DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

1:00 p.m., Tuesday, February 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

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. Approve 2020 Committee Goals
   D. 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. 2021 Schedule of Reports
      2. How to Read TRG Reports 2021
      3. 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
   C. Criteria for FY 2022 Service Categories – March Joint meeting — Tori Williams

(Continued on next page)

VI. New Business
    A. Elect a Committee Vice Chair

VII. Announcements

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 completed last week. She will send it 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,

recommended changes to the Part A standards of care. ***<u>Motion #3</u>**: it was moved and seconded (Starr, Rodriguez) to support 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 members would like to see on reports that are provided to the committee. If there is something you want to see added or changed on any of the reports for next year, please let her know.

Announcements: Williams stated that this is the last meeting of the year. She appreciated all of the work that the committee did especially considering the changes in meeting formats in response to the pandemic. Kelly said that the numbers are going up again and encouraged everyone to stay safe.

Adjourn: ***<u>Motion #4</u>**: 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

	Motion #1 Agenda				**Motion #2** Committee Meeting Minutes				**Motion #3** Part A Standards of Care			
MEMBERS:	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.

(Continued)

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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.

DRAFT

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.

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.

(continued)

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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.

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.

<table>
<tr><th>#</th><th>Standard</th><th>Measure</th></tr>
<tr><td colspan="3">9.0 Service-Specific Requirements</td></tr>
<tr><td>9.3</td><td><u>Services Requiring Licensed Personnel</u>
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.</td><td>• Documentation of qualification in personnel file</td></tr>
<tr><td>9.4</td><td><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 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</td><td>• Personnel Qualification on file
• Documentation of orientation of file</td></tr>
<tr><td>9.5</td><td><u>Doctor’s Order</u>
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.</td><td>• Review of client’s primary record indicates compliance.</td></tr>
<tr><td>9.6</td><td><u>Billing Requirement</u>
Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payers.</td><td>• Provider will provide evidence of third-party billing.</td></tr>
</table>

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

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

9.13	<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.

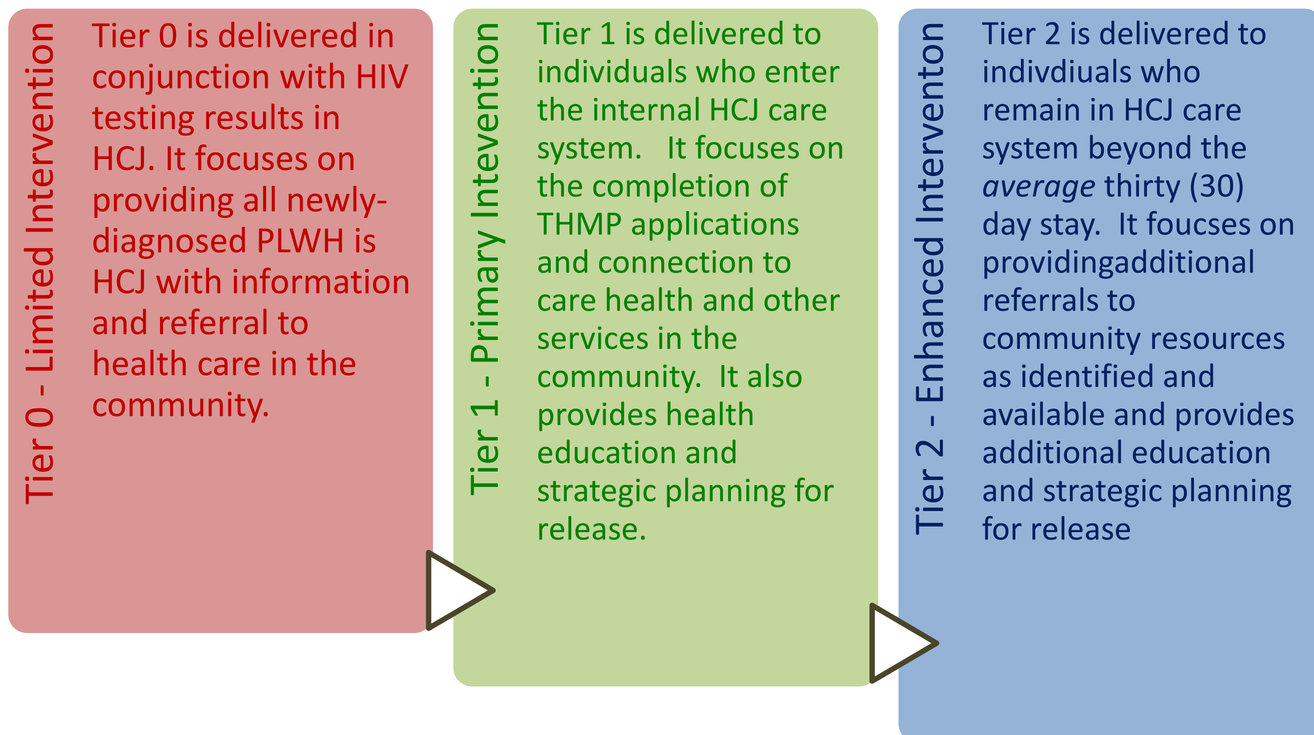
For additional EIS Performance Measures, see 2021 EIS Attachment A: Performance Measures.

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

#	Standard	Evidence
	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	Health Literacy: 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	Coordination of Community Care: 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	Medication Regimen Establishment/Maintenance: 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	Transitional Multidisciplinary Team: 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	External Referrals 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	Referral Packet 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	Referral Tracking/Follow-Up 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.

<table>
<tr><th>#</th><th>STANDARD</th><th>MEASURE</th></tr>
<tr><td colspan="3">9.0 Service-Specific Requirements</td></tr>
<tr><td>9.14</td><td><u>Client Education</u>
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.</td><td>• 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.</td></tr>
<tr><td>9.15</td><td><u>Decreasing Barriers to Service</u>
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.)</td><td>• Review of agency’s Policies & Procedures Manual indicates compliance.
• Review of client intake/assessment for service indicates compliance</td></tr>
<tr><td>9.16</td><td><u>Payer of Last Resort</u>
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.</td><td>• Review of agency’s Policies & Procedures Manual indicates compliance.
• Review of client intake/assessment for service indicates compliance.</td></tr>
</table>

#	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

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-05

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

<table>
<tr><th>#</th><th>STANDARD</th><th>MEASURE</th></tr>
<tr><td colspan="3">9.0 Service-Specific Requirements</td></tr>
<tr><td>9.12</td><td><u>Facility Licensure</u>
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.</td><td>• 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</td></tr>
<tr><td>9.13</td><td><u>Denial of Service</u>
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.</td><td>• Review of agency's Policies & Procedures Manual indicates compliance
• Documentation of notification is available for review.</td></tr>
<tr><td>9.14</td><td><u>Multidisciplinary Team Care</u>
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.</td><td>• Review of agency's Policies & Procedures Manual indicates compliance
• Documentation in client's primary records</td></tr>
<tr><td>9.15</td><td><u>Medication Administration Record</u>
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.</td><td>• Documentation in client's primary record</td></tr>
<tr><td>9.16</td><td><u>PRN Medication Record</u>
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.</td><td>• Documentation in client's primary record</td></tr>
</table>

#	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.

<table>
<tr><td>9.16</td><td><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</td><td>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.</td></tr>
<tr><td>9.17</td><td><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.</td><td>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.</td></tr>
<tr><td>9.18</td><td><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</td><td>Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.</td></tr>
</table>

#	Standard	Measure
	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).	
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	<u>Agency License</u> 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	<u>Program Policies and Procedures</u> 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.

<table>
<tr><th>#</th><th>STANDARD</th><th>MEASURE</th></tr>
<tr><td>9.10</td><td><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
Task(s)
Assistance in accessing services (types of assistance)
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.</td><td>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.</td></tr>
<tr><td>9.11</td><td><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.</td><td>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.</td></tr>
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#	STANDARD	MEASURE
9.12	<u>Increase Health Literacy</u> 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	<u>Transtheoretical Model of Change</u> 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	<u>Overdose Prevention & SUD Reduction</u> 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	<u>Substance Use Treatment</u> 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	<u>Harm- and Risk-Reduction</u> 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	<u>Case Closure/Graduation</u> PLWH who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • PLWH is referred to another case management program • PLWH relocates outside of service area • PLWH chooses to terminate services • PLWH is no longer eligible for services due to not meeting eligibility requirements • PLWH is lost to care or does not engage in service • PLWH incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • PLWH death Graduation criteria: • PLWH completed case management goals for increased access to services/care needs • PLWH is no longer in need of case management services (e.g. PLWH is capable of resolving needs independent of case management assistance) PLWH is considered non-compliant with care if three (3) attempts to contact PLWH (via phone, e-mail and/or written correspondence) are unsuccessful and the PLWH has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure appropriate *Releases of Information and consents are signed by the PLWH and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a PLWH, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).	• Percentage of PLWH with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary). • Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). • Percentage of PLWH notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the PLWH from case management services. • Percentage of PLWH with written documentation explaining the reason(s) for discharge and the process to be followed if PLWH elects to appeal the discharge from service. • Percentage of PLWH with information about reestablishment shared with the PLWH and documented in primary client record system. • Percentage of PLWH provided with contact information and process for reestablishment as documented in primary client record system. • Percentage of PLWH with documented Case Closure/Graduation in the primary client record system.

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

RYAN WHITE PART B/DSHS STATE SERVICES
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

- American Dental Association. Dental Practice Parameters. Patients requiring a comprehensive oral evaluation. Available at: http://www.ada.org/prof/prac/tools/parameters/eval_comprehensive.asp. Accessed on May 8, 2009.
- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2011, page 9-10.
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 9-10.
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Rule 7.Minimal Standards of Care. located at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm

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.

<table>
<tr><th>#</th><th>STANDARD</th><th>MEASURE</th></tr>
<tr><td>9.2</td><td><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).</td><td></td></tr>
<tr><td>9.3</td><td><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.</td><td>• Personnel Qualification on file
• Documentation of orientation of file</td></tr>
<tr><td>9.4</td><td><u>Staff Education</u>
• Education to be defined locally, but must have at minimum a high school degree or equivalency</td><td>• Documentation of education and/ or certification located in personnel file.</td></tr>
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#	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.

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<td>9.8</td>
<td>Benefits Counseling
Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and/or private benefits and/or resources for which they are eligible.

Staff will explore the following as possible options for clients, as appropriate:
• AIDS Drug Assistance Program (ADAP)
• Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/ Marketplace)
• SNAP
• Pharmaceutical Patient Assistance Programs (PAPS)
• Social Security Programs (SSI, SSDI, SDI)
• Temporary Aid to Needy Families (TANF)
• Veteran's Administration Benefits (VA)
• Women, Infants and Children (WIC)
• Other public/private benefits programs
• Other professional services

Staff will assist eligible clients with completion of benefits application(s) as appropriate within (14) business days of the eligibility determination date.

Conduct a follow-up within 90 days of completed application to determine if additional and/or ongoing needs are present.</td>
<td>• 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.</td>
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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)

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<td>9.10</td>
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<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.
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<td>• Documentation of lapse benefits due to non-completion of timely recertification/attestation in the client's record.</td>
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#	STANDARD	MEASURE
9.11	ARIES Document Upload Process ARIES Document Upload is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • Completed ADAP Applications (with supportive documentation) must be uploaded into ARIES for THMP consideration. All uploaded applications must be reviewed and certified as “complete” prior to upload. • ADAP applications should be uploaded according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be uploaded into ARIES within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed upload to ARIES. • Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction. Houston Only: Medication Certification forms for changes to medication should be faxed to THMP for approval.	• Documentation of upload receipt by THMP within (3) business days of application completion.
9.12	Tracking ADAP Applications Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible	
9.13	Case Closure Summary Clients who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the client primary record. The case closure summary must include a brief synapsis of all services provided and the result of those services documented as ‘completed’ and/or ‘not completed.’ A supervisor must sign the case closure summary.	• Clients who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary client record.

