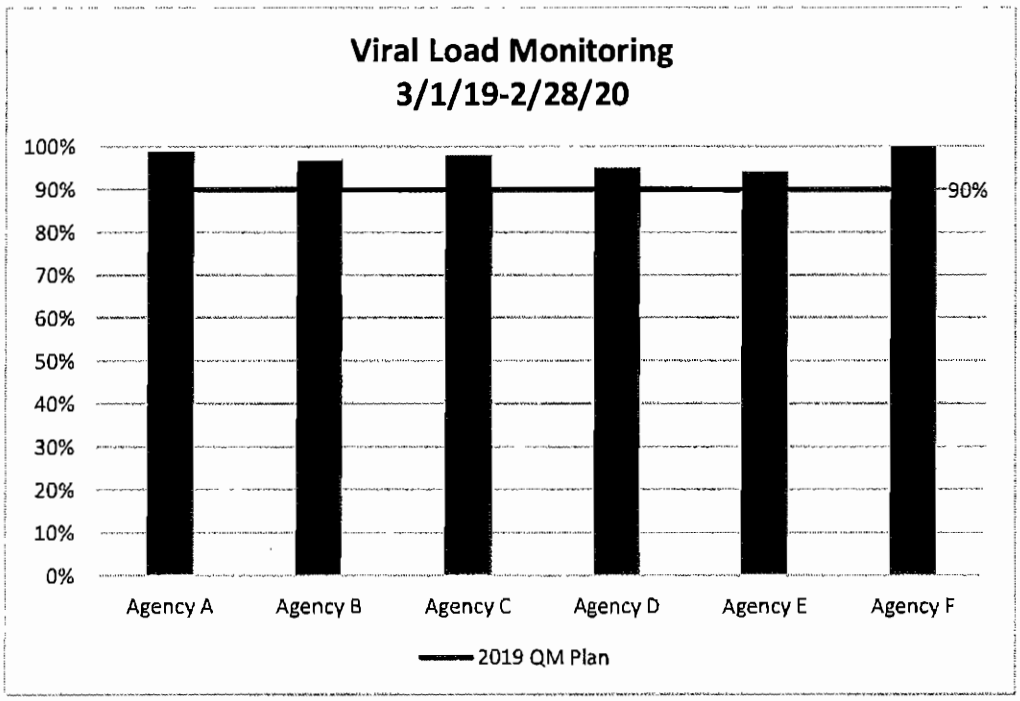
All Ages Performance Measures

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

	2017	2018	2019
Number of clients who had a viral load test performed at least every six months during the measurement year	622	624	619
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	**98%**	**98.3%**	**97.5%**
Change from Previous Years Results	**3.4%**	**.3%**	**-.8%**

2019 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	262	246	100
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	272	247	105
Rate	**96.3%**	**99.6%**	**95.2%**



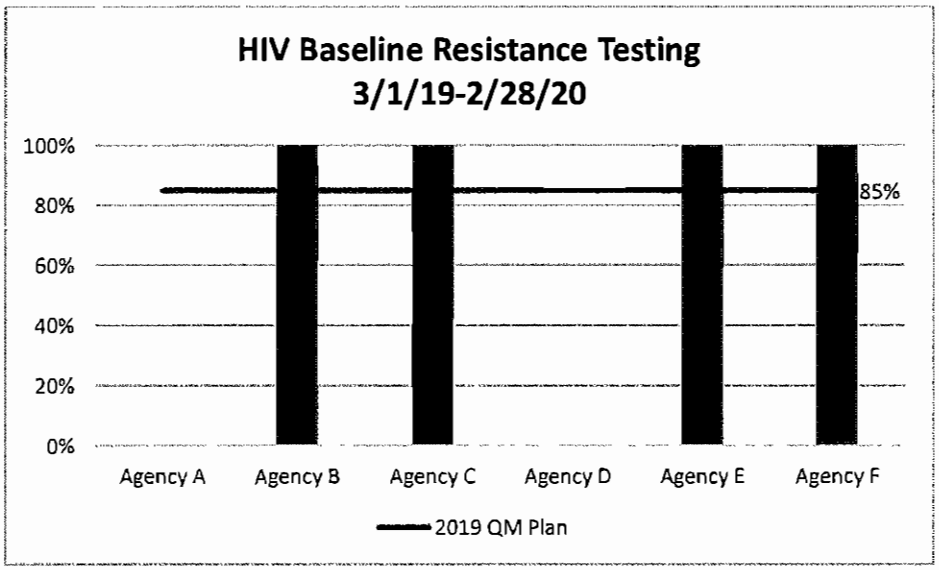
HIV Drug Resistance Testing Before Initiation of Therapy

- 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

	2017	2018	2019
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	5	6	5
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	7	8	7
Rate	**71.4%**	**75%**	**71.4%**
Change from Previous Years Results	**2.2%**	**3.6%**	**-3.6%**

2019 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	3	1
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	2	4	1
Rate	**50%**	**75%**	**100%**

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



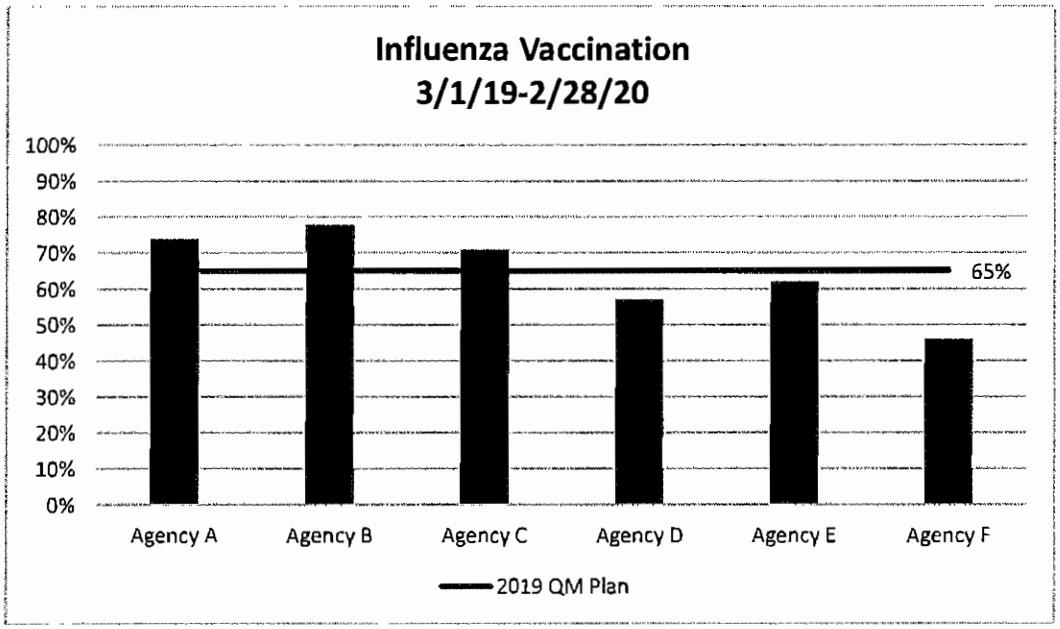
Influenza Vaccination

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

	2017	2018	2019
Number of clients who received influenza vaccination within the measurement year	310	336	362
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	579	534	531
Rate	**53.5%**	**62.9%**	**68.2%**
Change from Previous Years Results	**.4%**	**9.4%**	**5.3%**

