

**HOUSTON AREA HIV SERVICES  
RYAN WHITE PLANNING COUNCIL**



*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, December 8, 2016  
Meeting Location: 2223 W. Loop South, Room 532  
Houston, Texas 77027

- I. Call to Order
  - A. Welcoming Remarks and Moment of Reflection
  - B. Adoption of the Agenda
  - C. Approval of the Minutes
  - D. Training: Ryan White Election Policy
  - E. Training: Results of the 2016 HIV Needs Assessment
- II. Public Comments and Announcements  
(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV/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. Comprehensive HIV Planning Committee
    - Item:* Update on Speakers Bureau
    - Recommended Action:* FYI: The Speaker's Bureau Workgroup met on November 17<sup>th</sup> to discuss lessons learned and leads for 2017. The Workgroup will focus on specialized/ethnically-affiliated chambers of commerce in 2017.

Steven Vargas, Chair  
RW Planning Council

Curtis Bellard and  
Teresa Pruitt, Co-Chairs  
Operations Committee

Amber Harbolt,  
Health Planner

Carol Suazo, Secretary

John Lazo and  
Nancy Miertschin,  
Co-Chairs

*Item:* 2016 Houston HIV Care Services Needs Assessment  
*Recommended Action:* Motion: Approve the attached 2016 Houston HIV Care Services Needs Assessment Report.

*Recommended Action:* FYI: Addenda tables with service needs by population will be created in January 2017.

*Item:* 2016 Committee Quarterly Report

*Recommended Action:* FYI: See the attached 2016 Committee Quarterly Report.

B. Quality Improvement Committee

*Item:* Joint Committee Meeting Report

*Recommended Action:* FYI: Although there were no suggested changes to the Ryan White data reports prepared by the Ryan White administrative agents, the following suggestions were made:

- Add a glossary to each report or create a handout
- Amend the Council agendas so that Task Force reports are listed by speaker
- Train committee chairs on how to present reports

*Item:* FY 2017 Standards of Care and Performance Measures

*Recommended Action:* Motion: Approve the recommended changes regarding the FY 2017 Standards of Care and Performance Measures for Ryan White Part A, B and State Services.

*Item:* 2016 Quarterly Committee Report

*Recommended Action:* FYI: See the attached 2016 Quarterly Committee Report.

C. Operations

*Item:* 2017 Council Orientation

*Recommended Action:* FYI: Please note that the all-day 2017 Council Orientation will take place on Thursday, January 26th. The mentor luncheon is scheduled for 12 noon on Thursday, January 19, 2017.

*Item:* Project LEAP

*Recommended Action:* FYI: See the attached 2016 Project LEAP Evaluation.

*Item:* 2017 Project LEAP Service Definition

*Recommended Action:* Motion: Approve the attached 2017 Project LEAP service definition.

*Item:* 2017 Project LEAP Student Selection Guidelines

*Recommended Action:* Motion: Approve the attached 2017 Project LEAP Student Selection Guidelines.

Cecilia Ross and  
Robert Noble, Co-Chairs

Curtis Bellard and  
Teresa Pruitt,  
Co-Chairs

*Item: 2017 Council Election*

*Recommended Action:* ELECTION: All nominees are required to provide their qualifications before the elections are held for the 2017 Planning Council. Additional nominations can be made at this time.

*Item: 2016 Quarterly Committee Report*

*Recommended Action:* FYI: See the attached 2016 Quarterly Committee Report.

D. Affected Community Committee

*Item: November Committee Training*

*Recommended Action:* FYI: The Affected Community Committee held their November meeting at St. Hope Foundation in Conroe. Unfortunately, the speaker had an emergency and could not provide her presentation on *HIV and Substance Abuse*. The presentation will be rescheduled in 2017.

Allen Murray and  
Tana Pradia,  
Co-Chairs

*Item: Road 2 Success – Sat. Jan. 14, 2017*

*Recommended Action:* FYI: Please see Tori if you would like to volunteer to help with the third and last Road 2 Success class on Saturday, January 14, 2017.

*Item: 2017 Committee Goals*

*Recommended Action:* FYI: In 2017, the Affected Community Committee will dedicate their efforts to getting a better understanding of the needs of the Houston transgender community. They will do this through trainings and by participating in meetings with the transgender community.

*Item: 2016 Quarterly Committee Report*

*Recommended Action:* FYI: See the attached 2016 Quarterly Committee Report.

E. Priority and Allocations Committee  
No Report

Peta-gay Ledbetter  
and Bruce Turner,  
Co-Chairs

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
- B. Community Development Advisory Council (CDAC)
- C. HOPWA
- D. Community Prevention Group (CPG)
- E. Update from Task Forces:
  - African American
  - Latino
  - MSM
  - Transgender
  - Youth
  - Hepatitis C
  - Sexually Transmitted Infections (STI)
  - Urban AIDS Ministry
  - Heterosexual HIV Awareness
- F. Positive Women's Network
- G. HIV and Aging
- H. END HIV Houston
- I. Texas HIV Medication Advisory Committee
- J. Legislative Updates
- K. Texas HIV/AIDS Coalition
- L. SPNS Grant: HIV and the Homeless Program

Nancy Miertschin  
Tracy Gorden  
Melody Barr  
Herman Finley  
  
S. Johnson-Fairley  
Steven Vargas  
Ted Artiaga  
  
John Lazo  
Steven Vargas  
Herman Finley  
Amber David  
Ruth Atkinson  
Tana Pradia  
Bruce Turner  
Steven Vargas  
Bruce or Nancy  
  
Bruce Turner  
Nancy Miertschin

IX. Announcements

X. Adjournment

## HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL



*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.*

### MINUTES

12 noon, Thursday, November 10, 2016  
2223 W. Loop South, Room 532; Houston, Texas 77027

<b>MEMBERS PRESENT</b>	<b>MEMBERS PRESENT</b>	<b>OTHERS PRESENT</b>
Steven Vargas, Chair	Robert Noble	Shelly Lucas, DSHS
Tracy Gorden, Vice Chair	Tana Pradia	James Arango, DSHS
Carol Suazo, Secretary	Teresa Pruitt	Mikel Marshall, ViiV
Ted Artiaga	Leslie Raneri	Greg Town, Enroll Texas
Connie Barnes	Cecilia Ross	Johnetta Evans-Thomas
Melody Barr	Gloria Sierra	Kelvin Harris
Curtis Bellard	Isis Torrente	Denis Kelly
David Benson	C. Bruce Turner	Michael Kennedy
Ardry Skeet Boyle	Larry Woods	Alex Moses
Bianca Burley	David Watson	Samantha Robinson
Ella Collins-Nelson		Viviana Santibanez
Denny Delgado		
Evelio Salinas Escamilla	<b>MEMBERS ABSENT</b>	<b>STAFF PRESENT</b>
Herman Finley	Amber David	<i>Ryan White Grant Administration</i>
Paul Grunenwald	Rodney Mills, excused	Carin Martin
Angela F. Hawkins	Shital Patel	Heather Keizman
Arlene Johnson		Tasha Traylor
J. Hoxi Jones		
John Lazo		<i>The Resource Group</i>
Peta-gay Ledbetter		Sha'Terra Johnson-Fairley
Nancy Miertschin		
Allen Murray		<i>Office of Support</i>
		Tori Williams
		Amber Harbolt
		Diane Beck

**Call to Order:** Steven Vargas, Chair, called the meeting to order at 12:10 p.m.

During the welcoming remarks, Vargas invited those who were available after the Council meeting adjourns to see the presentation that was given at the HRSA All Grantees meeting in Washington D.C. in August. Members were urged to take a stack of Road 2 Success flyers and distribute them broadly. Vargas introduced Shelley Lucas, MPH, Manager, HIV/STD Prevention and Care Branch, TDSHS and invited her to give an update on activities at DSHS.

**Adoption of the Agenda: Motion #1:** *it was moved and seconded (Pruitt, Barnes) to adopt the agenda with one change: add under III.B. Motion: Ask the Chair of the Planning Council to send a letter of Support for the END HIV Houston campaign. Motion carried unanimously.*

**Approval of the Minutes: Motion #2:** *it was moved and seconded (Torrente, Pruitt) to approve the October 13, 2016 minutes. Motion carried.* Abstentions: Burley, Escamilla, Jones, Raneri, Ross and Turner.

**Shelly Lucas, MPH, Manager, HIV/STD Prevention and Care Branch, Texas DSHS:** She spoke briefly about ADAP and additional State Services funding which was recently received. She said that ADAP has added two Hepatitis C regimens to the ADAP formulary – there are 10 rolling slots for this pilot project which has been approved to spend up to one million dollars per year. She hopes to be able to expand the program after the pilot.

**Honoring External Committee Members:** Vargas welcomed the External Committee members and thanked them for their work this year. Each External Committee member received a certificate of appreciation.

**Public Comment and Announcements: #1:** Greg Town, President of Enroll Texas, thanked the Council for allowing him to introduce himself. He has been all over the state and met with planning councils as well as Part A and Part B providers. He wanted to take this opportunity at the beginning of Open Enrollment to share his information with the Council. Basically, they are a no cost resource for clients. They specialize in two things: Affordable Care Act Health Insurance and assisting Ryan White clients. They have helped over 6,000 Ryan White clients between Louisiana and Texas and worked with hundreds of case managers. The way they get paid is there is a small fee built into the policy – what that means is that there is no cost to the agency or the client. What they get when they work with us, and we work hand in hand with the agency, we understand the Ryan White program, we talk to administrators all over the state so we understand premium assistance, copay assistance, we understand getting into the right networks and looking at formularies for the right drugs. So, what he wants to share today is that we're stronger together, we support the Ryan White mandate as payer of last resort – the case managers are overwhelmed and overworked, they're not insurance experts and we can help take some of the load off of them. His contact information is on the flyers that he distributed; feel free to call him directly.

**#2:** Mr. Kelly - Now that everything's been over and there are many ASO people here, next year is going to be very, very, very important. You need to talk to your clients, they need to talk to their friends, it's going to be very, very important to be involved with legislation on the state and national level, whether they phone, email or whatever. The holidays are coming, but immediately after the first of the year everybody - infected and affected – needs to be involved. Just a friendly reminder to please get the message out after the first of the year because we've got to stay on top of what is going on politically on the state and national level otherwise there will be repercussions from the recent elections.

## Reports from Committees:

**Quality Improvement Committee:** Robert Noble, Co-Chair, reported on the following:

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

**Comprehensive HIV Planning Committee:** John Lazo, Co-Chair, reported on the following:

Speakers Bureau: Lazo said that the presentation scheduled for November 10<sup>th</sup> to the Spring-Klein Chamber of Commerce will be rescheduled due to a schedule conflict on their part. The final presentation of the year will be to the Cy-Fair Rotary Club on November 21<sup>st</sup>; Vargas will be the speaker for that one. The final workgroup meeting of the year will be November 17<sup>th</sup> at 10:15 a.m.

**Priority and Allocations Committee:** Bruce Turner, Co-Chair, reported on the following:

Reports from RW Administrative Agent – Part A/MAI: See the attached:

- FY16 Procurement Report – Part A/MAI, dated 10/27/16
- Approved List of Diagnostic procedures.

Reports from RW Administrative Agent – Part B/SS: See the attached, revised Health Insurance Assistance Service Utilization Report.

FY 2016 State Services Funding Increase: **Motion #4:** Fund the Health Insurance Assistance Program in the amount of \$796,034 pending a public comment period which ended at 5:00 p.m. on Wednesday, November 2, 2016. Justification for the allocation is based upon the increased cost of Marketplace and Medicare Health Insurance premiums. **Motion carried.** Abstention: Artiaga.

FY 2016 RW Part A Service Category Funding Increases: Please note that the correct total for the column labeled *Amount of Requests* should be \$579,380. This does not impact the following motion. **Motion #5:** Approve the attached requests for FY 2016 Ryan White Part A Service Category funding increases. **Motion carried.** Abstentions: Artiaga, Benson, Escamilla, Finley, Miertschin, Noble, Woods.

Ryan White Part A - FY 2016 Carryover Funds: **Motion #6:** If there are FY 2016 Ryan White Part A carryover funds, it is the intent of the committee to recommend allocating the full amount to Outpatient/Ambulatory Primary Medical Care. **Motion carried.** Abstentions: Artiaga, Benson, Escamilla, Finley, Miertschin, Noble, Woods.

FY 2016 Unspent Funds: **Motion #7:** In the final quarter of the FY 2016 Ryan White Part A, Part B and State Services grant years, after implementing the year end Council-approved reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, Ryan White Grant Administration (RWGA) may reallocate any remaining unspent funds as necessary to ensure the Houston EMA has less than 5% unspent Formula funds and no unspent Supplemental funds. The Resource Group (TRG) may reallocate any remaining unspent funds as necessary to ensure no funds are returned to the Texas Department of State Health Services. RWGA and TRG must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting. **Motion carried unanimously.**

Quarterly Committee Report: See the attached 2016 Quarterly Committee Report.

**Affected Community Committee:** Tana Pradia, Co-Chair, reported on the following:

Training: Prevention of Domestic and Sexual Violence: Heather Keizman, Project Coordinator for Ryan White Grant Administration, presented information on *The Prevention of Domestic and Sexual Violence*.

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

2016 Community Events: See the attached list of 2016 events at which there will be a Council presence. If anyone wishes to participate in a World AIDS Day event on Thursday, December 1, 2016, please see Tori. Also, if anyone would like to volunteer to help with Road 2 Success on Saturday morning, November 12, 2016 at the Montrose Center, please see Tori or Rod.

**Operations Committee:** Teresa Pruitt, Co-Chair, reported on the following:

2017 Council Orientation: Please note that the all-day 2017 Council Orientation will take place on Thursday, January 26th.

2017 Council Election Policy: Nominations for officers for the 2017 Planning Council may be submitted to the Manager of the Office of Support up until the end of the November Steering Committee meeting. After this time, nominations are added from the floor the day of the election. See the attached list of members who are eligible to run for Chair of the Planning Council.

2017 Slate of Officers: **Motion #8**: Accept the attached Slate of Nominees for the 2017 Ryan White Planning Council Officers. **Motion carried unanimously.**

Ryan White Memorandum of Understanding Among Part A Stakeholders and the Letter of Agreement Among Part A and B Stakeholders: It is recommended that neither the Memorandum of Understanding Among Ryan White Part A stakeholders nor the Letter of Agreement Among Ryan White Part B/SS stakeholders be amended at this time.

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

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

**Report from The Resource Group:** Sha'Terra Johnson-Fairley, Health Planner, submitted the attached report.

### **New Business**

**Community Prevention Group (CPG):** Finley said that they are talking about changing their meetings to every other month. Meetings have been quarterly this year since members have been participating on the Comprehensive Plan.

### **Updates from Task Forces:**

- **African American:** Johnson-Fairley said that the task force is having a World AIDS Day gala to honor HIV prevention front line staff on December 3<sup>rd</sup> at the Deluxe Theater. The next meeting is tomorrow at noon at the Fifth Ward Multi-Service Center 4014 Market Street. The final meeting of the year will be December 9<sup>th</sup> to elect new officers.
- **Texas Black Women's Initiative:** Johnson-Fairley said that last month they went to Prairie View A&M and partnered with sororities on the campus and tested 94 students in three hours.
- **Latino:** Vargas submitted the attached report.



- **MPact:** Artiaga submitted the attached report.
- **Transgender:** Finley said that they just started a new group called Save our Sisters; there are no minutes yet but he may be able to provide a report after the first of the year.
- **Youth:** Lazo said they will be meeting at 10:00 a.m. on November 22<sup>nd</sup> at Leonel Castillo Community Center.
- **Hepatitis C:** Vargas submitted the attached report.
- **Urban AIDS Ministry:** Collins-Nelson said they are commemorating World AIDS Day this year with a candlelight vigil to be held in the Sunnyside area.

**Positive Women’s Network:** Pradia said that they had a really good presentation on domestic violence last month at Houston Area Women’s Center in commemoration of the International Day for the Elimination of Violence against Women.

**HIV and Aging:** Turner submitted the attached report. He said that there are a few items needed for the Christmas party gift bags (hand sanitizers, note pads) and cash is always needed. Johnson-Fairley said she had note pads and Traylor said she will talk to her contact at Walgreens about donating hand sanitizer.

**Texas HIV Medication Advisory Committee:** Lucas said that a future meeting date has not been set.

**SPNS Grant: HIV and the Homeless Program:** Miertschin said that there have been some staffing changes within the program. There is less than a year left on the project.

**Announcements:** Lazo said that his friend Daniel Bauer is a magician/escape artist who will have a show in December and has offered a special discount for Planning Council members for the Friday night show. A portion of Friday night’s proceeds will go to Omega House. He distributed postcards about the event with the discount code. There is an article about Daniel Bauer on page 45 of this month’s Outsmart magazine. Gorden said that next year’s Poz cruise will be leaving out of San Juan, Puerto Rico, visiting 5 destinations in 8 days, see him for more information. Pradia said that she attended a training for the Southern AIDS Coalition in Atlanta. The epidemic is on the rise in the southern states and we need to get involved.

**Adjournment:** The meeting was adjourned at 1:40 p.m.

Respectfully submitted,

\_\_\_\_\_  
Victoria Williams, Director

\_\_\_\_\_  
Date

Draft Certified by  
Council Chair: \_\_\_\_\_

Date \_\_\_\_\_

Final Approval by  
Council Chair: \_\_\_\_\_

Date \_\_\_\_\_

### Council Voting Records for November 10, 2016

C = Chair of the meeting ja = just arrived lm = Left the meeting lr = Left the room	Motion #1 Agenda Carried				Motion #2 Minutes Carried				Motion #3 END HIV Letter of Support Carried					Motion #1 Agenda Carried				Motion #2 Minutes Carried				Motion #3 END HIV Letter of Support Carried			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN		MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO
MEMBERS																									
Steven Vargas, Chair				C				C				C	Peta-gay Ledbetter <i>lm 12:44pm</i>		X				X				X		
Tracy Gorden, Vice-Chair		X				X				X			Nancy Miertschin		X				X				X		
Carol Suazo, Secretary		X				X				X			Allen Murray		X				X				X		
Ted Artiaga		X				X				X			Robert Noble		X				X				X		
Connie Barnes		X				X				X			Tana Pradia		X				X				X		
Melody Barr <i>ja 12:17 pm</i>	X				X					X			Teresa Pruitt		X				X				X		
Curtis Bellard		X				X				X			Leslie Raneri		X				X				X		
David Benson		X				X				X			Cecilia Ross		X				X				X		
Skeet Boyle		X				X				X			Gloria Sierra		X				X				X		
Bianca Burley		X				X				X			Isis Torrente		X				X				X		
Ella Collins-Nelson		X				X				X			C. Bruce Turner		X				X						X
Denny Delgado <i>ja 12:54 pm</i>	X				X				X				David Watson		X				X				X		
Evelio Salinas Escamilla		X				X				X			Larry Woods		X				X				X		
Herman Finley		X				X				X															
Angela F. Hawkins		X				X				X															
Paul Grunenwald		X				X				X			<b>MEMBERS ABSENT</b>												
Arlene Johnson		X				X				X			Amber David												
J. Hoxi Jones		X				X				X			Rodney Mills												
John Lazo		X				X				X			Shital Patel												

### Council Voting Records for November 10, 2016

C = Chair of the meeting ja = just arrived lm = Left the meeting lr = Left the room	Motion #4 SS Increase Carried				Motion #5 Pt A Funding increase requests Carried				Motion #6 Part A Carryover Funds Carried					Motion #4 SS Increase Carried				Motion #5 Pt A Funding increase requests Carried				Motion #6 Part A Carryover Funds Carried			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN		MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO
MEMBERS																									
Steven Vargas, Chair				C				C				C	Peta-gay Ledbetter <i>lm 12:44pm</i>	X				X				X			
Tracy Gorden, Vice-Chair		X				X				X			Nancy Miertschin		X						X				X
Carol Suazo, Secretary		X				X				X			Allen Murray		X				X				X		
Ted Artiaga				X				X				X	Robert Noble		X						X				X
Connie Barnes		X				X				X			Tana Pradia		X				X				X		
Melody Barr		X				X				X			Teresa Pruitt		X				X				X		
Curtis Bellard		X				X				X			Leslie Raneri		X				X				X		
David Benson		X						X				X	Cecilia Ross		X				X				X		
Skeet Boyle		X				X				X			Gloria Sierra		X				X				X		
Bianca Burley		X				X				X			Isis Torrente		X				X				X		
Ella Collins-Nelson		X				X				X			C. Bruce Turner		X				X				X		
Denny Delgado <i>ja 12:54 pm</i>	X				X				X				David Watson		X				X				X		
Evelio Salinas Escamilla		X						X				X	Larry Woods		X						X				X
Herman Finley		X						X				X													
Angela F. Hawkins		X				X				X															
Paul Grunenwald		X				X				X			<b>MEMBERS ABSENT</b>												
Arlene Johnson		X				X				X			Amber David												
J. Hoxi Jones		X				X				X			Rodney Mills												
John Lazo		X				X				X			Shital Patel												

## Council Voting Records for November 10, 2016

C = Chair of the meeting ja = just arrived lm = Left the meeting lr = Left the room	Motion #7 Part A Unspent Funds Carried				Motion #8 Slate of Nominees Carried					Motion #7 Part A Unspent Funds Carried				Motion #8 Slate of Nominees Carried			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN		MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO
MEMBERS																	
Steven Vargas, Chair				C				C	Peta-gay Ledbetter lm 12:44pm	X				X			
Tracy Gorden, Vice-Chair		X				X			Nancy Miertschin		X				X		
Carol Suazo, Secretary		X				X			Allen Murray		X				X		
Ted Artiaga		X				X			Robert Noble		X				X		
Connie Barnes		X				X			Tana Pradia		X				X		
Melody Barr lm 1:20pm		X				X			Teresa Pruitt		X				X		
Curtis Bellard		X				X			Leslie Raneri		X				X		
David Benson		X				X			Cecilia Ross		X				X		
Skeet Boyle		X				X			Gloria Sierra		X				X		
Bianca Burley		X				X			Isis Torrente		X				X		
Ella Collins-Nelson		X				X			C. Bruce Turner		X				X		
Denny Delgado		X				X			David Watson		X				X		
Evelio Salinas Escamilla		X				X			Larry Woods		X				X		
Herman Finley		X				X											
Angela F. Hawkins		X				X											
Paul Grunenwald		X				X			<b>MEMBERS ABSENT</b>								
Arlene Johnson		X				X			Amber David								
J. Hoxi Jones lm 1:01pm		X			X				Rodney Mills								
John Lazo		X				X			Shital Patel								

**Comprehensive HIV  
Planning Committee  
Report**



## 2016 Houston HIV Care Services Needs Assessment

*A collaboration of:*

Houston Area HIV Services Ryan White Planning Council

Houston HIV Prevention Community Planning Group

Harris County Public Health, Ryan White Grant Administration

Houston Health Department, Bureau of HIV/STD and Viral Hepatitis  
Prevention

Houston Regional HIV/AIDS Resource Group, Inc.

Harris Health System

People Living with HIV in the Houston Area and Ryan White HIV/AIDS  
Program Consumers

Approved: PENDING

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**Disclaimer:**

The 2016 Houston Area HIV Care Services Needs Assessment summarizes primary data collected from January to June 2016 from 507 self-selected, self-identified people living with HIV (PLWH) using either a self-administered written survey or verbal interview. Most respondents resided in Houston/Harris County at the time of data collection. Data were statistically weighted for sex at birth, primary race/ethnicity, and age range based on a three-level stratification of HIV prevalence in the Houston EMA (2014). Though quality control measures were applied, limitations to the raw data and data analysis exist, and other data sources should be used to provide context for and to better understand the results. Data collected through this process represent the most current *primary* data source on PLWH in the Houston Area. Census, surveillance, and other data presented here reflect the most current data available at the time of publication.

**Funding acknowledgment:**

The 2016 Houston Area HIV Care Services Needs Assessment was made possible with funding from the Ryan White HIV/AIDS Treatment Extension Act of 2009. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Health Resources and Services Administration HIV/AIDS Bureau.

Incentives were provided by the Houston Regional HIV/AIDS Resource Group, Inc.

**Suggested citation:**

2016 Houston Area HIV Care Services Needs Assessment.

Approved: PENDING. Primary Author: Amber Lynn Harbolt, MA, Health Planner, Ryan White Planning Council Office of Support.