References

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

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

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

FY 2020 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,869,619**	**201,116**	**413,485**	**0**	**0**	**10,484,220**	**45.77%**	**10,335,560**	**148,660**		**3,436,575**	**33%**	**67%**
1.a	Primary Care - Public Clinic (a)	3,591,064					3,591,064	15.68%	3,591,064	0	3/1/2020	$288,133	8%	67%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	952,498		121,162			1,073,660	4.69%	1,073,660	0	3/1/2020	$924,802	86%	67%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	798,473		121,162			919,635	4.02%	919,635	0	3/1/2020	$747,626	81%	67%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,035,846		121,162			1,157,008	5.05%	1,157,008	0	3/1/2020	$302,703	26%	67%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761		25,000			1,174,761	5.13%	1,174,761	0	3/1/2020	$713,769	61%	67%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540					1,874,540	8.18%	1,874,540	0	3/1/2020	$209,667	11%	67%
1.g	Primary Care - Pediatric (a.1)	15,437	1,116				16,553	0.07%	16,553	0	3/1/2020	$5,100	31%	67%
1.h	Vision	452,000		25,000			477,000	2.08%	477,000	0	3/1/2020	$244,775	51%	67%
1.x	Primary Care Health Outcome Pilot	0	200,000				200,000	0.87%	51,340	148,660	7/14/2020	$0	0%	67%
2	**Medical Case Management**	**2,185,802**	**-160,051**	**25,000**	**0**	**0**	**2,050,751**	**8.95%**	**2,050,751**	**0**		**854,636**	**42%**	**67%**
2.a	Clinical Case Management	488,656		25,000			513,656	2.24%	513,656	0	3/1/2020	$269,270	52%	67%
2.b	Med CM - Public Clinic (a)	427,722					427,722	1.87%	427,722	0	3/1/2020	$50,549	12%	67%
2.c	Med CM - Targeted to AA (a) (e)	266,070					266,070	1.16%	266,070	0	3/1/2020	$197,127	74%	67%
2.d	Med CM - Targeted to H/L (a) (e)	266,072					266,072	1.16%	266,072	0	3/1/2020	$97,691	37%	67%
2.e	Med CM - Targeted to W/MSM (a) (e)	52,247					52,247	0.23%	52,247	0	3/1/2020	$60,255	115%	67%
2.f	Med CM - Targeted to Rural (a)	273,760					273,760	1.20%	273,760	0	3/1/2020	$103,199	38%	67%
2.g	Med CM - Women at Public Clinic (a)	125,311					125,311	0.55%	125,311	0	3/1/2020	$36,024	29%	67%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	-160,051				0	0.00%	0	0	3/1/2020	$0	#DIV/0!	67%
2.i	Med CM - Targeted to Veterans	80,025					80,025	0.35%	80,025	0	3/1/2020	$30,891	39%	67%
2.j	Med CM - Targeted to Youth	45,888					45,888	0.20%	45,888	0	3/1/2020	$9,628	21%	67%
3	**Local Pharmacy Assistance Program**	**3,157,166**	**0**	**0**	**0**	**0**	**3,157,166**	**13.78%**	**3,157,166**	**0**	3/1/2020	**$840,772**	**27%**	**67%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	610,360					610,360	2.66%	610,360	0	3/1/2020	$55,042	9%	67%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	2,546,806					2,546,806	11.12%	2,546,806	0	3/1/2020	$785,730	31%	67%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.73%**	**166,404**	**0**	3/1/2020	**75,200**	**45%**	**67%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404					166,404	0.73%	166,404	0	3/1/2020	$75,200	45%	67%
5	**Health Insurance (c)**	**1,339,239**	**43,898**	**0**	**0**	**0**	**1,383,137**	**6.04%**	**1,383,137**	**0**	3/1/2020	**$534,644**	39%	**67%**
6	**Mental Health Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
7	**Early Intervention Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Home and Community-Based Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.20%**	**45,677**	**0**	3/1/2020	**$1,850**	**0%**	**67%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**40,000**	**0**	**0**	**381,395**	**1.67%**	**381,395**	**0**	3/1/2020	**$257,325**	**67%**	**67%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.83%**	**420,000**	**0**	**3/1/2020**	**$163,800**	**39%**	**67%**
13	**Emergency Financial Assistance**	**525,000**	**0**	**0**	**0**	**0**	**525,000**	**2.29%**	**525,000**	**0**	**3/1/2020**	**$230,896**	**44%**	**67%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	0%	**0%**
15	**Non-Medical Case Management**	**1,381,002**	**0**	**117,000**	**0**	**0**	**1,498,002**	**6.54%**	**1,498,002**	**0**		**604,063**	**40%**	**67%**
15.a	Service Linkage targeted to Youth	110,793					110,793	0.48%	110,793	0	3/1/2020	$24,088	22%	67%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000					100,000	0.44%	100,000	0	3/1/2020	$24,330	24%	67%
15.c	Service Linkage at Public Clinic (a)	427,000					427,000	1.86%	427,000	0	3/1/2020	$98,147	23%	67%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	743,209		117,000			860,209	3.76%	860,209	0	3/1/2020	$457,498	53%	67%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.86%**	**424,911**	**0**		**234,748**	**55%**	**67%**
16.a	Medical Transportation services targeted to Urban	252,680					252,680	1.10%	252,680	0	3/1/2020	$164,434	65%	67%
16.b	Medical Transportation services targeted to Rural	97,185					97,185	0.42%	97,185	0	3/1/2020	$70,314	72%	67%
16.c	Transportation vouchering (bus passes & gas cards)	75,046					75,046	0.33%	75,046	0	3/1/2020	$0	0%	0%
17	**Linguistic Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
	Total Service Dollars	**19,856,215**	**84,963**	**595,485**	**0**	**0**	**20,536,663**	**87.83%**	**20,388,003**	**148,660**		**7,234,510**	**35%**	**67%**
	Grant Administration	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**7.84%**	**1,795,958**	0	**N/A**	**0**	**0%**	**67%**

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

FY 2020 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
BEU27517	HCPHES/RWGA Section	1,271,050		0		0	1,271,050	5.55%	1,271,050	0	N/A		0%	67%
PC	RWPC Support*	524,908			0	0	524,908	2.29%	524,908	0	N/A		0%	67%
BEU27521	**Quality Management**	**412,940**		**0**	**0**	**0**	**412,940**	**1.80%**	**412,940**	**0**	**N/A**		**0%**	**67%**
		22,065,113	**84,963**	**595,485**	**0**	**0**	**22,745,561**	**97.47%**	**22,596,901**	**148,660**		**7,234,510**	**32%**	**67%**
								Unallocated	Unobligated					
	Part A Grant Award:	**22,309,011**	***Carry Over:***	**595,485**		***Total Part A:***	**22,904,496**	**158,935**	**148,660**					

	Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent
Core (must not be less than 75% of total service dollars)	**17,105,302**	**84,963**	**478,485**	**0**	**0**	**17,668,750**	**86.04%**	**5,464,508**	**81.58%**
Non-Core (may not exceed 25% of total service dollars)	**2,750,913**	**0**	**117,000**	**0**	**0**	**2,867,913**	**13.96%**	**1,233,508**	**18.42%**
Total Service Dollars (does not include Admin and QM)	**19,856,215**	**84,963**	**595,485**	**0**	**0**	**20,536,663**		**6,698,016**	
Total Admin (must be ≤ 10% of total Part A + MAI)	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**7.06%**		
Total QM (must be ≤ 5% of total Part A + MAI)	**412,940**	**0**	**0**	**0**	**0**	**412,940**	**1.62%**		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**1,887,283**	**115,502**	**106,554**	**0**	**0**	**2,109,339**	**86.82%**	**2,109,339**	**0**		**831,875**	**39%**	**67%**
1.b (MAI)	Primary Care - CBO Targeted to African American	954,912	58,441	53,277			1,066,630	43.90%	1,066,630	0	3/1/2020	$482,625	45%	67%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	932,371	57,061	53,277			1,042,709	42.92%	1,042,709	0	3/1/2020	$349,250	33%	67%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**0**	**320,100**	**13.18%**	**320,100**	**0**		**$96,618**	**30%**	**67%**
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	6.59%	160,050	0	3/1/2020	$44,448	28%	67%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	6.59%	160,050	0	3/1/2020	$52,170	33%	67%
	Total MAI Service Funds	**2,207,383**	**115,502**	**106,554**	**0**	**0**	**2,429,439**	**100.00%**	**2,429,439**	**0**		**928,493**	**38%**	**67%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
BEO 27616	**Total MAI Funds**	**2,207,383**	**115,502**	**106,554**	**0**	**0**	**2,429,439**	**100.00%**	**2,429,439**	**0**		**928,493**	**38%**	**67%**
	MAI Grant Award	**2,429,513**	***Carry Over:***	**106,554**		***Total MAI:***	**2,536,067**							
	Combined Part A and MAI Orginial Allocation Total	**24,272,496**												

Footnotes:

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

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 2nd Quarter (3/1-8/31)

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Transgender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**5,378**	**73%**	**25%**	**2%**	**46%**	**12%**	**2%**	**39%**	**0%**	**0%**	**5%**	**27%**	28%	12%	26%	2%
1.a	Primary Care - Public Clinic (a)	2,350	1,785	69%	30%	1%	47%	8%	2%	43%	0%	0%	2%	16%	27%	14%	38%	3%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,475	66%	31%	3%	99%	0%	1%	0%	0%	0%	6%	36%	28%	11%	17%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,197	81%	15%	4%	0%	0%	0%	100%	0%	1%	6%	32%	31%	12%	18%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	466	87%	11%	2%	0%	86%	14%	0%	0%	0%	3%	27%	24%	11%	32%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	542	70%	29%	1%	44%	24%	2%	30%	0%	0%	6%	30%	26%	13%	23%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	495	0%	100%	0%	55%	6%	1%	38%	0%	0%	1%	11%	28%	19%	36%	4%
1.g	Primary Care - Pediatric (a)	7	8	75%	25%	0%	38%	0%	0%	63%	13%	38%	50%	0%	0%	0%	0%	0%
1.h	Vision	1,600	1,443	73%	26%	2%	50%	12%	2%	35%	0%	0%	5%	24%	25%	13%	30%	3%
2	**Medical Case Management (f)**	**3,075**	**3,816**															
2.a	Clinical Case Management	600	691	76%	21%	2%	56%	14%	1%	29%	0%	0%	4%	23%	26%	12%	31%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	366	89%	10%	1%	54%	14%	1%	31%	0%	0%	2%	21%	27%	10%	36%	3%
2.c	Med CM - Targeted to AA (a)	550	1,149	68%	29%	3%	99%	0%	1%	0%	0%	1%	6%	35%	25%	11%	20%	2%
2.d	Med CM - Targeted to H/L(a)	550	545	79%	16%	5%	0%	0%	0%	100%	0%	1%	6%	30%	28%	12%	20%	3%
2.e	Med CM - Targeted to White and/or MSM (a)	260	353	89%	10%	2%	0%	90%	10%	0%	0%	0%	3%	25%	21%	11%	34%	6%
2.f	Med CM - Targeted to Rural (a)	150	400	68%	31%	1%	48%	27%	3%	23%	0%	0%	6%	22%	22%	12%	35%	4%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	166	0%	100%	0%	70%	8%	1%	21%	0%	0%	2%	16%	31%	10%	38%	4%
2.h	Med CM - Targeted to Pedi (a)	125	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
2.i	Med CM - Targeted to Veterans	200	137	93%	7%	0%	68%	20%	0%	12%	0%	0%	0%	1%	5%	1%	65%	28%
2.j	Med CM - Targeted to Youth	120	9	67%	33%	0%	78%	11%	0%	11%	0%	11%	89%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**3,989**	**74%**	**23%**	**3%**	**47%**	**14%**	**2%**	**38%**	**0%**	**0%**	**4%**	**28%**	**28%**	**14%**	**24%**	**1%**
4	**Oral Health**	**200**	**161**	**62%**	**37%**	**1%**	**41%**	**28%**	**2%**	**29%**	**0%**	**0%**	**4%**	**20%**	**24%**	**14%**	**34%**	**5%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	161	62%	37%	1%	41%	28%	2%	29%	0%	0%	4%	20%	24%	14%	34%	5%
5	**Mental Health Services (d)**	**NA**	NA															
6	**Health Insurance**	**1,700**	**1,279**	**78%**	**20%**	**1%**	**46%**	**24%**	**3%**	**28%**	**0%**	**0%**	**2%**	**16%**	**18%**	**12%**	**42%**	**10%**
7	**Home and Community Based Services (d)**	**NA**	NA															
8	**Substance Abuse Treatment - Outpatient**	**40**	**6**	**100%**	**0%**	**0%**	**17%**	**67%**	**0%**	**17%**	**0%**	**0%**	**0%**	**33%**	**17%**	**33%**	**17%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	NA															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**395**	**75%**	**24%**	**1%**	**40%**	**22%**	**4%**	**35%**	**0%**	**0%**	**1%**	**11%**	**15%**	**12%**	**47%**	**14%**
11	**Hospice Services (d)**	**NA**	NA															
12	**Outreach**	**700**	**476**	**77%**	**20%**	**3%**	**60%**	**12%**	**1%**	**27%**	**0%**	**1%**	**6%**	**34%**	**24%**	**11%**	**23%**	**2%**
13	**Non-Medical Case Management**	**7,045**	**5,437**															
13.a	Service Linkage Targeted to Youth	320	109	72%	27%	1%	58%	3%	2%	38%	0%	14%	86%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	55	75%	22%	4%	64%	9%	0%	27%	0%	0%	0%	58%	20%	11%	11%	0%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	2,583	66%	33%	1%	56%	9%	1%	34%	0%	0%	0%	16%	25%	14%	40%	4%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	2,690	75%	22%	3%	53%	15%	2%	31%	1%	1%	5%	29%	23%	12%	25%	3%
14	**Transportation**	**2,850**	**1,341**															
14.a	Transportation Services - Urban	170	632	67%	30%	2%	58%	9%	2%	31%	0%	0%	4%	31%	27%	11%	22%	4%
14.b	Transportation Services - Rural	130	172	67%	31%	2%	36%	34%	2%	28%	0%	0%	5%	20%	24%	15%	31%	5%
14.c	Transportation vouchering	2,550	537															
15	**Linguistic Services (d)**	**NA**	NA															
16	**Emergency Financial Assistance (e)**	**NA**	**217**	**74%**	**24%**	**2%**	**50%**	**14%**	**0%**	**35%**	**0%**	**0%**	**3%**	**30%**	**23%**	**15%**	**27%**	**2%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	NA															
Net unduplicated clients served - all categories*		**12,941**	**11,150**	**73%**	**25%**	**2%**	**51%**	**14%**	**2%**	**33%**	**0%**	**1%**	**4%**	**24%**	**24%**	**12%**	**30%**	**4%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		**NA**																