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

2019 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	124	168	62
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	212	215	93
Rate	**58.5%**	**78.1%**	**66.7%**

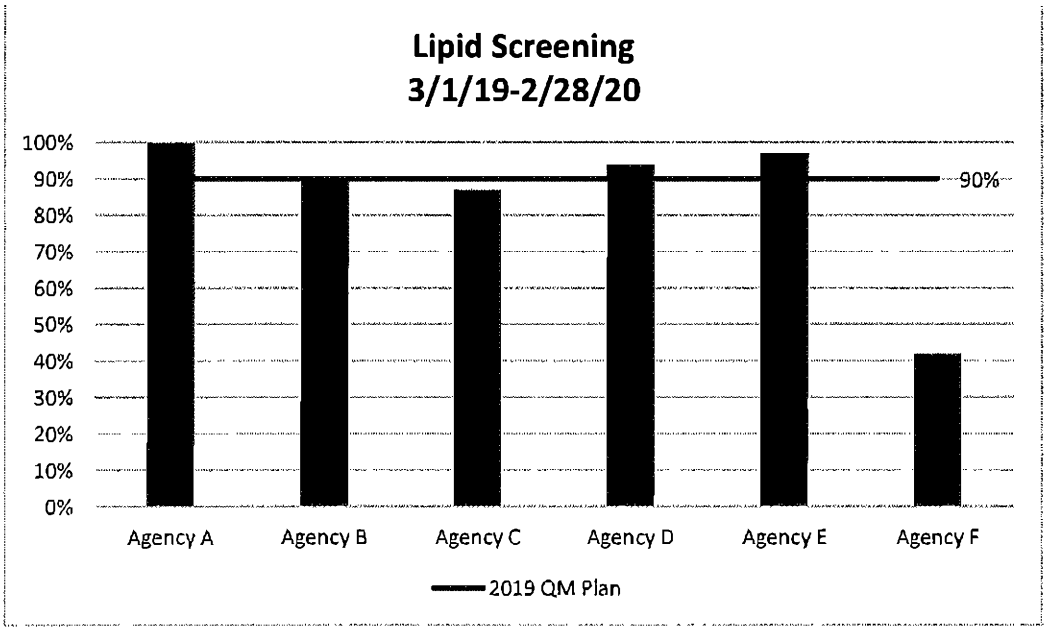


Lipid Screening

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

	2017	2018	2019
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	557	567	554
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	627	631	627
Rate	**88.8%**	**89.9%**	**88.4%**
Change from Previous Years Results	**-.1%**	**1.1%**	**-1.5%**

2019 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	236	216	91
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	267	247	102
Rate	**88.4%**	**87.4%**	**89.2%**

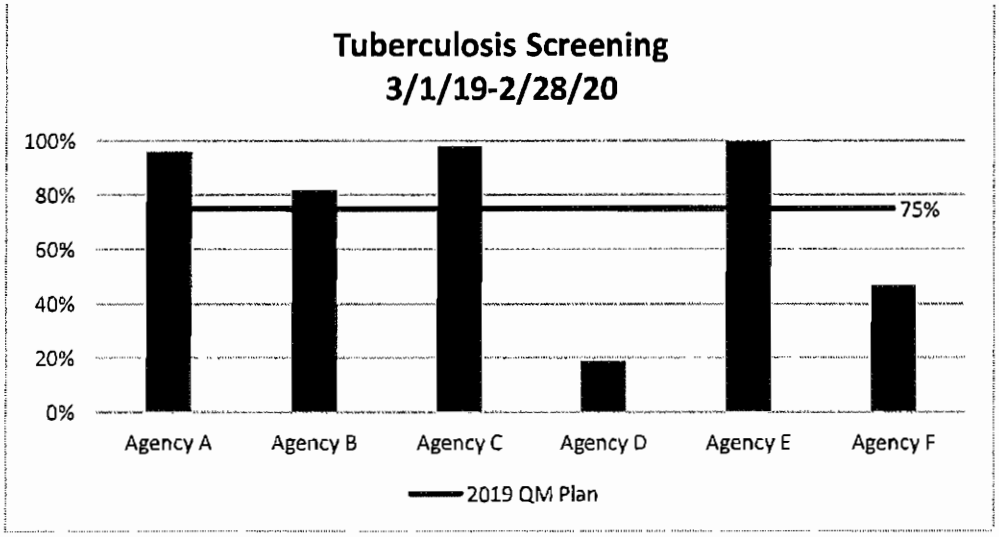


Tuberculosis Screening

- 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

	2017	2018	2019
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	375	401	426
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.	558	565	570
Rate	**67.2%**	**71%**	**74.7%**
Change from Previous Years Results	**.3%**	**3.8%**	**3.7%**

2019 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	164	173	79
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.	250	213	97
Rate	**65.6%**	**81.2%**	**81.4%**



Adolescent/Adult Performance Measures

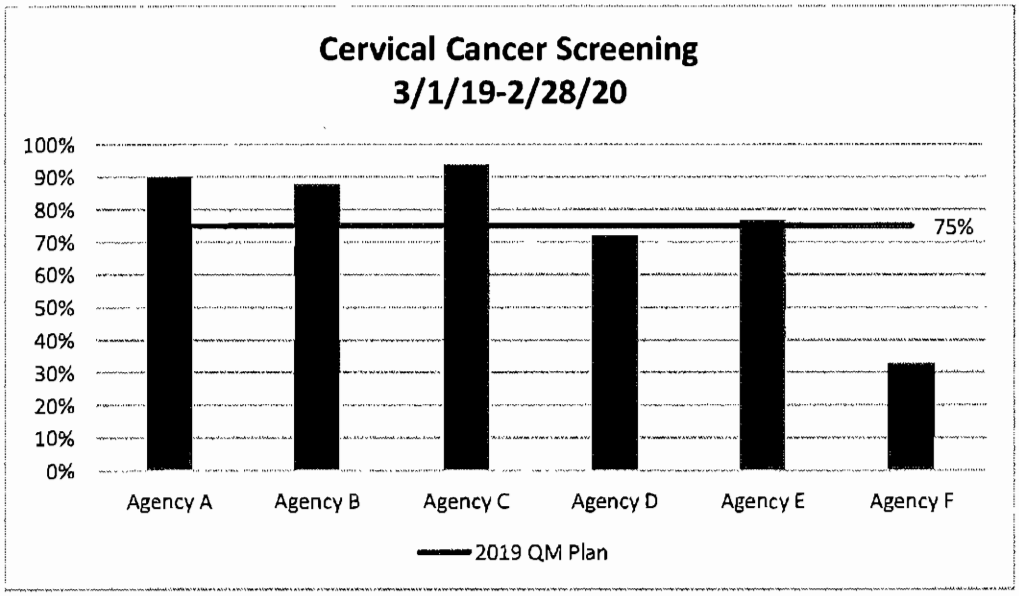
Cervical Cancer Screening

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

	2017	2018	2019
Number of female clients who had Pap screen results documented in the previous three years	226	199	214
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*	274	244	260
Rate	**82.5%**	**81.6%**	**82.3%**
Change from Previous Years Results	**2.4%**	**-.9%**	**.7%**