**For more information, contact:**

Houston Area Ryan White Planning Council  
2223 West Loop South #240  
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Fax: (713) 572-3740  
Web: [www.rwpchouston.org](http://www.rwpchouston.org)

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Community Planning Group  
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## ACKNOWLEDGMENTS

### Collaborating Partners:

The 2016 Houston Area HIV Care Services Needs Assessment is a collaboration of the following partners:

- Houston Area HIV Services Ryan White Planning Council
- Houston HIV Prevention Community Planning Group
- Harris County Public Health, Ryan White Grant Administration
- Houston Health Department, Bureau of HIV/STD and Viral Hepatitis Prevention
- Houston Regional HIV/AIDS Resource Group, Inc.
- Harris Health System
- People Living with HIV in the Houston Area and Ryan White HIV/AIDS Program Consumers

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## EXECUTIVE SUMMARY

The 2016 Houston Area HIV Care Services Needs Assessment presents data on HIV service needs, barriers, and other factors influencing access to care for people living with HIV (PLWH) in the Houston Area as determined through a consumer survey. Needs assessments ensure consumer experiences and perspectives are included in the data-driven decision-making processes of local HIV planning. Data are used to help set priorities for the allocation of HIV care services funding, in the development of the comprehensive HIV plan, and in designing annual service implementation plans. In 2016, 507 PLWH participated in the Needs Assessment survey, and the results were statistically weighted to better represent the demographic composition of all PLWH in the Houston Area today. The last Needs Assessment was conducted in 2014.

### HIV Service Needs in the Houston Area

According to the Houston Area HIV Care Services Needs Assessment, all currently funded HIV services in the Houston Area are needed by consumers. The top five most needed services are:

1. Primary care
2. Case management
3. Local medication assistance
4. Oral health care, and
5. Health insurance assistance

Compared to the 2016 Needs Assessment, local medication assistance and health insurance assistance rose while oral healthcare and housing fell.

### Accessibility of HIV Services in the Houston Area

In addition to revealing the most needed HIV services in the Houston Area, the Houston Area HIV Care Services Needs Assessment provides information about access to those services, which helps communities better understand where barriers to services may exist.

In 2016, at least 75% of the PLWH who said they needed each HIV service *also* said the service was easily accessible to them. There were some services, however, that were less accessible than others: food pantry vouchers, oral health care, and legal services were the three *least* accessible services according to 2016 Houston Area HIV Care Services Needs Assessment. Day treatment and substance abuse services were the most accessible services in 2016.

### Barriers to HIV Services in the Houston Area

To improve understanding of barriers to HIV services, the 2016 Houston Area HIV Care Services Needs Assessment also gathers information about the types of difficulties consumers experience when services are not easily accessible. For the first time, the 2016 Houston Area HIV Care Services Needs Assessment uses qualitative accounts of difficulties encountered for each service to provide in-depth information and context about the types barriers PLWH encounter. The most common types of barriers encountered are:

1. Education and awareness issues
2. Wait-related issues
3. Interactions with staff
4. Eligibility issues, and
5. Administrative issues

In addition to the above results, the 2016 Needs Assessment includes detailed information about a variety of issues that impact access to care, including:

- Service needs and barriers at each stage of the HIV care continuum, from HIV testing and initial diagnosis to treatment to support viral load suppression.
- The social, economic, health (both physical and mental), and behavioral characteristics of PLWH that may help or hinder HIV prevention and access to HIV care; and
- Needs and barriers for each HIV core medical, support, and housing service currently funded in the Houston Area, presented as a series of Fact Sheets.

Together, these data are used to better understand the HIV care needs and patterns of PLWH in the Houston Area, to identify new and emerging areas of need, and to ultimately improve the system of HIV services so that it best meets the needs of PLWH.

The 2016 Houston Area HIV Care Services Needs Assessment is collaboration between the Ryan White Planning Council, HIV Prevention Community Planning Group, Ryan White Grant Administration, Houston Health Department Bureau of HIV/STD and Viral Hepatitis Prevention, The Resource Group, Harris Health System, and Housing Opportunities for Persons with AIDS (HOPWA). A total of 69 individuals assisted in the planning and implementation of the needs assessment, of which 35% were PLWH.

For more information about the 2016 Houston Area HIV Care Services Needs Assessment, contact the Office of Support at (713) 572-3724 or visit [www.rvpchouston.org](http://www.rvpchouston.org).

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## INTRODUCTION

### What is an HIV needs assessment?

An HIV needs assessment is a process of collecting information about the needs of people living with HIV (**PLWH**) in a specific geographic area. The process involves gathering data *from multiple sources* on the number of HIV cases, the number of PLWH who are not in care, the needs and service barriers of PLWH, and current resources available to meet those needs. This information is then analyzed to identify what services are needed, what barriers to services exist, and what service gaps remain.

Special emphasis is also placed on gathering information about the need for services funded by the Ryan White HIV/AIDS Program and on the socio-economic and behavioral conditions experienced by PLWH that may influence their need for and access to services both today and in the future.

In the Houston Area, primary data collected directly from PLWH in the form of a *survey* are the principal source of information for the HIV/ needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Houston Area.

### How are HIV needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council (**RWPC**), including setting priorities for the allocation of funds, designing services that fit the needs of local PLWH, developing the comprehensive plan, and crafting the annual implementation plan. The community also uses needs assessment data are also used for a variety of *non-Council* purposes, such as in writing funding applications, evaluation and monitoring, and the improvement of services by individual providers.

In the Houston Area, HIV needs assessment data are used for the following purposes:

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.

- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

Needs assessment data are specifically mandated for use during the Planning Council's *How to Best Meet the Need, Priority & Allocations*, and Comprehensive HIV Planning processes.

Because surveys are administered every three years, results are used in RWPC activities for a three year period. Other data sources produced during interim years of the cycle, such as epidemiologic data and estimates of unmet need, are used to provide additional context for and to better understand survey results.

#### *Sources:*

- 2016 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2016 Needs Assessment Analysis. Approved 05-23-16.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

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## METHODOLOGY

### Needs Assessment Planning

Planning the 2016 Houston Area HIV Care Services Needs Assessment was a collaborative process between HIV prevention and care stakeholders, the Houston Area planning bodies for HIV prevention and care, all Ryan White HIV/AIDS Program Parts, and individual providers and consumers of HIV services. To guide the overall process and to provide specific subject matter expertise, a series of Needs Assessment-related Workgroups reconvened under the auspices of the Ryan White Planning Council (RWPC):

- The Needs Assessment Group (**NAG**) provided overall direction to the needs assessment process. As such, the NAG consisted of voting members from each collaborating partner and from the following subject matter workgroups.
- The Epidemiology Workgroup developed the consumer survey sampling plan, which aimed at producing a representative sample of surveys.
- The Survey Workgroup developed the survey instrument and consent language.
- The Analysis Workgroup determined how survey data should be analyzed and reported in order to serve as an effective tool for HIV planning.

In total, 69 individuals plus staff participated in the planning process, of which at least 35% were persons living with HIV (PLWH).

### Survey Sampling Plan

Staff calculated the 2016 Houston Area HIV Care Services Needs Assessment sample size based on current total HIV prevalence for the Houston Eligible Metropolitan Area (**EMA**) (2014), with 95% confidence interval, and at both a 3% and 4% margin of error. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Funded-agency representation was proportional to total client share for the same time period (2014). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Regular reports of select respondent characteristics were provided to NAG, the Comprehensive HIV Planning Committee, and RWPC during survey administration to assess real-time progress toward attainment of sampling goals and to make sampling adjustments were necessary.

### Survey Tool

Data for the 2016 Houston Area HIV Care Services Needs Assessment were collected using a 45-item paper survey of open-ended, multiple choice, and scaled questions addressing nine topic areas (in order):

- HIV services and wait-related concerns
- HIV diagnosis
- HIV care history including linkage to care
- Non-HIV co-occurring health concerns (incl. mental health)
- Substance use
- Housing, transportation, and social support
- Financial resources
- Demographics
- HIV prevention knowledge and behaviors

The Survey Workgroup determined topics and questions, restructuring and streamlining the 75-item 2014 needs assessment survey. Subject matter experts were also engaged to review specific questions. Consistency with the federally-mandated HIV prevention needs assessment for the Houston Area was assured through participation of Houston Health Department staff during the survey development process and alignment of pertinent questions such as those designed to gather demographic information and HIV prevention knowledge and behaviors. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent. A double-sided tear-sheet of emergency resources and HIV service grievance/complaint process information was also attached, and liability language was integrated within the survey.

### Data Collection

Surveys for the 2016 Houston Area HIV Care Services Needs Assessment were administered in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, and specific community locations and organizations serving special populations. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word of mouth, staff promotion, and cooperation with the Texas Department of State Health Services (**DSHS**).

Inclusion criteria were an HIV diagnosis and residency in counties in the greater Houston Area. Participants were self-selected and self-identified according to these criteria. Surveys were self-

administered in English, Spanish, and large-print formats, with staff and bilingual interpreters available for verbal interviewing. Participants recruited through cooperation with DSHS were interviewed by telephone. Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 15 to 20 minutes. Surveys were reviewed on-site by trained staff, interns, and interpreters for completion and translation of written comments; completed surveys were also logged in a centralized tracking database.

A total of 507 consumer surveys were collected from January to June 2016 during 50 survey sessions at 24 survey sites and via telephone.

### **Data Management**

Data entry for the 2016 Houston Area HIV Care Services Needs Assessment was performed by trained staff and interns at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for “check-all” questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff were eliminated (n=7). Data were periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. In addition, a data weighting syntax was created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2014), producing a total weighted sample size of 507 (11% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators vary across results. Also, proportions may not sum to 100% for every variable due to missing or “check-all” responses. All data management and analysis was performed in IBM® SPSS® Statistics (v. 19). and QSR International® NVivo 10.

### **Limitations**

The 2016 Houston Area HIV Care Services Needs Assessment produced data that are unique because they reflect the first-hand perspectives and lived experiences of PLWH in the Houston Area. However, there are limitations to the generalizability, reliability, and accuracy of the results that should be considered during their interpretation and use. These limitations are summarized below:

- *Convenience Sampling.* Multiple administrative methods were used to survey a representative sample of PLWH in the Houston Area proportional to geographic, demographic, transmission risk, and other characteristics. Despite extensive efforts, respondents were not randomly selected, and the resulting sample is not proportional to current HIV prevalence. To mitigate this bias, data were statistically weighted for sex at birth, primary race/ethnicity, and age group using current HIV/AIDS prevalence for the Houston EMA (2014). Results presented from Chapters 2 through the end of this report are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection, but may have received services outside the program that are similar to those currently funded. Therefore, it not possible to determine if results reflect non-Ryan White systems.
- *Sample size and confidence level.* Though the minimum sampling plan goal for the Needs Assessment was 587 surveys, the Comprehensive HIV Planning Committee voted to end data collection at 514 (507 valid) surveys completed in light of the limited amount of time to incorporate Needs Assessment findings into the 2017-2021 Comprehensive Plan. Staff calculated the new margin of error for this sample size as 4.31%, compared to 4% for the original minimum sample size, and verified with a statistician that this would have no bearing on generalizability of findings, particularly as the sample would be weighted by race/ethnicity, sex at birth, and age range.
- *Reporting bias.* Survey participants were self-selected and self-identified, and the answers they provided to survey questions were self-reported. Since the survey tool was anonymous, data could not be corroborated with medical or other records. Consequently, results should not be used as empirical evidence of reported outcomes. Other data sources should be used if confirmation of results is needed.
- *Instrumentation.* Full data accuracy cannot be assured due to variability in comprehension and completeness of surveys by individual respondents. Though real-time quality assurance reviews were performed of each survey by trained staff, there were missing data as well as indications of misinterpretation of survey questions. It is possible that literacy and language barriers contributed to this limitation as well.

- *Data management.* The use of multiple staff and interns to enter survey data could have produced transcription and transposition errors in the dataset. A line-list level data cleaning protocol was applied to help mitigate errors.

Data presented here represent the most current repository of *primary* data on PLWH in the Houston Area. With these caveats in mind, the results can be used to describe the experiences of PLWH in the

Houston Area and to draw conclusions on how to best meet the HIV service needs of this population.

*Sources:*

2016 Houston Area HIV Needs Assessment Group (NAG), Epidemiology Workgroup, 2016 Survey Sampling Principles and Plan, Approved 12-28-15.

Texas Department of State Health Services (DSHS) eHARS data through 12-31-2014, extracted as of summer 2015.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

## BACKGROUND

### The Houston Area

Houston is the fourth largest city in the U.S., the largest city in the State of Texas, and as well as one of the most racially diverse major American metropolitan area. Spanning 600 square miles, Houston is also the least densely populated major metropolitan area. Houston is the seat of Harris County, the most populous county in the State of Texas and the third most populous in the country. The United States Census Bureau estimates that Harris County has just over to 4.5 million residents, over half of which live in the city of Houston.

Beyond Houston and Harris County, local HIV planning extends to four geographic service areas in the greater Houston Area:

- *Houston/Harris County* is the geographic service area defined by the Centers for Disease Control and Prevention (CDC) for HIV prevention. It is also the local reporting jurisdiction for HIV surveillance, which mandates all laboratory evidence related to HIV/AIDS performed in Houston/Harris County be reported to the local health authority.
- The *Houston Eligible Metropolitan Area (EMA)* is the geographic service area defined by the Health Resources and Services Administration (HRSA) for the Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI). The Houston EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.
- The *Houston Health Services Delivery Area (HSDA)* is the geographic service area defined by the Texas Department of State Health Services (TDSHS) for the Ryan White HIV/AIDS Program Part B and the Houston Area's HIV service funds from the State of Texas. The HSDA includes the six counties in the EMA listed above plus four additional counties: Austin, Colorado, Walker, and Wharton.
- The *Houston Eligible Metropolitan Statistical Area (EMSA)* is the geographic service area defined by U.S. Department of Housing and Urban Development (HUD) for the Housing Opportunities for People with AIDS (HOPWA) program. The EMSA consists of the six counties in the EMA listed above plus Austin, Brazoria, Galveston, and San Jacinto Counties.

Together, these geographic service areas encompass 13 counties in southeast Texas, spanning from the Gulf of Mexico into the Texas Piney Woods.

### HIV in the Houston Area

In keeping with national new HIV diagnosis trends, the number of new cases of HIV in the Houston Area has remained relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV has steadily increased. According to current disease surveillance data, there are 26,041 diagnosed people living with HIV in the Houston EMA (Table 1). The majority are male (75%), over the age of 35 (75%), and MSM (56%), while almost half are African American (49%).

TABLE 1-Diagnosed People Living with HIV/AIDS in the Houston EMA, 2015<sup>a</sup>

	#	%
<b>Total</b>	26,041	100.0%
<b>Sex</b>		
Male	19,479	74.8%
Female	6,562	25.2%
<b>Race/Ethnicity</b>		
White	5,341	20.5%
Black/African American	12,721	48.8%
Hispanic/Latino	7,001	26.9%
Other/Multiple Races	978	3.8%
<b>Age at Diagnosis</b>		
0 - 12	68	0.3%
13 - 24	1,357	5.2%
25 - 34	5,115	19.6%
35 - 44	6,327	24.3%
45 - 54	7,463	28.7%
55+	5,711	21.9%
<b>Transmission Risk<sup>b</sup></b>		
Male-to-male sexual activity (MSM)	14,500	55.7%
Injection drug use (IDU)	2,354	9.0%
MSM/IDU	1,063	4.1%
Heterosexual contact	7,779	29.9%
Perinatal transmission	328	1.3%
Adult other risk	17	0.1%

<sup>a</sup>Source: Texas eHARS. Living HIV and AIDS cases as of 12/31/15. Data run August 2016.

<sup>b</sup>Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

CDC ranks the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) 11<sup>th</sup> highest in the nation for new HIV diagnoses and 13<sup>th</sup> in cases of HIV Stage 3 (formerly known as AIDS). In July 2015, the White House's National HIV/AIDS Strategy Updated to 2020 prioritized southern states in response to the number and disparities of new HIV diagnoses and HIV mortality in the American South. Of the 26,041 diagnosed PLWH in the Houston Area, 76% are in medical care for HIV, but only 57% have a suppressed viral load.

### **HIV Services in the Houston Area**

Both governmental agencies and non-profit organizations provide HIV services in the Houston Area through direct HIV services provision and/or function as Administrative Agents which contract to direct service providers. The goal of HIV care in the Houston Area is to create a seamless system to support for people at risk for or living with HIV with a full array of educational, clinical, mental, social, and support services to prevent new infections and support PLWH with high-quality, life-extending care. In addition, two local HIV Planning Bodies provide mechanisms for those living with and affected by HIV to design prevention and care services. Each of the primary sources in the Houston Area HIV service delivery system is described below:

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly-funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for HIV-diagnosed residents of the Houston EMA.

These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.

- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV/AIDS. HOPWA services include assistance with rent, mortgage, and utility payments, permanency planning, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

Together, these key agencies, the direct service providers that they fund, and the two local Planning Bodies ensure the greater Houston Area has a seamless system of prevention, care, treatment, and support services that best meets the needs of people at risk for or living with HIV.

#### *Sources:*

- Centers for Disease Control and Prevention, Diagnoses of HIV Infection in the United States and Dependent Areas, 2014; vol. 26. Published November 2015. Accessed 06/20/2016. Available at: [www.cdc.gov/hiv/topics/surveillance/resources/reports/](http://www.cdc.gov/hiv/topics/surveillance/resources/reports/).
- U.S. Census Bureau, State and County QuickFacts. Houston (city), Texas. Accessed: 06/20/2016. Available at: <http://quickfacts.census.gov/qfd/states/48/4835000.html>.
- White House Office of National AIDS Policy, National HIV/AIDS Strategy for the United States Updated to 2020. July 2015.





# Chapter 1: Demographics

## PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2016 Houston HIV Care Services Needs Assessment provides both a “snapshot” of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(Table 1) Overall, 93% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (67%), African American/Black (63%), and heterosexual (54%). Greater than half were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was \$9,380 annually, with the majority living below 100% of federal poverty (FPL). Most participants paid for healthcare using Medicaid/Medicare and assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2016

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	464	93.4%	13 to 17	1	0.2%	Male	341	67.3%
Fort Bend	21	4.2%	18 to 24	17	3.4%	Female	166	37.7%
Liberty	1	0.2%	25 to 49	219	43.2%	Intersex	0	-
Montgomery	6	1.2%	50 to 54	123	24.3%	Transgender	20	3.9%
Other	5	1.0%	55 to 64	133	26.2%	Currently pregnant	1	0.2%
			≥65	14	2.8%			
			Seniors (≥50)	270	53.3%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	60	11.8%	Heterosexual	274	54.0%	Private insurance	53	8.6%
African American/Black	318	62.7%	Gay/Lesbian	171	33.7%	Medicaid/Medicare	307	49.8%
Hispanic/Latino	121	23.9%	Bisexual	39	7.7%	Harris Health System	146	23.7%
Asian American	5	1.0%	Other	23	4.5%	Ryan White	105	17.0%
Other/Multiracial	3	0.6%	MSM	216	42.6%	None	6	1.0%
Immigration status			Yearly income (average: \$9,380)					
Born in the U.S.	427	84.6%	Federal Poverty Level (FPL)					
Citizen > 5 years	33	6.5%	Below 100%	278	78.8%			
Citizen < 5 years	4	0.8%	100%	45	12.7%			
Undocumented	10	2.0%	150%	13	3.7%			
Prefer not to answer	22	4.4%	200%	10	2.8%			
Other	9	1.8%	250%	2	0.6%			
			≥300%	5	1.4%			

(Table 2) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2016 needs assessment process to *oversample* PLWH who were also members of groups designated as “special populations” due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

**TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2016**

	No.	%
Unstable Housing	142	28.0%
Injection drug users (IDU)*	8	1.6%
Men who have sex with men (MSM)	216	42.6%
Not retained in care (last 6 months)	4	0.8%
Recently released from incarceration	41	8.1%
Rural (non-Harris County resident)	33	6.4%
Transgender	20	3.9%

\*See Limitations section for further explanation of identification of IDU

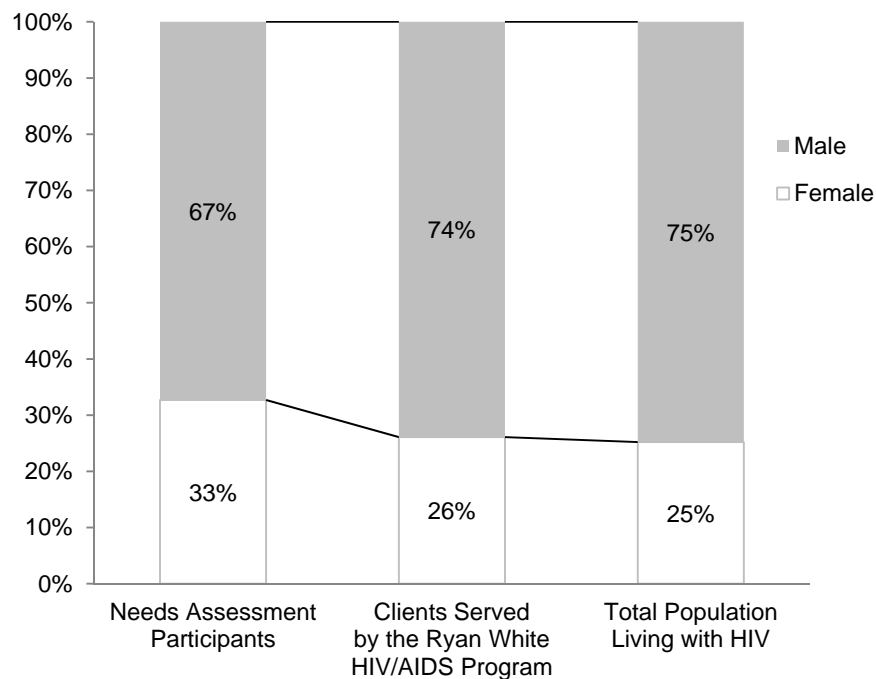
## COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

HIV needs assessments generate information about the needs and service barriers of persons living with HIV (PLWH) in a specific geographic area to assist planning bodies and other stakeholders with designing HIV services that best meet those needs. As it is not be feasible to survey every PLWH in the Houston area, multiple administrative and statistical methods are used to generate a sample of PLWH that are reliably representative of *all* PLWH in the area. The same is true in regards to assessing the needs of clients of the Ryan White HIV/AIDS Program.

As such, awareness of the level participant representation compared to the composition of both Ryan White HIV/AIDS Program clients and the total HIV diagnosed population is beneficial when reviewing needs assessment results to document actions taken to mitigate any disproportional results.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, males comprised 67% of participants, but 74% of all Ryan White clients and 75% of all PLWH in the Houston Eligible Metropolitan Area (EMA). This indicates that male PLWH were underrepresented in the needs assessment sample, while, female PLWH were overrepresented.

**GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients<sup>a</sup> and Total HIV Infected Population<sup>b</sup> in the Houston EMA, by Sex, 2015**

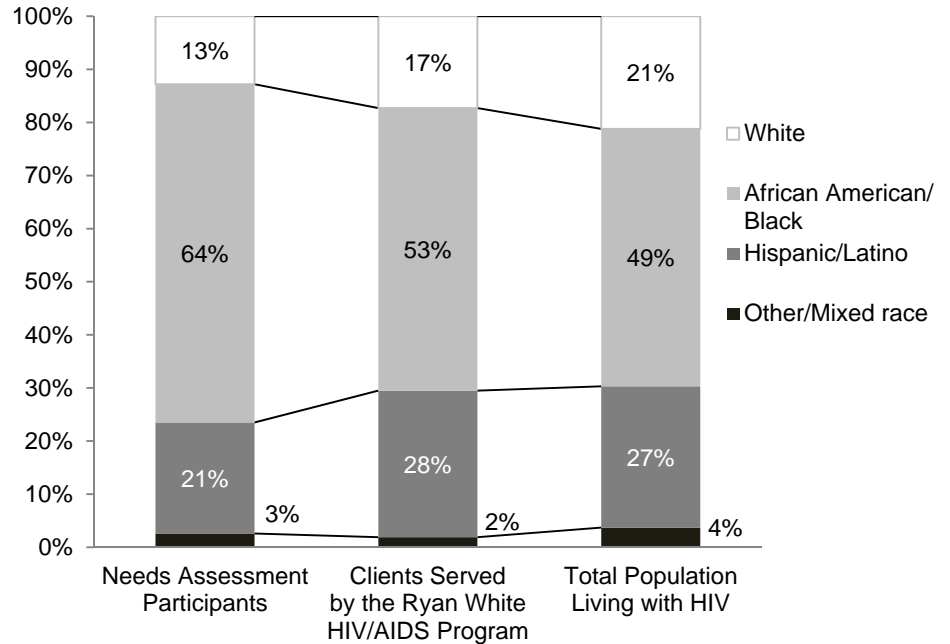


<sup>a</sup>Source: CPCDMS as of 12/31/15, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Presented 4/26/16.

