DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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We envision an educated community where the needs of all HIV/AIDS infected and/or affected individuals are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system. The community will continue to intervene responsibly until the end of the epidemic.

The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those infected and/or affected with HIV/AIDS by taking a leadership role in the planning and assessment of HIV resources

AGENDA

12 noon, Thursday, October 13, 2016
Meeting Location: 2223 W. Loop South, Room 416
Houston, Texas 77027

I. Call to Order — Steven Vargas, Chair, RW Planning Council
- A. Welcoming Remarks and Moment of Reflection
- B. Adoption of the Agenda
- C. Approval of the Minutes
- D. Training: Working with Transgender Communities — Lou Weaver, Consultant
- E. EIIHA Update — Amber Harbolt, Health Planner, Office of Support

II. Public Comments and Announcements — Carol Suazo, Secretary

(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/AIDS 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/AIDS 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 with HIV/AIDS", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Committees

A. Quality Improvement Committee — Robert Noble and Cecilia Ross, Co-Chairs

Item: Joint Committee Meeting

Recommended Action: FYI: There will be a Joint Committee meeting to review current reports and consider ways to update and/or improve staff reports to the Ryan White Council and committees in 2017. All are welcome to attend. The meeting is scheduled for 11 am on Thursday, November 17, 2016.

Item: Report from the Administrative Agent – Part A/MAI
Recommended Action: FYI: See the attached draft standards of care for Tax Preparation and Outreach service categories and the current standards of care and performance measures for other services. Recommendations regarding these documents will be voted on at the December Council meeting.

Item: Report from the Administrative Agent – Part B/SS
Recommended Action: FYI: See the attached Health Insurance Assistance Service Utilization Report, 09/01/15-07/31/16, dated 09/09/16.

B. Comprehensive HIV Planning Committee — John Lazo and Nancy Miertschin, Co-Chairs
Item: 2017 EIIHA Strategy
Recommended Action: FYI: See the attached regarding the approved list of FY 2017 EIIHA Target Populations.

Item: Report from the Speakers Bureau
Recommended Action: Verbal updates.

C. Priority and Allocations Committee — Peta-gay Ledbetter and Bruce Turner, Co-Chairs
No report.

D. Affected Community Committee — Allen Murray and Tana Pradia, Co-Chairs
Item: Consumer-only Workgroup Meeting
Recommended Action: FYI: Ryan White Grant Administration hosted a consumer-only workgroup to collect information for the proposed FY 2017 Standards of Care and Performance Measures.

Item: 2016 Monthly Meeting Schedule
Recommended Action: FYI: See the attached list of 2016 committee meetings and training topics.

Item: 2016 Community Events
Recommended Action: FYI: See the attached list of 2016 events at which there will be a Council presence.

E. Operations Committee — Curtis Bellard and Teresa Pruitt, Co-Chairs
No report.

IV. Report from the Office of Support — Tori Williams, Director

V. Report from Ryan White Grant Administration — Carin Martin, Manager

VI. Report from The Resource Group — S. Johnson-Fairley, Health Planner

VII. Medical Updates — Shital Patel, MD, Baylor College of Medicine

VIII. New Business (30 seconds/report)

A. Ryan White Part C Urban and Part D — Nancy Miertschin
B. Community Development Advisory Council (CDAC) — Tracy Gorden
C. HOPWA — Melody Barr
D. Community Prevention Group (CPG) — Herman Finley
E. Update from Task Forces:
- African American — S. Johnson-Fairley
- Latino — Steven Vargas
- MSM — Ted Artiaga
- Transgender
- Youth — John Lazo
- Hepatitis C — Steven Vargas
- Sexually Transmitted Infections (STI) — Herman Finley
- Urban AIDS Ministry — Amber David
- Heterosexual HIV Awareness — Ruth Atkinson

F. Positive Women's Network — Tana Pradia
G. HIV and Aging — Bruce Turner
H. END HIV Houston — Steven Vargas
I. Texas HIV Medication Advisory Committee — Bruce or Nancy
J. Legislative Updates
K. Texas HIV/AIDS Coalition — Bruce Turner
L. SPNS Grant: HIV and the Homeless Program — Nancy Miertschin

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those infected and/or affected with HIV/AIDS by taking a leadership role in the planning and assessment of HIV resources.

MINUTES

12 noon, Thursday, September 8, 2016
2223 W. Loop South, Room 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Steven Vargas, Chair	Tana Pradia	Pamela Chambers
Carol Suazo, Secretary	Teresa Pruitt	Dr. Charlene Flash, BCM
Ted Artiaga	Cecilia Ross	
Connie Barnes	Gloria Sierra	**STAFF PRESENT**
Curtis Bellard	Larry Woods	*Ryan White Grant Administration*
David Benson	Isis Torrente	Carin Martin
Ardry Skeet Boyle	C. Bruce Turner	Heather Keizman
Bianca Burley	David Watson	Tasha Traylor
Ella Collins-Nelson		
Amber David	**MEMBERS ABSENT**	*The Resource Group*
Evelio Salinas Escamilla	Melody Barr	Sha'Terra Johnson-Fairley
Herman Finley	Denny Delgado	
Paul Grunenwald	Tracy Gorden, excused	*Office of Support*
Angela F. Hawkins	Arlene Johnson	Tori Williams
John Lazo	J. Hoxi Jones, excused	Amber Harbolt
Nancy Miertschin	Peta-gay Ledbetter	Diane Beck
Rodney Mills	Shital Patel, excused	
Allen Murray	Leslie Raneri, excused	
Robert Noble		

Call to Order: Steven Vargas, Chair, called the meeting to order at 12:05 p.m.

During the welcoming remarks, Vargas said that today's meeting is going to be as concise and efficiently run as possible so that those who attended the END HIV Houston meetings in the morning can return to finish the group work this afternoon. Because of this, there will be no verbal reports from the task forces so be sure to read the reports from those who were kind enough to submit them in writing. Vargas continued by stating that he learned a lot at the All Grantees Conference in Washington DC. Regarding our presentation entitled *Education Buffet for Consumers and Council Members*, ten EMAs and TGAs requested more information. Atlanta is particularly interested in

starting a LEAP Program. Although he has two years left to serve on the Council, Vargas has decided that he will not to run for Chair of the Planning Council in 2017. Those who would like to run for any of the officer positions for 2017 must submit nominations, for themselves or for someone else, before the end of the November 3rd Steering Committee meeting. Please submit nominations to the Director of the Office of Support (Tori).

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Pruitt, Bellard) to approve the July 14, 2016 minutes.* **Motion carried.** Abstentions: Artiaga, Collins-Nelson, David, Turner.

Training – PrEP: Dr. Charlene Flash, Baylor College of Medicine presented information pertaining to PrEP. See attached.

Update – 2017 Houston Area Comprehensive HIV Prevention and Care Services Plan: Harbolt gave a brief update on the status of the Comprehensive Plan.

Public Comment and Announcements: None.

Reports from Committees:
Quality Improvement Committee: Cecilia Ross, Co-Chair, reported on the following:
Reports from the Part A/MAI Administrative Agent:

- FY16 RW Part A/MAI Procurement Report, dated 08-02-16
- FY15 Performance Measure Highlights

Reports from the Part B/SS Administrative Agent:

- FY16/17 RW Part B Procurement Report, dated 08-18-16
- FY15/16 DSHS State Services Procurement Report, dated 08-18-16
- Health Insurance Assistance Service Utilization Report, dated 08-05-16
- TRG Consumer Interview Results 2015
- TRG Quality Management Program, dated 08-17-16
- TRG 5-Year Quality Improvement Plan

UTMB-Galveston Outreach/Retention Program: Samantha Robinson, RN presented information on the UTMB-Galveston Outreach/Retention in Care Program for which she is a case manager.

FY15 Assessment of the Administrative Mechanism – Part A/MAI: ***Motion #3:*** *To approve the attached FY15 Assessment of the Administrative Mechanism – Part A/MAI. No corrective action required.* **Motion Carried Unanimously.**

Comprehensive HIV Planning Committee: John Lazo, Co-Chair, reported on the following:
The committee will meet next Thursday, September 15, 2016 at 11:00 am and the EIIHA workgroup will meet on Monday, September 12, 2016 at 2:00 pm.

Priority and Allocations Committee: Bruce Turner, Co-Chair, reported on the following:
FY 2015 Carryover Funds: Regarding the possible request for a waiver for administrative use of FY 2015 Ryan White Part A and Minority AIDS Initiative (MAI) carryover funds, Martin said that she did not get to speak to Frances Hodge, our HRSA Project Officer, about this until last week. Hodge said

that she believes it is feasible and will get back to Martin soon so Martin is going to move forward as if the waiver has been approved since the retention in care pilot program should be allowable.

Affected Community Committee: Tana Pradia, Co-Chair, reported on the following:
Committee Training: Amber Harbolt, Health Planner for the Office of Support gave a presentation on Standards of Care, what they are and how they impact consumers.

2016 Monthly Meeting Schedule: See the attached list of 2016 committee meetings and training topics.

2016 Community Events: See the attached list of 2016 events at which there will be a Council presence.

Operations Committee: Teresa Pruitt, Co-Chair, reported on the following:
2017 Council Applicants: The Committee members interviewed four individuals applying for Council membership in 2017. They will interview additional applicant(s) in October 2016.

2017 Council Orientation: The 2017 all-day Council Orientation will be held at Trevisio's Restaurant on Thursday, January 26, 2017.

Report from Office of Support: Tori Williams, Director, summarized the attached report.

Report from Ryan White Grant Administration: Carin Martin, Manager, summarized the attached report.

Report from The Resource Group: Sha'Terra Johnson-Fairley summarized the attached report.

Announcements:

- Turner said that the HIV and Aging Symposium will be streamed live on Facebook Live.
- Escamilla said that HACS received funds for Psychiatry and have a new program for Opiate Addiction.

Adjournment: The meeting was adjourned at 1:12 p.m.