- 16.4% (35/214) of pap smears were abnormal

2019 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	131	70	11
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	148	90	19
Rate	**88.5%**	**77.8%**	**57.9%**



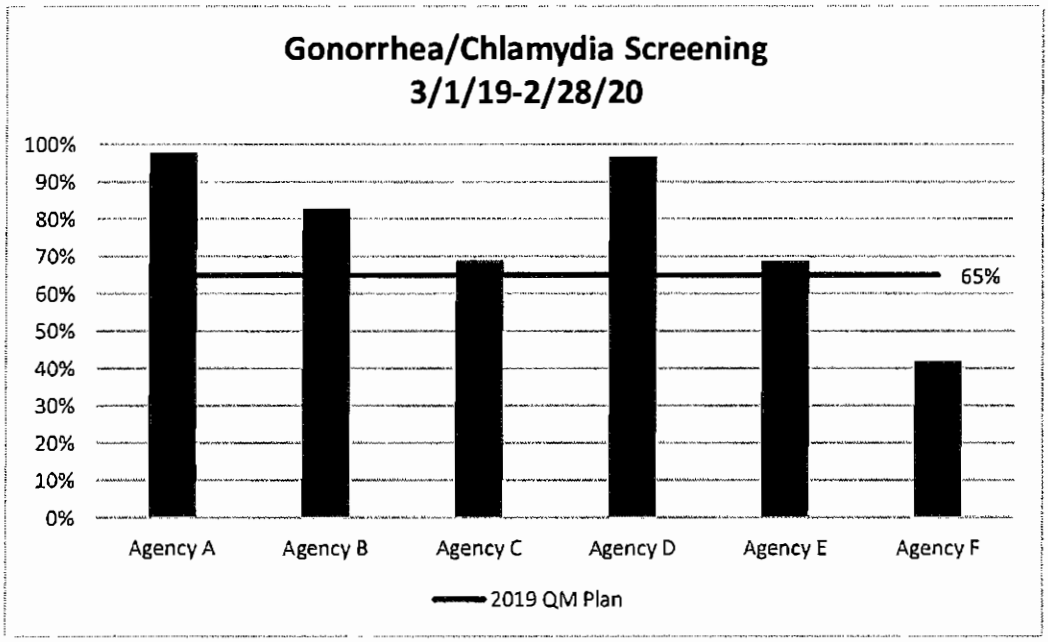
Gonorrhea/Chlamydia Screening

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

	2017	2018	2019
Number of clients who had a test for Gonorrhea/Chlamydia	493	501	506
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**77.6%**	**78.9%**	**79.7%**
Change from Previous Years Results	**4.7%**	**1.3%**	**.8%**

- 24 cases of chlamydia and 23 cases of gonorrhea were identified

2019 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	224	195	79
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	272	247	105
Rate	**82.4%**	**78.9%**	**75.2%**



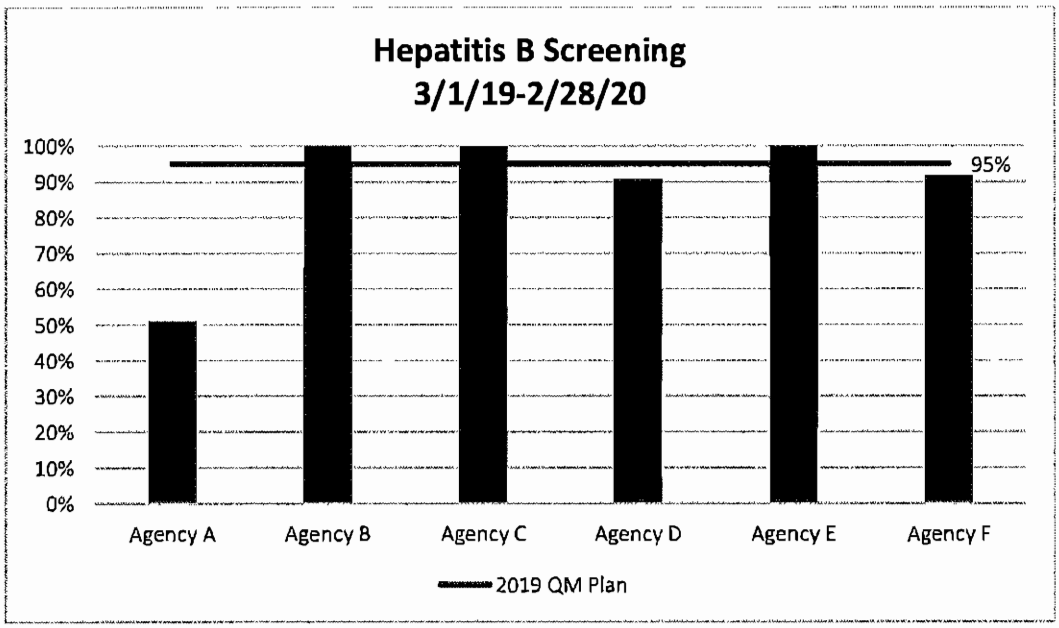
Hepatitis B Screening

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

	2017	2018	2019
Number of clients who have documented Hepatitis B infection status in the health record	553	577	571
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	**87.1%**	**90.9%**	**89.9%**
Change from Previous Years Results	**-9%**	**3.8%**	**-1%**

- 1.3% (8/635) were Hepatitis B positive

2019 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	252	215	93
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	272	247	105
Rate	**92.6%**	**87%**	**88.6%**