<sup>b</sup>Source: Texas eHARS. Living HIV cases as of 12/31/15.

(Graph 2) Analysis of race/ethnicity composition also shows disproportionate representation between participants, all Ryan White clients, and all PLWH in the Houston EMA. African American/Black participants were overrepresented at 64% of participants when compared to the proportions of African American/Black Ryan White clients and PLWH. Conversely, White PLWH and Hispanic/Latino PLWH were generally underrepresented in the needs assessment.

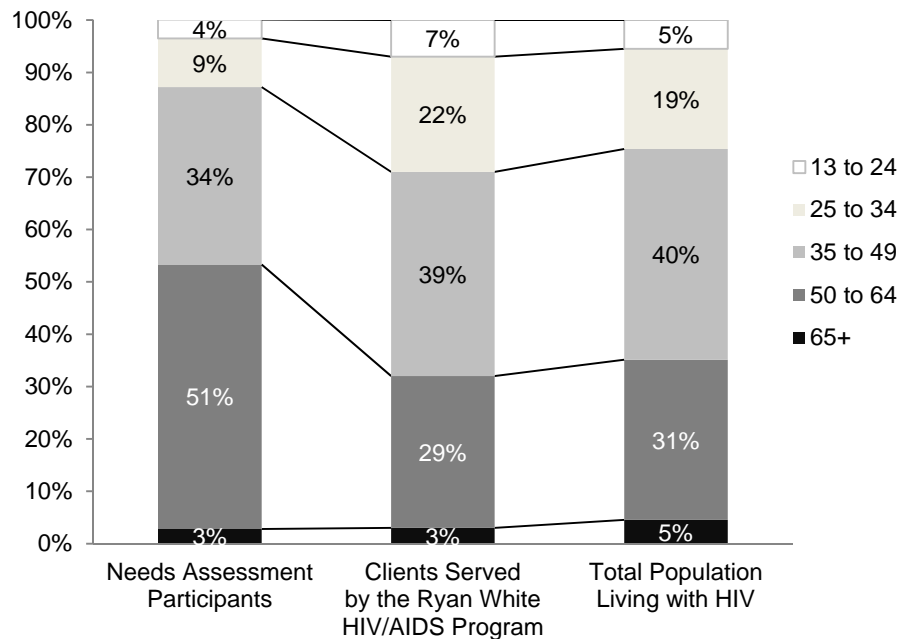
**GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients<sup>a</sup> and Total HIV Infected Population<sup>b</sup> in the Houston EMA, by Race/Ethnicity, 2015**



<sup>a</sup>Source: CPCDMS as of 12/31/15. Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Presented 4/26/16.  
<sup>b</sup>Source: Texas eHARS. Living HIV cases as of 12/31/15

(Graph 3) Lastly, an analysis of age range shows that more needs assessment participants were older than Ryan White clients and PLWH in the Houston EMA, with 54% of needs assessment participants were 50 years and older, while only than half of all Ryan White clients (32%) and less than half of all PLWH (36%) are in this age group. This suggests that, youth, and young adult PLWH (those age 13 to 34) are generally underrepresented in the needs assessment, while older adults (those age 45 and above) are overrepresented.

**GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients<sup>a</sup> and Total HIV Infected Population<sup>b</sup> in the Houston EMA, by Age<sup>c</sup>, 2014**



<sup>a</sup>Source: FY15 Service Utilization Report as of 2/29/16. Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Dated 6/08/16  
<sup>b</sup>Source: Texas eHARS. Living HIV cases as of 12/31/14.  
<sup>c</sup>Excludes ages 0-12

## **Weighting the Sample**

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2014) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2016 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data

weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

### *Sources:*

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2014, extracted as of August 2015.  
University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPSS Statistics 20, Post-stratification weights, 2009.



## **Chapter 2: Service Needs and Barriers**

## OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (PLWH) who may not have sufficient resources for managing HIV disease. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (HOPWA) program through the City of Houston Housing and Community Development Department. The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (HHD) prevention program.

### Overall Ranking of Funded Services, by Need

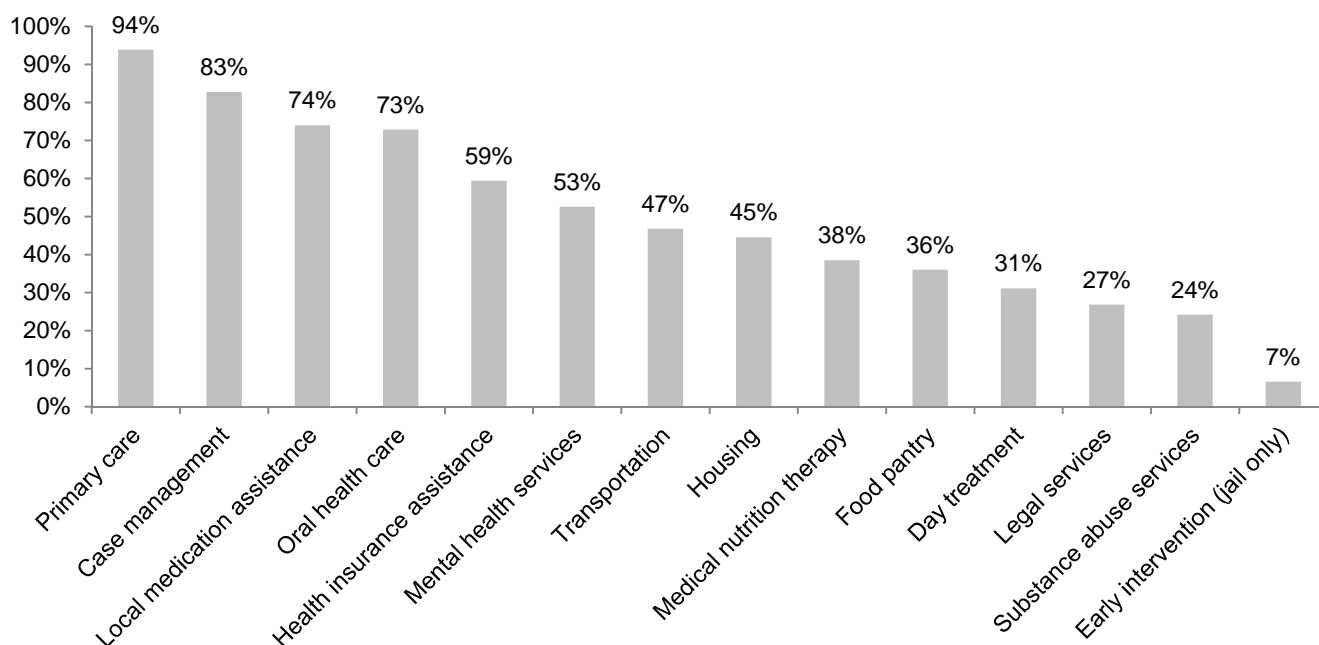
In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed.

Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(Graph 1) All funded services except hospice and linguistics were analyzed and received a ranking of need. At 94%, primary care was the most needed funded service in the Houston Area, followed by case management at 83%, local medication assistance at 74%, and oral health care at 73%. Primary care had the highest need ranking of any core medical service, while transportation received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2014, need ranking increased for many core medical services, and decreased for most support services. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

**GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2016**

*Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.*





**Overall Ranking of Funded Services, by Accessibility**

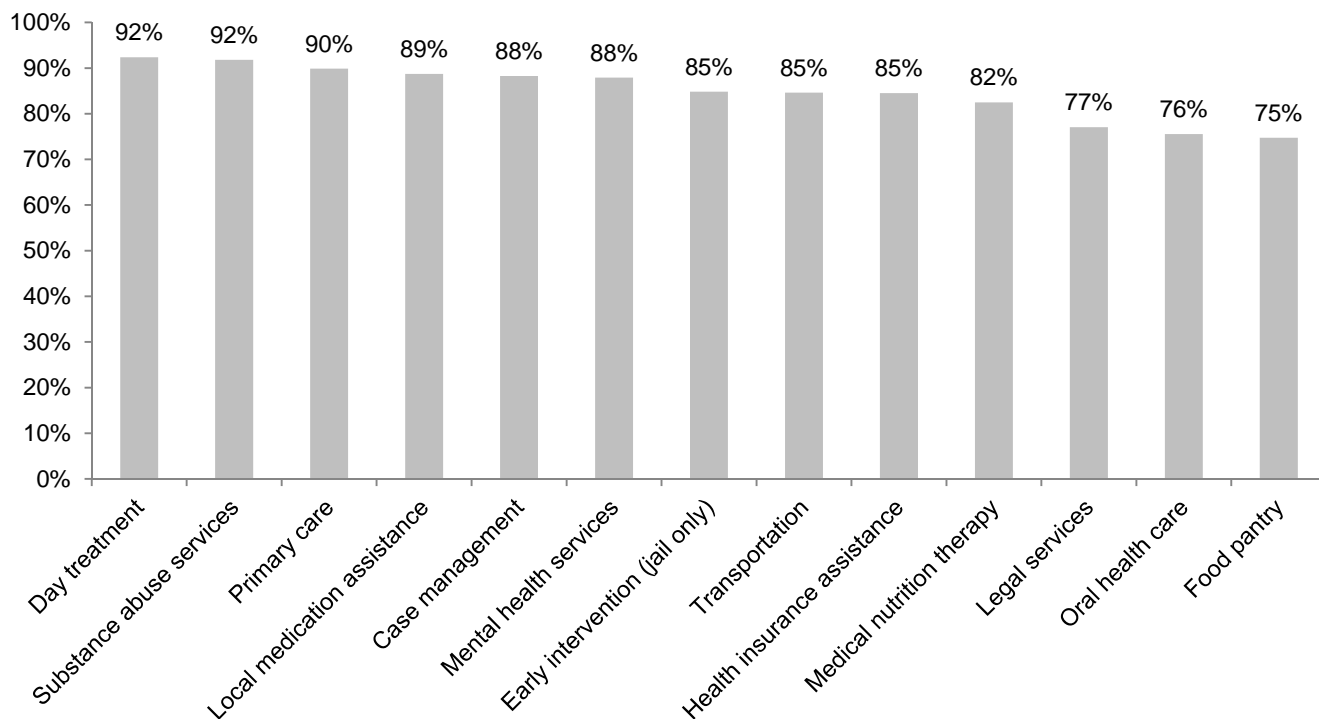
Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The two most accessible services were day treatment and substance abuse services at 92% ease of access, followed by primary care at 90% and local medication assistance at 89%. Day treatment had the highest accessibility ranking of any core

medical service, while transportation received the highest accessibility ranking of any support service. Compared 2014 needs assessment, reported accessibility increased for each service category, with an average increase of 9 percentage points. The greatest increase in percent of participants reporting ease of access was observed in early intervention services, while transportation experienced the lowest increase in accessibility. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

**GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2016**

*Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.*



### Overall Ranking of Barriers Types Experienced by Consumers

For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

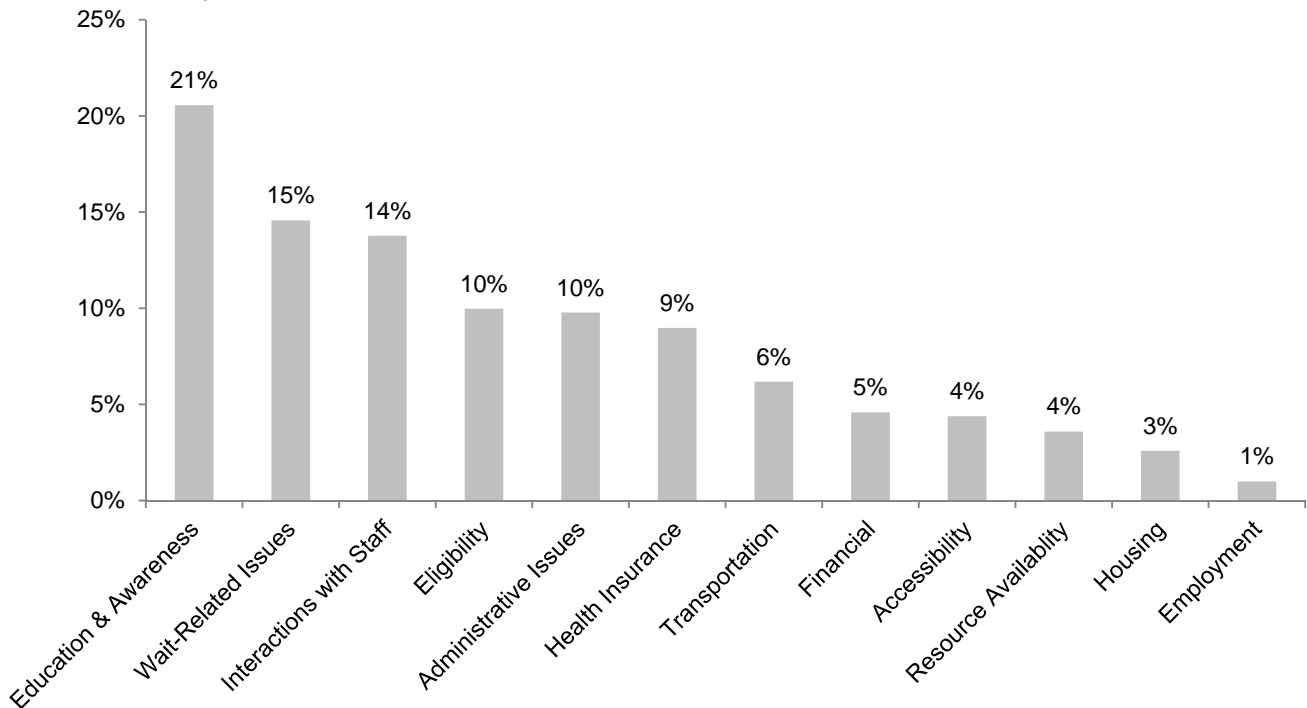
(**Graph 3**) Overall, the barrier types reported most often related to service education and awareness issues (21% of all reported barriers); wait-related

issues (15%); interactions with staff (14%); eligibility issues (10%); and administrative issues (10%). Employment concerns were reported least often (1%). Due to the change in methodology for barrier assessment between the 2011 and the 2016 HIV needs assessments, a comparison of the change in number of reports of barriers will not be available until the next HIV needs assessment.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

#### GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2016

*Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.*



## Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 33 reports of barriers per service. Participants reported the least barriers for Hospice (two barriers) and the most barriers for Oral Health Care (86 barriers). In total, 525 reports of barriers across all services were indicated in the sample.

(Table 1) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 82% barriers reported. Being put on a waitlist accounted for a majority (66%) of wait-related issues barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (51%) of barriers related to staff interactions. Almost all (86%) of eligibility barriers related to participants being told they did not meet eligibility requirements to receive the service or difficulty obtaining the required documentation to establish eligibility. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (59%) the barriers reported.

Most (84%) of health insurance-related barriers occurred because the participant was uninsured or underinsured and experiencing coverage gaps for needed services or medications. The largest proportion (81%) of transportation-related barriers occurred when participants had no access to transportation. It is notable that multiple participants reported losing bus cards and the difficulty of replacing the cards presented a barrier to accessing other services. Inability to afford the service accounted for all barriers relating to participant financial resources. The service being offered at a distance that was inaccessible to participants or being recently released from incarceration accounted for most (77%) of accessibility-related barriers, though it is worth note that low or no literacy accounted for 14% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Homelessness accounted for virtually all housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (60%) employment-related barriers.

**TABLE 1-Barrier Proportions within Each Barrier Type, 2016**

Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
<b>Availability</b> (Didn't know the service was available)	50%	<b>Waitlist</b> (Put on a waitlist)	66%	<b>Communication</b> (Poor correspondence/ Follow up from staff)	51%
<b>Definition</b> (Didn't know what service entails)	7%	<b>Unavailable</b> (Waitlist full/not available resulting in client not being placed on waitlist)	15%	<b>Poor Treatment</b> (Staff insensitive to clients)	17%
<b>Location</b> (Didn't know where to go [location or location w/in agency])	32%	<b>Wait at Appointment</b> (Appointment visits take long)	7%	<b>Resistance</b> (Staff refusal/ resistance to assist clients)	13%
<b>Contact</b> (Didn't know who to contact for service)	11%	<b>Approval</b> (Long durations between application and approval)	12%	<b>Staff Knowledge</b> (Staff has no/ limited knowledge of service)	7%
				<b>Referral</b> (Received service referral to provider that did not meet client needs)	17%
Eligibility	%	Administrative Issues	%	Health Insurance	%
<b>Ineligible</b> (Did not meet eligibility requirements)	48%	<b>Staff Changes</b> (Change in staff w/o notice)	12%	<b>Uninsured</b> (Client has no insurance)	53%
<b>Eligibility Process</b> (Redundant process for renewing eligibility)	16%	<b>Understaffing</b> (Shortage of staff)	2%	<b>Coverage Gaps</b> (Certain services/medications not covered)	31%
<b>Documentation</b> (Problems obtaining documentation needed for eligibility)	38%	<b>Service Change</b> (Change in service w/o notice)	10%	<b>Locating Provider</b> (Difficulty locating provider that takes insurance)	13%
		<b>Complex Process</b> (Burden of long complex process for accessing services)	59%	<b>ACA</b> (Problems with ACA enrollment process)	17%
		<b>Dismissal</b> (Client dismissal from agency)	4%		
		<b>Hours</b> (Problem with agency hours of operation)	16%		
Transportation		Financial	%	Accessibility	%
<b>No Transportation</b> (No or limited transportation options)	81%	<b>Financial Resources</b> (Could not afford service)	100%	<b>Literacy</b> (Cannot read/difficulty reading)	14%
<b>Providers</b> (Problems with special transportation providers such as Metrolift or Medicaid transportation)	19%			<b>Spanish Services</b> (Services not made available in Spanish)	9%
				<b>Released from Incarceration</b> (Restricted from services due to probation, parole, or felon status)	32%
				<b>Distance</b> (Service not offered within accessible distance)	45%
Resource Availability	%	Housing	%	Employment	%
<b>Insufficient</b> (Resources offered insufficient for meeting need)	56%	<b>Homeless</b> (Client is without stable housing)	100%	<b>Unemployed</b> (Client is unemployed)	40%
<b>Quality</b> (Resource quality was poor)	44%	<b>IPV</b> (Interpersonal domestic issues make housing situation unsafe)	0%	<b>Leave</b> (Employer does not provide sick/wellness leave for appointments)	60%

## Waiting List Barriers and Experiences

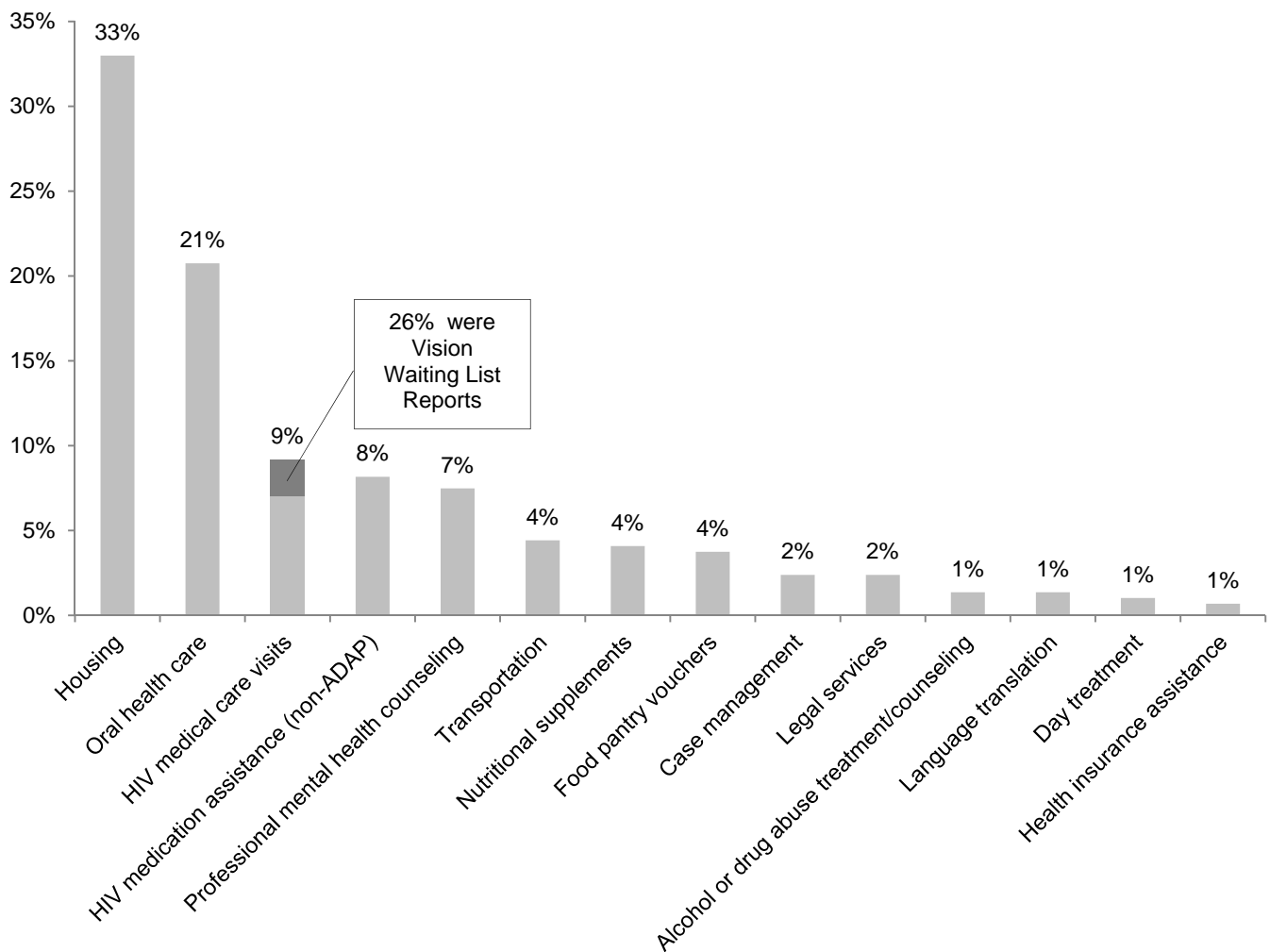
In February 2014, the Ryan White Planning Council formed the ad-hoc Waiting List Workgroup to evaluate the extent to which waiting and waitlists impact the receipt of HIV care and treatment services in the Houston Area, and propose ways to address wait-related issues through changes to the HIV care and treatment system. With input from the Waiting List Workgroup, the 2016 Houston HIV Care Services Needs Assessment included questions specifically designed to elicit information from participants about which services they had been placed on a waiting list for in the past 12 months, the time period between first request for a service and eventual receipt of the service, awareness of other providers of waitlisted services, and services for which

clients reported being placed on a waitlist more than once. Thirty-nine percent (39%) of participants indicated that they had been placed on a waiting list for at least one service in the past 12 months.

(**Graph 4**) A third of participant reports of being on a waiting list were for housing services. This was followed by oral health care (21%), HIV medical care (9%), local medication assistance (8%), and professional mental health counseling (7%). Of all participants reporting being on a wait list for HIV medical care visits, 26% indicated being placed on a waiting list specifically for vision services. There were no reports of participants being placed on a wait list for hospice or pre-discharge planning.

**GRAPH 4-Percentage of Waiting List Reports by Service, 2016**

Definition: Percent of times needs assessment participants reported being on a waiting list for each service.