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 2nd Quarter (03/01 -08/31)																		
Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	803	70%	28%	2%	99%	0%	1%	0%	0%	0%	6%	34%	31%	11%	17%	0%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	633	82%	15%	4%	0%	0%	0%	100%	0%	0%	6%	33%	32%	13%	15%	1%
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	392	79%	18%	3%	47%	16%	2%	35%	0%	1%	9%	33%	23%	14%	18%	2%
2.d	Med CM - Targeted to H/L(a)	960	319	86%	11%	2%	61%	23%	2%	14%	0%	0%	14%	32%	18%	11%	18%	7%

RW Part A New Client Service Utilization Report - 2nd Quarter (03/01-08/31) Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/20 - 2/28/21)																		
Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**634**	**76%**	**21%**	**3%**	**51%**	**13%**	**2%**	**34%**	**0%**	**1%**	**11%**	**36%**	**23%**	**11%**	**1%**	**18%**
2	**LPAP**	**1,200**	**359**	**79%**	**18%**	**3%**	**47%**	**16%**	**2%**	**35%**	**0%**	**1%**	**9%**	**33%**	**23%**	**14%**	**2%**	**18%**
3.a	Clinical Case Management	400	44	86%	11%	2%	61%	23%	2%	14%	0%	0%	14%	32%	**18%**	**11%**	7%	**18%**
3.b-3.h	Medical Case Management	1,600	540	76%	21%	3%	51%	15%	2%	31%	0%	1%	11%	37%	**21%**	**10%**	1%	**18%**
3.i	Medical Case Manangement - Targeted to Veterans	60	19	89%	11%	0%	84%	11%	0%	5%	0%	0%	0%	5%	**21%**	**0%**	16%	**58%**
4	**Oral Health**	**40**	**15**	**47%**	**53%**	0%	**40%**	**33%**	**7%**	**20%**	**0%**	**0%**	**13%**	**7%**	**20%**	**33%**	**0%**	**27%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**798**	**72%**	**26%**	**2%**	**58%**	**13%**	**2%**	**27%**	**1%**	**2%**	**9%**	**29%**	**22%**	**12%**	**24%**	**2%**
12.b	**Service Linkage at Testing Sites**	**260**	**32**	**78%**	**19%**	**3%**	**69%**	**9%**	**0%**	**22%**	**0%**	**3%**	**19%**	**41%**	**19%**	**13%**	**6%**	**0%**
Footnotes:																		
(a)	Bundled Category																	
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.																	
(d)	Funded by Part B and/or State Services																	
(e)	Total MCM served does not include Clinical Case Management																	
(f)	CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served																	

Available Data As Of: 11/12/2020

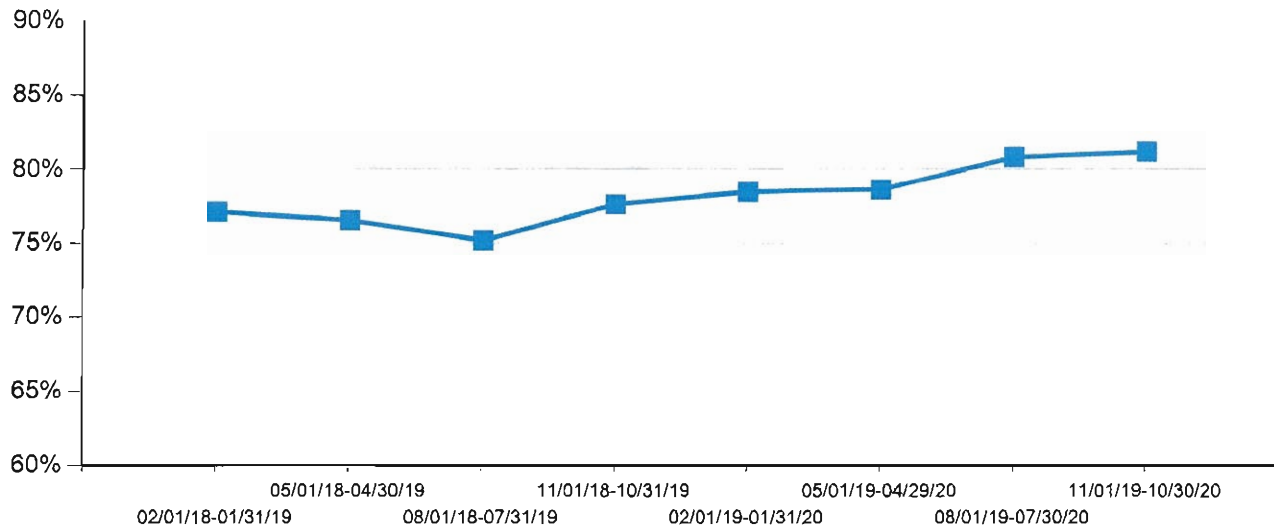
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Clinical Quality Management Committee Quarterly Report

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

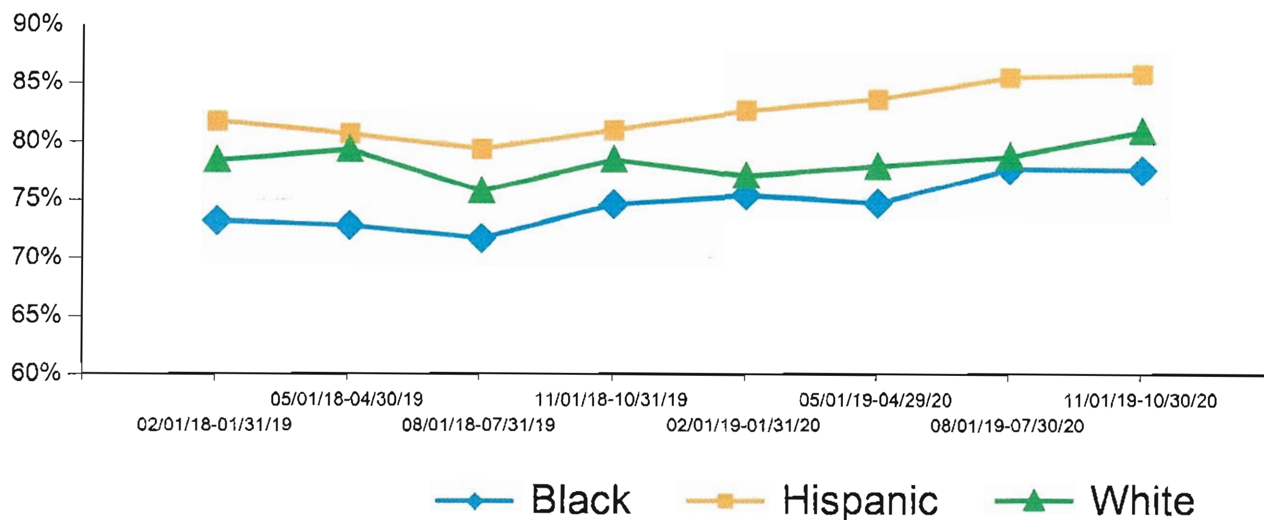
Viral Load Suppression 2- HAB Measure

	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	6,829	6,983	6,934
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%	80.8%	81.2%
Change from Previous Quarter Results	0.9%	0.1%	2.2%	0.3%



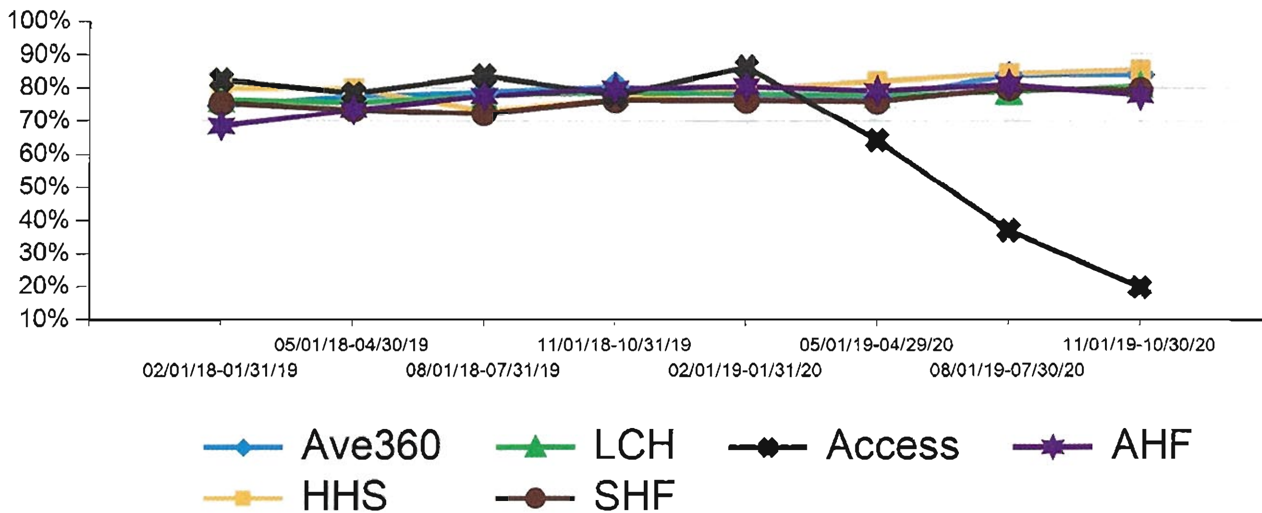
VL Suppression 2 by Race/Ethnicity

	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	3,087	2,736	844	3,165	2,811	850	3,145	2,764	873
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%	77.6%	85.4%	78.6%	77.5%	85.7%	80.8%
Change from Previous Quarter Results	-0.7%	1.0%	0.8%	3.0%	1.9%	0.8%	-0.1%	0.3%	2.1%