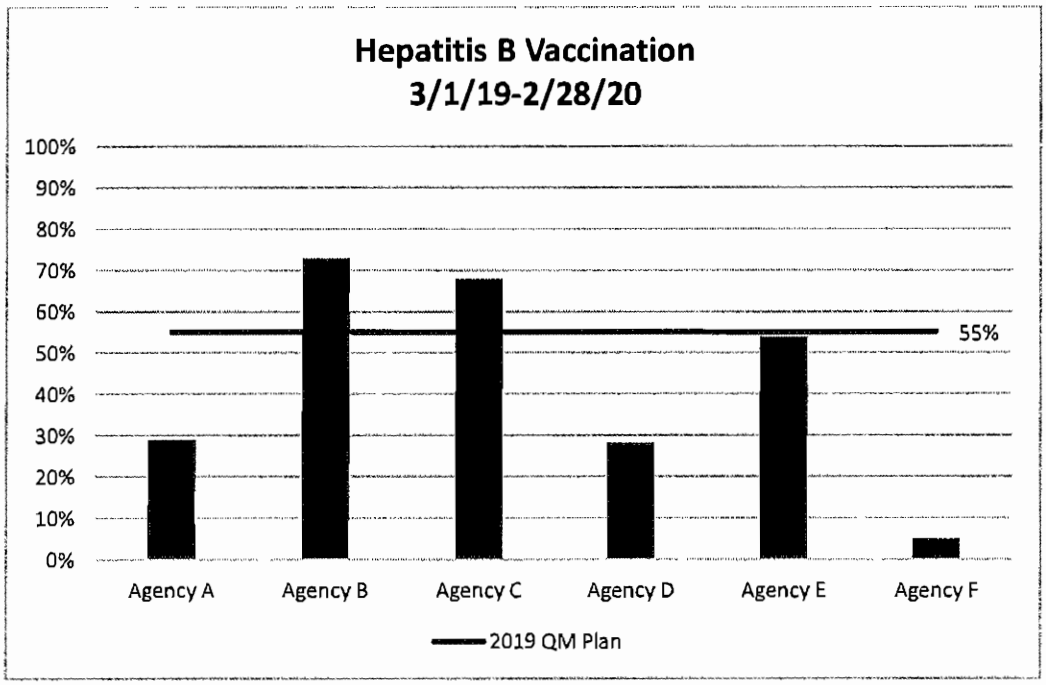


Hepatitis B Vaccination

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

	2017	2018	2019
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	196	171	177
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	381	347	342
Rate	**51.4%**	**49.3%**	**51.8%**
Change from Previous Years Results	**-4.2%**	**-2.1%**	**2.5%**

2019 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	52	95	27
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	120	161	55
Rate	**43.3%**	**59%**	**49.1%**



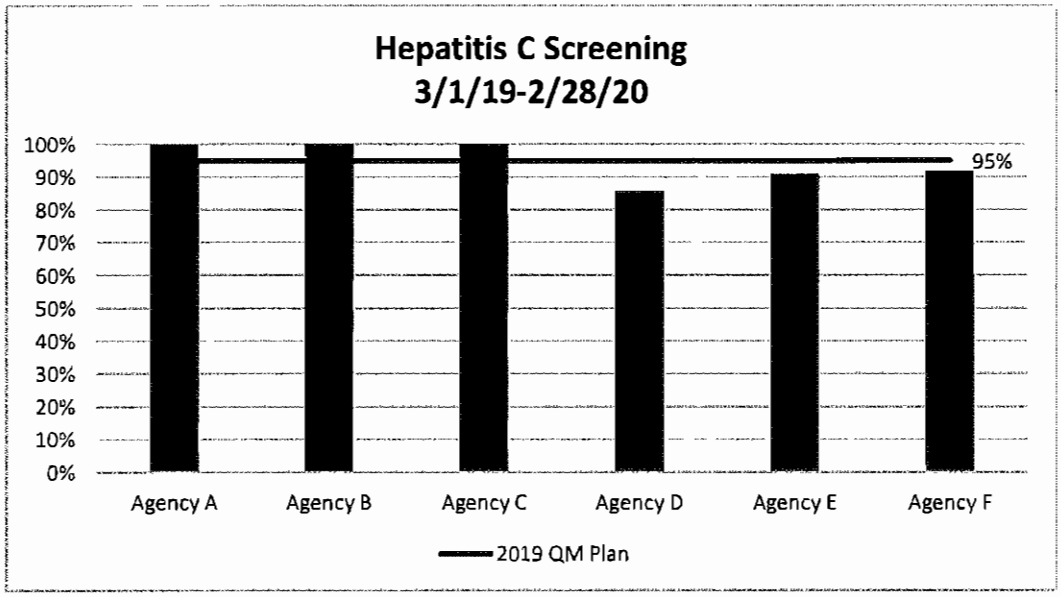
Hepatitis C Screening

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

	2017	2018	2019
Number of clients who have documented HCV status in chart	589	604	612
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	**92.8%**	**95.1%**	**96.4%**
Change from Previous Years Results	**-6.3%**	**2.3%**	**1.3%**

- 7.9% (50/635) were Hepatitis C positive, including 11 acute infections only and 30 cures (76.9%)

2019 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	257	240	104
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	272	247	105
Rate	**94.5%**	**97.1%**	**99%**

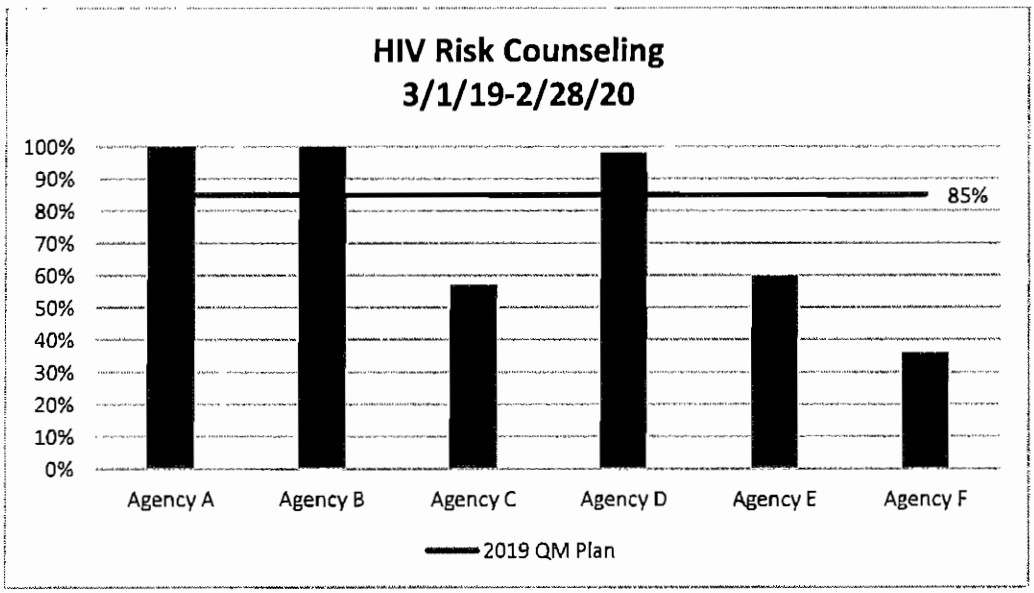


HIV Risk Counseling

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

	2017	2018	2019
Number of clients, as part of their primary care, who received HIV risk counseling	576	533	520
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	**90.7%**	**83.9%**	**81.9%**
Change from Previous Years Results	**21.3%**	**-6.8%**	**-2%**

2019 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	228	208	76
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	272	247	105
Rate	**83.8%**	**84.2%**	**72.4%**