Respectfully submitted,

_____ _____
Victoria Williams, Director Date

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for September 8, 2016

C = Chair of the meeting lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Assessment of Pt A Administrative Mechanism **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Assessment of Pt A Administrative Mechanism **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Steven Vargas, Chair				C				C				C	Robert Noble		X				X				X		
Carol Suazo, Secretary		X				X				X			Tana Pradia		X				X				X		
Ted Artiaga		X						X		X			Teresa Pruitt		X				X				X		
Connie Barnes		X				X				X			Cecilia Ross		X				X				X		
Curtis Bellard		X				X				X			Gloria Sierra		X				X				X		
David Benson		X				X				X			C. Bruce Turner		X						X		X		
Skeet Boyle		X				X				X			Isis Torrente		X				X				X		
Bianca Burley		X				X				X			David Watson		X				X				X		
Ella Collins-Nelson		X						X		X			Larry Woods		X				X				X		
Amber David		X						X		X															
Evelio Salinas Escamilla		X				X				X			**MEMBERS ABSENT**												
Herman Finley		X				X				X			Melody Barr												
Angela F. Hawkins		X				X				X			Denny Delgado												
Paul Grunenwald		X				X				X			Tracy Gorden												
Arlene Johnson		X				X				X			J. Hoxi Jones												
John Lazo		X				X				X			Peta-gay Ledbetter												
Nancy Miertschin		X				X				X			Shital Patel												
Rodney Mills		X				X				X			Leslie Raneri												
Allen Murray		X				X				X															

Public Comment

In an effort to save paper, see attached two sided copies

Sent: Thursday, September 15, 2016 10:42 AM
Subject: Ideas to Enhance HIV Servcies For the State, County and City

Hi Good Morning Health Department Leaders,

I am writing you to kindly request the need to please streamline the services in the State, of Texas, Harris County and The City of Houston in this area for citizens who are diagnosed as being HIV positive.
As I have taken advantage of these services, which are offered here and feel there has to be a better way of offering these services.

I became homeless in the fall of 2015 and being homeless, diagnosed with HIV along with having documented mental issues and without a job made life very difficult for me. I reached out to all the homeless shelters and they were at capacity, I had to go to each location all over the city and just to find out they were all out of funds. I even left voice mail messages to agencies who assisted with emergency housing just to find out no one contacted me back after several tries. After giving up, I had to even sleep in my car for months which was very uncomfortable because no one knew who to refer me to find out who had emergency housing options available. Then I finally tried one last time in my research and found Legacy Community Health who came to the rescue in getting me back on track. Thanks to this agency not only did they offer Housing options, but they shared all the resources I needed to get me on track from having a permanent housing, food referrals, medical and many other services. If it had not been for this agency I possibly would have been homeless permanently. There has to be a better way to communicate along with streamlining these services so that all agencies know who, what, where emergency or temporary housing options are offered in this county/city of Texas. It seems as if most agency I went to did not know much about what other agencies offered nor did they refer me else where and if I am correct they are all focused on the same goals, helping serve those in the HIV community. They must do better in working together and not against each other.

I also applied for food stamps and it took several weeks to get approved, can there not be an agency to offer frozen pre-made foods for those who don't have access to a place to cook, especially if they are staying in a emergency housing option such as a hotel.

With that being said, I feel it would be efficient to house a satellite office all under one roof for the following agencies to include: the Food Stamp office, Department of Health Services or agencies which offer medical/mental services, Drivers License office for those who need an ID in order to apply for services , Housing Agencies should all come together as one and create system, electronic system that all agencies have access to where everyone is connected, to address the needs for an emergency service center or centers with one being centrally located in the midtown part of downtown Houston where those who are HIV positive and homeless can be seen sooner to receive referrals sign up for services offered to the HIV community. Below you will find some suggestions I feel will help our HIV homeless community in details:

Place to go for hot meals
P.O. Box to receive mail especially from agencies
Access to get around on public transportation such as Metro Cards to get around if no transportation to go to agencies
A Voice Mail to be able to check messages if no cell phone is available to be able to be reached if case managers or social services need to reach clients for any reason
Partner with Hotel/Motels throughout the city and provide vouchers to HIV clients for a once a week basis and they renew every week by meeting with a case manager for up to a month or two, and the client meets once a week with a case manager to provide status updates, where all clients must be seeking a job, do random drug testing and must be in touch with referral services where they must be actively seeking permanent housing and this be documented in the clients notes
Food Stamps, where those who are diagnosed can access emergency food stamps quicker and not have to wait several weeks to receive if there are no option available to have frozen foods be made available
Medical treatment of services be able to have a fast track program to get those who are HIV positive be able to access these services immediately rather than weeks later
Partner with more agencies to offer urgent care counseling services

Create a policy that if one receives these emergency services they must:
1. Have documentation of diagnosis
2. Show proof of 1 or 2 more diagnosis attached with HIV in order to qualify for these services but with HIV plus 2 diagnosis they will be go ahead of someone who is just HIV positive.
3. Be homeless
4. Actively Job searching
5. Subject to drug testing for entry of the program and instant, random testing during onsite in order to qualify for the program and if client fails then they do not qualify until they can come back showing they are clean

Thank you for your taking time out of your schedule to address my concerns and feel free to contact me should you have any further questions or concerns.

Best,

Quality Improvement Committee Report

Tax Preparation Services

The Houston RW Part A Tax Preparation Services are a combination of the HRSA defined tax preparation and tax related planning services provided to PLWH individuals and/or their legal/custodial representatives by an tax accountant licensed to practice in Texas. Services include tax planning, tax preparation and filing, retirement and pension planning, and mutual funds.

1.0	**Services are part of the coordinated continuum of HIV/AIDS services.**	
1.1	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
2.0	**Tax Preparation services adhere to professional standards and regulations.**	
2.1	Licensure Tax preparers are licensed to practice accounting in the state of Texas and have a minimum educational level of a master's in finance and/or accounting.	• Staff records indicate compliance
2.2	Non-Licensed Staff Non-licensed staff members are supervised by tax preparers and or supervisors	• Review of agency's Policies & Procedures Manual indicates compliance
3.0	**Service providers are knowledgeable, accepting and respectful of the needs of individuals with HIV/AIDS.**	
3.1	Ongoing Staff Training Staff has access to appropriate training and resources needed to deliver services. Staff members are trained and knowledgeable and remain current in tax and financial issues in accordance with the rules of the IRS. Staff shall possess thorough knowledge about the Marketplace plans and should help clients with navigation as necessary Staff shall maintain knowledge of tax issues that may impact the financial assistance needs of PLWH. Agency paid tax staff and contractors must complete two (2) hours of HIV-specific training annually. New agency paid tax staff and contractors must complete two (2) hours of HIV-specific training within 90 days of start date. Volunteer tax staff are encouraged to complete HIV-specific	• Staff has attended and has continued access to training activities • Staff has access to manuals and regulations • Documentation of training on current applicable tax laws • Staff have access to updated HIV/AIDS information • Agency maintains system for dissemination of HIV/AIDS information relevant to the tax assistance needs of PLWH to paid staff and volunteers • Staff interviews indicate compliance

	tax training.	
4.0	**Client is kept informed and participates in decisions about his/her case.**	
4.1	Service Agreement Clients are kept informed and work together with staff to determine the objective of the tax preparation and to achieve goals.	• Copy of service agreement between client and agency is in client record
4.2	Case Closure Agency will develop case closure criteria and procedures. Cases may be closed: • when the client's tax issue has been resolved, or when the client: • has become ineligible • has had no direct program contact for over six months • is deceased • no longer needs the service • discontinues the service • improperly utilizes the service • has not complied with the client services agreement Agency will attempt to notify clients about case closure.	• Case closure criteria and procedures on file at provider agency • Client chart will include attempts at notification and reason for case closure

APPENDIX

Non-Medical Case Management Services (Outreach and Reengagement/Re-linkage Specialist/Worker)

Non-medical case management services (Outreach and Reengagement/Re-linkage Specialist (ORRS) is co-located in ambulatory/outpatient medical care centers with 80% of their time spent in the field. HRSA defines Non-Medical case management services as the "provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services" and does not include coordination and follow-up of medical treatment. The Ryan White Part A/B ORRS provides services to clients who require more intensive relinkage and reengagement services and these include the provision of information, such as, but not limited to address and/or place of residence , contact number and a secondary telephone number, as well as an emergency contact as a back-up and secondary contact/source. The ORRS positon will act in a mentoring capacity and serve as a liaison as necessary for the primary care physician, service linkage worker and clinical or medical case manager. As such, the ORRS will identify clients who have missed an appointment and are on the verge of disengaging from care or appear upon the cusp of dropping out of care.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications Outreach and Reengagement/Re-linkage Specialist – unlicensed community field caseworker. Outreach and Reengagement/Re-linkage Specialists must have experience working with, mentoring and/or collaborating with PLWH. Exposure to PLWH and the community this group is comprised of is essential. Outreach and Reengagement/Re-linkage Specialists – must have a minimum of 1 year paid/volunteer work experience with PLWH. Bilingual (English/Spanish) targeted Outreach and Reengagement/Re-linkage Specialists must have written and verbal fluency in English and Spanish. Agency will provide Outreach and Reengagement/Re-linkage Specialist a written job description upon hiring.	• A file will be maintained on Outreach and Reengagement/Re-linkage Specialist. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.
2.0	**Timeliness of Services/Documentation**	
2.1	Client Eligibility Outreach and Reengagement/Re-linkage– targeted to Not-in-Care and Newly Diagnosed (COH Only) In addition to general eligibility criteria individuals must meet the	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of "not in care" status

	following in order to be eligible for non-medical case management services: • HIV+ and not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS	through the CPCDMS
2.2	Outreach and Reengagement/Re-linkage Specialist Reassessment begins upon re-engagement of the client. The outreach and reengagement/re-linkage specialist will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The Outreach and Reengagement/Re-linkage Specialist – will complete RWGA –approved reassessment tool within five (2) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager. **Low-need, non-primary care clients who have only an intermittent need for information about services may receive brief SLW services without being placed on open status.**	• Documentation in client record on the brief assessment form, signed and dated • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.3	Outreach and Reengagement/Re-linkage Specialist –Reassessment Clients on **open status** will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (COH Only) outreach and reengagement/re-linkage specialist – s targeting their services to Not-in-Care and newly diagnosed clients will work with	• Documentation in client record and in the CPCDMS

	clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services. Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	
2.5	<u>Primary Care Newly Diagnosed and Lost to Care Clients</u> Agency must have a written policy and procedures in place that address the role of Outreach and Reengagement/Re-linkage Specialist in the relinking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals • Description of service linkage worker job duties conducted in the field • Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	○ Review of Agency's Policies and Procedures Manual indicates compliance.
3.0	**Supervision and Caseload**	
3.1	<u>Outreach and Reengagement/Re-linkage Specialist – Supervision</u> A minimum of four (4) hours of supervision per month must be provided to each outreach and reengagement/re-linkage specialist – a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record
3.2	<u>Caseload Coverage – Outreach and Reengagement/Re-linkage</u>	• Documentation of all client encounters in

	Specialist Supervisor ensures that there is coverage of the caseload in the absence of the outreach and reengagement/re-linkage specialist or when the position is vacant. Outreach and Reengagement/Re-linkage Specialists may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	client record and in the Centralized Patient Care Data Management System
3.3	Case Reviews – Outreach and Reengagement/Re-linkage Specialists Supervisor reviews a random sample equal to 10% of unduplicated clients served by each outreach and reengagement/re-linkage Specialist – at least once every ninety (60) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and ORRS

1718 HOUSTON HSDA STANDARDS OF CARE
SUMMARY OF CHANGES

COMMUNITY-BASED HEALTH SERVICES

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 conspicuous highly-visible place at the site where services are provided to clients.