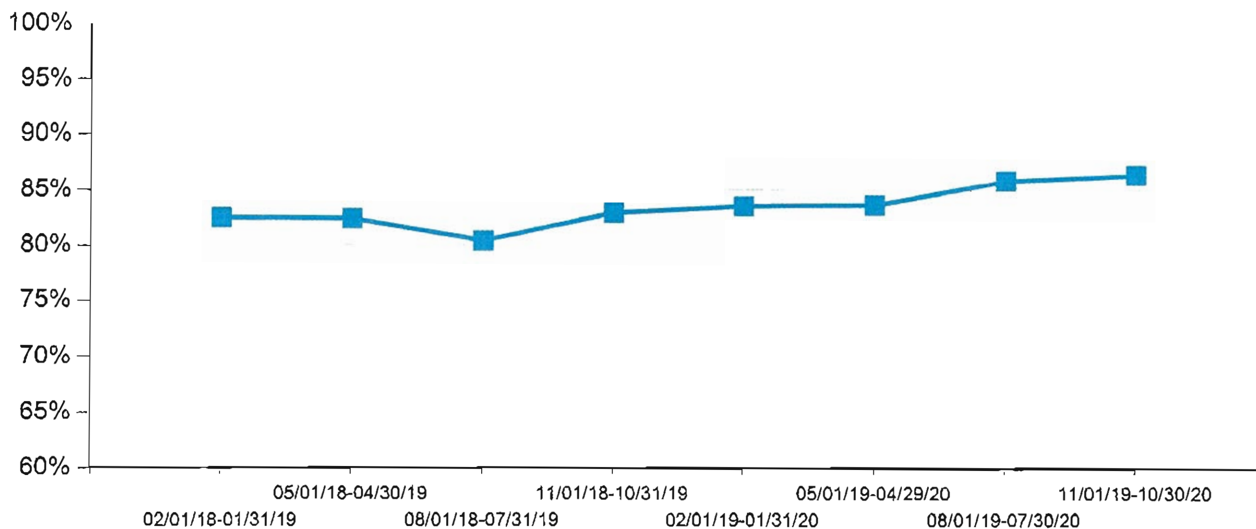
Viral Load 2 Suppression by Agency

	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
Number of clients who have a viral load of <200 copies/ml during the measurement year	561	2,213	2,220	1,677	27	398	557	2,135	2,274	1,650	14	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%	37.0%	81.1%	83.9%	85.4%	80.7%	79.3%	19.7%	77.8%
Change from Previous Quarter Results	6.4%	2.4%	1.0%	3.9%	-27.2%	2.0%	0.2%	1.0%	1.8%	-0.6%	-17.3%	-3.3%



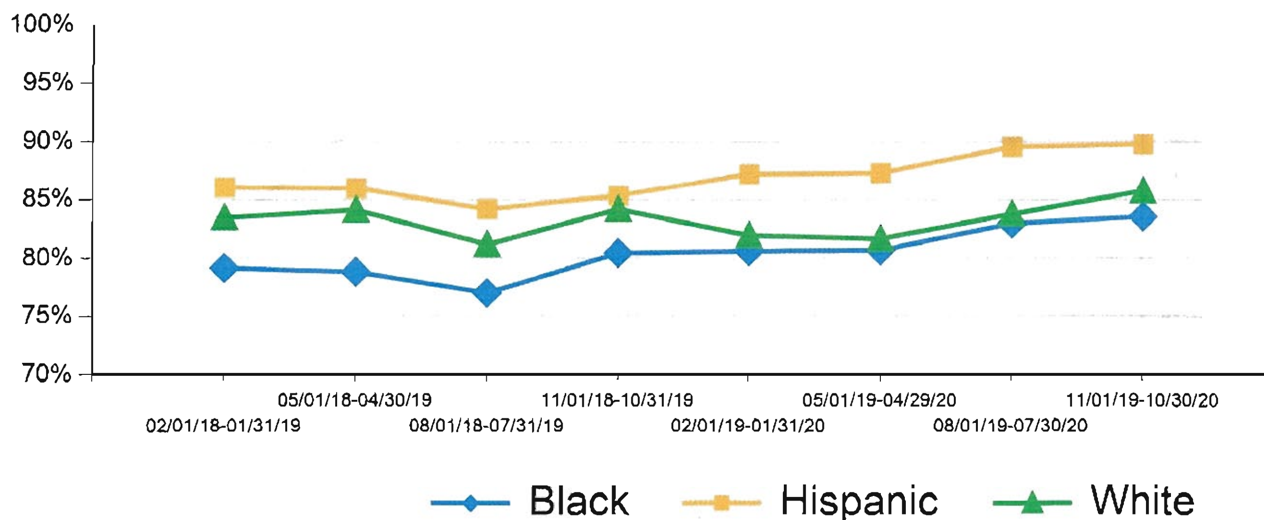
Viral Load Suppression

	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	5,146	5,048
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	5,999	5,847
Percentage	83.5%	83.6%	85.8%	86.3%
Change from Previous Quarter Results	0.6%	0.1%	2.2%	0.6%



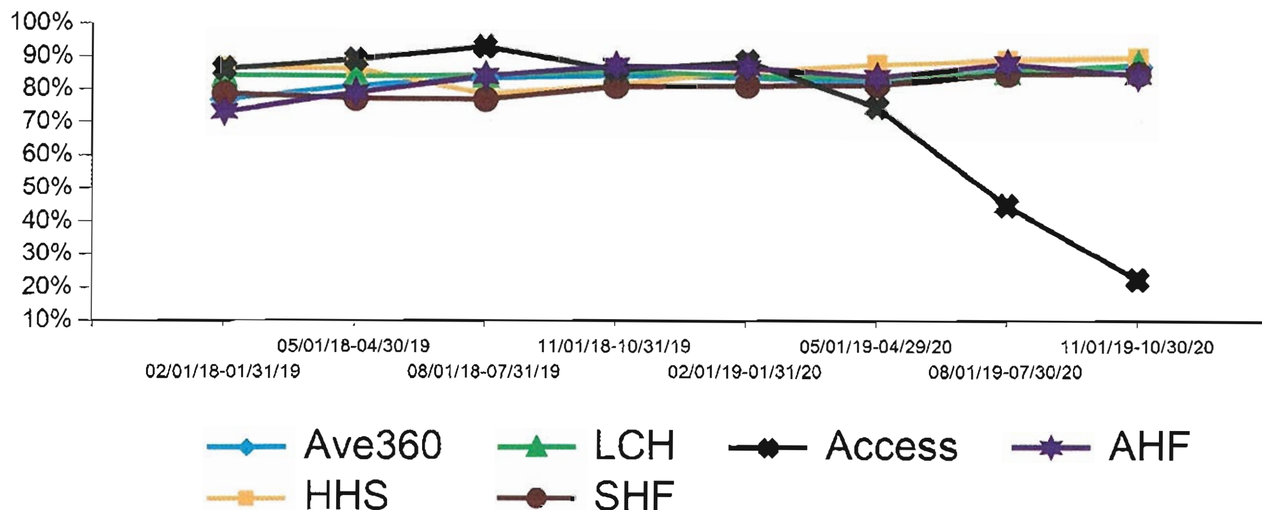
VL Suppression by Race/Ethnicity

	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	2,311	2,105	610	2,280	2,066	602
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	2,785	2,351	728	2,729	2,302	702
Percentage	80.7%	87.3%	81.7%	83.0%	89.5%	83.8%	83.5%	89.7%	85.8%
Change from Previous Quarter Results	0.1%	0.1%	-0.3%	2.3%	2.2%	2.1%	0.6%	0.2%	2.0%



VL Suppression by Agency

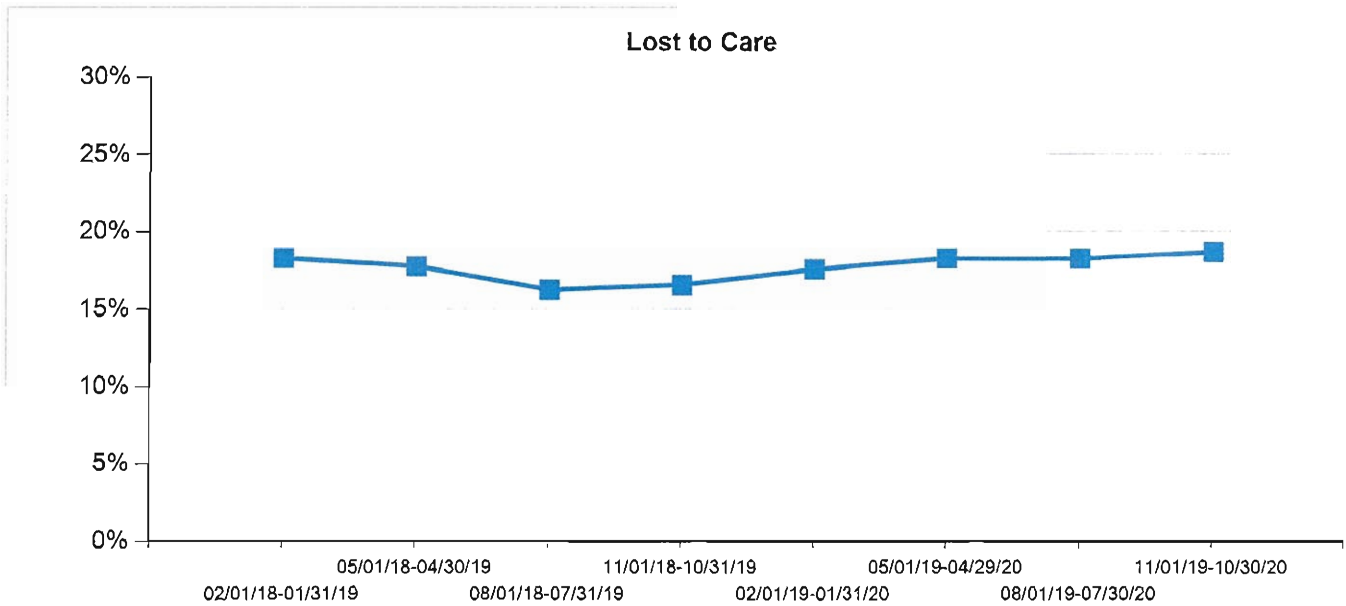
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
Number of clients who have a viral load of <200 copies/ml during the measurement year	481	1,413	1,532	1,476	17	268	483	1,324	1,506	1,480	9	280
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	560	1,593	1,798	1,747	38	306	557	1,479	1,724	1,748	40	333
Percentage	85.9%	88.7%	85.2%	84.5%	44.7%	87.6%	86.7%	89.5%	87.4%	84.7%	22.5%	84.1%
Change from Previous Quarter Results	4.1%	1.3%	1.8%	3.2%	-29.7%	4.1%	0.8%	0.8%	2.1%	0.2%	-22.2%	-3.5%



Lost to Care

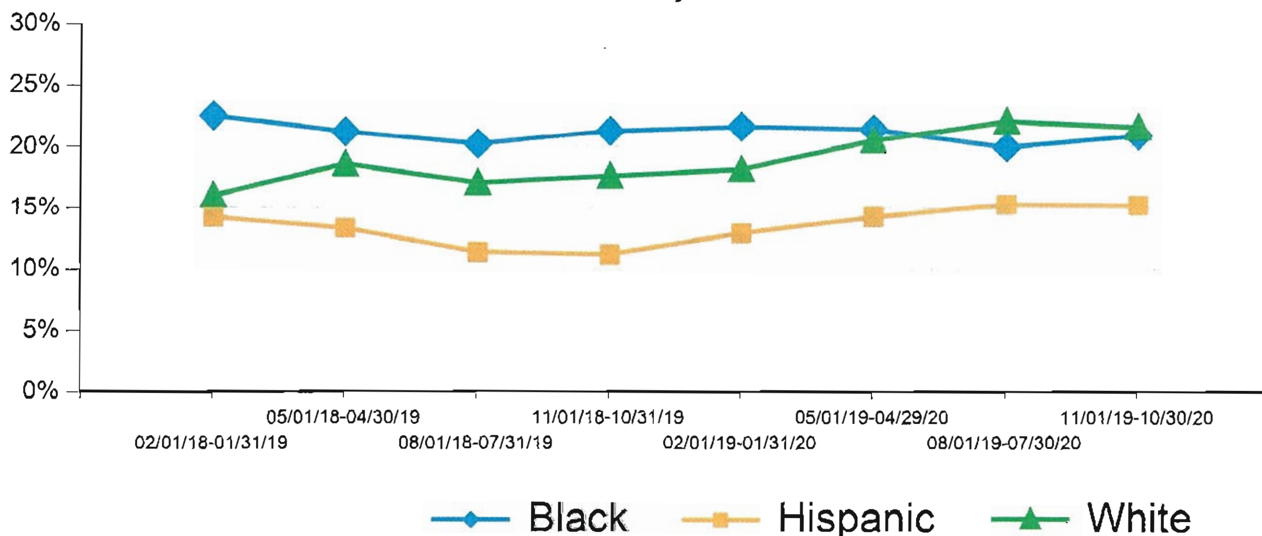
In+Care Campaign Gap Measure

	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	1,141	1,169
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	6,249	6,259
Percentage	17.6%	18.3%	18.3%	18.7%
Change from Previous Quarter Results	1.0%	0.7%	0.0%	0.4%