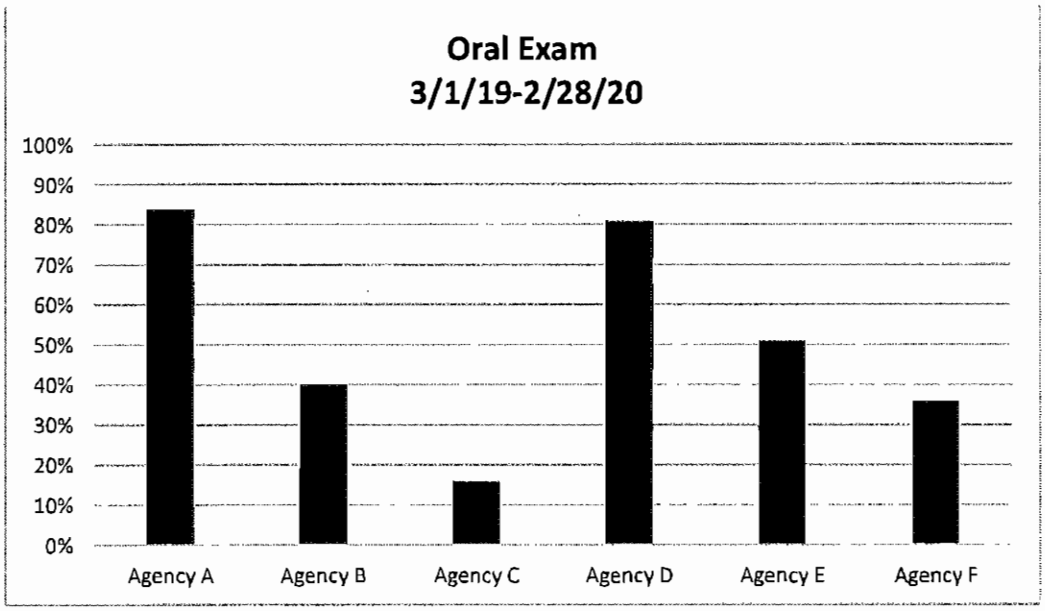


Oral Exam

- 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

	2017	2018	2019
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	272	355	291
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	**42.8%**	**55.9%**	**45.8%**
Change from Previous Years Results	**-8.7%**	**13.1%**	**-10.1%**

2019 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	130	115	41
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	272	247	105
Rate	**47.8%**	**46.6%**	**39%**



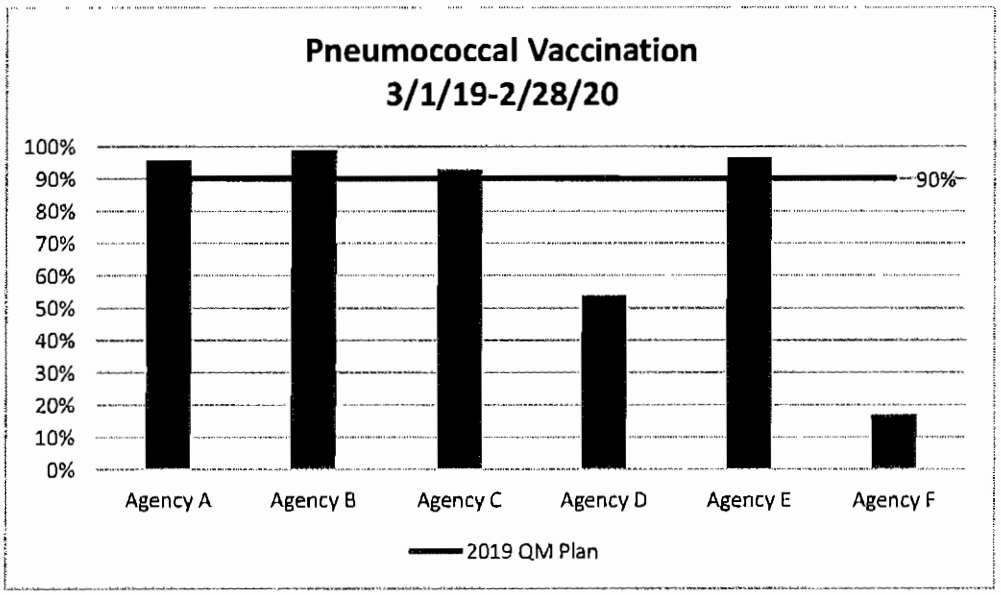
Pneumococcal Vaccination

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

	2017	2018	2019
Number of clients who received pneumococcal vaccination	514	507	523
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	610	612
Rate	**83.4%**	**83.1%**	**85.5%**
Change from Previous Years Results	**-3.3%**	**-.3%**	**2.4%**

- 363 clients (59.3%) received both PPV13 and PPV23 (FY18- 65.1%, FY17- 60.5%)

2019 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	216	216	82
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	262	239	101
Rate	**82.4%**	**90.4%**	**81.2%**

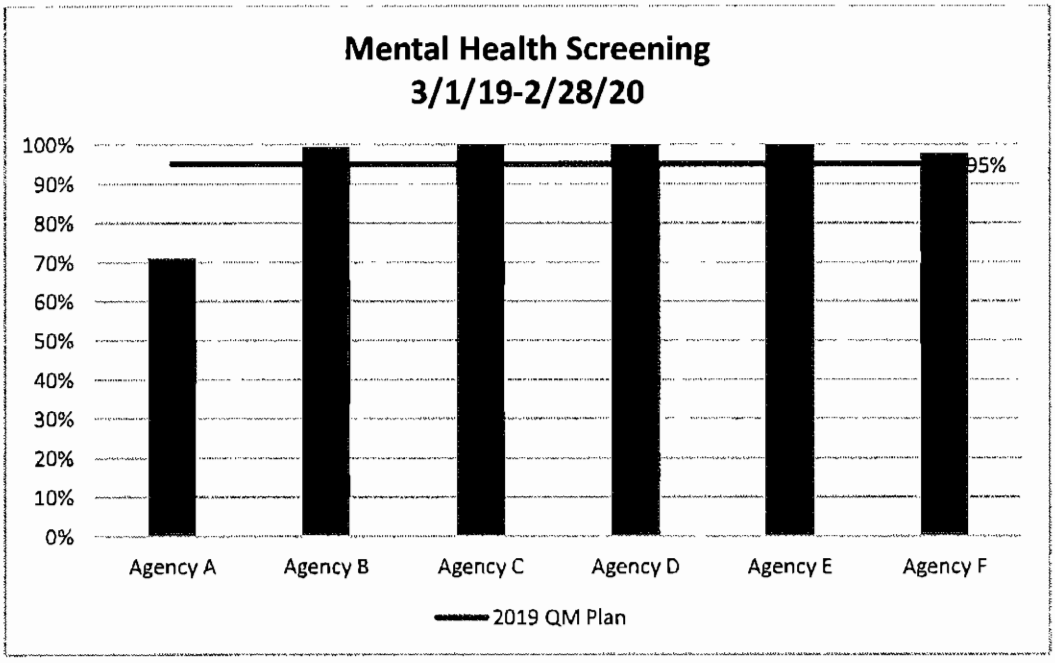


Preventative Care and Screening: Mental Health Screening

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

	2017	2018	2019
Number of clients who received a mental health screening	612	623	604
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	**96.4%**	**98.1%**	**95.1%**
Change from Previous Years Results	**8.5%**	**1.7%**	**-3%**

- 27.2% (173/635) had mental health issues. Of the 90 who needed additional care, 82 (91.1%) were either managed by the primary care provider or referred; 8 clients refused a referral.