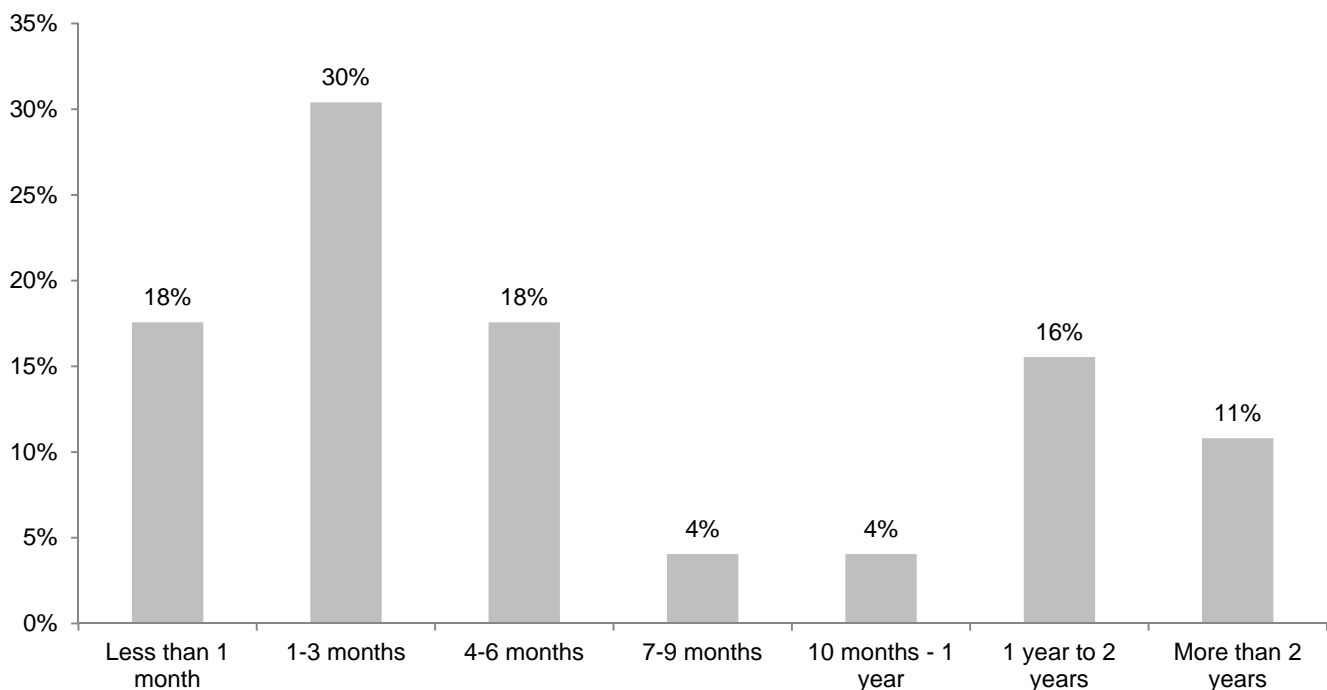
(Graph 5) Participant reports of time elapsed from the initial request for a service until receipt of the service vary from 1 day to over 2 years. The greatest number of reports of time elapsed occurred for wait times between one and three months (30%), followed by less than one month (18%) and four to six months (18%).

Most wait times reported for housing services occurred for one to three months (26%), one to two years (26%), or 10 months to one year (18%). It is worth noting that 8% of participants reporting a wait time for housing services had over two years elapse

between first request and receipt of service, with several expressing that they were on a housing wait list at the time of survey. Most reports of wait times for oral health care were less than one month (26%) or four to six months (26%). However, 14% of participants indicating a wait time for oral health care services reported wait times of over one year. Finally, most participants (64%) indicating wait times for HIV medical care including vision services reported waiting one to three months.

**GRAPH 5-Percentage of Wait Times Reports, 2016**

*Definition: Percent of times needs assessment participants reported time elapsed from the initial request for a service until receipt of the service each time period.*



Awareness of other providers for services operating waiting lists can offer timely service to consumers with acute needs and reduce wait times for those remaining on wait lists. A majority (83%) of participants who reported being on a wait list for at least one in the past 12 months stated that they were not aware of another provider of the service for which they were waiting, or did not remember if they were aware of another provider. Of the remaining 35% of participants who were aware of another

provider, over half (59%) reported not seeking service from the alternative provider.

Nearly one-third of participants who reported being placed on a wait list in the past 12 months also reported having been placed on a wait list for the service more than once. This was observed primarily for among participants reporting being placed on a wait list for housing services (34%) and oral health care (29%).

### Other Identified Needs

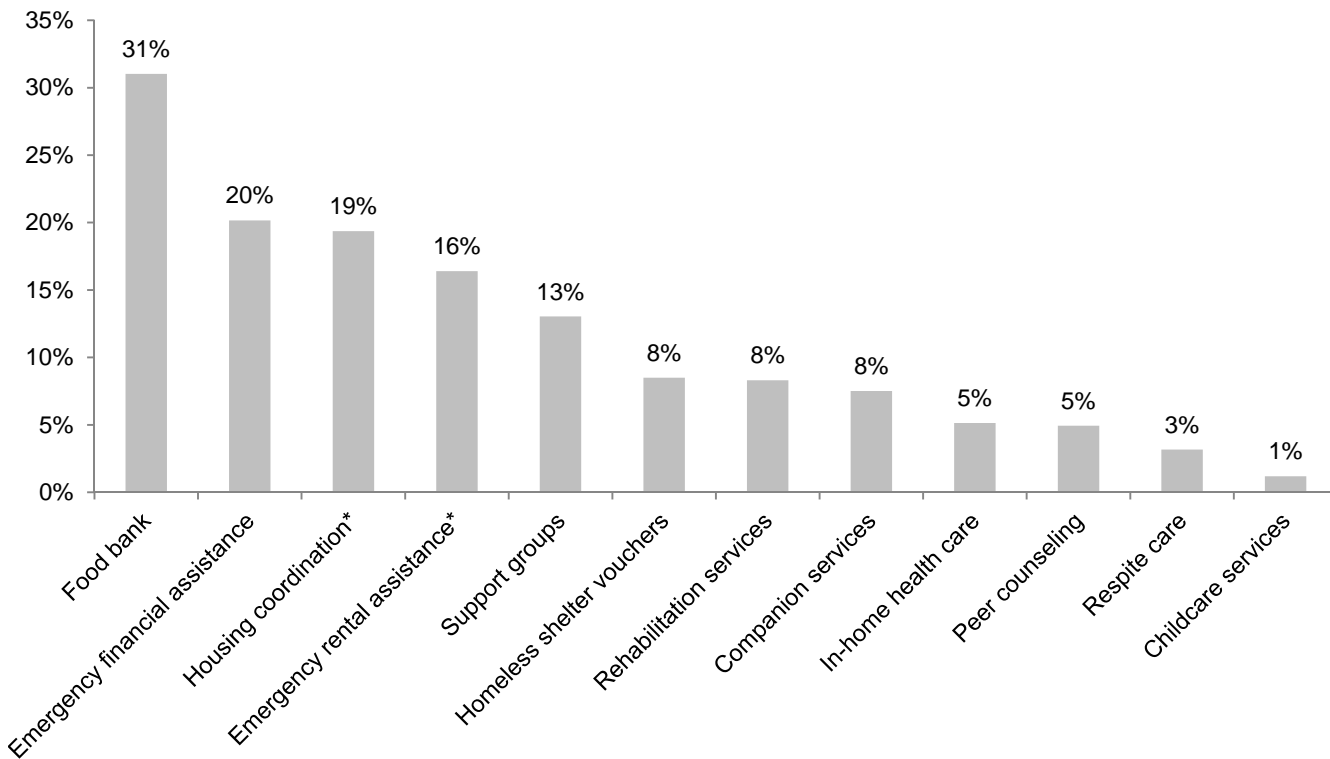
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2016 Houston HIV Care Services Needs Assessment measured the need for these services to order to gauge any new or emerging service needs in the community. In addition, some of these services are currently funded through other HIV-specific non-Ryan White sources, namely housing-related services provided by the Housing Opportunities with People with AIDS (HOPWA) program, as indicated.

(Graph 6) Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services. Of the 12 services options provided, 31% of participant selected food bank was needed services, a decrease of 14 percentage points from the 2014 needs assessment. Emergency financial assistance was selected second (20%), followed by housing-related services cited third (20%) and fourth (16%), and support groups cited fifth (13%).

Services that were written-in most often as a need (and that are not currently funded by Ryan White) were (*in order*): employment assistance and job training, vision hardware/glasses, and services for spouses/partners.

**GRAPH 6-Other Needs for HIV Services in the Houston Area, 2016**

Definition: Percent of needs assessment participants, who selected each service in response to the survey question, “What other kinds of services do you need to help you get your HIV medical care?”



\*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



## **Chapter 3: Needs Across the HIV Care Continuum**



## HIV CARE CONTINUUM

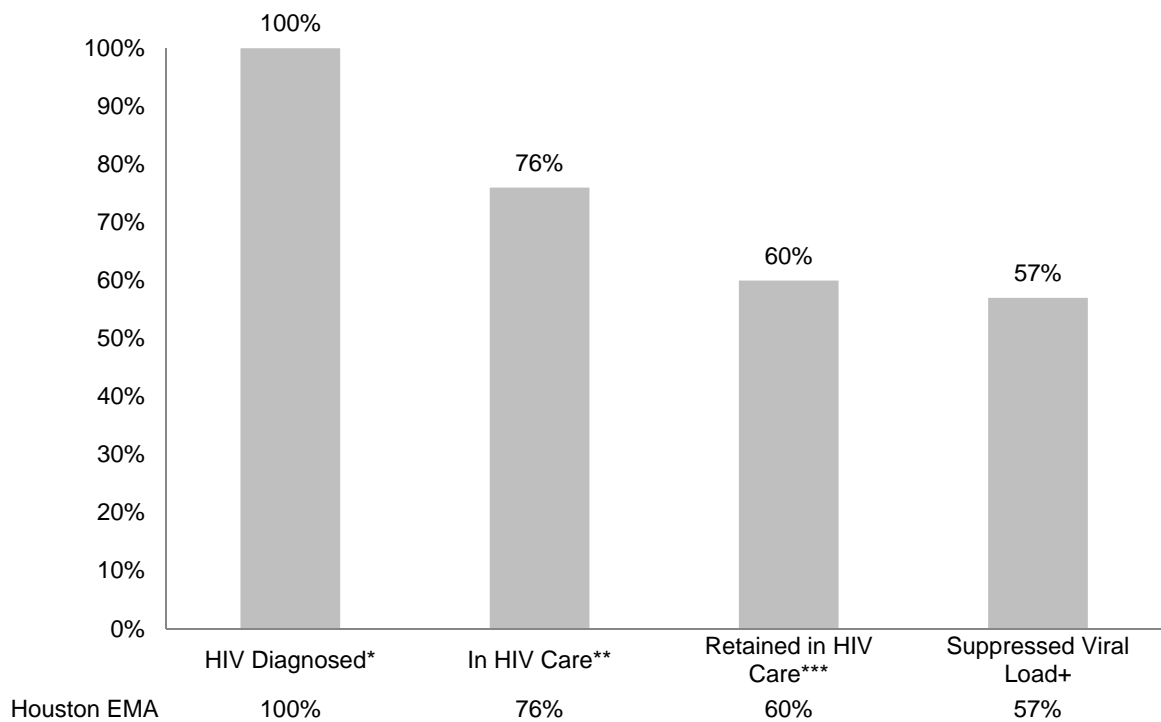
In July 2012, the Centers for Disease Control and Prevention (CDC) released an analysis of the number and percentage of people in the U.S. at each stage of the HIV care continuum originally developed by Gardner et al (2011). The continuum represents the sequential stages of HIV care – from being diagnosed to suppressing the virus through treatment. This analysis is now commonly referred to as the *HIV care continuum* and, in July 2013, the White House launched a national initiative to expand and accelerate efforts along each stage of the continuum.

HIV care continua that incorporate local data allow communities to evaluate the extent to which national and local goals related to increasing HIV awareness, linkage to care, and viral load suppression are being met or exceeded. This model is also useful for identifying local prevention and care service gaps, and targeting efforts to bridge each stage of the continuum.

### Engagement in Care in the Houston Area

(Graph 1) Each year, the Houston Area HIV Care Continuum (HCC) is updated using local epidemiological data. Several questions included in the 2016 Houston HIV Care Services Needs Assessment assess barriers to engagement at certain points along the HIV care continuum. The first stage of the HCC was explored in the needs assessment through analysis of diagnosis locations and years. Linkage to care and met need were evaluated through services and materials provided at diagnosis, as well as encountered barriers to timely linkage. Retention was addressed through investigating causes for lost to care and falling out of care. Finally, as the defining component of achieving viral suppression, motivations among participants not currently taking antiretroviral medication are assessed at the end of this chapter

**GRAPH 1-Houston Area HIV Care Continuum, 2015**



\*No. persons who are HIV diagnosed in 2015 in the Houston EMA.

\*\*No. persons who are HIV diagnosed with met need in 2015 in the Houston EMA.

\*\*\*No. HIV diagnosed persons with retained in care (PLWH with at least 2 visits, labs, or ARVs in 12 months, at least 3 months apart) in 2015 in the Houston EMA.

+No. HIV diagnosed persons whose last VL of 2015  $\leq 200$  (among persons with  $\geq 1$  VL test) in 2015 in the Houston EMA.

Data Source: TDSHS, HIV Care Continuum for the Houston EMA, 2015. Data from among adults and adolescents ( $\geq 13$  years of age as of end of the year 2015) residing in Texas diagnosed with HIV infection through 2015 and living with HIV infection on 12/31/2015. Data extracted as of August 2016

## TESTING AND DIAGNOSIS

The 2016 Houston HIV Care Services Needs Assessment asked participants to share some information from when they were first diagnosed, including when and where they were diagnosed. This information helps identify effective locations for HIV testing in the Houston Area toward the goal of increasing the proportion of people living with HIV (PLWH) who are aware of their status. This corresponds with both the National HIV/AIDS Strategy (NHAS) Updated to 2020 indicator to increase the percentage of people living with HIV who know their serostatus to at least 90% by 2020 and the Houston Area 2017-2021 Comprehensive Plan goal to maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their positive status, beginning at 94.4%.

### HIV Testing Location

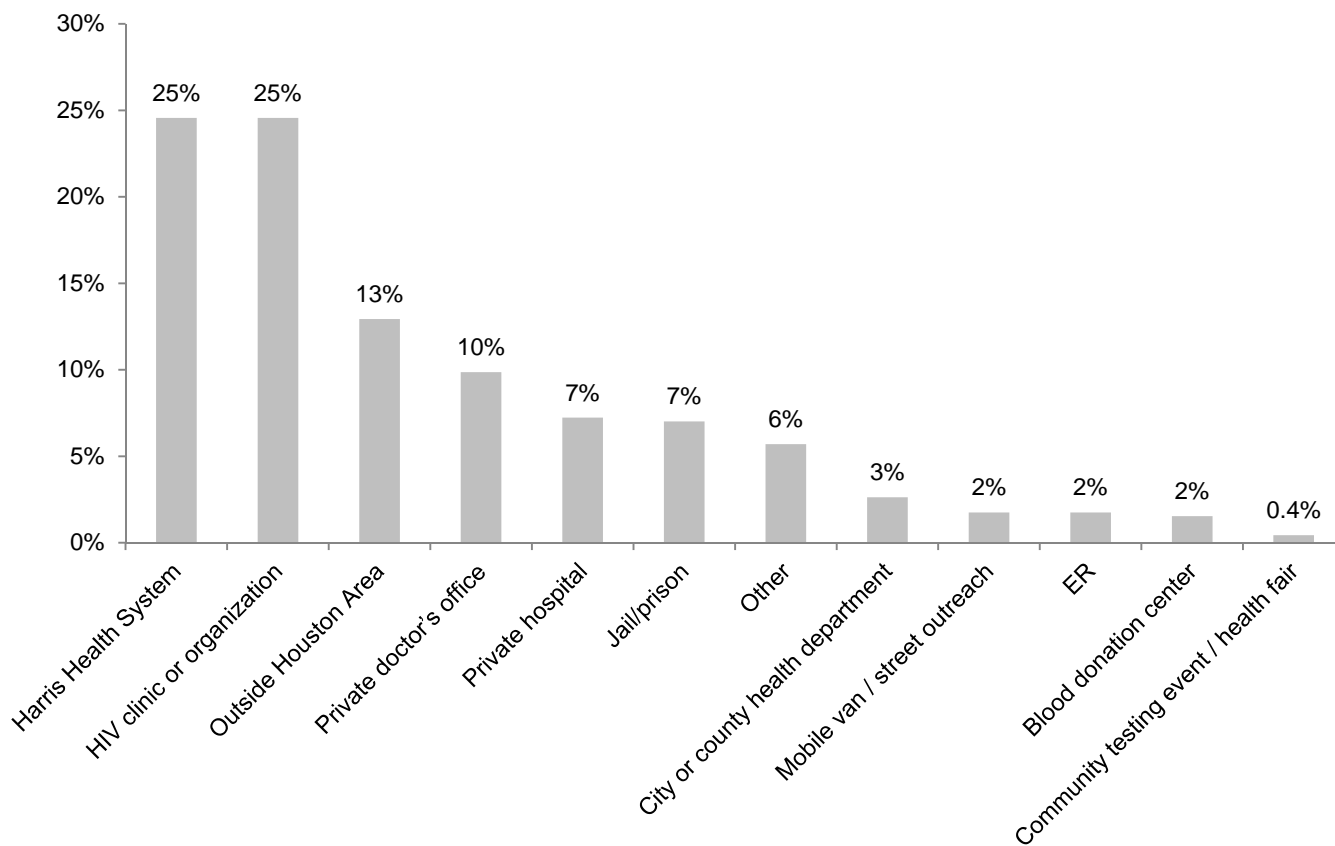
(Graph 2) The most common location for being diagnosed with HIV among needs assessment

participants was tie between a Harris Health System facility or an HIV clinic or organization at 25%, followed by receipt of diagnosis outside the Houston area (13%), a private doctor's office or clinic (10%), and a private hospital or ER (7%). At less than 1%, community testing events and health fairs were cited least often.

While out of care, unstably housed, MSM, and transgender PLWH as were diagnosed most often at a Harris Health System facility, population-level analysis shows some difference in diagnosis location for other groups. Youth (age 18 to 24) were diagnosed most often at a blood donation center while newly diagnosed PLWH were diagnosed most often at an HIV clinic or organization. Rural participants (not residing in Houston/Harris County) were diagnosed most often outside the Houston area. PLWH released from incarceration in the past 12 months were diagnosed most often while incarcerated.

**GRAPH 2-Locations of HIV Diagnosis for PWLH in the Houston Area, 2016**

*Definition: Percent of times each type of location was reported as the location where participants were first diagnosed with HIV.*



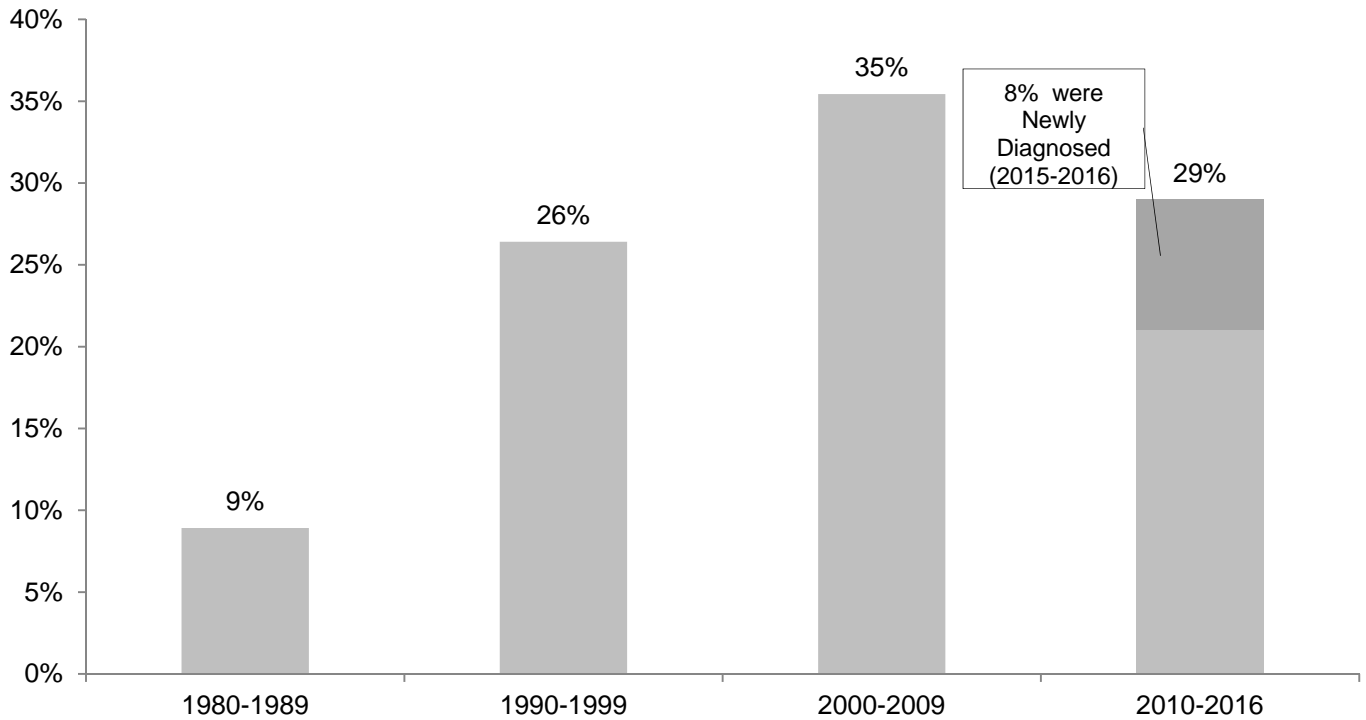
### Year HIV Diagnosed

(Graph 3) The average length of time since HIV diagnosis among needs assessment participants was 13 years. This means that most participants were diagnosed prior to major expansions in HIV testing in the Houston Area, including annual mass testing events and routine/opt-out testing. More participants

were diagnosed between 2000 and 2009 than any other time period. However, the mean number of participants diagnosed each year between 2010 and 2016 was 21, more than any other diagnosis time period.

**GRAPH 3-Year of HIV Diagnosis for PWLH in the Houston Area, 2016**

*Definition: Percent of participants who were first diagnosed with HIV in each time period.*



## LINKAGE TO CARE

The 2016 Houston HIV Care Services Needs Assessment asked participants about initial entry into HIV care following diagnosis. Information on linkage to care for newly diagnosed individuals can help communities identify strategies to make linkage to HIV care timely and effective for promoting retention in care and viral suppression. Linkage to care information also helps communities identify gaps that result in delayed entry into care as well as potential solutions for bridging linkage gaps with HIV services. The NHAS Updated to 2020 indicator and Houston Area 2017-2021 Comprehensive Plan goal to increase linkage to HIV care within one month of diagnosis to at least 85%

*Notes:* As the average length of time since HIV diagnosis among needs assessment participants was 13 years, most participants were diagnosed prior to the introduction of proactive service linkage efforts such as Service Linkage Workers. Service linkage activities and barriers to timely linkage are discussed for all participants and newly diagnosed participants in **Graph 4** and **Graph 5**.

### Linkage Services at Diagnosis

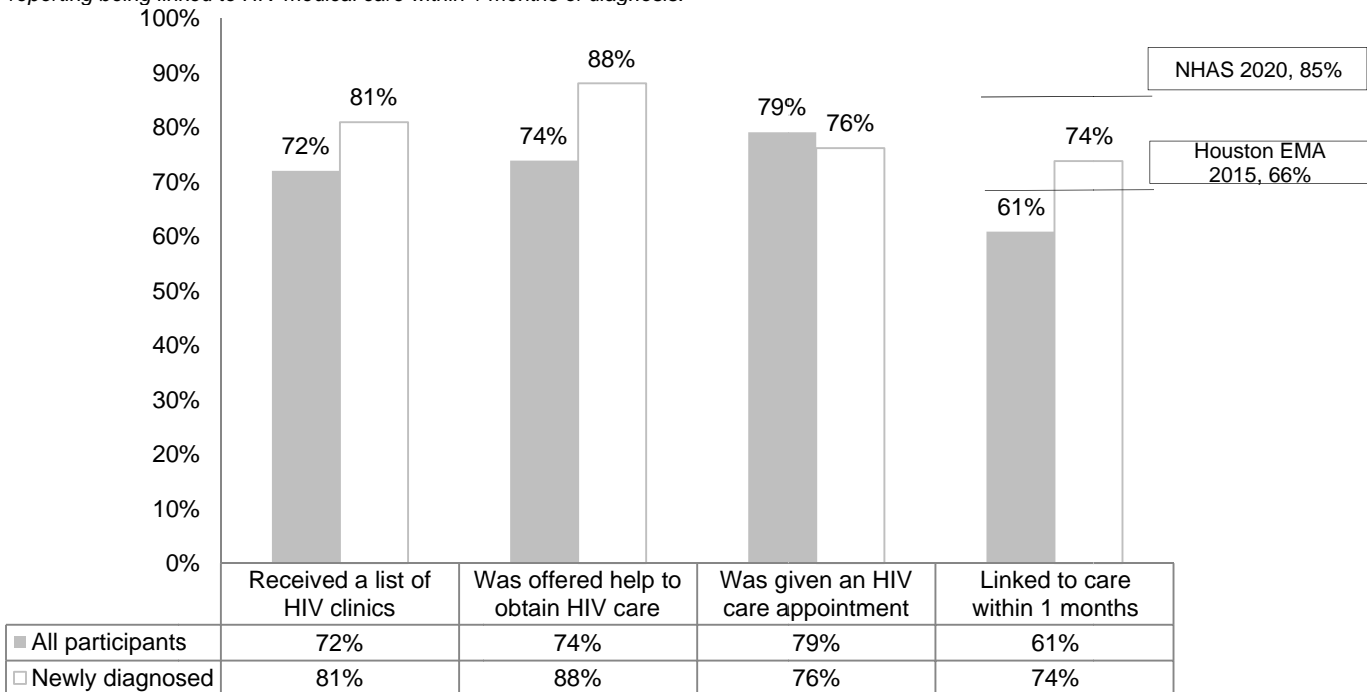
(**Graph 4**) 61% of all needs assessment participants reported linkage to care within 1 month of diagnosis. 72% reported receiving a list of HIV clinics at the time of diagnosis (also referred to as *passive* linkage), while slightly higher proportions (74% and 79%) reported *active* linkage, either assistance obtaining HIV care or an appointment for their first medical visit.