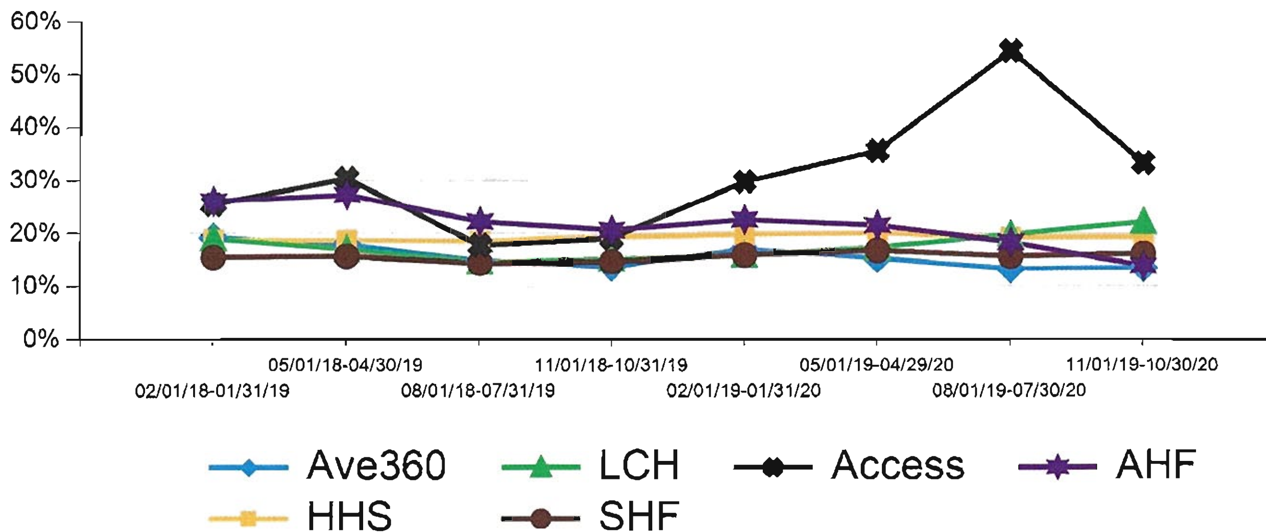
Lost to Care by Race/Ethnicity

	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	561	386	171	598	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	2,483	776	2,814	2,521	776	2,859	2,503	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					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
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	30	58	70	357	423	264	17	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	518	1,908	1,902	1,602	55	317	520	1,853	1,914	1,633	51	333
Percentage	13.3%	19.2%	19.8%	15.7%	54.5%	18.3%	13.5%	19.3%	22.1%	16.2%	33.3%	13.8%
Change from Previous Quarter Results	-2.0%	-0.7%	2.4%	-1.1%	19.0%	-3.2%	0.1%	0.0%	2.3%	0.5%	-21.2%	-4.5%

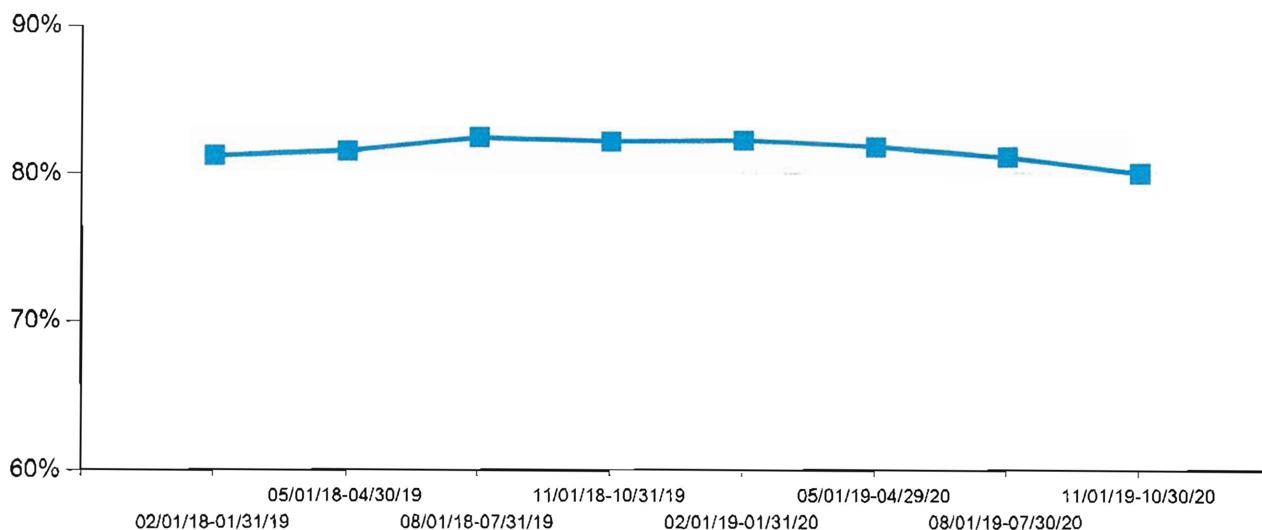


Annual Retention In Care

Houston EMA Medical Visits Measure

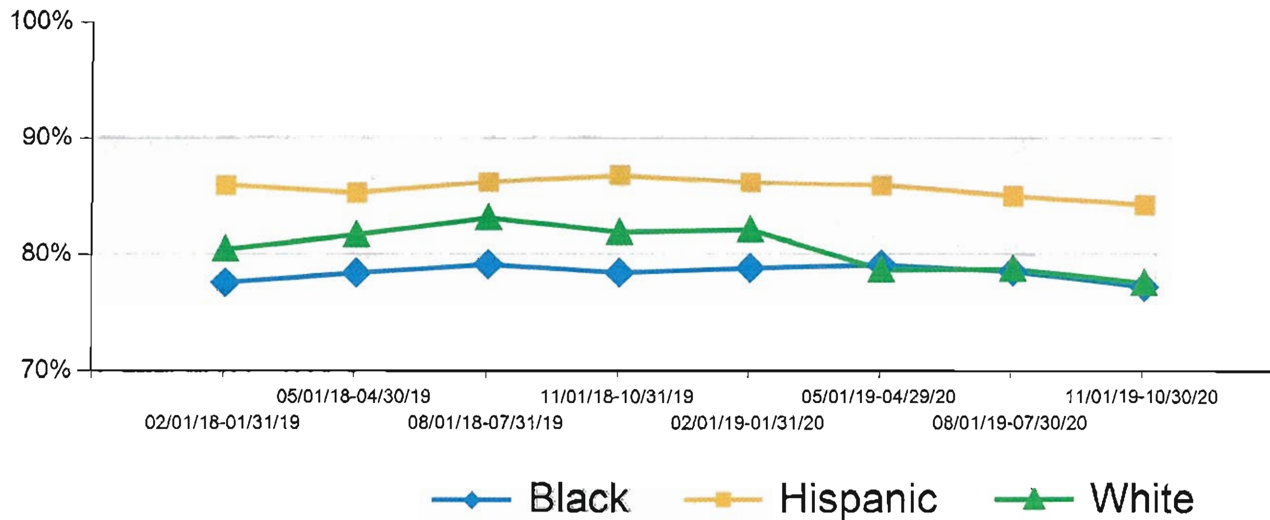
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year*	6,400	6,484	6,442	6,304
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



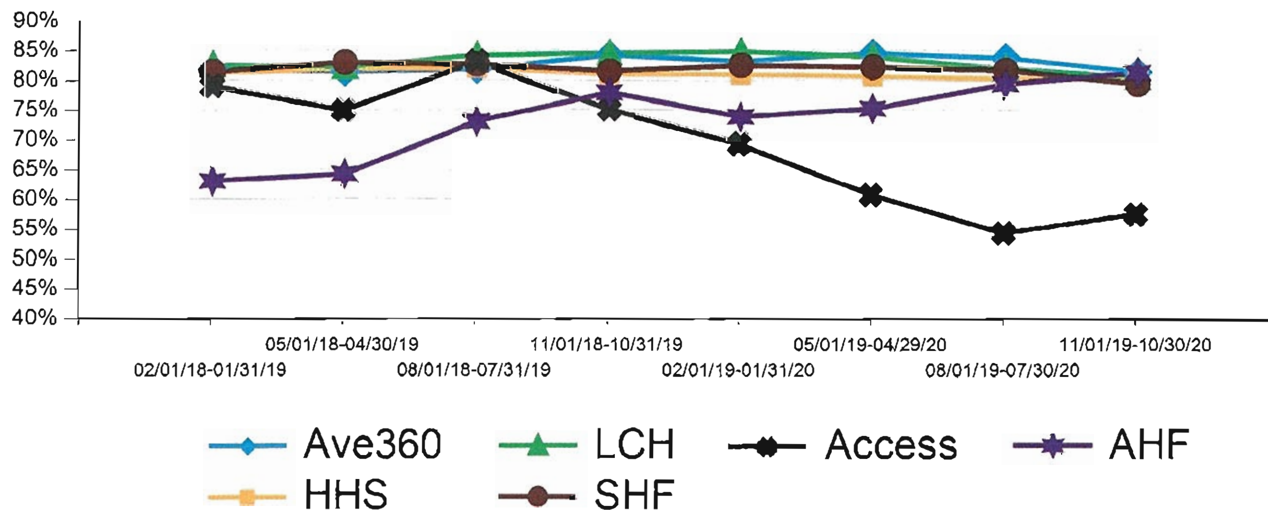
Annual Retention In Care by Race/Ethnicity

	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	2,974	2,589	763	2,940	2,588	770	2,890	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%	78.5%	85.0%	78.7%	77.2%	84.2%	77.5%
Change from Previous Quarter Results	0.3%	-0.3%	-3.4%	-0.6%	-0.9%	0.1%	-1.4%	-0.8%	-1.2%



Annual Retention In Care by Agency

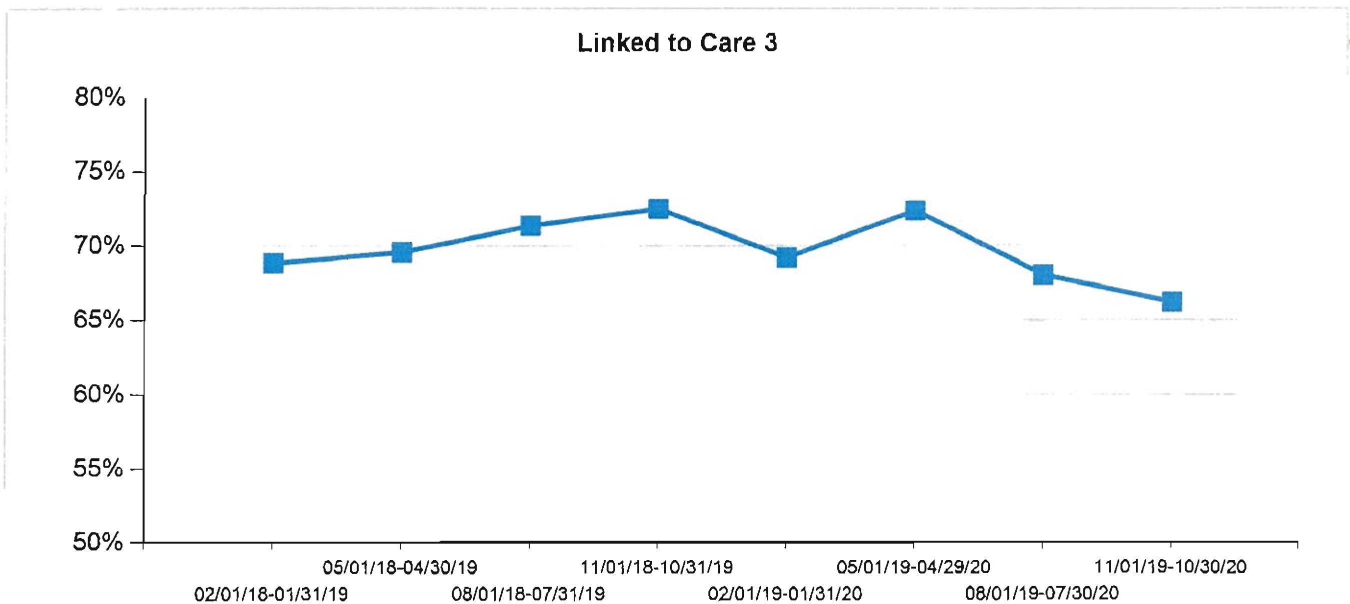
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	539	1,967	2,089	1,601	37	307	519	1,871	2,058	1,556	38	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%	54.4%	79.3%	81.3%	80.1%	80.5%	79.3%	57.6%	81.3%
Change from Previous Quarter Results	-0.8%	-0.4%	-1.9%	-0.5%	-6.4%	4.1%	-2.3%	-0.2%	-1.5%	-2.3%	3.2%	2.0%