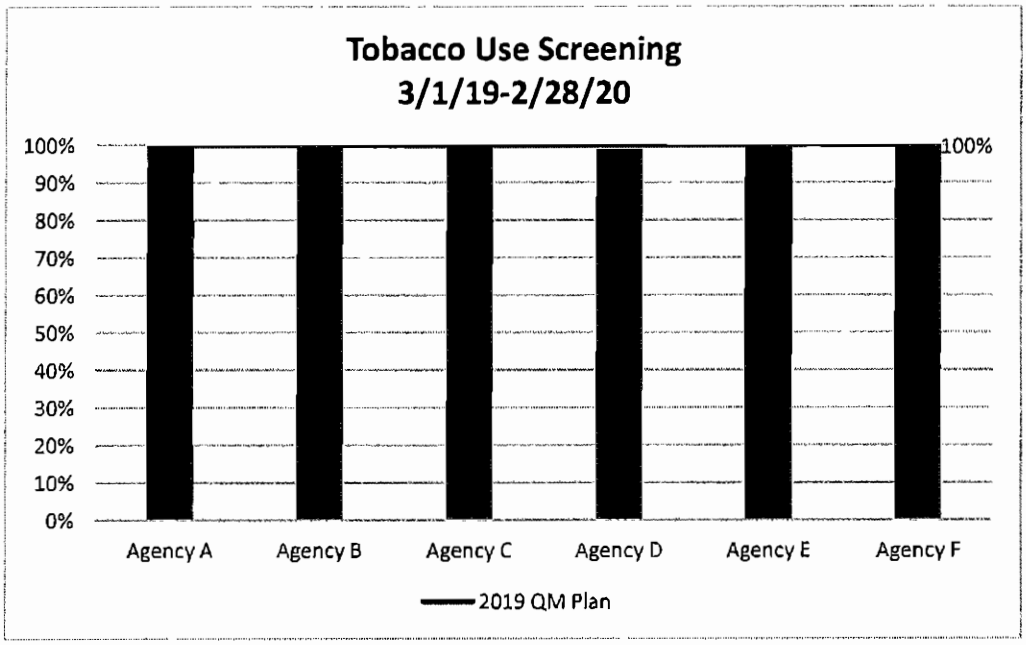


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

- 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

	2017	2018	2019
Number of clients who were screened for tobacco use in the measurement period	635	627	634
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	**100%**	**98.7%**	**99.8%**
Change from Previous Years Results	**.6%**	**-1.3%**	**1.1%**

- Of the 634 clients screened, 153 (24.1%) were current smokers.
- Of the 153 current smokers, 104 (68%) received smoking cessation counseling, and 11 (7.2%) refused smoking cessation counseling



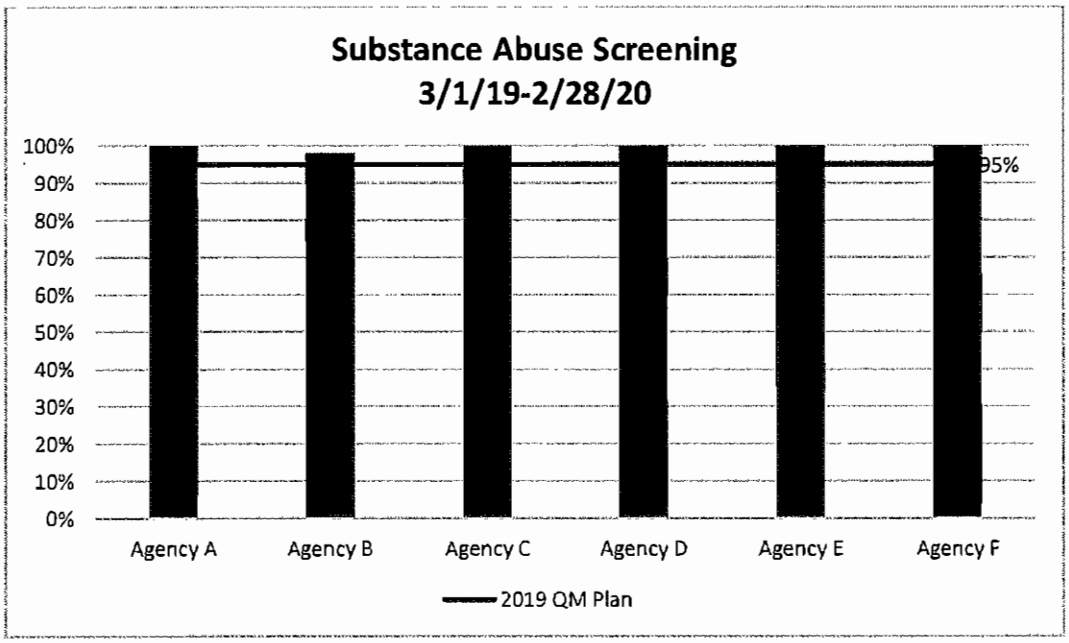
Substance Use Screening

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

	2017	2018	2019
Number of new clients who were screened for substance use within the measurement year	629	631	632
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	**99.1%**	**99.4%**	**99.5%**
Change from Previous Years Results	**.5%**	**.3%**	**.1%**

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

- 4.3% (27/635) had a substance use disorder. Of the 27 clients who needed referral, 16 (59.3%) received one, and 10 (37%) refused.

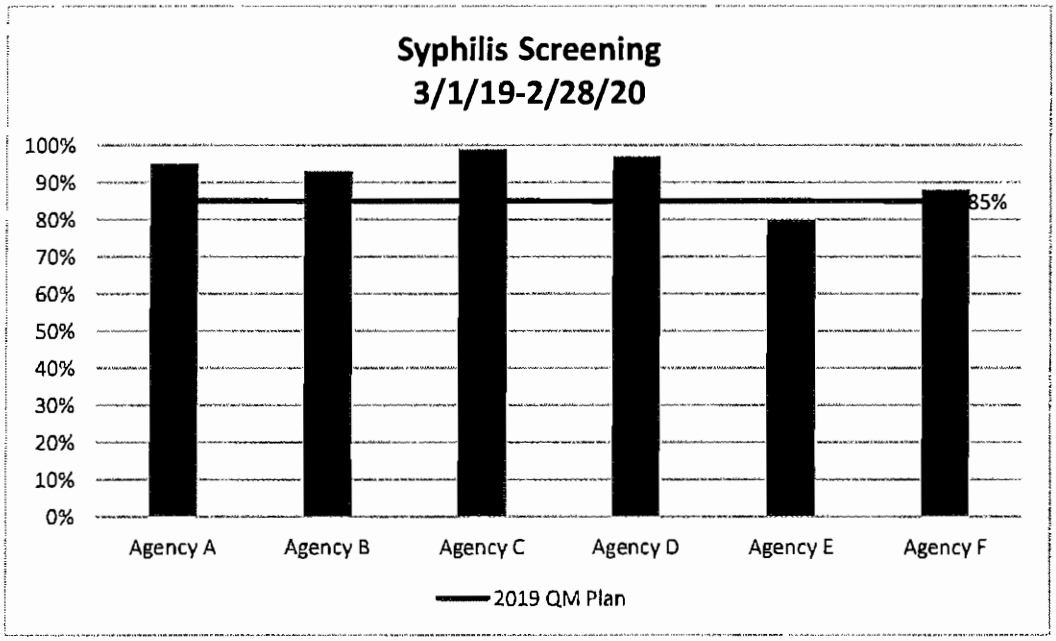


Syphilis Screening

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

	2017	2018	2019
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	587	602	600
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	**92.4%**	**94.8%**	**94.5%**
Change from Previous Years Results	**-1.6%**	**2.4%**	**-.3%**