HEALTH INSURANCE ASSISTANCE

Service Category Name Changed

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-1601).	• Annual Review of agency shows compliance with established policy.

Harris County

HCPHES

Public Health & Environmental Services

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

Tele: 713 439-6000
Fax: 713 439-6080

FY 2015 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY

PUBLIC HEALTH & ENVIRONMENTAL SERVICES

(HCPHES)

TABLE OF CONTENTS

Highlights from FY 2015 Performance Measures

Clinical Case Management

- During FY 2015, from 3/1/2015 through 2/29/2016, 1,018 clients utilized Part A clinical case management. According to CPCDMS, 402 (40%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 247 (24%) accessed mental health services at least once during this time period after utilizing clinical case management.

Local Pharmacy Assistance

- Among LPAP clients with viral load tests, 2,549 (74%) clients were virally suppressed during this time period.

Medical Case Management

- During FY 2015, 5,047 clients utilized Part A medical case management. According to CPCDMS, 2,484 (49%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these medical case management clients, 599 (12%) accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 2,078 (41%) clients had third-party payer coverage after accessing medical case management.

Non-Medical Case Management / Service Linkage

- During FY 2015, 6,249 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 2,870 (46%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, the average number of days between the first service linkage visit and the first primary medical care visit was 29 days during this time period.

Primary Medical Care

- During FY 2015, 6,966 clients utilized Part A primary medical care. According to CPCDMS, 4,019 (76%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 299 (21%) had an AIDS diagnosis (CD4 < 200) within the first 90 days of initial enrollment in primary medical care.
- Among clients with viral load tests, 6,962 (74%) clients were virally suppressed during this time period.

Transportation

- Van-Based Transportation:
  - During FY 2015, 464 (69%) clients accessed primary care after utilizing van transportation services.

- Among van-based transportation clients, 345 (51%) clients accessed LPAP services at least once during this time period after utilizing van transportation services.

- Bus Pass Transportation:
  - During FY 2015, 898 (34%) clients accessed primary care after utilizing bus pass services.
  - Among bus pass clients, 440 (17%) clients accessed LPAP services at least once during this time period after utilizing bus pass services.

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Clinical Case Management
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 1,018 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2014	FY 2015	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	641 (50.6%)	402 (39.5%)	**-11.1%**
Percentage of clinical case management clients who utilized mental health services	298 (23.5%)	247 (24.3%)	**0.8%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	491 (74.6%)	382 (73.0%)	**-1.6%**
Percentage of clients identified with an active substance abuse condition who received Ryan White funded substance abuse treatment	0 (0.0%)	0 (0.0%)	**0.0%**
Percentage of clients who were homeless or unstably housed	411 (32.5%)	327 (32.1%)	**-0.4%**

According to CPCDMS, 8 (0.8%) clients utilized primary care for the first time and 57 (5.6%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2014
Percentage of HIV-infected clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year	29%

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Legal Services

HIV Performance Measures	FY 2014	FY 2015	Change
Change in the number of permanency planning cases completed over time	63	51	
65% of completed SSI disability, insurance, public benefits and income-related cases will result in access to or continued access to benefits	40 (45.5%)	44 (47.3%)	**1.8%**

Type of Case	Number of Completed Cases FY 2015	Number and Percent of Completed Cases that Resulted in Access (or Continued Access) to Benefits	
SSI Disability	27	20	74%
Insurance	1	1	100%
Public Benefits	7	5	71%
Income-Related	16	7	44%
Other	42	11	26%
Total	**93**	**44**	**47%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2014	FY 2015	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,631 (74.4%)	2,549 (73.9%)	**-0.5%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Medical Case Management
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 5,047 clients utilized Part A medical case management.

HIV Performance Measures	**FY 2014**	**FY 2015**	**Change**
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,664 (52.7%)	2,484 (49.2%)	**-3.5%**
Percentage of medical case management clients who utilized mental health services	548 (10.8%)	599 (11.9%)	**1.1%**
Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	2,060 (40.8%)	2,078 (41.2%)	**0.4%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,188 (71.8%)	2,110 (70.9%)	**-0.9%**
Percentage of 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	2,171 (23.7%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	664 (24.9%)	545 (23.3%)	**-1.6%**
Percentage of clients who were homeless or unstably housed	1,751 (34.7%)	1,879 (37.2%)	**2.5%**

According to CPCDMS, 194 (3.8%) clients utilized primary care for the first time and 241 (4.8%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	**FY 2014**
60% of HIV-infected medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	33%

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Medical Nutritional Supplements

HIV Performance Measures	FY 2014	FY 2015	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	395 (80.1%)	396 (79.7%)	**-0.4%**
90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year	N/A	7 (58.3%)	**N/A**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Oral Health Care
All Providers

HIV Performance Measures	**FY 2015**
75% of diagnosed HIV/AIDS-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up	See Oral Pathology Table

Clinical Chart Review Measures*	**FY 2013**	**FY 2014**
75% of HIV-infected oral health patients will have a dental health history (initial or updated) at least once in the measurement year	73%	97%
75% of HIV-infected oral health patients will have a medical health history (initial or updated) at least once in the measurement year	72%	81%
90% of HIV-infected oral health patients will have a dental treatment plan developed and/or updated at least once in the measurement year	93%	89%
85% of HIV-infected oral health patients will receive oral health education at least once in the measurement year	85%	87%
90% of HIV-infected oral health patients will have a periodontal screen or examination at least once in the measurement year	91%	91%
60% of HIV-infected oral health patients will have a Phase 1 treatment plan that is completed within 12 months	N/A	79%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/cms/One.aspx?portalId=73056&pageId=107877

Oral Pathology	Number of Diagnoses	Number with Follow-Up	*Resolved at Follow-up		*Improved at Follow-up		*Same at Follow-up		*Worsened at Follow-up	
			#	%	#	%	#	%	#	%
Atrophic candidiasis										
HIV-related periodontal disease										
Idiopathic thrombocytopenia purpura										
Kaposi's sarcoma										
Lymphomas										
Oral hairy leukoplakia										
Oral ulcerations										
Papilloma										
Pseudomembranous candidiasis										
Salivary gland disease										
Squamous cell carcinoma										
Other										
Total	**0**	**0**								

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Primary Medical Care
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 6,966 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2014	FY 2015	Change
90% of clients with HIV infection will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,106 (74.9%)	4,019 (76.3%)	**1.4%**
Less than 20% of clients who have a CD-4 < 200 within the first 90 days of initial enrollment in primary medical care	272 (20.0%)	299 (20.6%)	**0.6%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD-4 cell counts or percentages performed during the measurement year at least three months apart	4,107 (74.9%)	3,683 (69.9%)	**-5.0%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,154 (73.4%)	5,081 (72.9%)	**-0.5%**
Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year	1,987 (28.3%)	1,729 (24.8%)	**-3.5%**
85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year	6,046 (86.1%)	5,791 (83.2%)	**-2.9%**
95% of clients with HIV infection will be screened for Hepatitis B virus infection status (ever)	5,114 (72.8%)	5,211 (74.8%)	**2.0%**
90% of clients with a diagnosis of HIV/AIDS will have a viral load test performed at least every six months during the measurement year	3,797 (86.6%)	3,405 (78.0%)	**-8.6%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	6,928 (72.9%)	6,962 (73.7%)	**0.8%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,171 (23.7%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	1,566 (28.6%)	1,394 (26.5%)	**-2.1%**

Clinical Chart Review Measures	FY 2014
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	Data below
Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network who had a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	Data below

From 3/1/2014 through 2/29/2015, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 5.7 Days

Agency 1: 5.4
Agency 2: 7.4
Agency 3: 2.7
Agency 4: 8.5
Agency 5: 4.7

From 3/1/2014 through 2/29/2015, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 10.1 Days

Agency 1: 6.6
Agency 2: 10.0
Agency 3: 10.0
Agency 4: 14.0
Agency 5: 10.1

Clinical Chart Review Measures*	FY 2013	FY 2014
100% of clients with a diagnosis of HIV/AIDS will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	98.7%	100%
100% of pregnant women with HIV infection will be prescribed antiretroviral therapy	100%	100%
Percentage of female clients with a diagnosis of HIV who have a pap screening in the measurement year	61.2%	63.5%
55% of clients with HIV infection will complete the vaccination series for Hepatitis B	50.3%	55.6%
85% of clients with HIV infection will receive HIV risk counseling within the measurement year	82.8%	77.0%
95% of clients with a diagnosis of HIV will be screened for substance abuse (alcohol and drugs) in the measurement year	97.6%	98.3%
90% of clients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	92.3%	93.1%
65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	62.4%	67.2%
75% of clients with a diagnosis of HIV/AIDS, for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	62.0%	71.1%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	62.3%	66.6%
95% of clients will be screened for clinical depression using a standardized tool with follow up plan documented	81.9%	89.3%
90% of clients with HIV infection will have ever received pneumococcal vaccine	84.7%	89.2%
100% of clients will be screened for tobacco use at least one during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user	99.7%	99.4%
95% of clients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	95.9%	95.3%
85% of clients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	66.7%	85.0%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/cms/One.aspx?portalId=73056&pageId=107877

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Non-Medical Case Management / Service Linkage
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 6,249 clients utilized Part A non-medical case management.