Among participants who were *newly diagnosed*, 74% reported linkage to care within 1 month. This group also reported receiving a list of clinic and being offered help to obtain care more often than did all participants. 81% received a list of HIV clinics at the time they were diagnosed, 88% were offered assistance in obtaining HIV care, and 76% were provided an appointment for their first medical visit.

Among the newly diagnosed, reported linkage to care exceeds epidemiological data show for the Houston EMA. According to those data (generated by the Texas Department of State Health Services), 66% of persons in the Houston EMA were linked to care within 1 months of diagnosis (2015).

**GRAPH 4-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, 2016**

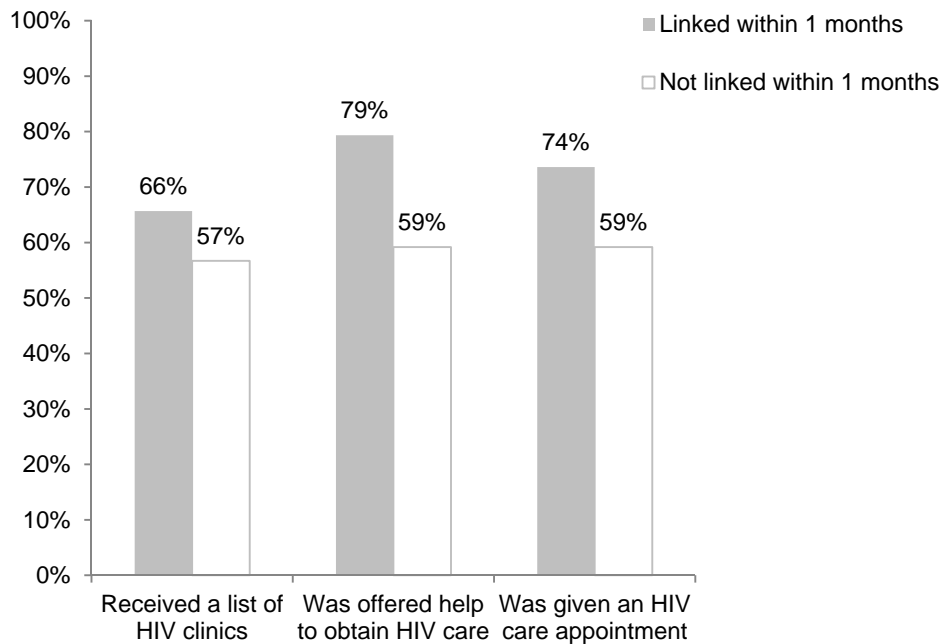
*Definition:* Percent of needs assessment participants who received each of type of linkage service at the time of diagnosis, and the percent reporting being linked to HIV medical care within 1 months of diagnosis.



(Graph 5) Receipt of an appointment for the first medical visit appears to be positively associated with early linkage: 74% of those who linked to care within 1 months received an appointment at the time of diagnosis, while only 59% of those who did *not* link to care within 1 months received an appointment at the time of diagnosis.

**GRAPH 5-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, by Linkage Timeframe, 2016**

*Definition: Percent of linked and non-linked needs assessment participants who received each type of linkage service at the time of diagnosis.*



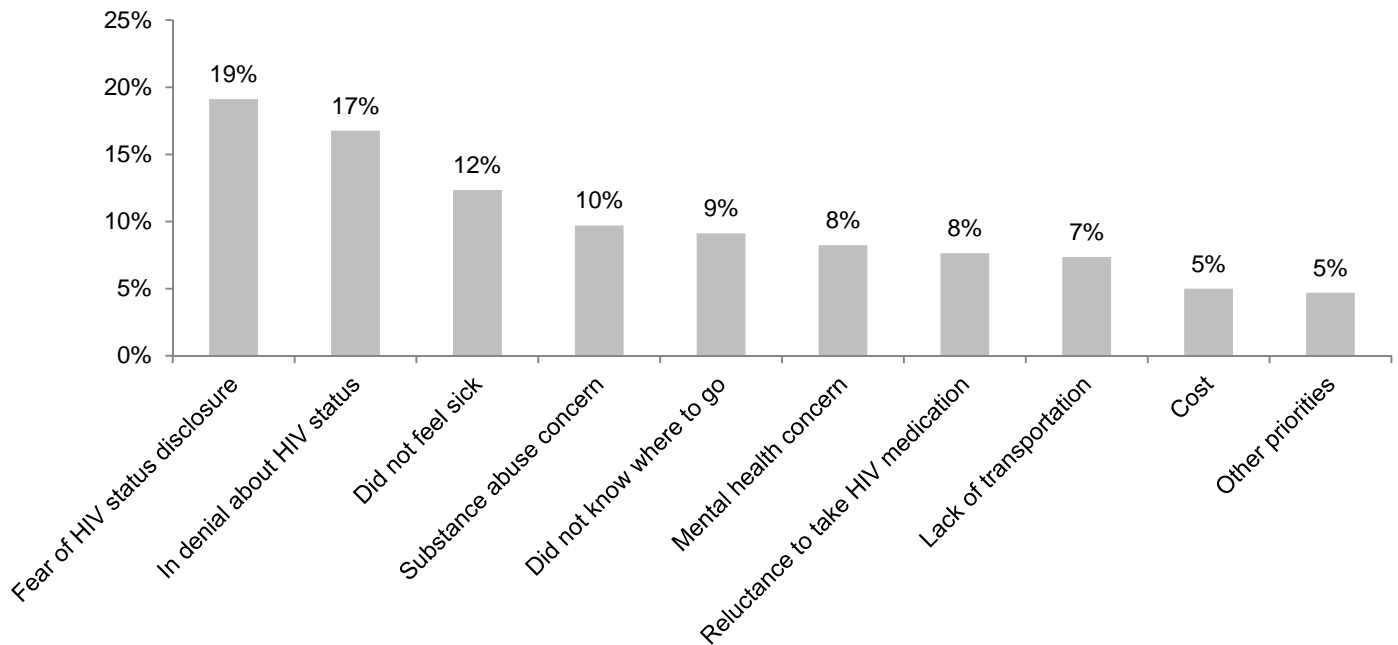
### Barriers to Early Linkage

(Graph 6) Participants who delayed entry into HIV care for more than 1 month after diagnosis were asked the reasons for delayed entry. Ten commonly reported barriers were provided as options in the survey, participants could select multiple reasons for delayed entry, and participants could write in their reasons.

Of the 10 options provided, fear of HIV status disclosure was selected most often at 19% of all reasons reported. This was closely followed by denial (17%) and not feeling sick (12%). The most common write-in reasons for delayed entry were delay issues with the provider such as appointment rescheduling and having been diagnosed before HIV medication was available.

**GRAPH 6-Reasons for Delayed Linkage to HIV Care in the Houston Area, 2016**

*Definition: Percent of times each item was reported by needs assessment participants as the reason they were not linked to HIV care within 1 months of diagnosis.*



## RETENTION IN CARE

The 2016 Houston HIV Care Services Needs Assessment explored history of HIV care continuity since diagnosis to gather information about barriers to retention. These results help communities identify assets and effective strategies for increasing retention in care in the Houston Area. The NHAS Updated to 2020 retention indicator and Houston Area 2017-2021 Comprehensive Plan retention objective is to increase retention in HIV medical care to at least 90%.

### Barriers to Retention in Care

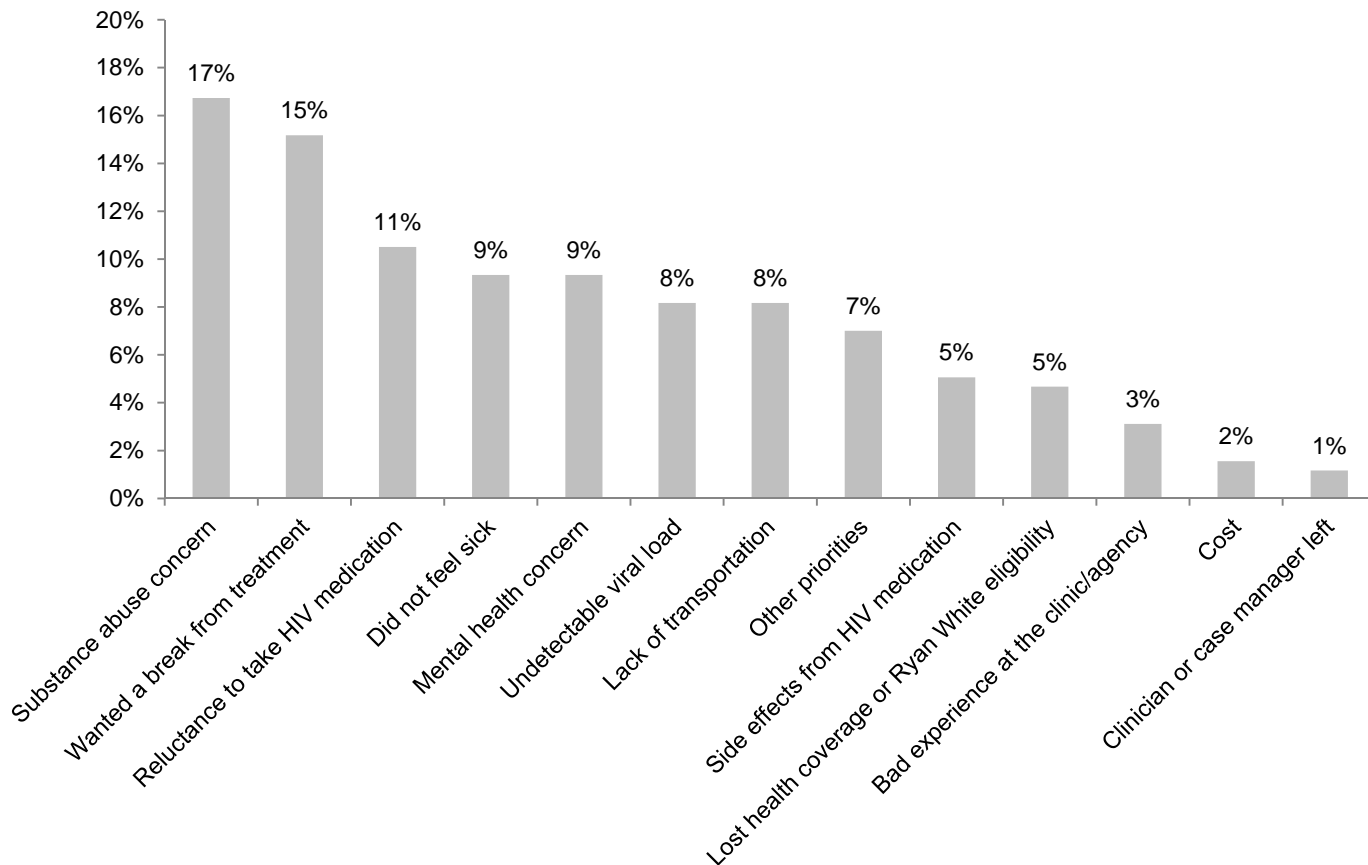
(Graph 7) 71% of needs assessment participants reported no interruption in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in

*Notes:* Most needs assessment participants (99%) reported being retained HIV care in the past 12 months. This is likely an artifact of the sampling process and does not represent the Houston Area as a whole. According to local epidemiological data (generated by the Texas Department of State Health Services), 76% of all diagnosed PLWH in the Houston EMA were in HIV care in the past 12 months, and 60% were retained in care throughout the year (2015)

their reasons. Of the 13 options provided, substance abuse concerns selected most often at 17% of all reasons reported. This was followed by wanting to take a break from treatment (15%), reluctance to take HIV medication (11%), not feeling sick (9%), and mental health concerns (9%). The most common write-in reason for falling out of care was relocation.

**GRAPH 7-Reasons for Falling Out of HIV Care in the Houston Area, 2016**

*Definition: Percent of times each item was reported by needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care .*



## HIV MEDICATION

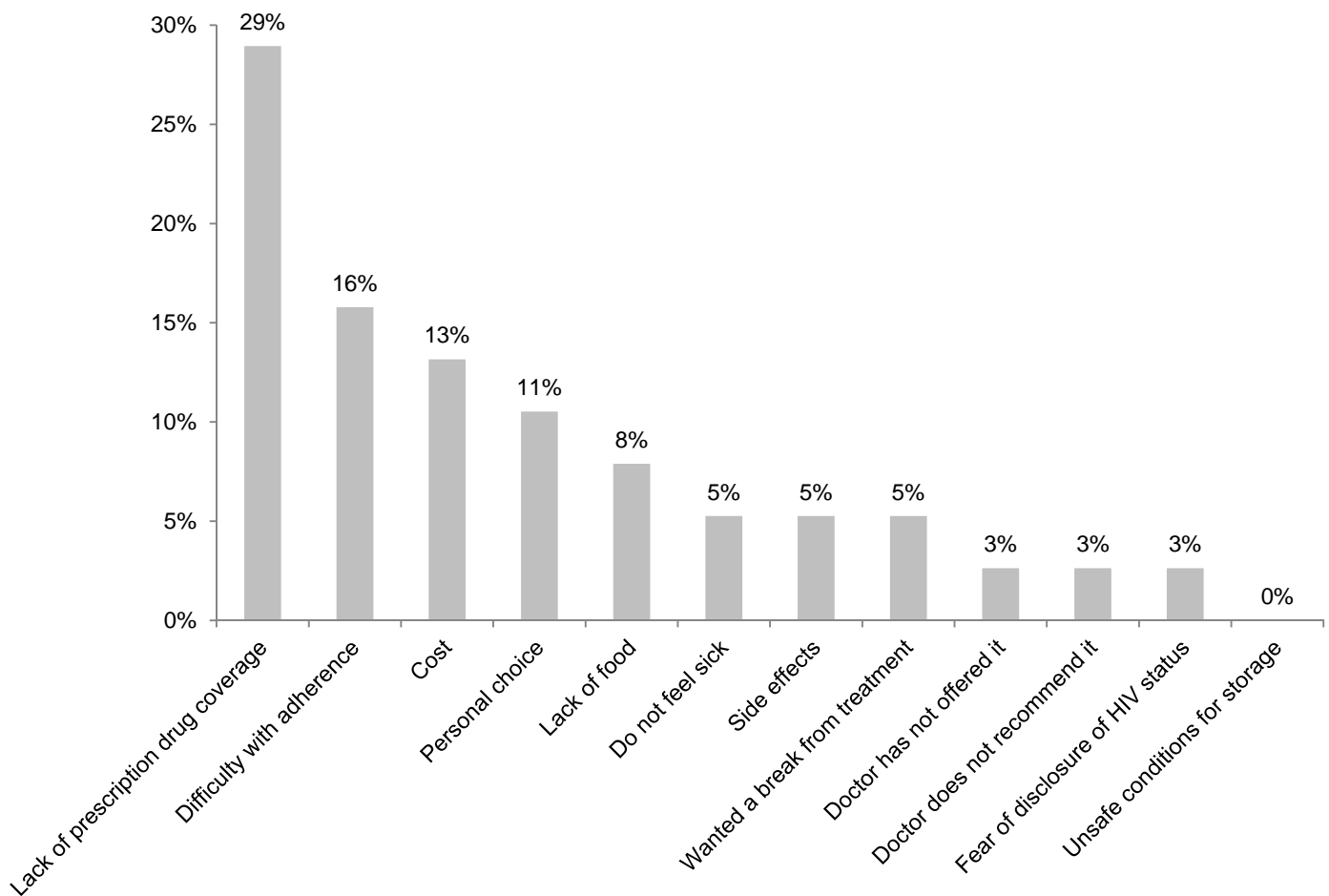
### Barriers to HIV Medication

(Graph 7) Though 91% of participants reported currently taking HIV medications at the time of survey, information on barriers to medication adherence helps communities design services to ensure HIV medication is available and accessible and support viral suppression. Participants who were not taking HIV medications at the time of survey asked to share the reason they were not taking medication. Twelve commonly reported reasons were provided, and participants could also write in their response. Of the 12 options provided, the reason selected most often at 29% of all reasons reported lack of

prescription drug coverage. This was followed by difficulty taking HIV medication as directed (16%), cost (13%), personal choice (11%), and lack of correct food to take with HIV medication (8%). The most common write-in reasons for not taking HIV medication were not getting a refill, having an undetectable viral load, forgetting to take medication, and waiting on the pharmacy to deliver the medication via mail.

**GRAPH 7-Barriers to HIV Medication in the Houston Area, 2016**

*Definition: Percent of times each item was reported by needs assessment participants as the reason they were not currently taking HIV medication.*







## **Chapter 4: Determinants of HIV Care**

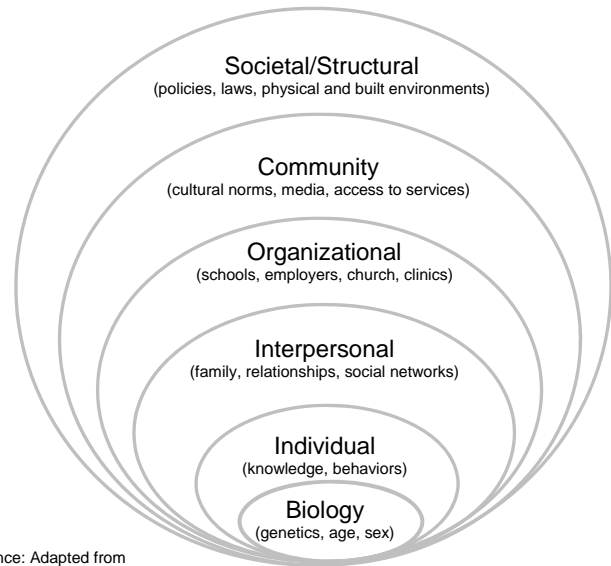
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## DETERMINANTS OF HIV CARE

Based on a model called the socio-ecological framework of health (**Figure 1**), *determinants of health* are the layers of individual, community, and societal level factors that can influence health, risk, resources, and access to care. Biological factors typically include bodily or physical factors such as genetics, age, sex at birth, and ability/disability. Individual determinants include personal knowledge and behaviors that influence health such as safer sex practices, substance use, needle sharing, unprotected sex, and smoking. Interpersonal interactions such as family, relationships, and social networks influence health risks or protections like intimate partner violence and social support. Organizational components like schools, employers, churches, and clinics can either facilitate or hinder access to health resources, services, and information. Community-level determinants like cultural norms, media, and accesses to services surrounding an area or a group can influence stigma, awareness, and healthcare seeking behaviors. Societal/structural determinants refer to both social structures that influence health such as laws, public policy, structural violence like income, gender, or racial discrimination or inequality, as well as the physical environment such as pollution, food deserts, and overcrowded conditions.

The 2016 Houston HIV Care Services Needs Assessment evaluated the ways in which participant experiences with health determinants like those referenced above influence participant health, risks, resources, and access to HIV services. The details of these conditions and experiences are described in the rest of this Chapter, and can help communities better understand the HIV care needs and patterns of PLWH in the Houston Area, as well as identify new or emerging areas of need related to HIV care due to the presence of other personal, community, or societal level conditions.

**FIGURE 1-The Socio-Ecological Framework of Health**



Reference: Adapted from  
*Healthy People 2020, Determinants  
of Health*

## CO-OCCURRING HEALTH CONDITIONS

The 2016 Houston HIV Care Services Needs Assessment asked participants if they had a current diagnosis of a physical health condition *in addition to* HIV. Options provided included common chronic diseases, age-related conditions, auto-immune disorders, and infectious diseases. Participants were also encouraged write in other conditions not listed. Overall, two-thirds of needs assessment participants (68%) reported a current diagnosis of *at least one* co-occurring physical health condition. This proportion was also positively associated with participant age, with 84% of participants age 50 and over reporting at least one co-occurring physical health condition, compared to 54% of participants age 18 to 24.

*Notes:* Mental health conditions were addressed separately from physical health conditions in the survey, and those results are presented in the *Behavioral*

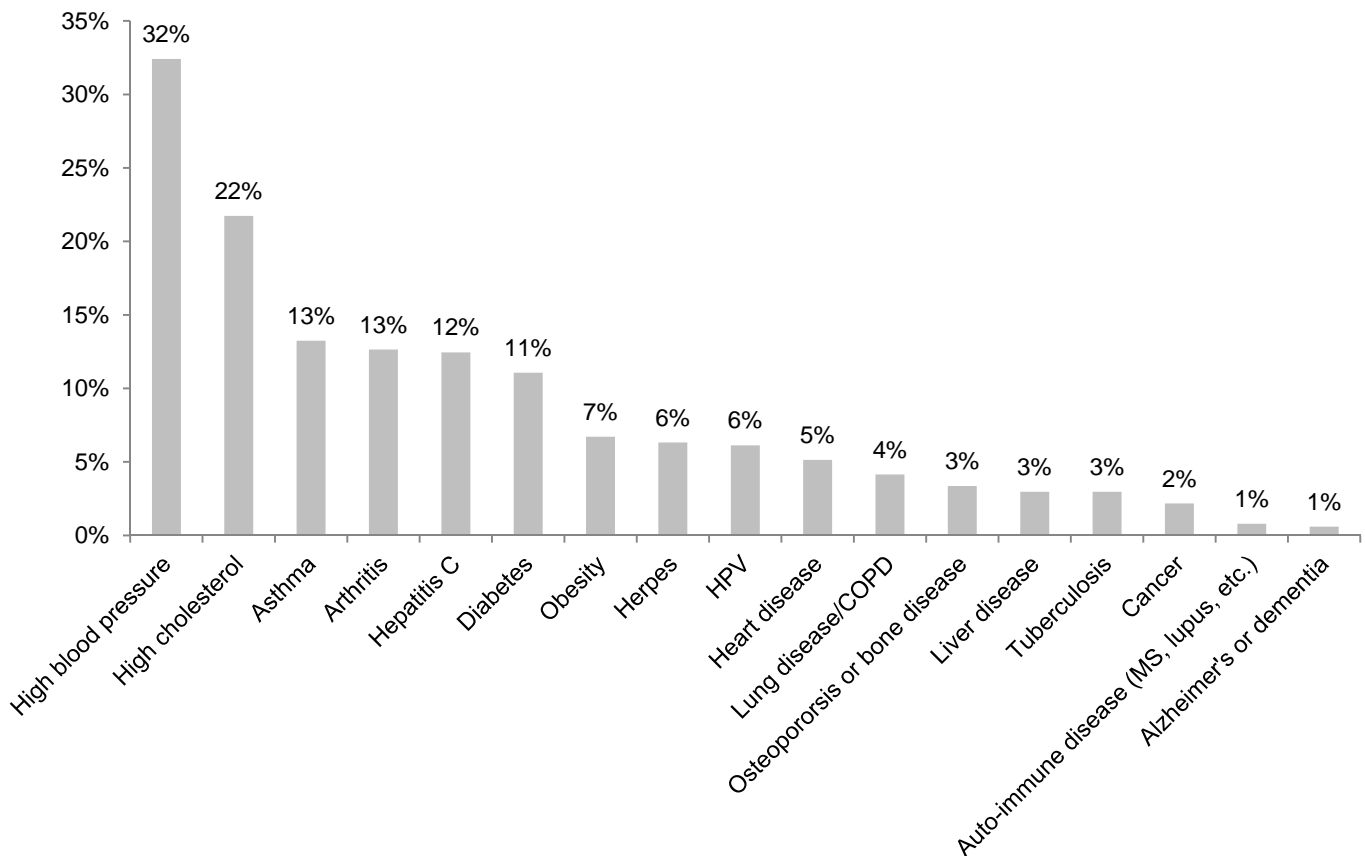
*Health* section of this Chapter. Additionally, non-HIV sexually transmitted diseases (STDs) testing diagnosis, and treatment are discussed in the *HIV Prevention Behaviors and Risks* section of this Chapter.