Linked to Care 3

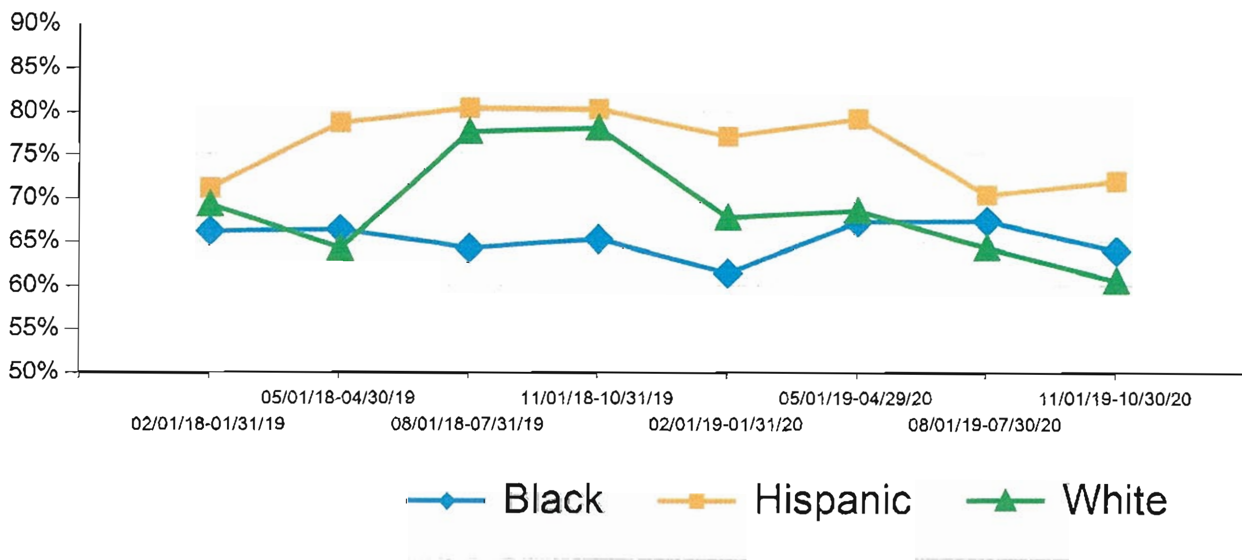
Medical Visits for Newly Enrolled Clients

	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%



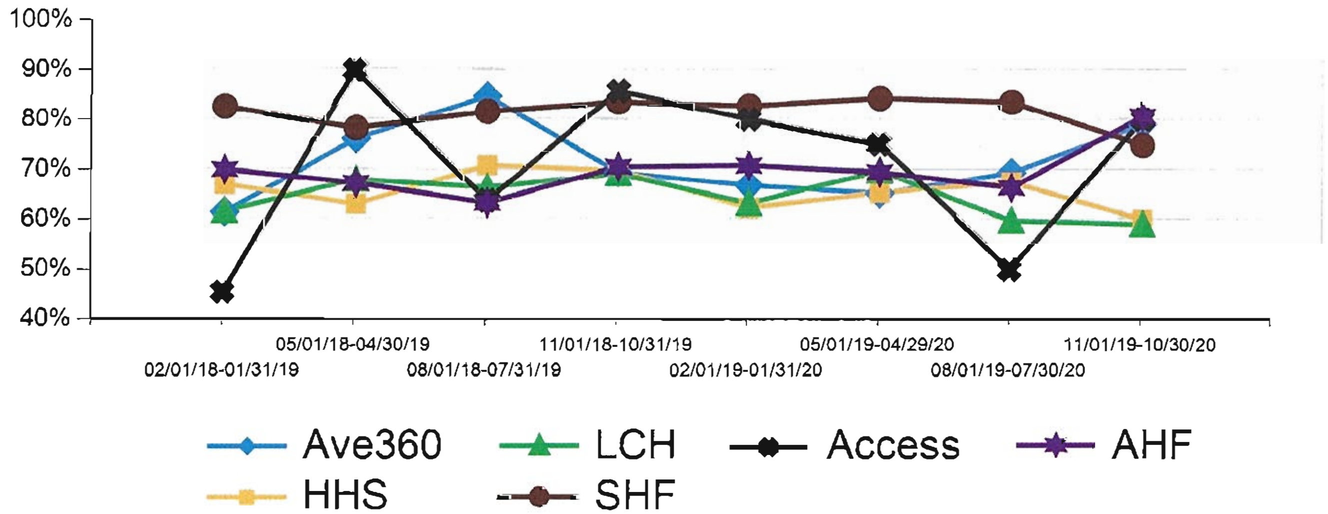
Linked to Care 3 by Race/Ethnicity

	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

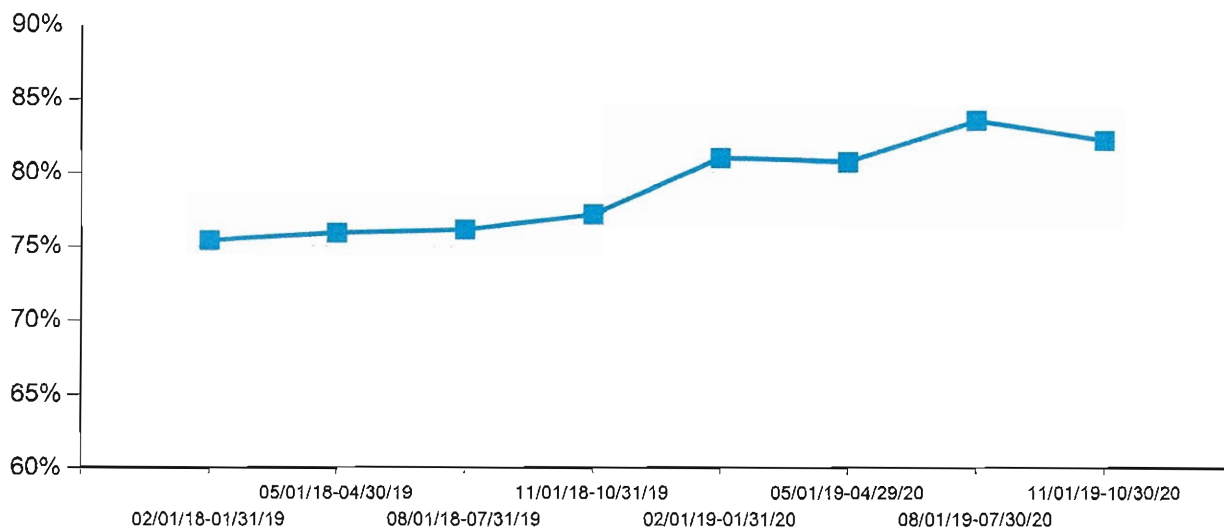
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	9	95	112	106	2	53	15	79	107	86	4	58
Number of newly enrolled clients who 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

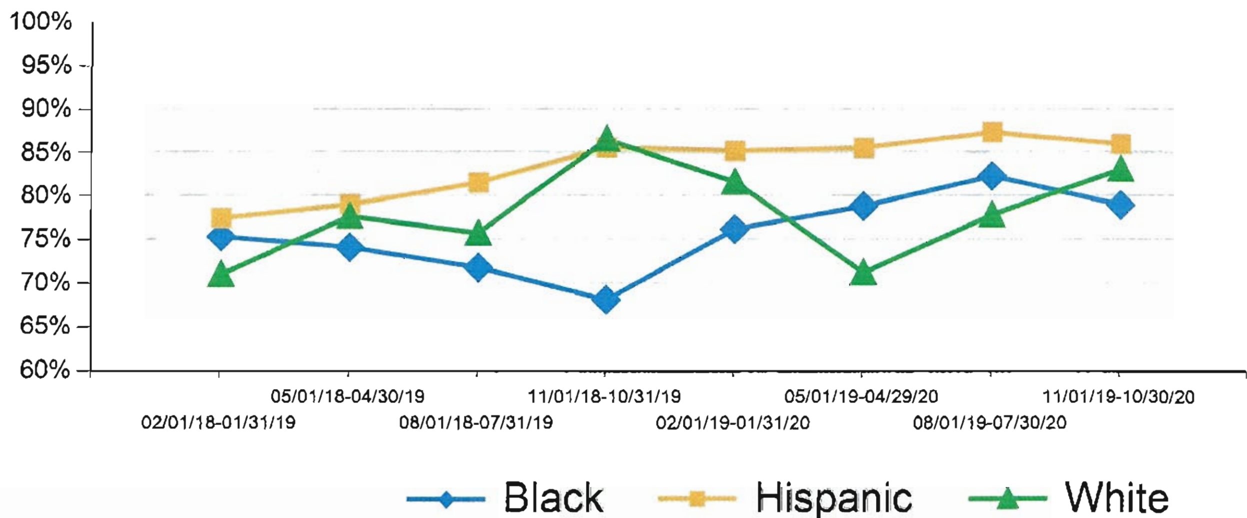
Viral Load Suppression Measure for Newly Enrolled Clients

	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	289	281
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%	83.5%	82.2%
Change from Previous Quarter Results	3.8%	-0.3%	2.8%	-1.4%



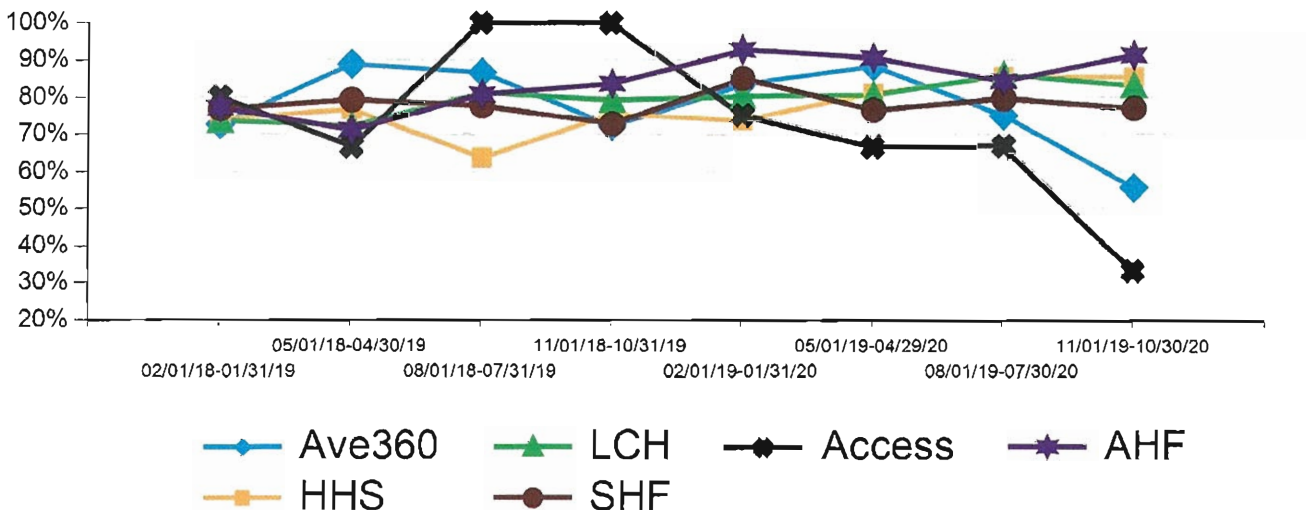
Linked to Care 2 by Race/Ethnicity

	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	130	117	35	127	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%	82.3%	87.3%	77.8%	78.9%	86.0%	83.1%
Change from Previous Quarter Results	2.6%	0.3%	-10.5%	3.5%	1.8%	6.7%	-3.4%	-1.4%	5.3%



Linked to Care 2 by Agency

	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	3	71	98	70	2	48	5	82	93	60	1	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%	66.7%	84.2%	55.6%	85.4%	83.0%	76.9%	33.3%	91.3%
Change from Previous Quarter Results	-13.2%	4.6%	5.6%	3.2%	0.0%	-6.3%	-19.4%	-0.1%	-2.9%	-2.6%	-33.3%	7.1%