HIV Performance Measures	**FY 2014**	**FY 2015**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	3,528 (49.7%)	2,870 (45.9%)	**-3.8%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage	345 (4.9%)	336 (5.4%)	**0.5%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	43	29	**-32.6%**
Median	19	14	**-26.3%**
Mode	7	7	**0.0%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	136 (54.6%)	105 (49.3%)	**-5.3%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Substance Abuse Treatment

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	7 (43.8%)	12 (50.0%)	**6.2%**
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	8 (57.1%)	11 (57.9%)	**0.8%**
Change in the rate of program completion over time	See data below		

***Overall, the number of clients who received primary care in FY 2016 was 20 (83.3%), with 12 receiving the services through Ryan White and 8 receiving the services through other insurance such as Medicare.**

Number of clients completing substance abuse treatment program from March 2015 to February 2016: **19**

Number of clients engaged in substance abuse treatment program from March 2015 to February 2016: **24**

Number of clients completing substance abuse treatment from March 2015 to February 2016 who entered treatment in FY 2014: **3**

Number of clients who received treatment in FY 2014 who are still in treatment from March 2015 to February 2016: **0**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Transportation

Van-Based Transportation	FY 2014	FY 2015	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Van Transportation services	417 (68.2%)	464 (68.8%)	**0.6%**
35% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	353 (57.8%)	345 (51.2%)	**-6.6%**

Bus Pass Transportation	FY 2014	FY 2015	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Bus Pass services	1,166 (41.9%)	898 (34.3%)	**-7.6%**
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	600 (21.6%)	440 (16.8%)	**-4.8%**
A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services	2,404 (86.4%)	1,993 (76.2%)	**-10.2%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Vision Care
All Providers

HIV Performance Measures	**FY 2015**
75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve or stay the same over time	See ocular disorder table

Clinical Chart Review Measures*	**FY 2013**	**FY 2014**
100% of HIV-infected vision patients will have a medical health history (initial or updated) at least once in the measurement year	99%	100%
100% of HIV-infected vision patients will have a vision history (initial or updated) at least once in the measurement year	99%	100%
100% of HIV-infected vision patients will have a comprehensive eye examination at least once in the measurement year	100%	99%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/cms/One.aspx?portalId=73056&pageId=107877

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Accommodation Spasm										
Acute Retinal Necrosis										
Anisocoria										
Bacterial Retinitis	1	0								
Cataract										
Chalazion										
Chorioretinal Scar										
Chorioretinitis										
CMV Retinitis - Active										
CMV Retinitis - Inactive										
Conjunctivitis										
Covergence Excess										
Convergence Insufficiency										
Corneal Edema										
Corneal Erosion										
Corneal Foreign Body										
Corneal Opacity										
Corneal Ulcer										
Cotton Wool Spots										
Diabetic Retinopathy										
Dry Eye Syndrome										
Ecchymosis										
Esotropia										
Exotropia										
Glaucoma										
Glaucoma Suspect										
Iritis										
Kaposi Sarcoma										
Keratitis										
Keratoconjuctivitis										
Keratoconus										
Lagophthalmos										
Macular Hole										
Meibomianitis										
Molluscum Contagiosum										
Optic Atrophy										
Papilledema										

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Paresis of Accommodation										
Pseudophakia										
Refractive Change/Transient										
Retinal Detachment										
Retinal Hemorrhage										
Retinopathy HTN										
Retinal Hole/Tear										
Suspicious Optic Nervehead(s)										
Toxoplasma Retinochoriochitis										
Thyroid Eye Disease										
Visual Field Defect										
Vitreous Degeneration										
Other										
Total	**1**	**0**								

2016-2017 Houston Eligible Metropolitan Area: Ryan White CARE Act Part A/B
Standards of Care For HIV Services
Ryan White Grant Administration Section
Harris County Public Health (HCPH)

TABLE OF CONTENTS

Introduction

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

Purpose

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

Scope

The Houston EMA SOCs apply to Part A, Part B and State Services, funded HRSA defined core and support services including the following services in FY 2015-2016:

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

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

Standards Development

The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

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

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy). Initial training must be completed within 60 days of hire.	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 year with their current employer must receive four (4) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire.	• Documentation of training is maintained by the agency in the personnel file

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

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

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

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

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

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

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

	An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that HIV+ clients are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with TRG Policy SG-06 Documentation of Third Party Payer Eligibility or RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Agency conducts six (6) month re-certification of eligibility for all clients. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. At one of the two required re-certifications during a year, agency may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the RWGA eligibility requirements. Appropriate documentation is required for changes in	• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every six (6) months • Review of Policies and Procedures indicates compliance • Information in client's files that includes proof of screening for insurance

	status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent)	coverage (i.e. hard/scanned copy of results) • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02
4.9	Charges for Services Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance • Review of system for tracking patient charges and payments indicate compliance • Review of charges and payments in client records indicate compliance with annual cap • Sliding fee application forms on client record is consistent with Federal guidelines
4.10	Information on Program and Eligibility/Sliding Fee Schedule Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service

	Agency should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	<u>Linkage Into Core Services</u> Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record • Review of agency's policies & procedures' manual indicates compliance
4.12	<u>Wait Lists</u> It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of compliance with TRG's Policy SG-19 Client Wait Lists • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted

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

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

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

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

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

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

[3] National Association of Social Workers (1992). NASW standards for social work case management. Retrieved 02/9/2009 from www.socialworkers.org/practice/standards/sw_case_mgmt.asp

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 1012013 Update, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. RWGA expects HIV Case Management 1012013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. For cultural competency training only, Agency may request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.	• Certificates of completion for applicable trainings in the case manager's file • Sign-in sheets for agency based trainings maintained by Agency • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, case managers will successfully complete CAC training and maintain CAC certification by their Certificated Application Counselor Designated Organization employer. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance
1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	• Documentation of staff training
2.0	**Timeliness of Services**	

2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record
2.2	Acuity The case manager should use an acuity scale or other standardized system as a measurement tool to determine client needs (applies to TDSHS funded case managers only).	• Completed acuity scale in client's records
2.3	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes
2.4	Client Referral and Tracking Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager • Work with the Client to determine barriers to referrals and facilitate access to referrals • Utilize a tracking mechanism to monitor completion of all case management referrals	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking activities in clients records • A current list of agencies that provide services including availability of the Blue Book
2.5	Client Notification of Service Provider Turnover	• Documentation in client record

	Client must be provided notice of assigned service provider's cessation of employment within 30 days of the employee's departure.	
2.6	<u>Client Transfers between Agencies: Open or Closed less than One Year</u> The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a "consent for transfer and release/exchange of information" form be completed and signed by the client, the client's record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and submitted to RWGA by the receiving agency.	• Documentation in client record
2.7	<u>Caseload</u> Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.	• Review of the agency's policies and procedures for Staffing ratios

Clinical Case Management Services

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines medical case management as "a range of client-centered services that link clients with health care, psychosocial, and other services" including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments". The definition outlines the functions of the medical case manager as including assessments and reassessments, individualized comprehensive service planning, service plan implementation and periodic evaluation, client advocacy and services utilization review. The Ryan White Grant Administration categorizes medical case management services co-located in a Mental Health treatment/counseling and/or Substance Abuse treatment services as Clinical Case Management (CCM) services.
Each Ryan White Part A FTE CCM is expected to serve approximately 150 People with HIV/AIDS (PLWHA) within the contract term. CCM services may be targeted to underserved populations such as Hispanics, African Americans, MSM, etc.

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

	continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	
2.0	**Timeliness of Services/Documentation**	
2.1	<u>Client Eligibility</u> In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: • HIV+ individual in mental health treatment/counseling and/or substance abuse treatment services or HIV+ individual whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. • Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record
2.2	<u>Discharge/Closure from Clinical Case Management Services</u> In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence.	• Documentation in client record.

	➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	
2. 3	<u>Coordination with Primary Medical Care and Medical Case Management Provider</u> Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White **Part A/B**-funded Medical Case Management programs. Clinical Case Management services provided to clients accessing primary medical care from a Ryan White **Part A/B**-funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every three (3) months for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi-disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Review of Agency's Policies and Procedures Manual indicates compliance • Case conferences are documented in the client record
2.4	<u>Assessment</u> Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate

	behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	
2.5	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.6	Service Plan Service planning begins at admission to clinical case management services and is based upon assessment. The clinical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care,	• Documentation in client record on the clinical case management service plan or agency's equivalent form • Service plan signed by client and the case manager

	mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The clinical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the clinical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Non-Medical Case Management Services (Service Linkage Worker)

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

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

	• Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS	
2.2	Service Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager. **Low-need, non-primary care clients who have only an intermittent need for information about services may receive brief SLW services without being placed on open status**.	• Documentation in client record on the brief assessment form, signed and dated • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.3	Service Linkage Worker Reassessment Clients on **open status** will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (COH Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services.	• Documentation in client record and in the CPCDMS

	Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	
2.5	<u>Primary Care Newly Diagnosed and Lost to Care Clients</u> Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals • Description of service linkage worker job duties conducted in the field • Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.0	**Supervision and Caseload**	
3.1	<u>Service Linkage Worker Supervision</u> A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record
3.2	<u>Caseload Coverage – Service Linkage Workers</u> Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System

3.3	<u>Case Reviews – Service Linkage Workers.</u> Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW

Medical Case Management

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

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

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

	psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services; • Client is in mental health counseling or chemical dependency treatment.	
2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated

	risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.4	<u>Service Plan</u> Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	• Documentation in client's record on the medical case management service plan or agency's equivalent form • Service Plan signed by the client and the case manager
2.5	<u>Brief Interventions</u> Clients who are not appropriate for medical case management services may still receive brief interventions. In lieu of completing the comprehensive client re-assessment, the medical case manager should complete the brief re-assessment and service plan and document in the progress notes. Any referrals made should be documented, including their outcomes in the progress notes.	• Documentation in the progress notes reflects a brief re-assessment and plan (referral) • Documentation in client record on the brief re-assessment form • Documentation of referrals and their outcomes in the progress notes • Documentation of brief interventions in the progress notes.
3.0	**Supervision and Caseload**	

3.1	Clinical Supervision and Caseload Coverage The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Health Insurance Assistance

The Health Insurance Premium and Cost Sharing Assistance service category is intended to help HIV positive individuals continue medical care without gaps in health insurance coverage or discretion of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Agency may provide help with client co-payments, co-insurance, deductibles, and Medicare Part D premiums in amounts up to $650.00 per month.

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

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

	• Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment
	• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods
	• Submit prior year tax information no later than May 31st. Tax information must include:
	  o Federal Marketplace Form 1095-A
	  o IRS Form 8962
	  o IRS Form 1040 (excludes 1040EZ)
	• Reconciliation of APTC credits or liabilities	

3.0	**Client Access.**	
3.1	<u>Clients Referral and Tracking</u> 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
3.2	<u>Prioritization of Service</u> Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing 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 (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	<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	• Review of agency's Policies & Procedures Manual indicates compliance.

	substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.)	• Review of client intake/assessment for service indicates compliance

Legal Services

The Houston RW Part A Legal Services are a combination of the HRSA defined legal and Permanency planning services provided to HIV-infected individuals and/or their legal representatives by an attorney licensed to practice in Texas. Services include estate planning, permanency planning, discrimination, entitlement, and insurance disputes. The Resource group DSHS Legal services include only estate planning, discrimination entitlement and insurance disputes. Criminal matters, divorce proceedings and adoption services are not eligible for DSHS-funded legal assistance. The clients' legal representative and/or affected significant other is no longer eligible for Ryan White Part A/B legal assistance services once the HIV-positive individual is deceased.