### Chronic and Co-Occurring Conditions

(**Graph 1**) The most frequently reported chronic and/or co-occurring health condition was hypertension (32% of participants), followed by high cholesterol (22%), asthma (13%), arthritis (13%), hepatitis C (12%), and diabetes (11%). Among the 3% of participants who reported being diagnosed with tuberculosis, 20% experiencing active tuberculosis. The most common write-in chronic conditions included (*in order*): chronic back pain, thyroid disease, neuropathy, blood clotting disorders, hepatitis B, sleep disorders, and seizures/epilepsy.

**GRAPH 1-Chronic and Co-Occurring Disease among PLWH in the Houston Area, 2016**

*Definition:* Percent of needs assessment participants reporting a current diagnosis from a health professional of each medical condition in addition to HIV/AIDS.



## **Emergency Care**

The Houston Area experiences a unique challenge in meeting the health and medical needs for a large PLWH population that is unable to access non-Ryan White health care coverage due to the state of Texas decision to not expand Medicaid. As such, emergency care comprises a substantial component of non-Ryan White funded care provided to PLWH in the Houston Area, and can provide insight into the prevention and management of both chronic conditions and opportunistic infections.

The 2016 Houston HIV Care Services Needs Assessment asked participants had sought care from an emergency room/emergency department in the past 12 months because they felt sick. Among all participants, 31% sought emergency care in the past 12 months due to feeling sick. When participants reporting incomes below 100% FPL were analyzed, 34% reported seeking emergency care for feeling sick in the past 12 months.

## BEHAVIORAL HEALTH

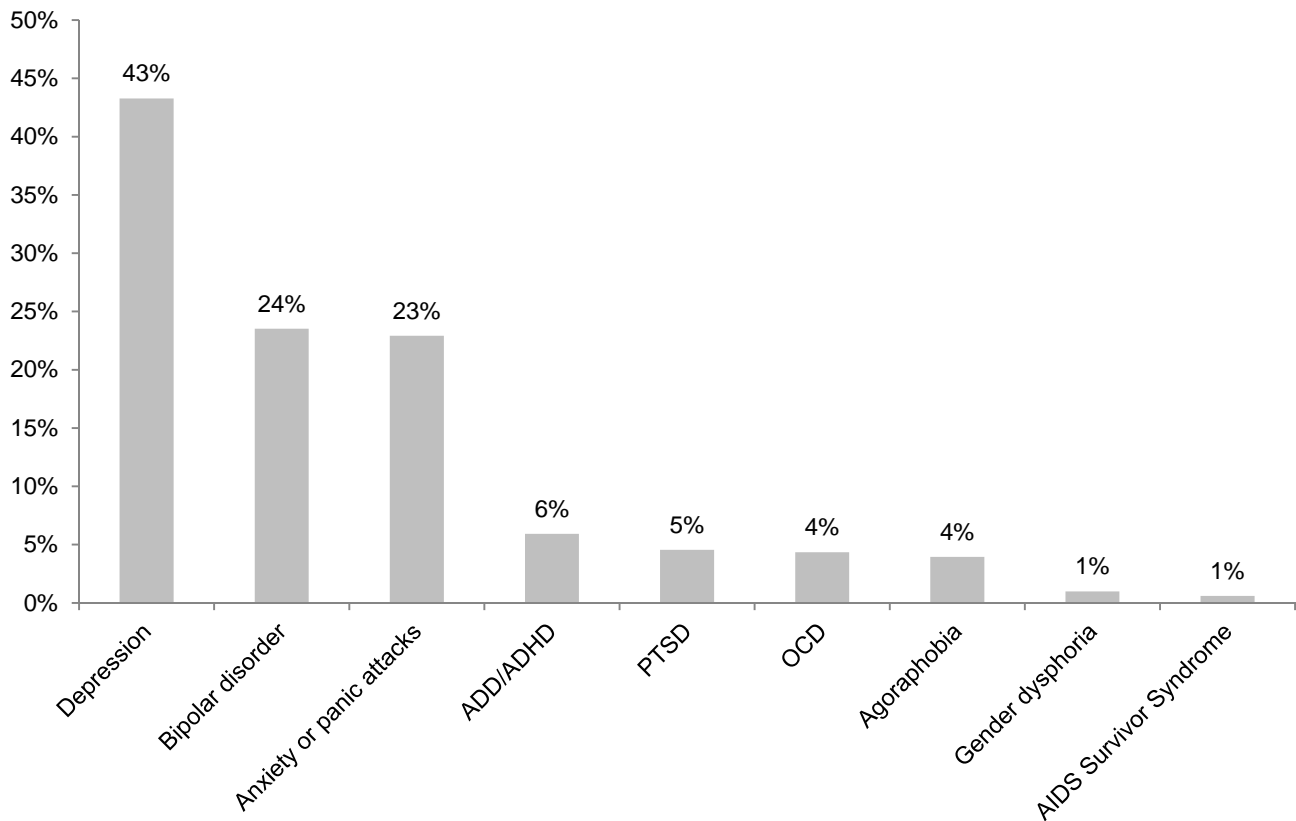
Behavioral health refers to the range of conditions related to or impacting mental or emotional well-being. It includes both diagnosed mental illness, indications of psychological distress, and substance use and misuse (Substance Abuse and Mental Health Services Administration, 2011). The 2016 Houston HIV Care Services Needs asked participants about each of these behavioral health concerns including current mental health diagnoses, mental/emotional distress symptoms, and substance abuse. Each type is discussed in detail in this Chapter.

### Mental Health Diagnoses

(Graph 2) Over half of needs assessment participants (57%) reported having a current *diagnosis* of at least one mental health condition from among a provided list of common conditions, a three percentage point increase from the 2014 needs assessment. The most frequently reported diagnosis was for depression at 42% of participants, followed by bipolar disorder and anxiety or panic attacks. All write-in mental health diagnoses were psychosis or schizophrenia.

**GRAPH 2-Mental Health Diagnoses among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants reporting a current diagnosis from a health professional of each medical condition in addition to HIV/AIDS.*



### Mental/Emotional Distress

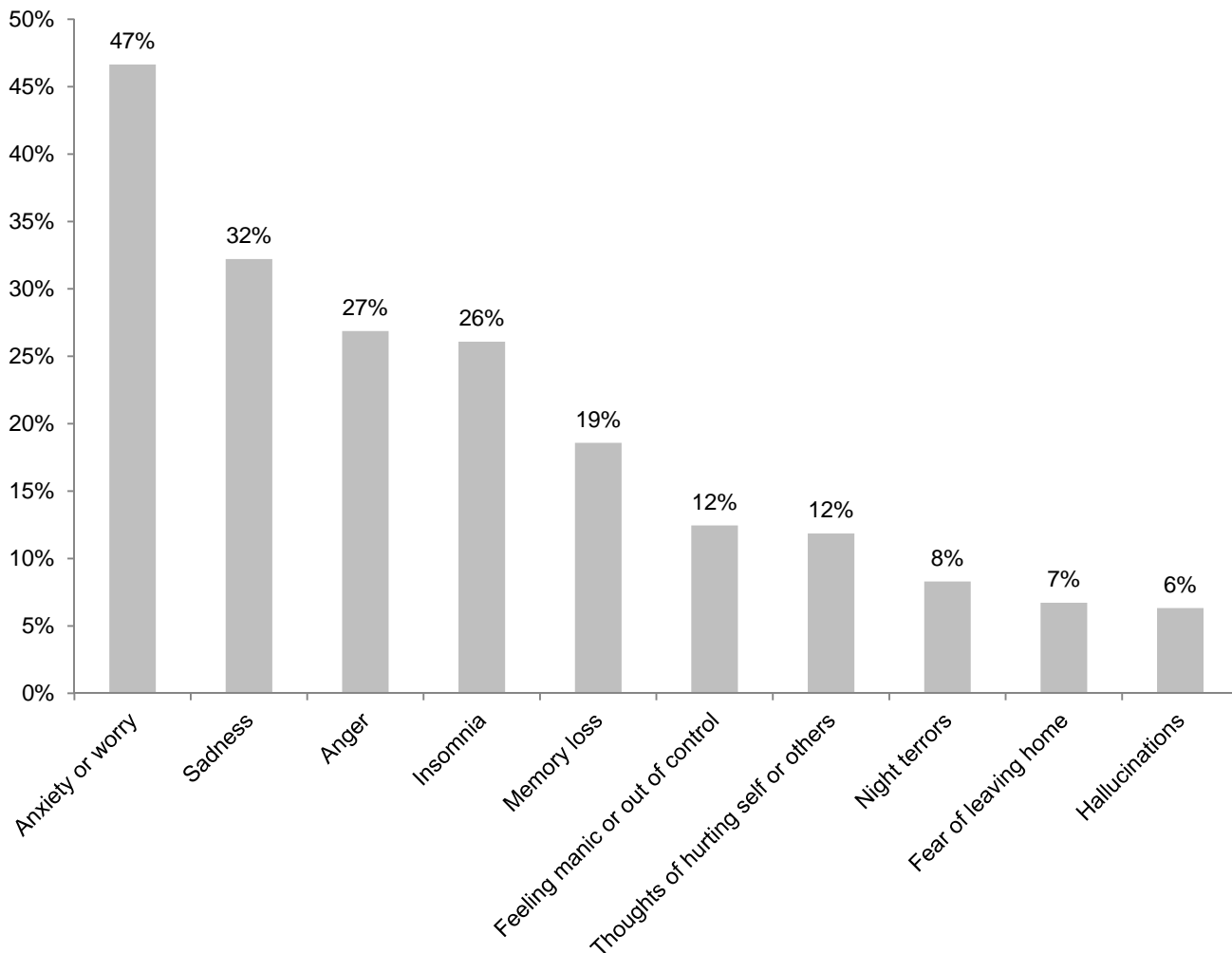
(Graph 3) In addition to mental health diagnoses, participants were also asked if they had experienced any symptoms of mental/emotional distress in the past 12 months *to such an extent* that they desired professional help.

Overall, 65% of participants reported at least one such symptom, an increase of 4 percentage points

from the 2014 needs assessment. Of those listed, the most frequently reported was anxiety or worry (47% of participants), followed by sadness (32%), anger (27%), insomnia (26%), and memory loss (19%). The most common write-in mental/emotional distress symptoms were loneliness/isolation, trouble focusing, and mood swings

**GRAPH 3-Mental/Emotional Distress Symptoms among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants reporting having each of the following symptoms in the past 12 months to such an extent that they desired professional help.*



## Social Support

Participants were asked about sources of social support for managing HIV, including emotional support, assistance, advice, and/or companionship. The majority of participants (71%) reported feeling that they had sufficient social support in their lives.

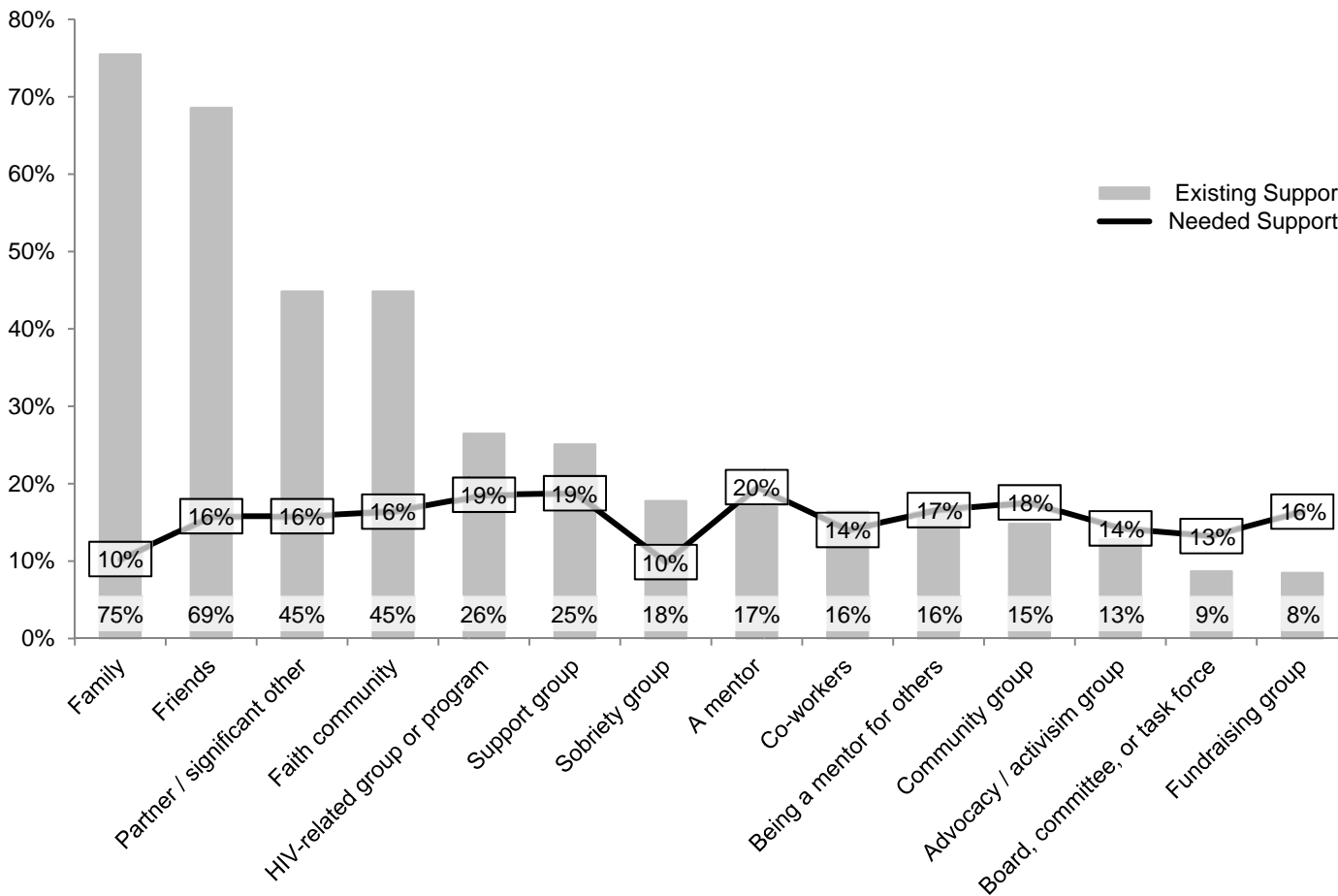
Variance in sufficient levels of social support was observed upon population-level analysis. Ninety-two percent (92%) of participant age 18-24 felt they had sufficient social support, whereas 69% of participants age 50 and over felt they had sufficient social support. Proportions of sufficient social support were also lower among participants who were unstably housed (51%), recently released from incarceration (57%), or transgender (59%).

(Graph 4) Participants were also asked to review a list of 14 types of social support, and indicate whether each type was a source of support they currently had,

did not currently have, but needed, and neither had nor needed. The most frequently reported *existing* sources of social support were family (85% of participants), friends (69%), a partner or significant other (45%), a faith community (45%), and an HIV-related group or program. Participants were also encouraged to write in other existing sources of social support, the most common of which were a substance abuse counselor and doing volunteer work. The most frequently reported *needed* sources of social support were a mentor (20%), an HIV-related program (19%) or support group (19%), a community group, and opportunities to mentor others (17%). The greatest disparity between existing and needed sources of social support were observed for fundraising groups (8 percentage points), a board, committee, or task force (5 percentage points), having a mentor (3 percentage points), and community groups (3 percentage points).

**GRAPH 4-Existing and Needed Sources of Social Support among PLWH in the Houston Area, 2016**

Definition: Percent of needs assessment participants, who reported having or not having, but needing, various sources of social support



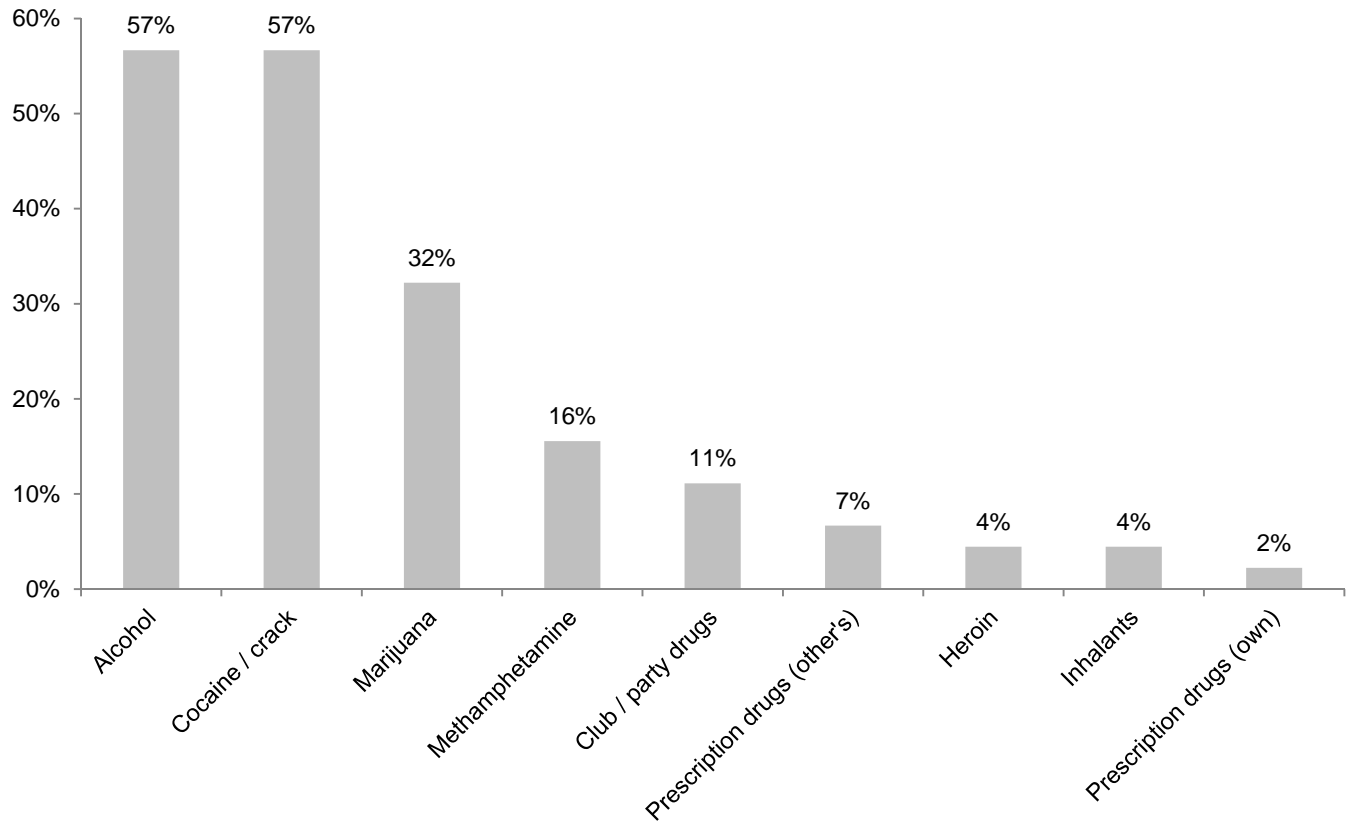
### Substance Use

(Graph 5) Participants were asked to indicate whether alcohol or drug use had ever interfered with the participant getting HIV medical. Those who indicated an alcohol or drug use barrier to care were then asked to select or write in the substance(s) that contributed to the barrier. While 50% of the participants indicated a history of alcohol or drug use, only 18% identified this substance use as a barrier to HIV care.

Among participants who indicated alcohol or drug use had ever interfered with getting HIV medical care, equal proportions (57%) of indicated that alcohol and cocaine/crack was used, followed by marijuana (32%), methamphetamine (16%), and club/party drugs (11%). No participants indicated hallucinogens or legal drug use as a barrier to care, and there were no substances written in.

**GRAPH 5-Substance Use as a Barrier to Care among PLWH in the Houston Area, 2016**

*Definition: Percent of each substance used when participants reported history of substance use barriers*





## SOCIO-ECONOMIC DETERMINANTS OF HEALTH

The social and economic circumstances of individuals can directly influence their health status and access to care. Factors such as income, medical coverage, housing, and transportation may serve as gateways or barriers to health. These factors are often the underlying causes for health disparities in certain populations. (Source: Centers for Disease Control

(Table 1) Participants were asked to estimate their current monthly household income, regardless of source. The average annual household income reported was \$10,522, or \$877 per month. This average annual is more than five times lower than the average median household income of the general population in the Houston HSDA, and more than six times lower than the average household income of the

and Prevention. *Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States*. October 2010). The 2016 Houston HIV Care Services Needs Assessment asked participants about these social and economic circumstances.

### Household Income and Federal Poverty Level

general population in the Houston EMA in 2014. Among participants reporting income, 71% reported incomes below 100% of the 2016 Federal Poverty Level (FPL). Comparatively, the average percentage below 100% FPL was 16% for the general population in Houston HSDA and 15% in the Houston EMA in 2014.

**TABLE 1-Average Annual Household Income and Federal Poverty Level among PLWH in the Houston Area, 2016**

	Mean Annual Household Income	Percentage Below 100% of Federal Poverty Level
PLWH (2016)	\$10,522	71%
HSDA Average (2014) <sup>a</sup>	\$56,073	16%
EMA Average (2014) <sup>a</sup>	\$63,328	15%

<sup>a</sup>Source: U.S. Census. 2010-2014 American Community Survey 5-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 11/3/16.

### Medical Care Coverage

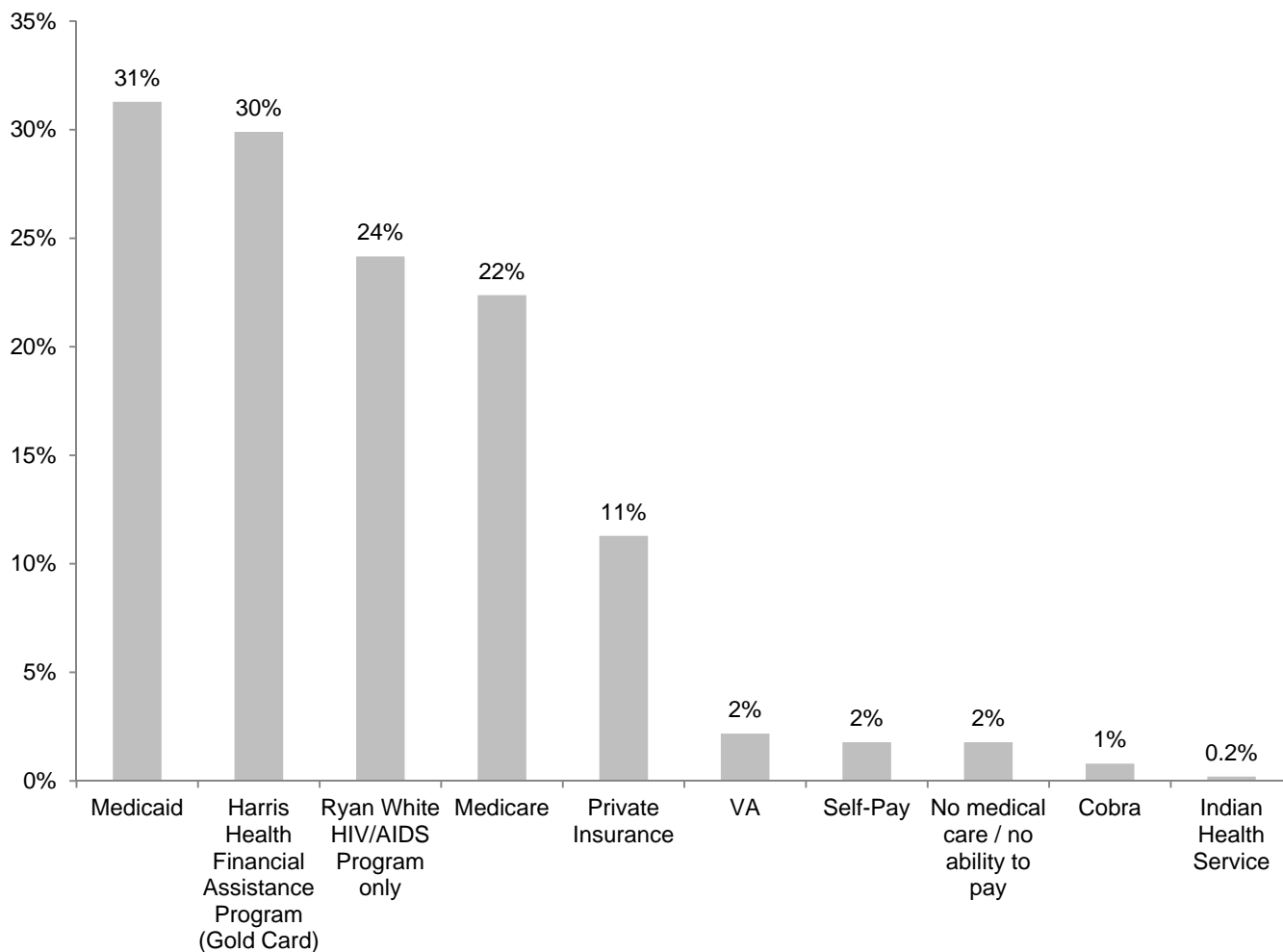
Participants were asked details about their medical care coverage for themselves and their families, including how they cover general medical costs; if they experience difficulty covering HIV medication, non-HIV related medications, and medications for mental health conditions; and when difficulty was reported, whether assistance was received to pay for the medications.