- 7.1% (45/635) new cases of syphilis diagnosed

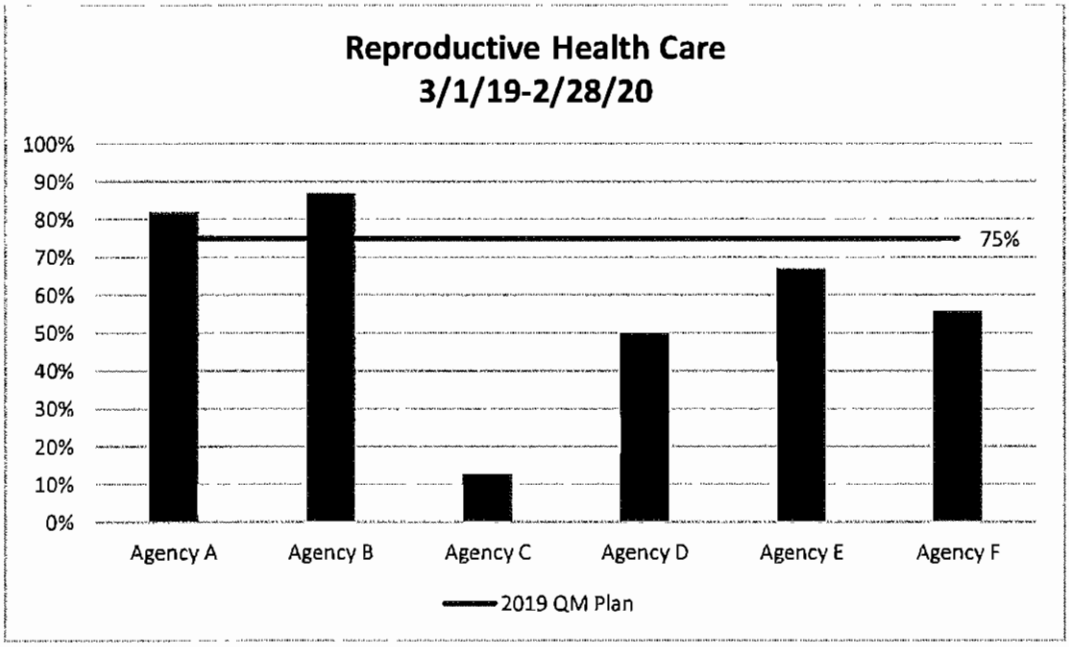


Other Measures

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)

	2017	2018	2019
Number of reproductive-age women who received reproductive health assessment and care	22	29	37
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	54	66
Rate	**34.9%**	**53.7%**	**56.1%**
Change from Previous Years Results	**-19.1%**	**18.8%**	**2.4%**

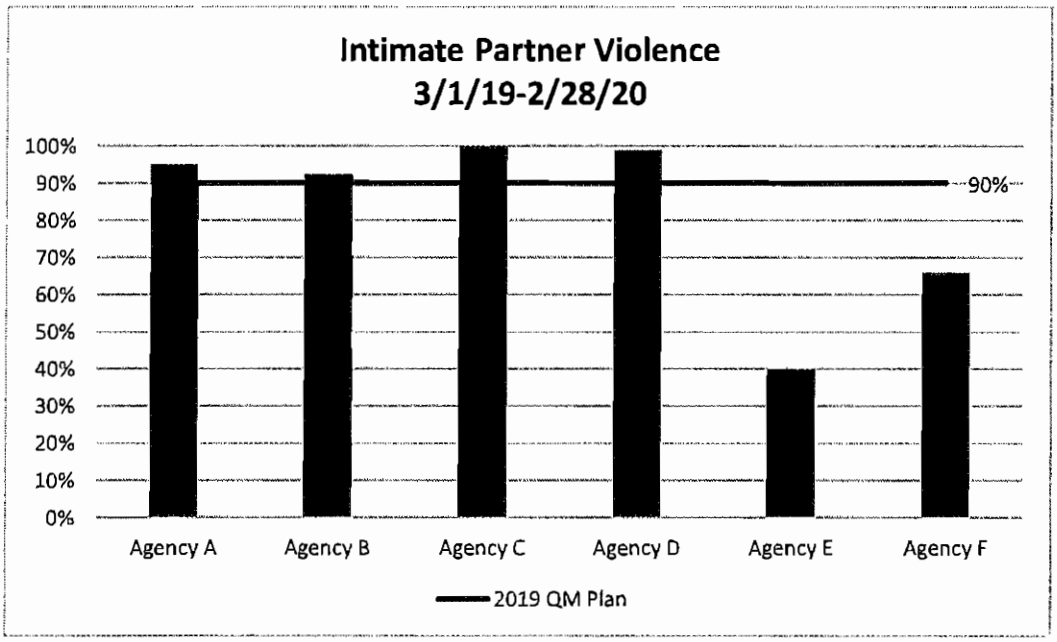


Intimate Partner Violence Screening

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

	2017	2018	2019
Number of clients who received screening for current intimate partner violence	499	592	577
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	**78.6%**	**93.2%**	**90.9%**
	-3.3%	**14.6%**	**-2.3%**

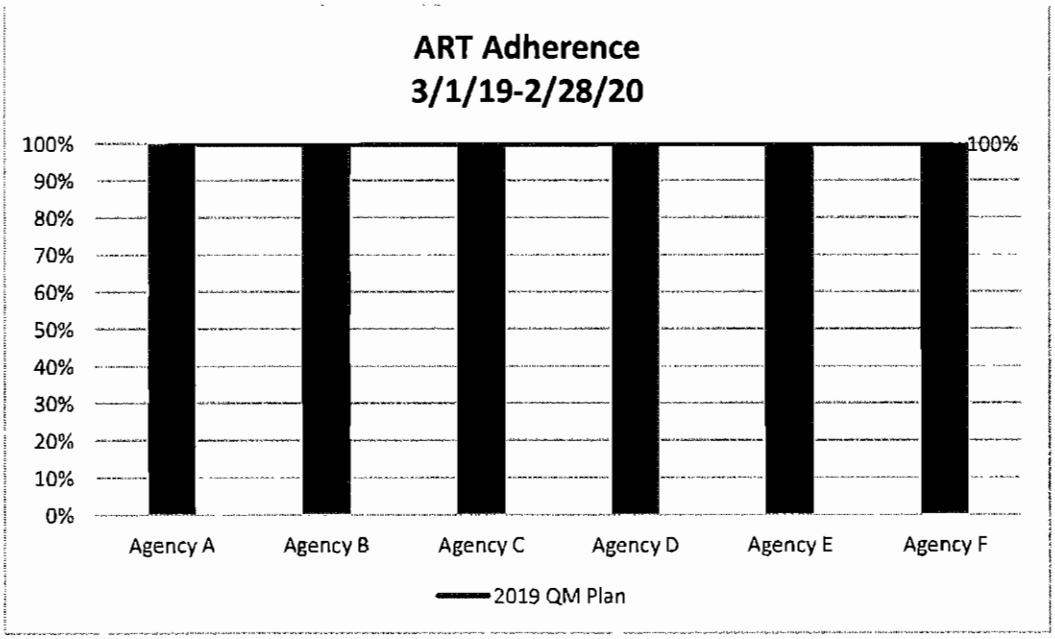
* 4/635 screened positive



Adherence Assessment & Counseling

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

	Adherence Assessment		
	2017	2018	2019
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	627	631	627
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	627	631	627
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**.5%**	**0%**	**0%**