1.0	**Services are part of the coordinated continuum of HIV/AIDS services.**	
1.1	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
2.0	**Legal services adhere to professional standards and regulations.**	
2.1	Licensure Attorneys are licensed to practice law in the state of Texas and have a minimum educational level of a doctorate in Jurisprudence.	• Staff records indicate compliance
2.2	Non-Licensed Staff Non-licensed staff members are supervised by attorneys.	• Review of agency's Policies & Procedures Manual indicates compliance
3.0	**Service providers are knowledgeable, accepting and respectful of the needs of individuals with HIV/AIDS.**	
3.1	Ongoing Staff Training Staff has access to appropriate training and resources needed to deliver services. Staff members are trained and knowledgeable and remain current in legal issues in accordance with the rules of the State Bar of Texas. Staff shall maintain knowledge of legal issues that may impact the legal assistance needs of PLWHA. Agency paid legal staff and contractors must complete two (2) hours of HIV-specific training annually. New agency paid legal staff and contractors must	• Staff has attended and has continued access to training activities • Staff has access to manuals and regulations • Documentation of training on current applicable laws through the State Bar • Staff have access to updated HIV/AIDS information • Agency maintains system for dissemination of HIV/AIDS information

	complete two (2) hours of HIV-specific training within 90 days of start date. Volunteer legal staffs are encouraged to complete HIV-specific legal training.	relevant to the legal assistance needs of PLWHA to paid staff and volunteers • Staff interviews indicate compliance
4.0	**Client is kept informed and participates in decisions about his/her case.**	
4.1	<u>Service Agreement</u> Clients are kept informed and work together with staff to determine the objective of the representation and to achieve goals.	• Copy of service agreement between client and agency is in client record
4.2	<u>Case Closure</u> Agency will develop case closure criteria and procedures. Cases may be closed: • when the client's legal or benefit issue has been resolved, or when the client: • has become ineligible • has had no direct program contact for over six months • is deceased • no longer needs the service • discontinues the service • improperly utilizes the service • has not complied with the client services agreement Agency will attempt to notify clients about case closure.	• Case closure criteria and procedures on file at provider agency • Client chart will include attempts at notification and reason for case closure

Local Pharmacy Assistance Program

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

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

2.1	Orientation Initial orientation includes twelve (12) hours of HIV/AIDS basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
2.3	Pharmacy Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present

Medical Nutritional Therapy/Supplements

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

1.0	**Services are individualized and tailored to client needs.**	
1.1	Education/Counseling – Clients Receiving New Supplements All clients receiving a supplement for the first time will receive appropriate education/counseling. This must include written information regarding supplement benefits, side effects and recommended dosage in client's primary language.	• Client record indicates compliance
1.2	Education/Counseling – Follow-Up Clients receive education/counseling regarding supplement(s) again at: • follow-up • when there is a change in supplements • at the discretion of the registered dietician if clinically indicated	• Client record indicates compliance
2.0	**Services adhere to professional standards and regulations.**	
2.1	Nutritional Supplement Formulary RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Providers wishing to prescribe/order other supplements not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Department of Health	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record

	and Human Services guidelines for ART and treatment of opportunistic infections.	
2.2	Inventory Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.	• Review of agency's Policies & Procedures Manual indicates compliance • Staff interviews
2.3	Licensure Providers/vendors maintain proper licensure. A physician or physician extender (PE) with prescribing privileges at a Part A/B/C and/or MAI-funded agency or qualified primary care provider must write an order for Part A-funded nutritional supplements. A licensed registered dietician must provide an individualized nutritional plan including education/counseling based on a nutritional assessment	• Documentation of current licensure • Nutritional plan in client's record
2.4	Protocols Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV/AIDS including the *American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care.*	• Chart Review shows compliance • Review of agency's Policies & Procedures Manual indicates compliance

Oral Health

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

1.0	**Staff HIV/AIDS knowledge is based on documented training.**	
1.1	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
1.2	Experience – HIV/AIDS A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
2.2	Consultation for Treatment	• Documentation of communication in the client record

	Agency consults with client's medical care providers when indicated.	
2.3	<u>Health History Information</u> Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline (current within the last 12 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems	• Documentation of health history information in the client record. Reasons for missing health history information are documented
2.4	<u>Client Health History Update</u> An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
2.5	<u>Comprehensive Periodontal Examination (Part B Only)</u> 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	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance

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

Primary Medical Care

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

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

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

	• Maintain a minimum of 15 hours of HIV-specific CME (including a minimum of 5 hours related to antiretroviral therapy) per year. Agencies using contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Physician extenders must obtain this experience within six months of hire • All staff receive professional supervision • Staff show training and/or experience with the medical care of adults with HIV	
1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).	• Provider will document peer review has occurred annually
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and. must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed , updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (**http://www.aidsinfo.nih.gov/guidelines/**).	• Documentation in client's record • Exceptions noted in client's record
1.6	Medical Evaluation/Assessment All HIV infected clients receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client.	• Completed assessment in client's record

	A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include: • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results • Resistance testing and co receptor tropism assays as clinically indicated • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care • Sexual history • Substance abuse history • Review of Systems	
1.7	<u>Medical Records</u> Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered • The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies)	• Documentation in client's record
1.8	<u>Plan of Care</u>	• Plan of Care documented in client's record

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

	➢ An initial negative pap test should be followed with another pap test in 6-12 months and if negative, annually thereafter. ➢ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years ➢ Women 30 years old and older may have pap test and HPV co-testing, and if normal, repeated every 3 years ➢ A pap test showing abnormal results should be managed per guidelines • Screening for anal cancer, if indicated • Resistance Testing if clinical indicated • Chem. panel with LFT and renal function test • Influenza vaccination • Annual Mental Health Screening with standardized tool • TST or IGRA (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Service, Infectious Diseases Society of America. *Guidelines for preventing opportunistic infections among HIV-infected persons***)** (Available at aidsinfo.nih.gov/Guidelines/) • Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated	
1.11	<u>Preconception Care for HIV Infected Women of Child Bearing Age</u> In accordance with the US Department of Health and Human Services recommendations <u>(http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf),</u> preconception care shall be a component of routine primary care for HIV infected women of child bearing age and should include preconception counseling. In addition to the general components of preconception counseling, health care providers should, at a minimum: • Assess women's pregnancy intentions on an ongoing basis and discuss reproductive options • Offer effective and appropriate contraceptive methods to women who wish to prevent unintended pregnancy	• Documentation of preconception counseling and care at initial visit and annual updates in Client's record as applicable

	• Counsel on safe sexual practices • Counsel on eliminating of alcohol, illicit drugs and smoking • Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, and prevention and potential effects of HIV and treatment on pregnancy course and outcomes • Inform women of interventions to prevent sexual transmission of HIV when attempting conception with an HIV-uninfected partner Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur • Maximum suppression of viral load prior to conception	
1.12	Obstetrical Care for HIV Infected Pregnant Women Obstetrical care for HIV infected pregnant women shall be provided by board certified obstetrician experienced in the management of high risk pregnancy and has at least two years experience in the care of HIV infected pregnant women. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines http://www.aidsinfo.nih.gov/Guidelines.	• Documentation in client's record
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of HIV-Exposed and HIV- Infected Infants, Children and Pre-pubertal Adolescents Care and monitoring of HIV-exposed children must be done in accordance to the HHS guidelines. Treatment of HIV infected infants and children should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use	• Documentation in client's record

	of Antiretroviral Agents in Pediatric HIV Infection (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	
1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year paid experience in HIV/AIDS care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e. initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record • Documentation of counseling in client records

1.17	Documented Non-Compliance with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-compliance with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-compliance with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care coordination with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	• Review of Policies and Procedures Manual indicates compliance.
1.19	Intimate Partner Violence Screening Policy The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: • process for ensuring clients are screened for IPV no less than annually • intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management • State reporting requirements associated with IPV • Description of required medical record documentation • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel • Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Procedures Manual indicates compliance. • Documentation in patient record
1.20	Patient Retention in Care The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include:	• Review of Agency's Policies and Procedures Manual indicates compliance

	• process for client appointment reminders (e.g. timing, frequency, position responsible) • process for contacting clients after missed appointments (e.g. timing, frequency, position responsible) • measures to promote retention in care • process for re-engaging those lost to care (no primary care visit in 6 months)	
2.0	**Psychiatric care for persons with HIV disease should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines**	
2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.	• Documentation in patient record
3.0	**In addition to demonstrating competency in the provision of HIV disease specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	
3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services	• Agency Policy and Procedure regarding continuity of care.

	➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	
3.2	<u>Continuity with Referring Providers</u> Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.3	<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems
3.4	<u>Client Notification of Service Provider Turnover</u> Client must be provided notice of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record
3.5	<u>Recommended Format for Operational Standards</u> Detailed standards and routines for program assessment are found in most recent Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performance standards.	• Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission on the Accreditation of Healthcare Organizations.

Substance Abuse Services

The Houston EMA Substance Abuse Treatment/Counseling service is an outpatient service providing treatment and/or counseling to HIV-infected individuals with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse and must be coordinated with local TDSHS/SAS HIV Early Intervention funded programs. All services must be provided in accordance with the Texas Department of State Health Services/Substance Abuse services (TDSHS/SAS) Chemical Dependency Treatment Facility Standards as well as current treatment guidelines.