(Graph 6) 24% of participants stated they receive medical care *only* for HIV through the Ryan White Program, 2% stated that they pay for all medical care for themselves or their family out-of-pocket with no assistance, and 2% stated they did not receive medical care due to inability to pay. This means that the remaining participants (or 72%) reported *some form* of medical coverage, including public health insurance

such as Medicaid or Medicare, private health insurance, or health care via programs for specific populations such as veterans or American Indians/Alaska Natives. Of these specific sources for coverage, 32% of participants said they have Medicaid, 30% were in the Harris Health Financial Assistance Program (formerly Gold Card), and 22% had Medicare. Additionally, 11% had private health insurance. This is an increase of 175% from the 4% of participants who reported having private insurance in the 2014 needs assessment. This is most likely due to a combination of the opening of the Federal Health Insurance Marketplace as well as proactive efforts in the Houston Area to educate and assist PLWH with enrollment in Qualified Health Plans (QHP).

**GRAPH 6-Sources of Medical Care Coverage among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated having each source of health care coverage, including if their only health care is for HIV through the Ryan White HIV/AIDS Program and if they did not receive medical care due to inability to pay.*



**(Graph 7, Graph 8, and Graph 9)**

Participants were asked if they had experienced difficulty paying for prescription medications for HIV, other co-occurring physical conditions, or mental health conditions. Results are as follows (*in order*):

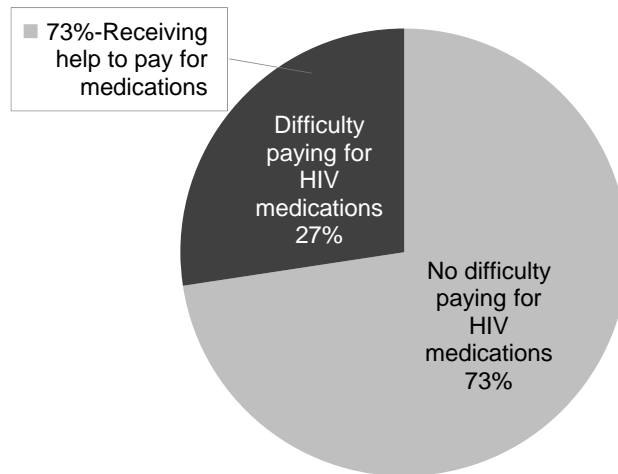
- 27% of participants on HIV medications reported difficulty paying for their prescriptions and, of those reporting difficulty, 73% were receiving financial assistance.

- 31% of participants taking medication for a co-occurring physical health conditions (other than HIV) reported difficulty paying for their prescriptions and, of those reporting difficulty, 59% were receiving financial assistance.

- 26% of participants taking medication for a mental health condition reported difficulty paying for their prescriptions and, of those reporting difficulty, 64% were receiving financial assistance.

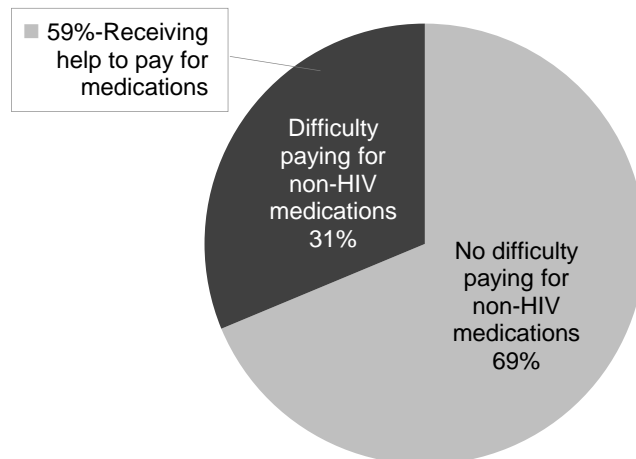
**GRAPH 7-Difficulty Paying for HIV Medications among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated difficulty paying for HIV medications and, of those, the percent receiving help.*



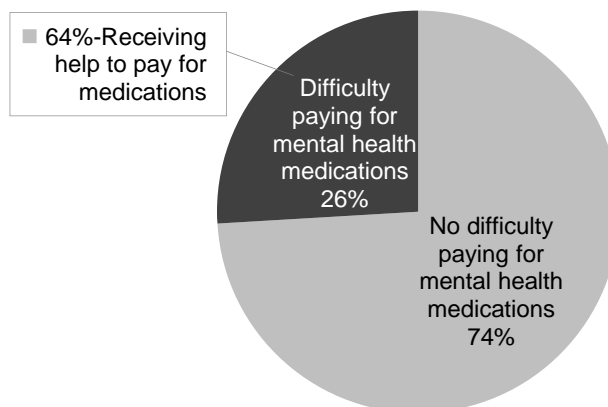
**GRAPH 8-Difficulty Paying for Non-HIV Medications among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated difficulty paying for medications for non-HIV health conditions and, of those, the percent receiving help.*



**GRAPH 9-Difficulty Paying for Mental Health Medications among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated difficulty paying for medications for a mental health condition and, of those, the percent receiving help.*



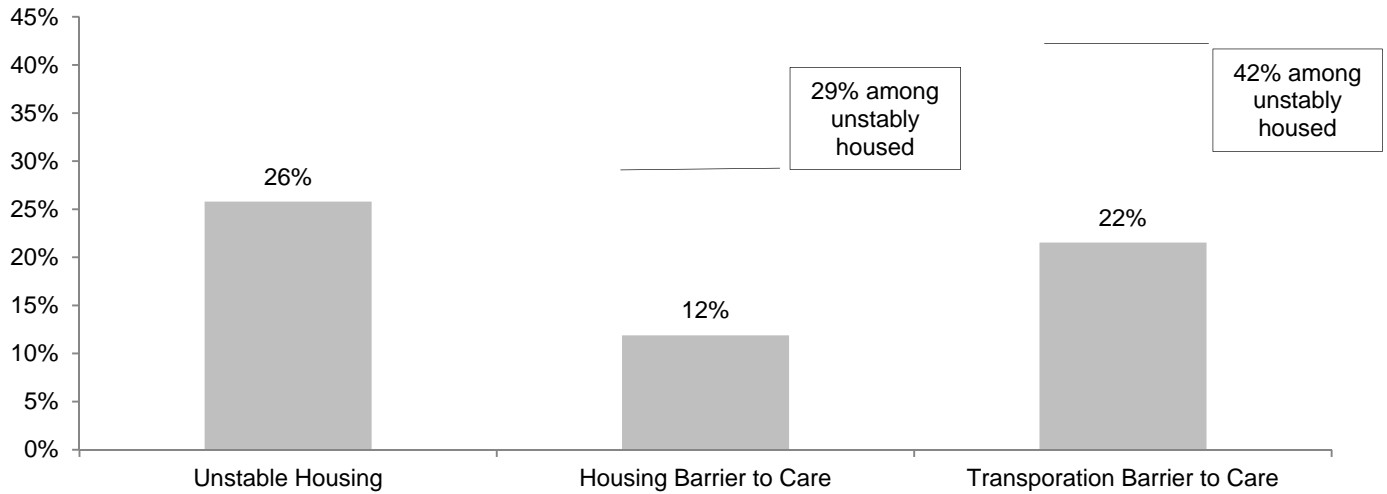
## Housing and Transportation

**(Graph 10)** When asked whether their housing was stable, 74% of participants reported currently experiencing unstable housing situations. Participants were also asked whether their housing and transportation situations have interfered with getting HIV medical care. Twelve percent (12%) of all

participants reported that their housing situation was a barrier to care, while 22% reported their transportation situation was a barrier to care. These proportions increased to 29% and 42% respectively when analyzed for unstably housed participants.

### GRAPH 10-Housing and Transportation Barriers among PLWH in the Houston Area, 2016

*Definition: Percent of needs assessment participants who selected reported unstable housing, a housing situation that interfered with HIV medical care, or a transportation situation that interfered with HIV medical care*



## EXPERIENCE WITH DISCRIMINATION AND VIOLENCE

Despite the widespread presence of HIV in the U.S., PLWH can encounter discrimination and stigma due to their HIV status. Research also suggests a link between HIV and violence, including intimate partner violence. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, *HRSA CARE Action*, Intimate Partner Violence, September 2009). The physical and emotional effects of experiencing discrimination and violence can impact the health of PLWH as well as their ability to access HIV care and other needed resources. The 2016 Houston HIV Care Services Needs Assessment explored participant experiences with discrimination, physical violence, and psychological violence.

### HIV-Related Discrimination

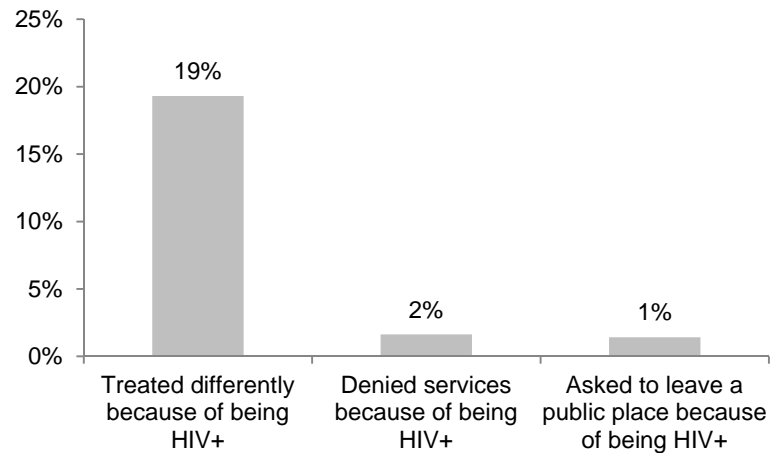
(**Graph 11**) Twenty percent (20%) of participants reported experiencing some form of discrimination in the past 12 months, most often in the form of being treated differently because of their positive status (19%), though this very rarely resulted in being denied services (2%) or being asked to leave a public place (1%).

### Experience with Violence

(**Graph 12**) Another 13% reported being threatened in the past 12 months, most often as threats of violence (12%) or verbal harassment (8%). Four percent (5%) had been physically assaulted, and 4% had been sexually assaulted. Among participants whose answers indicated they were transgender or gender non-conforming, the proportions who reported experiencing physical assault or sexual assault rose to 9% and 16%, respectively. Three percent (3%) of participants reported being in an intimate relationship with someone who made them feel afraid, threatened, isolated, who forced them to have sex, or who physically hurt them at the time of survey.

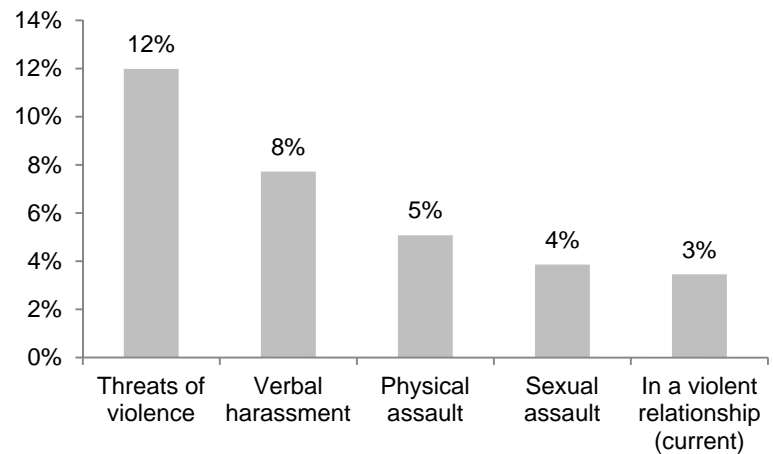
**GRAPH 11-HIV-Related Discrimination in the Houston Area, 2016**

*Definition: Percent of needs assessment participants reporting each of the following experiences in the past 12 months.*



**GRAPH 12-Violence Experienced by PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants reporting each of the following experiences in the past 12 months.*



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## **HIV PREVENTION BEHAVIORS AND RISKS**

Prevention knowledge and behaviors lower the risk of HIV transmission to others, as well as acquisition of other sexually transmitted diseases (**STDs**) or blood borne infections. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, Guide for HIV/AIDS Clinical Care, *Preventing HIV Transmission/Prevention with Positives*, January 2011). Moreover, awareness of interventions like pre-exposure prophylaxis (**PrEP**) and non-occupational

post-exposure prophylaxis (**nPEP**) as well as PrEP and nPEP resources can empower people living with HIV (**PLWH**) and the community to help those who are HIV-negative decrease their risk. The 2016 Houston HIV Care Services Needs Assessment asked participants about their needs related to HIV prevention information, safer sex behaviors, and PrEP awareness

**STD Testing and Treatment  
(Graph 13, Graph 14, and Graph 15)**

Participants were asked if they had been tested, diagnosed, and/or treated for chlamydia, gonorrhea, and syphilis in the past six months. Results are as follows (*in order*):

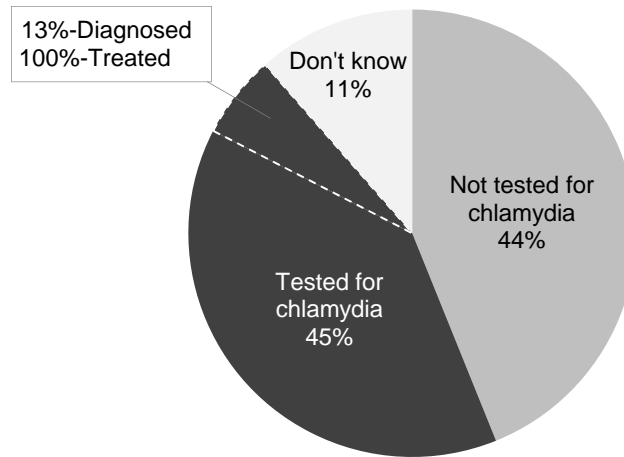
- 45% of participants were tested for chlamydia in the past six months, 13% of those who were tested were diagnosed, and all participants who were diagnosed with chlamydia received treatment.

- 46% of participants were tested for gonorrhea in the past six months, 14% of those who were tested were diagnosed, and all participants who were diagnosed with gonorrhea received treatment.

- 49% of participants were tested for syphilis in the past six months, 24% of those tested were diagnosed, and all participants who were diagnosed with syphilis received treatment.

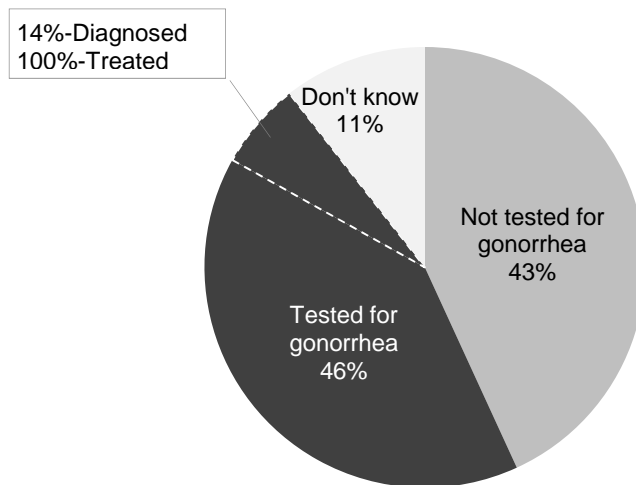
**GRAPH 13-Chlamydia Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for chlamydia in the past six months.*



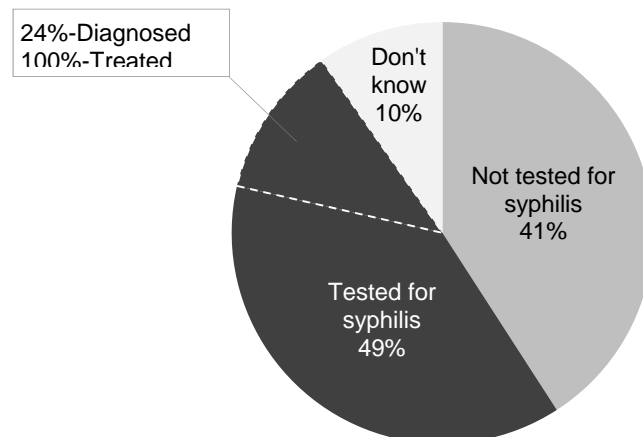
**GRAPH 14-Gonorrhea Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for gonorrhea in the past six months.*



**GRAPH 15-Syphilis Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2016**

*Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for syphilis in the past six months.*



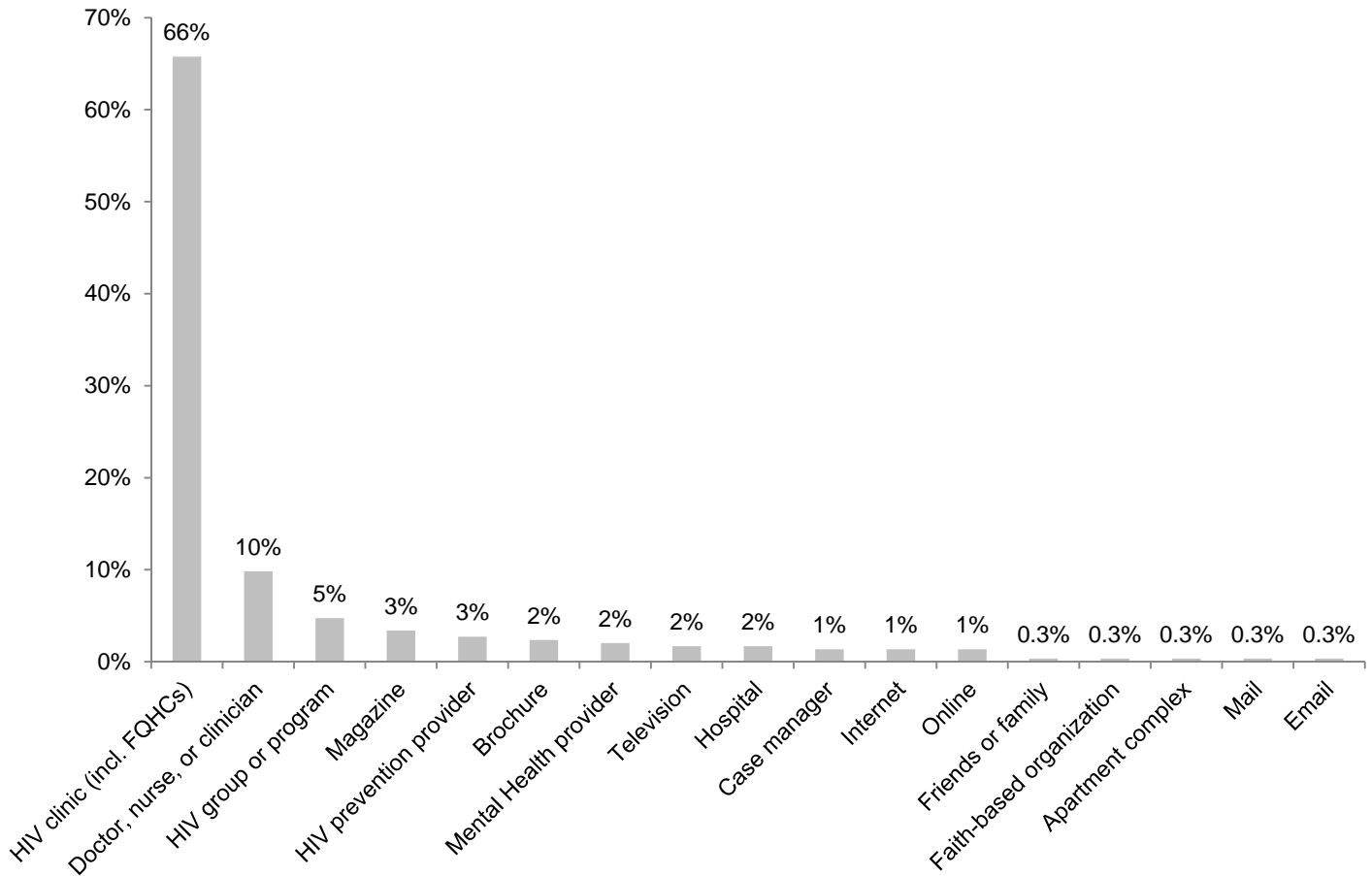
**Access to HIV Prevention Information**

Needs assessment participants were asked if they had received any information about HIV prevention in the past 12 months. Overall, 67% of participants said they *had* received information in the past year, a decrease of three percentage points from 2014. Those who had received information were then asked to identify the location or source of this information.

(**Graph 16**) The location or source cited most often by participants for receiving HIV prevention information (when information had been received in the past 12 months) was an HIV clinic or primary care (66% of all reported locations or sources), followed by a medical professional (10%), and an HIV group or program. At less than 1%, family or friends, faith-based organizations, apartment complexes, mail, and email were reported least.

**GRAPH 16-Locations or Sources of HIV Prevention Information for PLWH in the Houston Area, 2016**

*Definition: Percent of times each location or source was reported by needs assessment participants as the location or source for HIV prevention education received in the past 12 months.*





**PrEP Awareness**

(Table 2) When asked if they had ever heard of PrEP, 56% of participants were PrEP aware (Table 13). However, only 34% of all participants and 31% of those who had heard of PrEP prior to being surveyed knew where someone who is HIV-negative could go to access PrEP resources. This may indicate

that, while community saturation of PrEP as a topic has been substantial, more work may be necessary to ensure PLWH in the Houston Area are aware of PrEP resources in their community to refer partners and friends.

**TABLE 2- Crosstabulation of PrEP Awareness with PrEP Resource Awareness among PLWH in the Houston Area, 2016**

	“Do you know where a person who does not have HIV can go to get on PrEP?”		<b>Total</b>
	<b>Yes</b>	<b>No</b>	
“Have you heard about PrEP before?”	<b>Yes</b>	156 (31%)	<b>282 (56%)</b>
	<b>No</b>	13 (3%)	<b>192 (38%)</b>
	<b>Don’t Remember</b>	3 (0.6%)	<b>28 (6%)</b>
	<b>Total</b>	<b>172 (34%)</b>	<b>502</b>

### Sexual Activity and Condom Use

Participants were asked details regarding current sexual activity and use of safer sex practices, in particular, condom use, barriers to consistent condom use, and disclosure of HIV status to potential sex partners.

When asked about their own behavior and motivations for behavioral risk reduction, the greatest proportion of participants (37%) indicated that they had not had sex in the past six months. Twenty-six percent (26%) indicated that they had at least one sexual partner who was HIV positive, 23% reported that they had at least one sexual partner who was presumably HIV negative, and 11% reported that they did not know the HIV status of at least one sexual partner.

(Table 3) Thirty-one percent (31%) of participants said they *always* use condoms during at least one type of sexual activity. However, population-level analysis shows some differences within overall results. A greater proportion of males (50%) reported consistent condom use during at least one type of sexual activity than females (47%) or transgender individuals (38%). Consistent condom use was also observed more often among Hispanics/Latinos (53%), African Americans/blacks (50%), and whites (47%) than other or multiracial individuals (27%).