ART for Pregnant Women

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

	2017	2018	2019
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	3	3	2
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	2
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

	2017	2018	2019
Number of diabetic clients whose last HbA1c in the measurement year was <8%	48	35	38
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	74	67	65
Rate	**64.9%**	**52.2%**	**58.5%**
Change from Previous Years Results	**-8%**	**-12.7%**	**6.3%**

- 635/635 (100%) of clients where screened for diabetes and 65/635 (10.2%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2017	2018	2019
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	166	145	147
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	206	180	181
Rate	**80.6%**	**80.6%**	**81.2%**
Change from Previous Years Results	**6.7%**	**0%**	**.6%**

- 181/635 (28.5%) 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

	2017	2018	2019
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	150	141	142
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	171	164	167
Rate	**87.7%**	**86%**	**85%**
Change from Previous Years Results	**13.8%**	**-1.7%**	**-1%**

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

	2017	2018	2019
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	93	127	123
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	151	160	173
Rate	**61.6%**	**79.4%**	**71.1%**
Change from Previous Years Results	**7.7%**	**17.8%**	**-8.3%**

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, Pneumococcal, and Hepatitis B Vaccination. Mental Health Screening experienced a decrease in performance. Racial and ethnic disparities continue to be seen, particularly for viral load suppression rates. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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Oral Health Care-Rural Target Chart Review FY 2019

Ryan White Part A Quality Management Program–Houston EMA

November 2020

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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 19, a comprehensive review of client dental records was conducted for services provided between 3/1/19 to 2/29/20. 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 19 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 3/1/19 and 2/29/20. 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 3/1/19 and 2/29/20 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 19 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	34	45.3%	143	43.9%
White	39	52%	177	54%
Asian	1	1.3%	2	.6%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	1	1.3%	3	.9%
Multi-Race	0	0%	1	.3%
	75		**326**	
Hispanic Status				
Hispanic	20	26.7%	79	24.2%
Non-Hispanic	55	73.3%	247	75.8%
	75		**326**	
Gender				
Male	52	69.3%	217	66.56%
Female	22	29.3%	105	32.2%
Transgender	1	1.3%	4	1.2%
	75		**326**	
Age				
<=24	1	1.3%	14	4.3%
25 – 34	15	20%	74	22.7%
35 – 44	21	28%	86	26.4%
45 – 49	9	12%	50	15.3%
50 – 64	25	33.3%	89	27.3%
65+	4	5.3%	13	4%
	75		**326**	

Findings

Clinic Visits

Information gathered during the FY 19 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 five.

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

	2017	2018	2019
Primary Care Provider	100%	97%	100%
Medical/Dental Health History*	95%	100%	99%
Medical History 6 month Update	100%	96%	95%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2017	2018	2019
Vital Signs	99%	100%	100%
CBC documented	97%	92%	96%
Antibiotic Prophylaxis Given if Indicated		0% (0/1)	100% (1/1)

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.

	2017	2018	2019
Oral Health Education*	99%	99%	99%
Hard Tissue Exam	88%	96%	92%
Soft Tissue Exam	88%	96%	92%
Periodontal screening*	81%	97%	94%
X-rays present	92%	99%	88%
Treatment plan*	99%	99%	100%

*HIV/AIDS Bureau (HAB) Performance Measures

Phase I Treatment Plan Status

Twenty clients had a Phase I Treatment plan.

	2019
Phase I Treatment plan complete*	55%
Dental procedures done, additional procedures needed	35%
No procedures done	10%

*HIV/AIDS Bureau (HAB) Performance Measures

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

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Vision Care Chart Review Report FY 2019

Ryan White Part A Quality Management Program–Houston EMA

November 2020

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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 19, a comprehensive review of client vision records was conducted for services provided between 3/1/19 to 2/29/20.

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 19 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 2,546 unduplicated clients who accessed Part A vision care between 3/1/19 and 2/29/20. The medical charts of 150 of these clients were used in the review, representing 5.9% 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 3/1/19 and 2/29/20 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 19 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%	1,265	50%
White	73	49%	1,201	47%
Asian	3	2%	40	2%
Native Hawaiian/Pacific Islander	0	0%	5	<1%
American Indian/Alaska Native	0	0%	11	<1%
Multi-Race	1	<1%	24	<1%
TOTAL	**150**		**2,546**	
Hispanic Status				
Hispanic	53	35%	918	36%
Non-Hispanic	97	65%	1,628	64%
TOTAL	**150**		**2,546**	
Gender				
Male	113	75%	1,869	73%
Female	34	23%	642	25%
Transgender Male to Female	3	2%	34	1%
Transgender Female to Male	0	0%	1	<1%
TOTAL	**150**		**2,546**	
Age				
<= 24	3	2%	94	4%
25 – 34	36	24%	585	23%
35 – 44	34	23%	641	25%
45 – 49	18	12%	326	13%
50 – 64	53	35%	805	32%
65+	5	3%	95	4%
TOTAL	**150**		**2,546**	

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.

	2017	2018	2019
CD4	80%	83%	94%
VL	80%	83%	94%

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.

	2017	2018	2019
Primary Care Provider	81%	87%	97%
Medication Allergies	99%	100%	100%
Medical History	99%	100%	99%
Current Medications	99%	100%	100%
Reason for Visit	100%	100%	100%
Ocular History	99%	100%	100%

Eye Examinations (Including CEE/DFE) and Exam Findings

Complete and thorough examination of the eye performed on a routine basis is essential for the prevention, detection, and treatment of eye and vision disorders. When providing care to 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). No clients in this sample had CD4 counts <50 cells/mm3.

	2017	2018	2019
Complete Eye Exam	100%	100%	100%
Dilated Fundus Exam	98%	94%	95%
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%	94%	95%

Ocular Disease

Twelve clients (8%) demonstrated ocular disease, including keratitis, stye, keratoconus, iridocyclitis, optic atrophy, pinguecula, blepharitis, and conjunctivitis. Nine clients received treatment for ocular disease, two clients were referred to a specialty eye clinic, and one client did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 97% (95%-FY18) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 19 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 19-Vision Chart Review Data Collection Tool

Mar 1, 19 to Feb 29, 20

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.

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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.

2021 Ryan White Planning Council

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(Updated 01-21-21)

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