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

	• Legal history • Family history and constellation • Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	
1.3	<u>Treatment Plan</u> Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in the Texas Department of State Health Services Administrative code for substance abuse including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address full range of substances the patient is abusing Treatment plans must be completed no later than five working days of admission. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse as clinically indicated.	• Completed treatment plan in client's record • Treatment Plan review documented in client's records
1.4	<u>Treatment Plan Review</u> In accordance with the Texas Department of State Health Services Administrative code on Substance Abuse, the treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	• Review of agency's Policy and Procedure Manual indicates compliance • Updated treatment plan in client's record
2.0	**Services are part of the coordinated continuum of HIV/AIDS services.**	

2.1	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agency must have collaboration agreements with mental health and primary care providers or demonstrate that they offer these services on-site.	• Documentation of referrals received • Documentation of referrals out • Staff interviews indicate compliance • Collaborative agreements demonstrate that these services are offered on an off-site
2.2	Facility License Agency is appropriately licensed by the Texas Department of State Health Services – Substance Abuse Services (TDSHS/SAS) with outpatient treatment designations.	• Documentation of current agency licensure
2.3	Minimum Qualifications All agency staff that provides direct client services must be properly licensed per current TDSHS/SAS requirements. Non-licensed staff must meet current TDSHS/SAS requirements.	• Documentation of current licensure in personnel files
3.0	**Staff HIV/AIDS knowledge is based on documented training and experience.**	
3.1	Staff Training All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance to the Texas Administrative Code, rule §448.603 (a), (c) & (d).	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines • Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b)
3.2	Experience – HIV/AIDS A minimum of one (1) year documented HIV/AIDS work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV/AIDS work experience.	• Documentation of work experience in personnel file
4.0	**Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV/AIDS. Staff efforts are compassionate and sensitive to client needs.**	

4.1	<u>Staff Supervision</u> The agency shall ensure that each substance abuse Supervisor shall, at a minimal, be a Masters level professional (e.g. LPC, LCSW, LMSW, LMFT, Licensed Clinical Psychologist, LCDC if applicable) and licensed by the State of Texas and qualified to provide supervision per applicable TDSHS/SAS licensure requirements. Professional staff must be knowledgeable of the interaction of drug/alcohol use and HIV transmission and the interaction of prescribed medication with other drug/alcohol use.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance

Transportation Services

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

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

	for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV disease, or ➢ Documentation that the bus voucher is needed to ensure an out-of-care client is re-engaged in primary medical care • Gas Card: Eligible clients in the rural area will receive gas cards from their Ryan White Part A/B rural case management provider or their rural primary care provider, if the client is not case managed, per RWGA business rules • Taxi Voucher: for emergencies, to access emergency shelter vouchers and to attend Social Security disability hearings only	(preferred) or proof client is on ART (HIV medications) for clients in medical care with Ryan White or non-Ryan White funded providers in client record OR • Engagement/re-engagement in medical care is documented in client's case management assessment and service plan, OR •
1.3	<u>Eligibility for Van-Based Transportation (Urban Transportation Only)</u> Written certification from the client's principal medical provider (e.g. medical care coordinator) is required to access van-based transportation and must be renewed every 180 days. All clients may receive a maximum of 4 non-certified round trips per year (includes taxi vouchers).	• Client record indicates compliance
2.0	**ACCESSIBILITY** **Transportation services are offered in such a way as to overcome barriers to access and utilization.**	
2.1	<u>Notification of Service Availability</u> Prospective and current clients are informed of service availability, prioritization and eligibility requirements.	• Program information is clearly publicized • Availability of services, prioritization policy and eligibility requirements are defined in the information publicized
2.2	<u>Access</u> Clients must be able to initiate and coordinate their own services with the transportation providers in accordance with transportation system guidelines. This does not mean an advocate (e.g. social worker) for the client cannot assist the client in accessing transportation services.	• Agency's policies and procedures for transportation services describe how the client can access the service • Review of agency's complaint and grievances log • Signed agreement in client's records

	Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle. This statement should include the consequences of violating the agreement.	
2.3	Handicap Accessibility Transportation services are handicap accessible. Agency/Driver may refuse service to client with open sores/wounds or real exposure risk. Agency must have a policy in place regarding training for drivers on the proper boarding/unloading assistance of passengers with wheel chairs and other durable health devices.	• Agency compliance with the Americans with Disabilities Act (ADA) • Agency documentation of reason for refusal of service • Documentation of training in personnel records
2.4	EMA Accessibility Services are available throughout the Houston EMA as contractually defined in the RFP.	• Review of agency's Transportation Log and Monthly Activity Reports for compliance
2.5	Service Availability The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and coverage must be available for medical and health-related appointments on Saturdays.	• Review of Transportation Logs • Transportation services shall be available on Saturdays, by pre-scheduled appointment for core services • Review of agency policy and procedure
2.6	Service Capacity Agency will notify RWGA and other Ryan White providers when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services. * Maximized means the agency will not be able to provide service to client within the next 72 hours.	• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized • Agency will document all clients who were denied transportation or a voucher
3.0	**Timeliness and Delays: Transportation services are provided in a timely manner**	
3.1	Timeliness There is minimal waiting time for vehicles and vans; appointments are kept • Waiting times longer than 2 hours will also be documented in the client record	• Waiting times longer than 60 minutes will be documented in Delay Incident Log. • Review of Delay incident log • Review of client's record

	• If a cumulative incident of clients kept waiting for more than 2 hours reaches 75 clients in the contract year, this must be reported in writing within one business day to the administrative agent • Review of agency's complaint and grievance logs Client interviews and client satisfaction survey	
3.2	<u>Immediate Service Problems</u> Clients are made aware of problems immediately (e.g. vehicle breakdown) and notification documented.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievance logs • Client interviews and client satisfaction survey
3.3	<u>Future Service Delays</u> Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievance logs • Client interviews and client satisfaction survey • Documentation exists in the client record
3.4	<u>Confirmation of Appointments</u> Agency must allow clients to confirm appointments at least 48 hours in advance.	• Review of agency's transportation policies and procedures indicates compliance • Review of agency's complaint and grievance logs • Client interviews and client satisfaction survey.
3.5	<u>"No Shows"</u> "No Shows" are documented in Transportation Log and client record. Passengers who do not cancel scheduled rides for two (2) consecutive times or who "no show" for two (2) consecutive times or three times within the contract year *may be* removed from the van/vehicle roster for 30 days. If client is removed from the roster, he or she must be referred to other transportation	• Review of agency's transportation policies and procedures indicates compliance • Documentation on Transportation Log • Documentation in client record

	services. One additional no show and the client can be suspended from service for one (1) year.	
3.6	System Abuse If an agency has verified that a client has falsified the existence of an appointment in order to access transportation, the client can be removed from the agency roster. If a client cancels van/vehicle transportation appointments in excess of three (3) times per month, the client may be removed from the van/vehicle roster for 30 days. Agency must have published rules regarding the consequences to the client in situations of system abuse.	• Documentation in the client record of verification that an appointment did not exist • Documentation in the client record of client cancellation of van/vehicle appointments • Availability of agency's published rules • Written documentation in the client record of specific instances of system abuse
3.7	Documentation of Service Utilization Transportation Provider must ensure: • Follow-up verification between transportation provider and destination service program confirming use of eligible service(s) or • Client provides proof of service documenting use of eligible services at destination agency on the date of transportation or • Scheduling of transportation services by receiving agency's case manager or transportation coordinator • In order to mitigate Agency exposure to clients who may fail to follow through with obtaining the required proof of service, Agency is allowed to provide one (1) one-way trip per client per year without proof of service documentation. The content of the proof of service will include: • Agency's letter head • Date/Time • CPCDMS client code	• Documentation of confirmation from destination agency in agency/client record • Client's original receipt from destination agency in agency/client record • Documentation in Case Manager's progress notes • Documentation in agency/client record of the one (1) allowable one-way trip per year without proof of service documentation

	• Name and signature of Agency's staff who attended to client • Agency's stamp	
4.0	**Safety/Vehicle Maintenance: Transportation services are safe**	
4.1	<u>Vehicle Maintenance and Insurance</u> Vehicles are in good repair and equipped for adverse weather conditions. All vehicles will be equipped with both a fire extinguisher and first aid and CPR kits. A file will be maintained on each vehicle and shall include but not be limited to: description of vehicle including year, make, model, mileage, as well as general condition and integrity and service records. Inspections of vehicle should be routine, and documented not less than quarterly. Seat belts/restraint systems must be operational. When in place, child car seats must be operational and installed according to specifications. All lights and turn signals must be operational, brakes must be in good working order, tires must be in good condition and air conditioning/heating system must be fully operational. Driver must have radio or cell phone capability.	• Inspection of First Aid/CPR kits indicates compliance • Review of vehicle file • Current vehicle State Inspection sticker. • Fire extinguisher inspection date must be current • Proof of current automobile liability and personal injury insurance in the amount of at least $300,000.00
4.2	<u>Emergency Procedures</u> Transportation emergency procedures are in place (e.g. breakdown of agency vehicle). Written procedures are developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service, and will be in-serviced annually.	• A copy of each in-service and sign-in roster with names both printed and signed and maintained in the driver's personnel file
4.3	<u>Transportation of Children</u> Children must be transported safely. When transporting children, the agency will adhere to the Texas Transportation code 545.412 child Passenger Safety Seat Systems. Information regarding this code can be obtained at	• Review of Transportation Log indicates compliance

	http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm. Necessity of a car seat should be documented on the Transportation Log by staff when appointment is scheduled. Children 15 years old or younger must be accompanied by an adult caregiver in order to be transported.	• Review of client records indicates compliance • Review of agency policies and procedures
4.4	<u>Staff Requirements</u> Picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting clients Drivers must have annual proof of a safe driving record, including history of tickets, DWI/DUI, or other traffic violations Conviction on more than three (3) moving violations within the past year will disqualify the driver Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.	• Documentation in vehicle • Documentation in personnel file
5.0	**Records Administration: Transportation services are documented consistently and appropriately**	
5.1	<u>Transportation Consent</u> Prior to receiving transportation services, clients must read and sign the Transportation Consent.	• Review of client records indicates compliance
5.2	<u>Van/Vehicle Transportation</u> Agency must document daily transportation services on the Transportation Log.	• Review of agency files indicates compliance • Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.
5.3	<u>Mileage Documentation</u> Agency must document the mileage between Trip Origin and Trip Destination (e.g. where client is transported to access eligible service) per a standard Internet-based mapping program (e.g. Yahoo Maps, Map Quest, Google Maps) for all clients receiving Van-based transportation services.	• Map is printed out and filed in client chart

Vision Services

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

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

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

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RYAN WHITE PART B/DSHS STATE SERVICES
1718 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 files.
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 ~~conspicuous~~ highly-visible place at the site where services are provided to clients.

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

#	STANDARD	MEASURE
9.7	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 files indicates compliance. • Acuity levels documented as part of assessment.
9.8	Nutritional Evaluation Each client shall receive a nutritional evaluation within 15 days of initiation of care.	• Documentation is on file.
9.9	Meal Plan Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
9.10	Plan of Care A written plan of care is completed for each client within seven (7) days of intake and updated every six (6) months thereafter. Development of plan of care incorporates a multidisciplinary team approach. Care plan is signed by both case manager and clinical health care professional.	• Review of client files indicates compliance
9.11	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.	• Documentation in the client chart indicates services provided were consistent with the treatment plan.