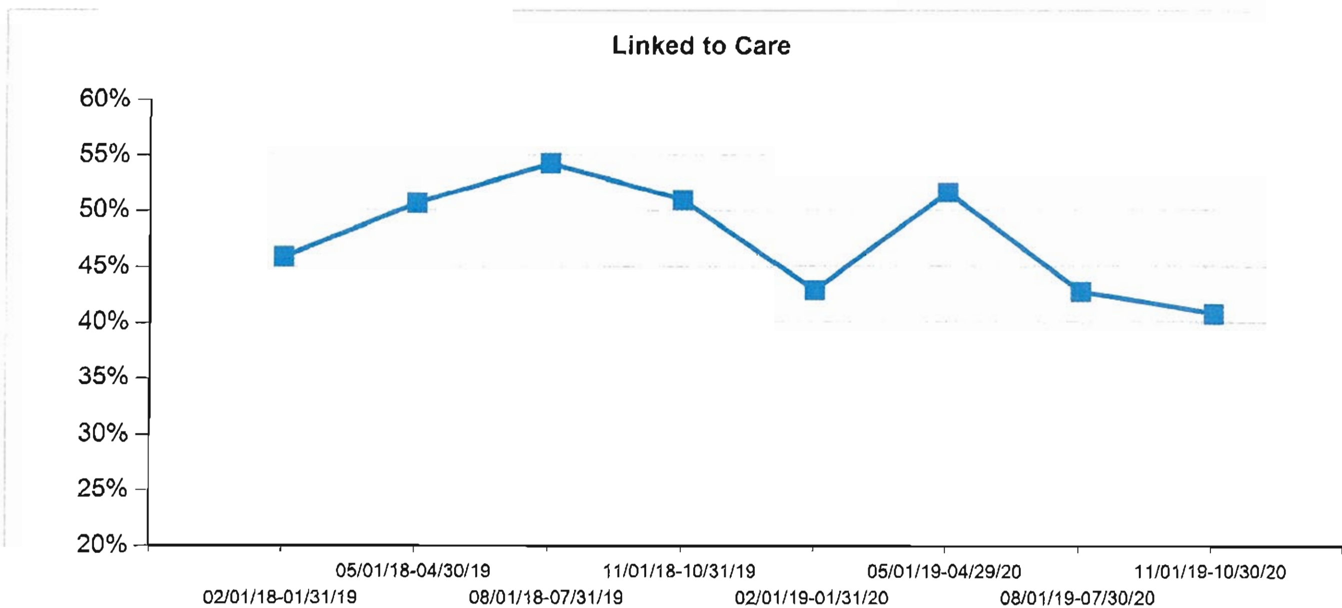


Linked to Care

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	127	94	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	246	220	221
Percentage	42.9%	51.6%	42.7%	40.7%
Change from Previous Quarter Results	-8.1%	8.8%	-8.9%	-2.0%

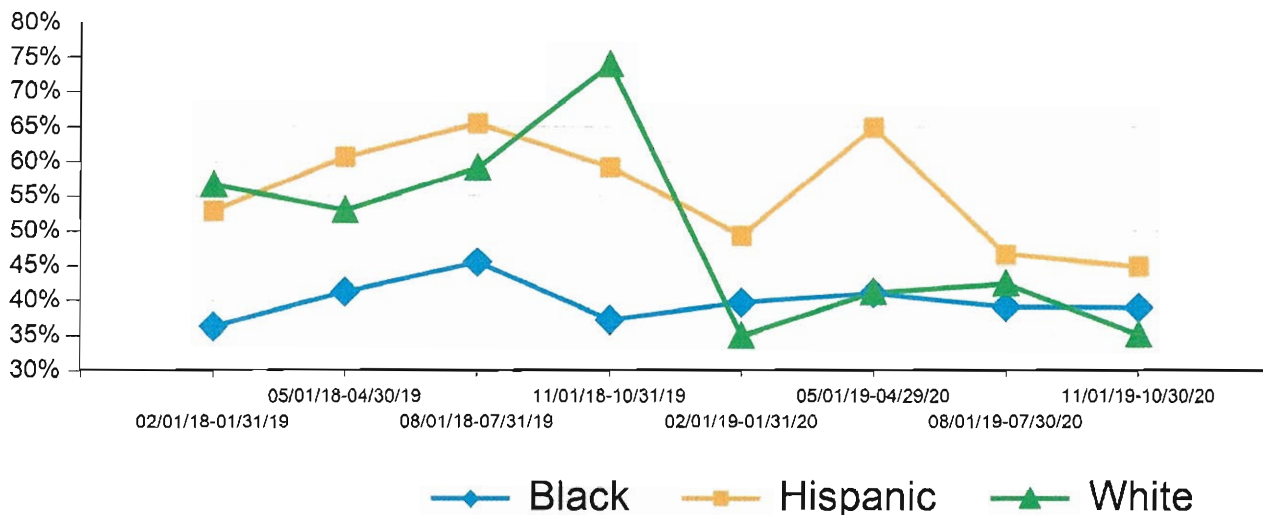
* exclude if vl<200 in 1st 4 months



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	39	72	14	36	42	14	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	95	111	34	92	90	33	105	78	37
Percentage	41.1%	64.9%	41.2%	39.1%	46.7%	42.4%	39.0%	44.9%	35.1%
Change from Previous Quarter Results	1.3%	15.5%	6.2%	-1.9%	-18.2%	1.2%	-0.1%	-1.8%	-7.3%

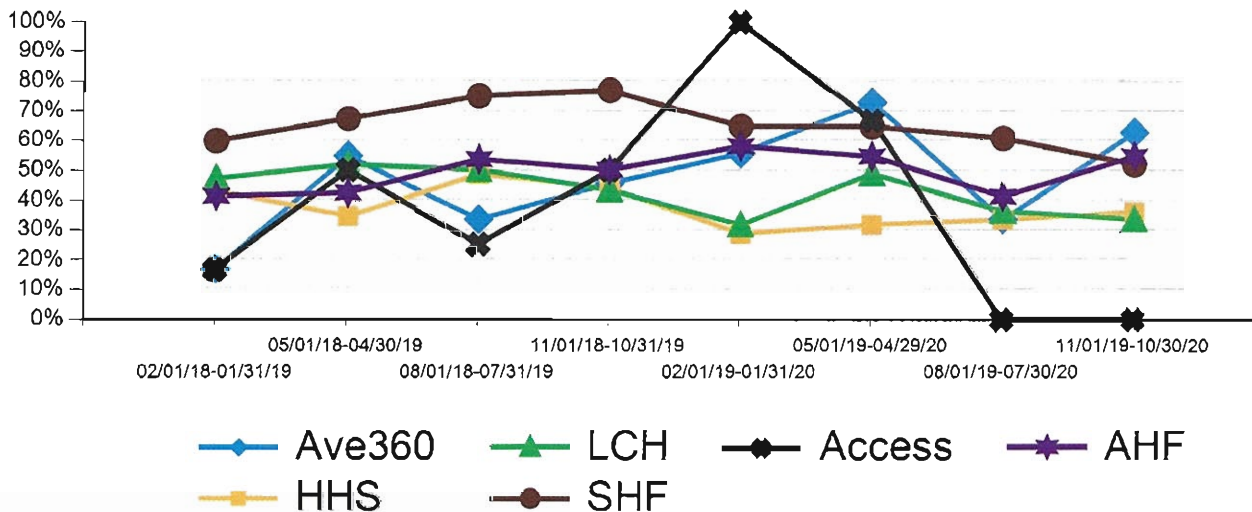
* exclude if vl<200 in 1st 4 months



Linked to Care by Agency

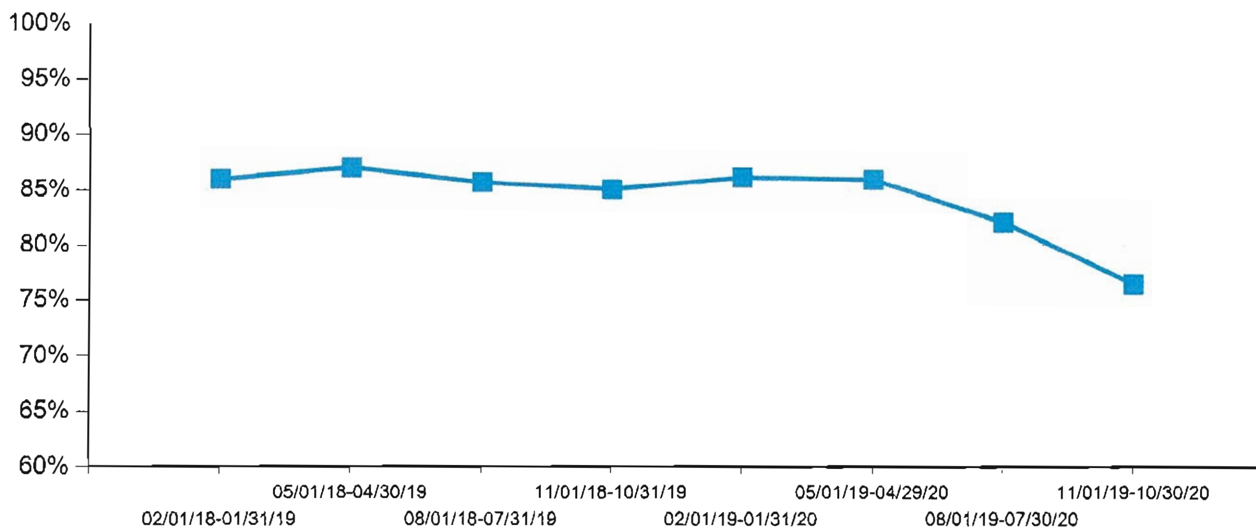
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	1	17	26	37	0	14	5	23	25	27	0	12
Number of newly enrolled 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	51	72	61	1	34	8	64	75	52	2	22
Percentage	33.3%	33.3%	36.1%	60.7%	0.0%	41.2%	62.5%	35.9%	33.3%	51.9%	0.0%	54.5%
Change from Previous Quarter Results	-39.4%	1.8%	-12.6%	-3.9%	-66.7%	-13.4%	29.2%	2.6%	-2.8%	-8.7%	0.0%	13.4%

* exclude if vl<200 in 1st 4 months



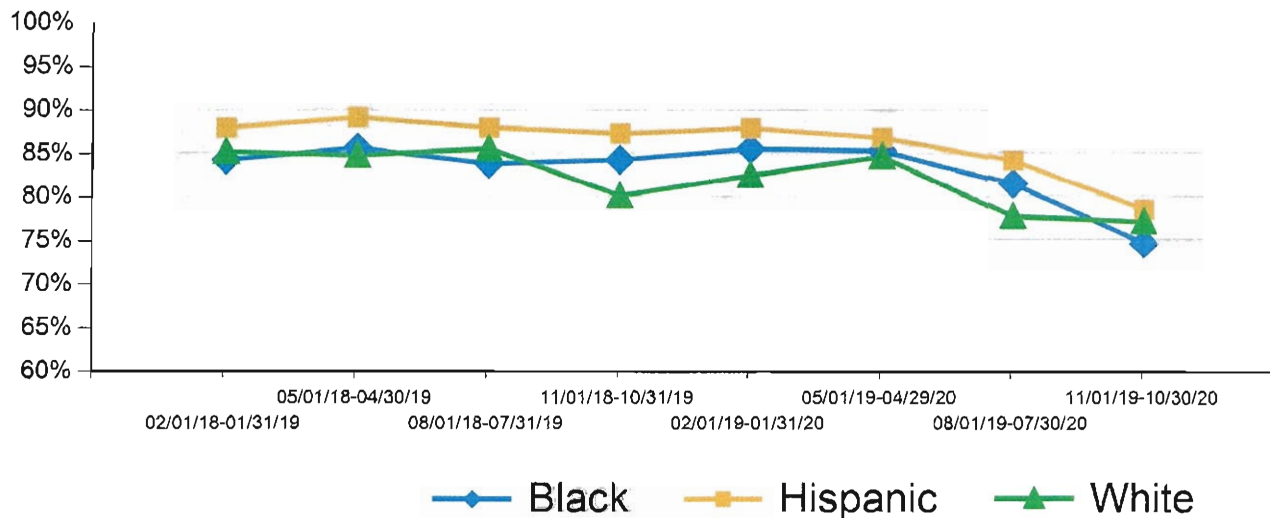
Viral Load Monitoring

	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	4,594	4,230	3,801
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%	85.9%	82.0%	76.4%
Change from Previous Quarter Results	1.1%	-0.2%	-3.9%	-5.6%