#	STANDARD	MEASURE
9.11	Implementation of Care Plan (Cont'd • 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.	• Documentation in the client chart indicates services provided were consistent with the treatment plan.
9.12	Refusal of referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home/community setting. The agency must document the situation in writing and immediately contact the client's primary medical care provider.	• Documentation in the client chart will indicate the reason for refusal
9.13	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 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.	• Documentation in client chart of specific criteria indicating appropriateness of discharge

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
EARLY INTERVENTION SERVICES FOR THE INCARCERATED

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

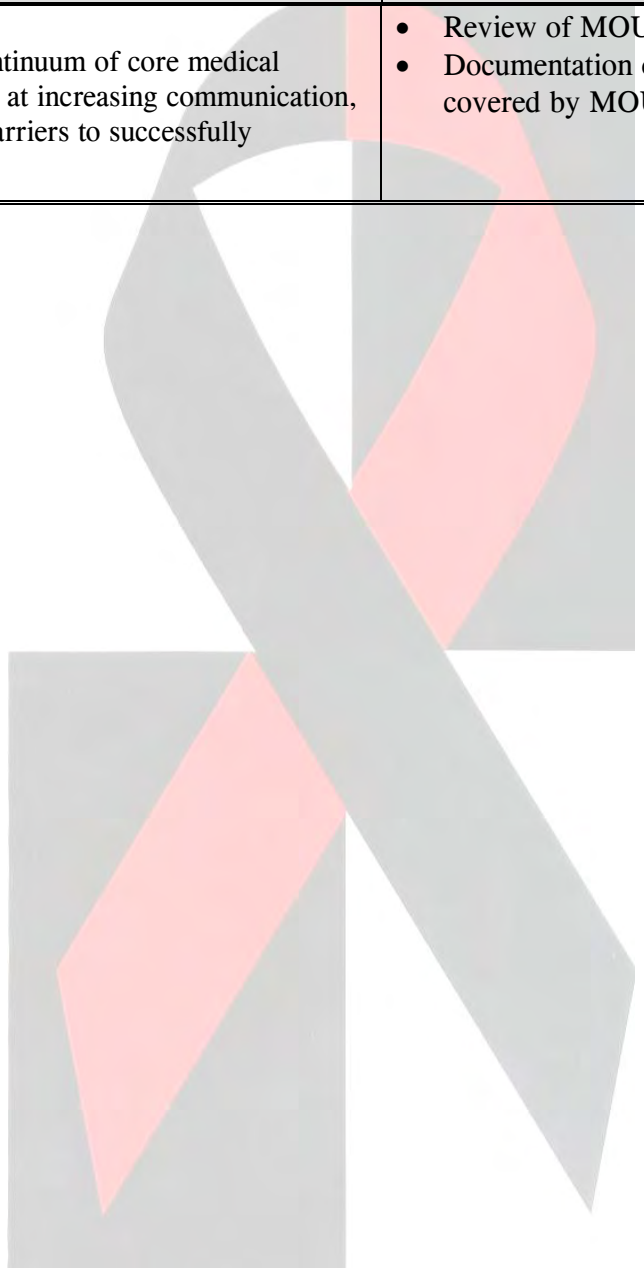
#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service The goal of Early Intervention Services (EIS) is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care, educating and motivating clients on the importance and benefits of getting into care,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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Agency License The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.	• Review of agency
9.3	Program Policies and Procedures Agency will have a policy that: • Defines and describes EIS services (funded through Ryan White or other sources) that include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found • Requires monitoring of referrals into care and treatment	• Program's Policies and Procedures indicate compliance with expectations.
9.4	Staff Qualifications All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. Supervisors must possess a degree in a health/social service field or equivalent experience.	• Review of personnel files indicates compliance
9.5	Continuing Education Each staff will complete a minimum of 12 hours of training annually to remain current on HIV care.	• Evidence of training will be documented in the staff personnel records.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Supervision Each agency must have and implement a written plan for supervision of all Early Intervention staff. Supervisors must review a 10 percent sample of each staff member's client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Each supervisor must maintain a file on each staff supervised and hold supervisory sessions on at least a monthly basis. The file must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
9.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV-positive status • Language(s) spoken and Literacy level (client self-report) *Due to client's state of incarceration, this service is excluded from the requirement to document income and residency.*	• Documentation of HIV status is present in the client file. • Documentation in compliance with TRG Policies for Documentation of HIV Status.
9.8	CPCDMS Update/Registration As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.	• Current registration of client is present in CPCDMS.
9.9	Assessment of Client Staff will complete an intake assessment form for all clients served. The assessment will include identified needs upon release, assessment of support system upon release, and desired provider to receive referral information on.	• Intake assessment form is present in the client file.
9.10	Provision of Client Education Staff provide client with education regarding the disease and its management, risk reduction, medication adherence and other health-related education.	• Documentation of client education is present in the client file.
9.11	Increase Health Literacy Staff assesses client ability to navigate medical care systems and provides education to increase client ability to advocate for themselves in medical care systems.	• Documentation of health literacy evaluation and education is present in the client file.

#	STANDARD	MEASURE
9.12	Coordination of Care Staff assists in the coordination of client medical care while incarcerated including, but not limited to, medical appointments and medications.	• Documentation of coordination of care is present in the client file.
9.13	Medication Regimen Establishment/Transition Staff assists clients to become eligible for TXMP/ADAP medication program prior to release. Staff assists client with transition of medication from correctional facility to outside pharmacy.	• Documentation of THMP/ADAP application and its submission is present in client file. • Documentation of connection/referral to outside pharmacy.
9.14	Transitional Team Multidisciplinary (TTMD) Review Staff creates opportunities for MDT review with all involved agencies to discuss client's case.	• Schedule of available times for TTMD reviews with involved agencies available for review. • Documentation of TTMD reviews present in client file.
9.15	Discharge Planning Staff 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 • Creation of a discharge plan.	• Documentation of review of services present in client file. • Documentation of client discharge plan is present in client file.
9.16	HIV Testing and Targeted Counseling According to the HRSA National Monitoring Standards all four components must be present. Part B funds can only be used for HIV testing to supplement, not supplant, existing funding. • If Ryan White Part B funds are used for HIV testing, agency must submit a waiver to TRG and document the reason(s) necessary to supplement existing funding.	• Review of monthly expenses indicates compliance • Waiver are present when funds are utilized for testing
9.17	Referral Process Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral will include a packet with a. A copy of the Harris County Jail Intake/Assessment Form, b. Proof of HIV diagnosis, c. A list of current medications, and d. Provide client ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community.	• Documentation of referral present in client file • Documentation of referral feedback present in client file. • Copy of "known to me as" letter present in client file.

#	STANDARD	MEASURE
9.18	MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting clients into ongoing care.	• Review of MOUs at annual quality compliance reviews. • Documentation of communication and referrals with agencies covered by MOUs is present in client file.



RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service **Health Insurance Assistance:** The Health Insurance Assistance (HIP) service category is intended to help HIV positive individuals maintain a continuity of medical benefits without gaps in health insurance coverage or discretion of treatment. This financial assistance program enables eligible individuals who are HIV positive to utilize their existing third party or public assistance (e.g. Medicare) medical insurance, not to exceed the cost of care delivery. Under this provision an agency can provide assistance with health insurance premiums, co-payments, co-insurance, deductibles, Medicare Part D premiums, and tax reconciliation. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement 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. Revised Income Guidelines: Marketplace Plans: 100-400% of Federal Poverty Level All other plans: 0-400% of Federal Poverty Level Exception: Clients who were enrolled 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-1601).	• 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 indentify 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 one 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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.7	Program Policies Agency will develop policies and procedures regarding HIP 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.
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.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)* 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. Only Medical, Dental and Vision plans are covered. 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.
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIC funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a clients failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIP 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.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Health Insurance Premium Assistance The following criteria must be met for a health plan to be eligible for HIP assistance: 1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 1. Health Insurance coverage must be evaluated for cost effectiveness 2. Health insurance plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 3. COBRA plans must be evaluated based on cost effectiveness and client benefit. Additional Requirements for ACA plans: 1. If a clients between 100%-250% FPL, only SILVER level plans are eligible for HIP 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 HIP 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 HIP 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.
9.12	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.
9.13	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.14	Waiver Process In order to ensure proper program delivery, a waiver from the AA is required for the following circumstances: 1. HIC 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 HIC payment assistance due to client conduct or fraud, 5. Refusing HIC assistance for a client who is eligible and whom HIC 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 HIC payment assistance.	•
9.15	Payer of Last Resort Agencies must assure that all clients are screened for potential third party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist clients in enrollment.	•
9.16	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.	•

RYAN WHITE PART B/DSHS STATE SERVICES
1718 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 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 files.

#	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.	
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 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 PLWHA to paid staff and volunteers. • Agency will document provision of in-service education to staff regarding current treatment methodologies and promising practices.

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

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

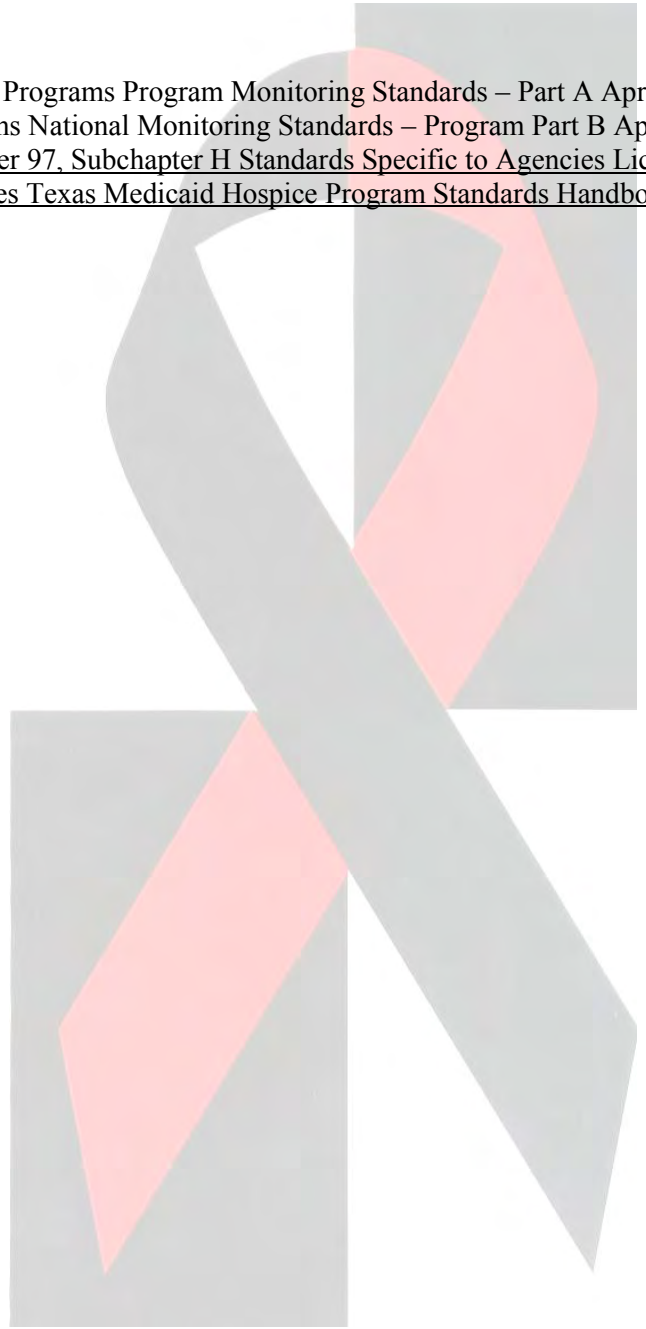
#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Medication Administration Record Agency documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	• Documentation in client's record
9.16	PRN Medication Record Agency documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.	• Documentation in client's record
9.17	Physician Orders 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 in client's record
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 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 in client's 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 48 hours 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 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 record
9.22	Bereavement Counseling Bereavement counseling must bwe 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.	• Assessment present in the client's record. • Referral and/or service provision documented.
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.	• Assessment present in the client's record. • Referral and/or service provision documented.

#	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.	• Assessment present in the client's record. • Referral and/or service provision documented.
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.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.26	Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.	• Assessment present in the client's record. • Documentation in client's records.
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 record. • Documentation in client's 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. • 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 records.

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, 201, 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



RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

Definition:

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

#	STANDARD	MEASURE
9.0	**Services are part of the coordinated continuum of HIV/AIDS and social services**	
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.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	Staff Qualifications and Training • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI). Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), or the National Interpreter Certification (NIC) at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting	• Program Policies and Procedures will ensure the contracted agency is in compliance with legislation/regulations • Legislation and Regulations • (Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act
9.3	Program Policies Agency will develop policies and procedures regarding the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and procedures to providers seeking to utilize the service.	• Review of Program Policies.

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

9.4	Provision of Services
	• 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 of provision of services present in client files indicates compliance.

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	Interpreter Certifications All American Sign Language interpreters will be certified in the State of Texas. Level II and III interpreters are recommended for medical interpretation.	• Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency requests denote appropriate levels of interpreters are requested.
9.7	Subcontractor Exclusion: Due to the nature of subcontracts under this service category, the staff training outlined in the General Standards are excluded from being required for interpreters.	• No Measure

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Definition:
Mental Health Services include 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, and 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 professionals judgment) bereavement support is available for non-HIV infected family members or significant others.	• 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	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 emergency 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, time line 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	• Documentation in client record indicates compliance. • Annual Client Interviews indicates compliance.

#	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.
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 in client record. • Exceptions noted in client file.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Treatment Plan (Cont'd) Initial treatment plans must be completed no later than the third counseling session. 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 shall be reviewed and modified at least every 90 days 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. • Client's records • Exceptions noted in client files.
9.14	Progress Notes Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	• Legible, signed and dated documentation in client record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	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.
9.16	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, • Date	• Documentation in client record.
9.17	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.
9.18	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.

RYAN WHITE PART B/DSHS STATE SERVICES
1718 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

Definition:
Support for Oral Health Services including diagnostic, preventive, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals.

#	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), endodontistry 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 to HIV infected individuals 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 with HIV. All licensed personnel shall received 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	• 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 made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
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.	• Review of client records indicate compliance

#	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)	• Review of client records indicate compliance
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 should include: • Assessment of medical and dental histories • Quantity and quality of attached gingival • Bleeding • Tooth mobility • 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.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance

#	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.	• Treatment plan dated and signed by both the provider and patient in patient file • Annually updated treatment plan dated and signed by both the provider and patient in patient file
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 • Annually updated Phase 1 treatment plan dated and signed by both the provider and patient in patient file

#	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 • 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.	•
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

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

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2015-7/31/16

Revised: 9/9/2016

	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	770	$60,336.49	436			*0*
Medical Deductible	708	$152,591.60	422			*0*
Medical Premium	6576	$2,025,679.19	1032			*0*
Pharmacy Co-Payment	5756	$484,246.14	1390			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	14	$2,158.00		*NA*	*NA*	*NA*
Totals:	13824	$2,720,695.42		0	$0.00	

Comments: This report represents services provided under all grants.

Comprehensive HIV Planning Committee Report

Approved 09/15/16

FY 2017 EIIHA Target Populations

The EIIHA Workgroup met on September 12, 2016. Participants included representatives from prevention and care, community members, and consumers. The Workgroup reviewed the FY 2017 guidance from HRSA, adopted selection criteria, and recommended the following FY 2017 target populations. Per Council instructions, staff distributed this information to all Council and External Committee members with an invitation to provide input. On September 15, 2016, the Comprehensive HIV Planning Committee provided final approval of the following motions:

Item: FY 2017 EIIHA Plan Target Populations
Recommended Action: Motion: Approve following target populations for the FY 2017 EIIHA Plan:

1. African Americans
2. Hispanics/Latinos age 35 and over
3. Men who have Sex with Men (MSM)

Office of Support is to include information on HIV and aging in the EIIHA section of the HRSA application.

Recommended Action: Motion: Office of Support is to include a statement in the EIIHA section of the HRSA application recognizing that currently available epidemiologic data do not portray the need for testing, referral, and linkage in at-risk populations such as among those who are transgender, intersex, homeless, or those released from incarceration.

Affected Community Committee Report

DRAFT

Schedule of Topics for
2016 Affected Community Committee Meetings

(revised 07-20-16)

Shaded areas indicate an off-site meeting location; black areas = meeting rooms not available

Confirmed	Month 2016	Topic	Speaker/Facilitator	Meeting Location
✓	12 noon, Tues. February 23	• Purpose of the Council and Public Hearings • Participation in Health Fairs • Why meetings are held off-site	Tori Williams	Office of Support
✓	12 noon, Tues. March 17	Joint meeting of the Affected Community, Priority & Allocations and Quality Improvement Committees	Committee Co-Chairs	Office of Support
✓	12 noon, Tues. March 22	***Training for Consumers:*** The RW How To Best Meet the Need Process - Part 1	Tori Williams	Office of Support
✓	1:30 - 4 p.m., Thurs. April 14	How To Best Meet the Need Training – Part 2	Planning Council Chairs	Office of Support
✓	10:30 a.m. – 4 p.m. Tues. April 26 &/or Wed. April 27	How To Best Meet the Need Workgroups	Quality Improvement Committee	Office of Support
✓	12 noon, Tues. May 24	HIV and the Asian Community	Peta-gay Ledbetter, PhD	Hope Clinic 7001 Corporate Dr., #120 Houston, Tx 77036 713 773-0803
✓	6:30 – 8:00 p.m. WEDNESDAY June 15	HIV and the Heterosexual Community Advisory Board (CAB)	Amana Turner	Change Happens 3353 Elgin St. Houston, TX 77004
✓	12 noon, Tues. July 26	PrEP	Adonis May	Bee Busy Wellness Center 8785 West Bellfort Ave. Houston, TX 77031
✓	12 noon, Tues. August 23	***Training for Consumers:*** Standards of Care, Why Should I Care?	Amber Harbolt, Health Planner, Office of Support	Office of Support
✓	12 noon, Tues. Sept. 20	Standards of Care and Performance Measures **Consumer Only** Workgroup	Carin Martin, Manager Ryan White Grant Administration	Office of Support
TENTATIVE	12 noon, Tues. October 25	HIV and the Rural Community	????	Access Health
TENTATIVE	12 noon, Tues. November 22	HIV and Substance Abuse	Pennye Rhodes, PA St. Hope Foundation	St. Hope Foundation, **Conroe**

Possible Topics:

Community Involvement in HIV Clinical Research Trials - Morénike Giwa

Medication Updates – Shital Patel, MD or Ben Barnett, MD OR invite all drug reps. Include info on getting Rx's FDA approved, change to generic status – how does this impact ADAP pricing?

Affected Community Committee
2016 Community Events (as of 09/27/16)

Point Person (PP): Committee member who picks up display materials and makes sure they are returned to the Office of Support.

Day, date, times	Event	Location	Participants
Sunday, March 6 1pm-Walk	AIDS Foundation Houston (AFH) AIDS Walk	Houston Park Downtown 1100 Bagby Street, 77002	Allen Murray will distribute Project LEAP flyers.
Friday, May 6; 6 – 9 pm Contact: H. Finley/J. Humphries	Houston Splash 2016	Double Tree Hotel – Galleria	Allen, Teresa, Curtis, Arlene, Cecilia **PP: Teresa; back up Skeet**
Saturday, June 25 Noon – 7:00 pm	Pride Festival	Downtown near City Hall	Shift 1 (11:30 am-2 pm) : **PP Curtis,** Peta, Tana, Johnetta Shift 2 (2-4:30 pm) John L, Ruth, Teresa, Allen Shift 3 (4:30-7 pm): **PP Teresa,** John L., Tracy, Rodney **To be Assigned:** Steven , Carol, Arlene
Friday, September 16	HIV and Aging Symposium	Montrose Center	Tana, Allen, Curtis, Cecilia, Teresa, Rodney, Johnetta, Viviana, Tracy G. **PP: Skeet**
Sunday, September 18	MISS UTOPIA	Crowne Plaza Northwest-Brookhollow 12801 Northwest Freeway Houston, TX 77040	**Need 3 volunteers** Carol, Peta, Skeet, Tana, Cecilia **PP: Peta, Curtis, Skeet_**
October	Road 2 Success		
Tuesday, December 1	World AIDS Day Events		Most committee members attend events
December Contact: Herman Finley	Gay Men's Health Summit New Name: Live Out Loud	Hiram Clarke Multi Service Center 810 W. Fuqua St., 77045 MAY BE MOVED TO UNITED WAY	Teresa (PP), Curtis, Allen, Cecilia, Arlene
January 2017	Road 2 Success		
NEW DATE: Saturday, January 21 2017 8:00 a.m. – 2:30 p.m.	HIV Testing and Prevention: Tools for Your Practice	Houston Marriott Medical Center 6580 Fannin Street (Driveway Entrance on 1730 Dryden Rd) Houston, TX 77030 (713) 796-0080	Curtis, Rodney, Allen, Tracy, Tana **CONFIRM IF AVAILABLE FOR NEW DATE:** Cecilia, Teresa, Isis