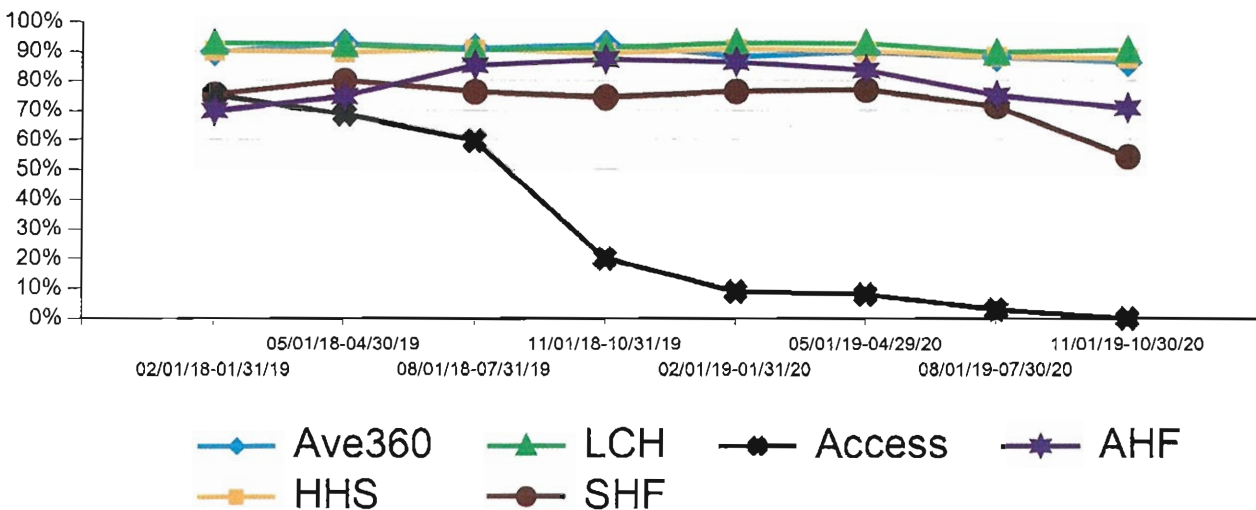
VL Monitoring Data by Race/Ethnicity

	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	2,043	1,895	541	1,894	1,754	483	1,670	1,609	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	85.3%	86.8%	84.7%	81.4%	84.1%	77.7%	74.5%	78.4%	77.0%
Change from Previous Quarter Results	-0.2%	-1.1%	2.2%	-3.9%	-2.8%	-7.0%	-6.9%	-5.6%	-0.6%



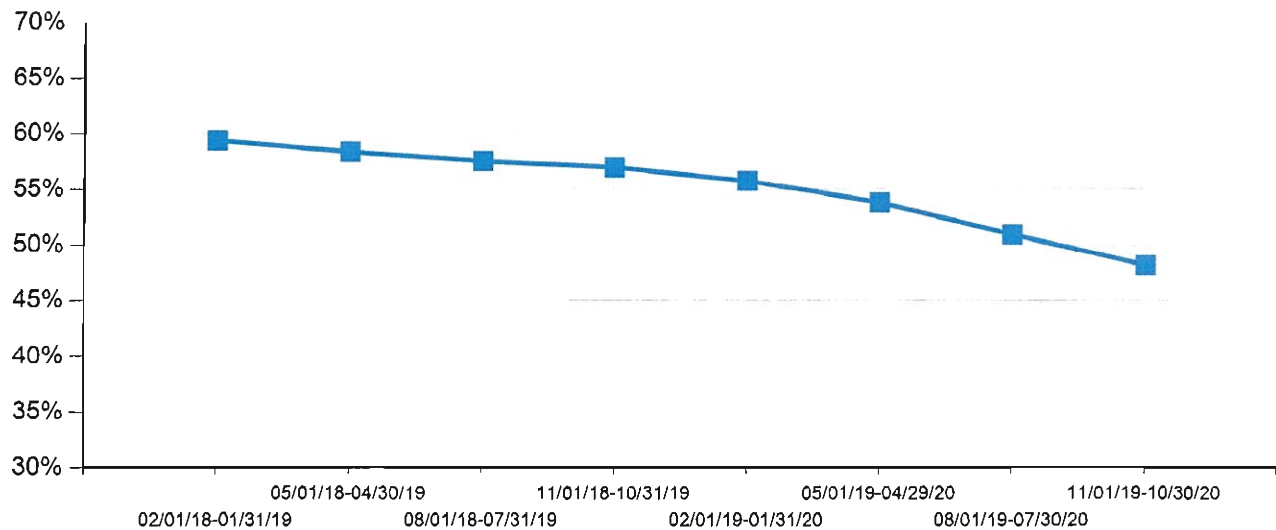
VL Monitoring by Agency

	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
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	1	202	404	1,042	1,329	801	0	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%	2.9%	74.8%	86.1%	87.5%	90.2%	54.1%	0.0%	70.7%
Change from Previous Quarter Results	-1.6%	-1.8%	-3.1%	-5.6%	-5.0%	-8.7%	-1.7%	-0.6%	0.8%	-17.0%	-2.9%	-4.1%



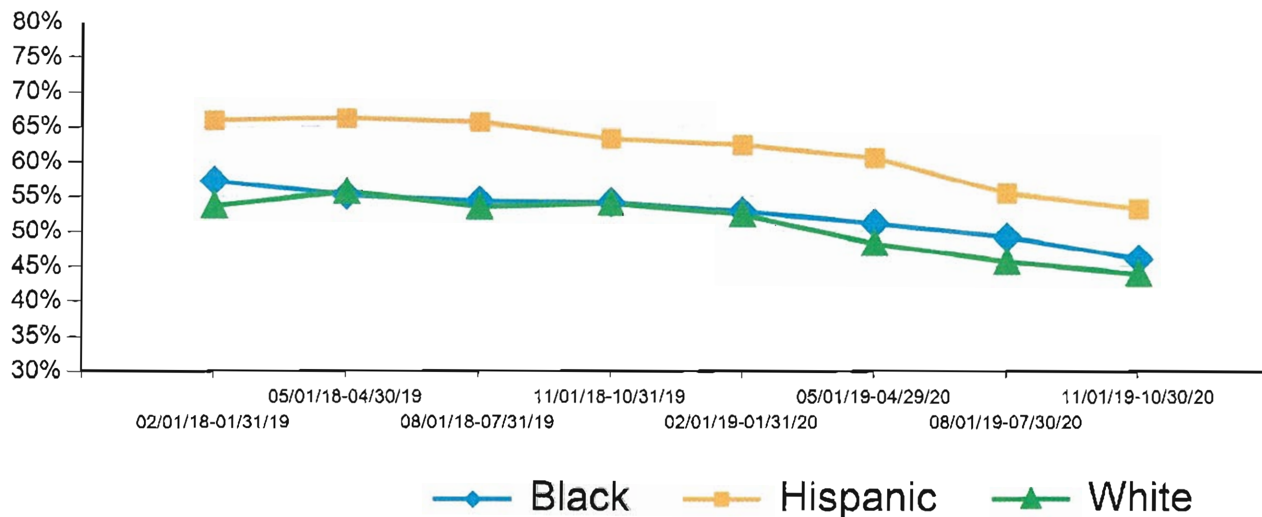
Cervical Cancer Screening

	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	973
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%	48.2%
Change from Previous Quarter Results	-1.2%	-2.0%	-2.8%	-2.8%



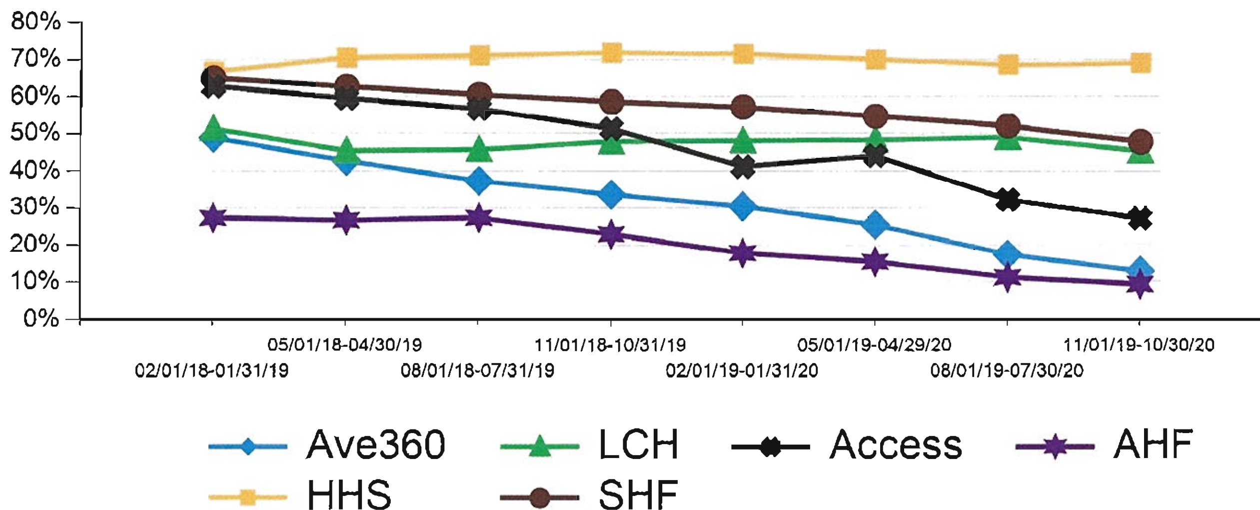
Cervical Cancer Screening Data by Race/Ethnicity

	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	571	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%	46.0%	53.2%	43.9%
Change from Previous Quarter Results	-1.7%	-1.9%	-4.2%	-1.9%	-5.1%	-2.5%	-3.2%	-2.2%	-1.8%



Cervical Cancer Screening by Agency

	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	Ave360	HHS	LCH	SHF	Access	AHF	Ave360	HHS	LCH	SHF	Access	AHF
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	9	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%	27.3%	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%	-5.0%	-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"

2021 Ryan White Planning Council

STANDING COMMITTEE MEMBERSHIP

(Updated 01-21-21)

Red = Committee Vice Chair Yellow = Committee Mentor

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Allen Murray, RWPC Chair	Ronnie Galley, Co-Chair, Operations
Denis Kelly, Vice Chair	Veronica Ardoin , Co-Chair, Operations
Crystal Starr, Secretary	Bobby Cruz, Co-Chair, Priority and Allocations
Rosalind Belcher, Co-Chair, Affected Community	Peta-Gay Ledbetter, Co-Chair, Priority and Allocations
Tony Crawford, Co-Chair, Affected Community	Kevin Aloysius, Co-Chair, Quality Improvement
Daphne L. Jones, Co-Chair, Comprehensive HIV Planning	Steven Vargas , Co-Chair, Quality Improvement
Rodney Mills Co-Chair, Comprehensive HIV Planning	

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3. Veronica Ardoin	10. Diana Morgan	*2. Ms Dee Francis*	*8.*
4. Ardry "Skeet" Boyle Jr.	11.	*3. Josie Rodriguez*	*9.*
5. Enrique Chavez	12.	*4. Beto Ramirez*	
6. Johnny Deal	13.	*5. Trina Wright*	
7. Ronnie Galley		*6.*	

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3. Dawn Jenkins	10. Steven Vargas	*2. Lisa Felix*	
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5 Tom Lindstrom		*4. Esther Ogunjimi*	
6. Shital Patel		*5. Debra Reagans*	
7. Faye Robinson		*6.*	

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2. Veronica Ardoin, Co-Chair	5. Denis Kelly		
3. Bobby Cruz	6. Matilda Padilla		

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2. Peta-Gay Ledbetter, Co-Chair	5. Kimberley Collins	8. Robert Sliepka	*1.*
3. Ardry "Skeet" Boyle Jr.	6. Roxane May	9. Bruce Turner	

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3. Johanna Castillo	10. Crystal Starr	*2. Karla Mills*	
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5. Josh Mica		*4. Tana Pradia*	
6. Nkechi Onyewuenyi		*5. Deborah Somoye*	
7. Oscar Perez		*6.*	