The greatest proportion of participants reported never using condoms when both receiving and performing

**TABLE 3-Consistent Condom Use among PLWH in the Houston Area, by Demographic Categories, 2016**

		% Reporting Always Using Condoms
All Participants		31%
Sex/Gender		
	Male	50%
	Female	47%
	Transgender	38%
Race/Ethnicity		
	White	47%
	African American/Black	50%
	Hispanic/Latino	53%
	Other/ Multiracial	27%
Age at Survey		
	18 to 24	59%
	25 to 49	46%
	50+	33%

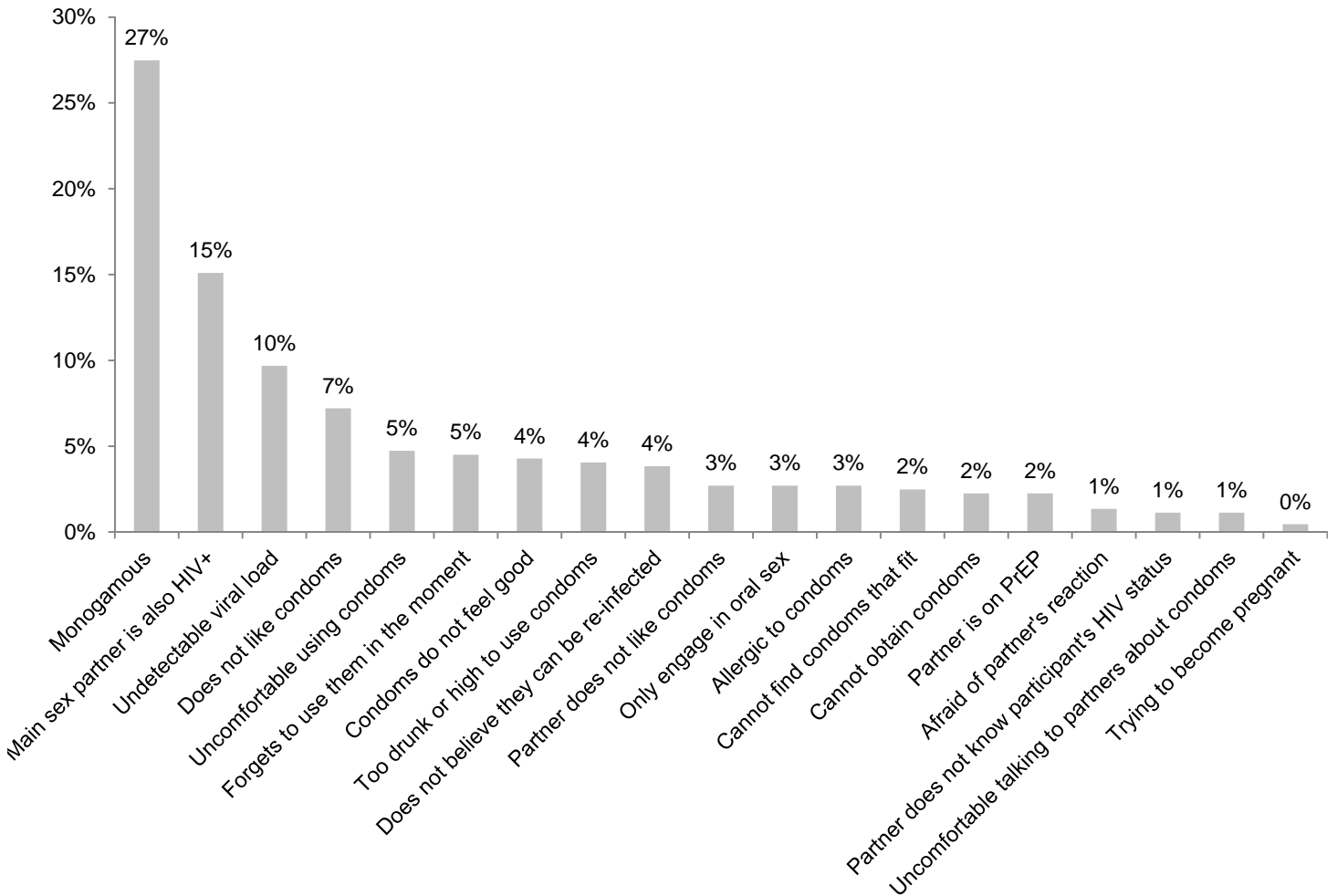
oral sex in the past six months (23% for both). This was followed by 10% of participants reporting never using condoms for anal receptive and anal insertive sex, and 9% reporting never using condoms for vaginal sex in the past six months. Only 31% of participants reported discussing their positive HIV status with new sex partners.

(Graph 17) When inconsistent condom use was reported, participants were asked about their motivation for not using a condom. Participants were provided with a list of 19 common reasons for not using condoms, and could also write-in their reasons. The most frequently selected reasons participants cited for not using condoms were only having one sexual partner (27%), having a sexual partner who was already HIV positive as well (15%), self-reported

undetectable viral load (10%), disliking condoms (7%), discomfort with using condoms (5%), and getting caught up in the moment (5%). Reasons for inconsistent condom use that were written-in most often were (in order): fear that the partner will disclose the participant’s status to others, only using adult toys with partnered sex, and using condoms for anal insertive or receptive sex only.

**GRAPH 17-Barriers to Condom Use among PLWH in the Houston Area, 2016**

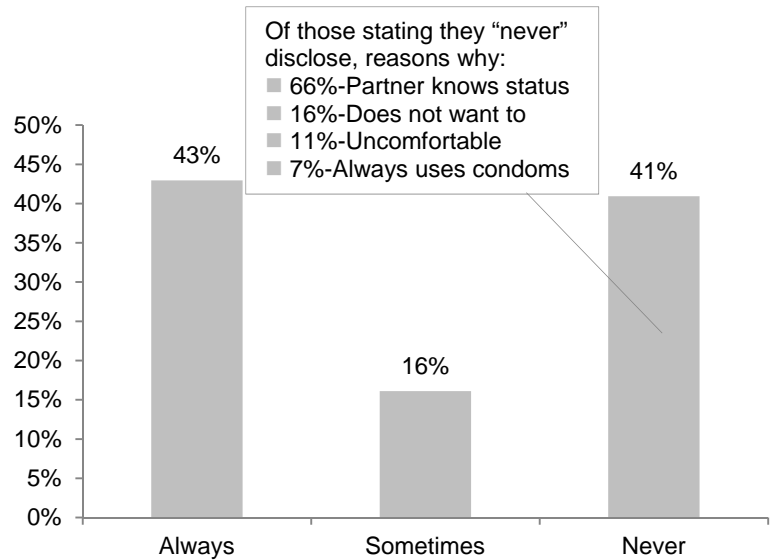
*Definition: Percent of times each reason for not always using condoms during sexual activity was reported among all reasons given by sexually active needs assessment participants who were sexually active and did not always use condoms*



(Graph 18) Lastly, participants were asked how frequently they disclosed their HIV status to new sex partners. Overall, 43% stated they “always” disclose their HIV status with every partner, while 41% stated they never disclose their HIV status. Of those stating “never,” the most common reason given was that their main sex partner already knows their HIV status.

**GRAPH 18-Disclosure of HIV Status among PLWH in the Houston Area, 2016**

*Definition: Percent of sexually active needs assessment participants selecting each answer in response to the survey question, “How often do you talk about your HIV status with new sex partners?”*





## Service-Specific Fact Sheets

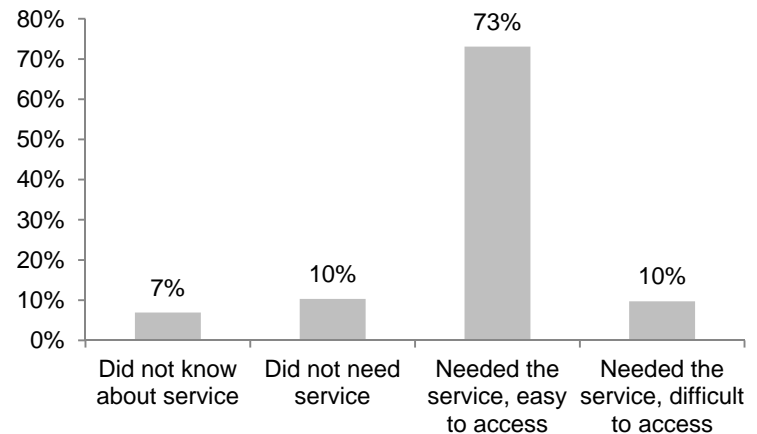
## CASE MANAGEMENT

*Case management*, technically referred to as *medical case management*, *clinical case management*, or *service linkage*, describes a range of services that help connect persons living with HIV (PLWH) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Case management also includes treatment readiness and adherence counseling.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 83% of participants indicated a need for *case management* in the past 12 months. 73% reported the service was easy to access, and 10% reported difficulty. 7% stated they did not know the service was available.

(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (54%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

**GRAPH 1-Case Management, 2016**



**TABLE 1-Top 5 Reported Barrier Types for Case Management, 2016**

	No.	%
1. Interactions with Staff (S)	19	54%
2. Education and Awareness (EA)	6	17%
3. Administrative (AD)	5	14%
4. Resource Availability (R)	2	6%
5. Eligibility (EL)	1	3%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *case management*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.

In addition, more MSM PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Case Management, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	8%	1%	9%	7%	13%	13%	7%	7%
Did not need service	11%	8%	10%	11%	11%	0%	13%	7%	16%
Needed, easy to access	73%	76%	72%	73%	72%	87%	75%	76%	68%
Needed, difficult to access	10%	9%	17%	7%	11%	0%	0%	11%	9%

**TABLE 3-Case Management, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	8%	6%	0%	5%	0%	18%
Did not need service	7%	12%	0%	0%	3%	9%
Needed, easy to access	76%	71%	100%	89%	91%	64%
Needed, difficult to access	10%	11%	0%	5%	6%	9%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

## DAY TREATMENT

*Day treatment*, technically referred to as *home and community-based health services*, provides therapeutic nursing, support services, and activities for persons living with HIV (PLWH) at a community-based location. This service does not currently include in-home health care, in-patient hospitalizations, or long-term nursing facilities.

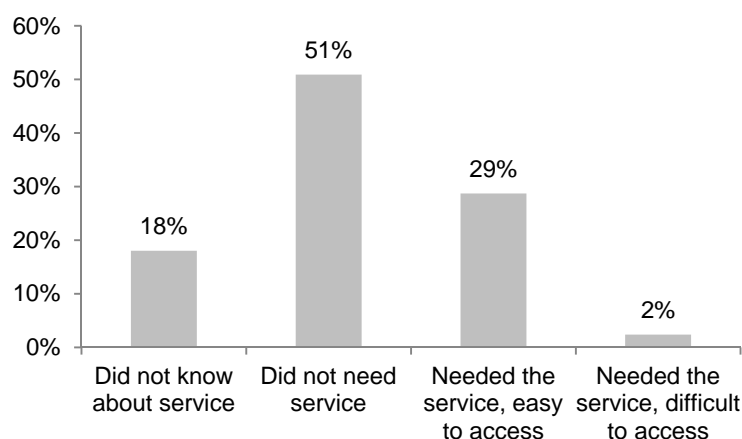
(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 31% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 2% reported difficulty. 18% stated that they did not know the service was available.

(**Table 1**) When barriers to *day treatment* were reported, the most common barrier types were administrative (complex processes), eligibility (ineligible), health insurance-related (being uninsured), interactions with staff (poor communication or follow up), transportation (lack of transportation).

**TABLE 1-Top 5 Reported Barrier Types for Day Treatment, 2016**

	No.	%
1. Administrative (AD)	1	17%
2. Eligibility (EL)	1	17%
3. Health Insurance Coverage (I)	1	17%
4. Interactions with Staff (S)	1	17%
5. Transportation (T)	1	17%

**GRAPH 1-Day Treatment, 2016**



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *day treatment*, this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more unstably housed PLWH found the service difficult to access when compared to all participants.

**TABLE 2- Day Treatment, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	18%	18%	28%	17%	15%	0%	30%	20%	12%
Did not need service	49%	56%	56%	49%	50%	53%	52%	45%	61%
Needed, easy to access	30%	23%	13%	33%	31%	47%	17%	32%	24%
Needed, difficult to access	2%	3%	3%	1%	5%	0%	0%	2%	3%

**TABLE 3- Day Treatment, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	27%	19%	50%	24%	32%	18%
Did not need service	38%	49%	50%	38%	50%	27%
Needed, easy to access	32%	30%	0%	38%	18%	55%
Needed, difficult to access	3%	2%	0%	0%	0%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

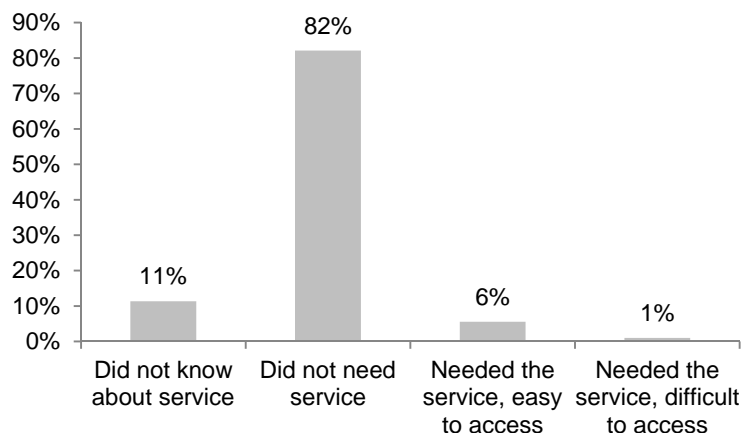
## EARLY INTERVENTION (JAIL ONLY)

*Early intervention services (EIS)* refers to the provision of HIV testing, counseling, and referral in the Ryan White HIV/AIDS Program setting. In the Houston Area, the Ryan White HIV/AIDS Program funds EIS to persons living with HIV (PLWH) who are incarcerated in the Harris County Jail. Services focus on post-incarceration care coordination to ensure continuity of primary care and medication adherence post-release.

(**Graph 1**) In the 2014 Houston Area HIV needs assessment, 7% of participants indicated a need for *early intervention services* in the past 12 months. 6% reported the service was easy to access, and 1% reported difficulty. 11% stated that they did not know the service was available.

(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was accessibility (40%). Accessibility barriers reported include release from incarceration.

**GRAPH 1-Early Intervention (Jail Only), 2016**



**TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2016**

	No.	%
1. Accessibility (AC)	2	40%
2. Interactions with Staff (S)	1	20%
3. Resource Availability (R)	1	20%
4. Transportation (T)	1	20%
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(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *early intervention services*, this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more recently release and unstably housed PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	8%	13%	13%	7%	14%	4%	15%	7%
Did not need service	81%	86%	86%	80%	88%	43%	96%	77%	88%
Needed, easy to access	6%	5%	1%	6%	5%	43%	0%	6%	5%
Needed, difficult to access	1%	2%	0%	2%	0%	0%	0%	1%	1%

**TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	11%	12%	0%	26%	0%	9%
Did not need service	78%	82%	100%	26%	97%	86%
Needed, easy to access	9%	6%	0%	42%	3%	5%
Needed, difficult to access	2%	1%	0%	5%	0%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

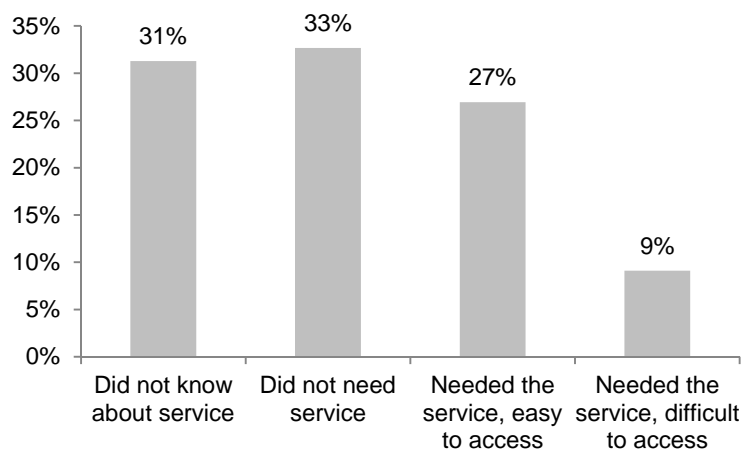


## FOOD PANTRY

*Food pantry* is the provision of food and/or household items to persons living with HIV (PLWH). This service can be provided in the form of actual goods (such as through a food bank) or as vouchers for food. In the Houston Area, other non-Ryan White programs provide food bank services to PLWH.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 36% of participants indicated a need for *food pantry* in the past 12 months. 27% reported the service was easy to access, and 9% reported difficulty. 31% stated that they did not know the service was available.

**GRAPH 1-Food Pantry, 2016**



(**Table 1**) When barriers to *food pantry* were reported, the most common barrier type was education and awareness (45%). Education and awareness barriers reported include lack of knowledge about service availability, location, staff contact.

**TABLE 1-Top 5 Reported Barrier Types for Food Pantry, 2016**

	No.	%
1. Education and Awareness (EA)	19	45%
2. Eligibility (EL)	5	12%
3. Interactions with Staff (S)	5	12%
4. Resource Availability (R)	3	7%
5. Transportation (T)	3	7%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *food pantry*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more out of care, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Food Pantry, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	32%	30%	33%	31%	31%	21%	48%	32%	28%
Did not need service	34%	27%	40%	28%	36%	36%	52%	31%	33%
Needed, easy to access	26%	31%	16%	33%	23%	43%	0%	30%	27%
Needed, difficult to access	8%	12%	10%	8%	10%	0%	0%	8%	12%

**TABLE 3-Food Pantry, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	42%	31%	50%	28%	35%	29%
Did not need service	17%	36%	0%	28%	41%	19%
Needed, easy to access	31%	23%	0%	38%	15%	52%
Needed, difficult to access	11%	10%	50%	5%	9%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

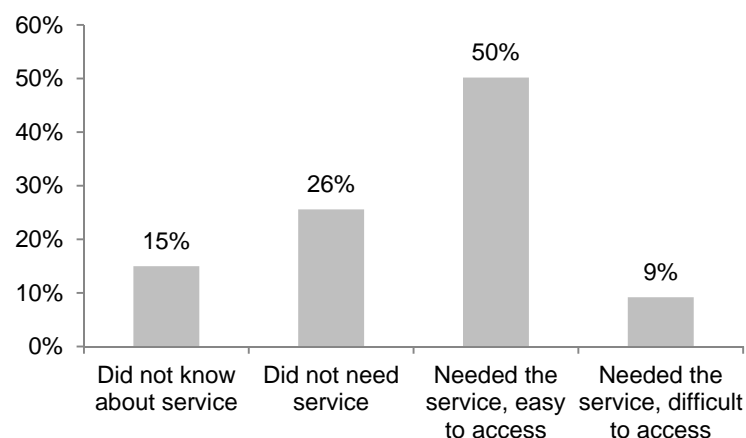
## HEALTH INSURANCE ASSISTANCE

*Health insurance assistance*, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 59% of participants indicated a need for *health insurance assistance* in the past 12 months. 50% reported the service was easy to access, and 9% reported difficulty. 15% stated that they did not know the service was available.

(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier type was related to health insurance coverage (31%). Health insurance-related barriers reported include being uninsured, having coverage gaps, and difficulty with ACA enrollment.

**GRAPH 1-Health Insurance Assistance, 2016**



	No.	%
1. Health Insurance Coverage (I)	15	31%
2. Education and Awareness (EA)	10	21%
3. Administrative (AD)	6	13%
4. Eligibility (EL)	6	13%
5. Financial (F)	5	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *health insurance assistance* this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more recently released and rural PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Health Insurance Assistance, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	14%	19%	8%	17%	16%	20%	35%	18%	8%
Did not need service	25%	27%	26%	27%	25%	0%	30%	23%	28%
Needed, easy to access	52%	42%	54%	46%	53%	67%	30%	50%	54%
Needed, difficult to access	8%	12%	11%	10%	6%	13%	4%	9%	9%

**TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	21%	12%	0%	16%	15%	5%
Did not need service	27%	25%	0%	24%	24%	27%
Needed, easy to access	42%	56%	100%	42%	47%	64%
Needed, difficult to access	9%	7%	0%	18%	15%	5%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

## HOSPICE

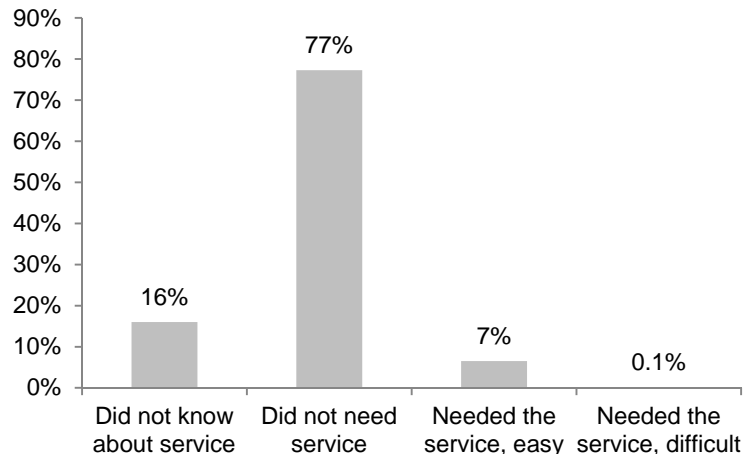
*Hospice* is end-of-life care for persons living with HIV (PLWH) who are in a terminal stage of illness (defined as a life expectancy of 6 months or less). This includes room, board, nursing care, mental health counseling, physician services, and palliative care.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 7% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 0.1% reported difficulty. 16% stated that they did not know the service was available.

(**Table 1**) When barriers to *hospice* were reported, the only barrier type identified was education and awareness (lack of knowledge about the availability the service)

	No.	%
1. Education and Awareness (EA)	2	100%
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**GRAPH 1-Hospice, 2016**



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *hospice*, this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- No PLWH in special populations found the service difficult to access compared to all participants.

TABLE 2-Hospice, by Demographic Categories, 2016

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	16%	17%	10%	16%	20%	0%	21%	18%	12%
Did not need service	77%	77%	84%	75%	74%	13%	75%	77%	78%
Needed, easy to access	7%	6%	6%	8%	5%	87%	4%	5%	11%
Needed, difficult to access	0%	0%	0%	0%	0%	0%	0%	0%	0%

TABLE 3- Hospice, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	20%	13%	50%	21%	15%	14%
Did not need service	74%	80%	50%	74%	79%	77%
Needed, easy to access	6%	7%	0%	5%	6%	9%
Needed, difficult to access	0%	0%	0%	0%	0%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

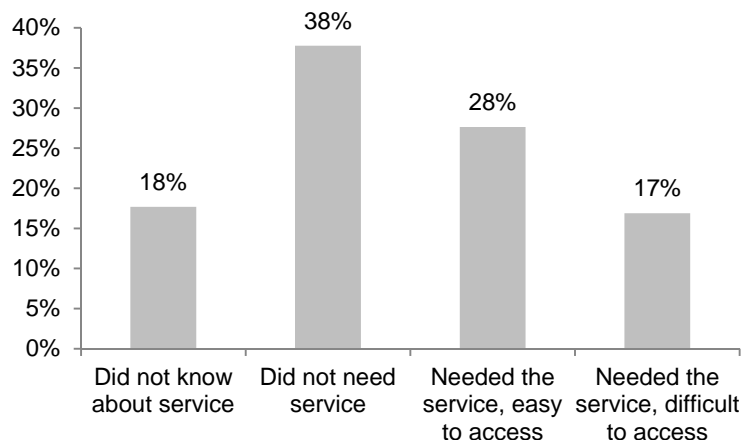
## HOUSING

*Housing* for persons living with HIV (PLWH) is provided by the Housing Opportunities for People with AIDS (HOPWA) program through the Houston Housing and Community Development Department. Services include short-term rent, mortgage, and utility assistance as well as community-based supportive housing facilities for PLWH and their families.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 45% of participants indicated a need for *housing* in the past 12 months. 28% reported the service was easy to access, and 17% reported difficulty. 18% stated that they did not know the service was available.

(**Table 1**) When barriers to *housing* were reported, the most common barrier types were education and awareness (25%) and wait-related issues (25%). Education and awareness barriers reported include lack of knowledge about service availability, location, staff contact, and definition. Wait-related barriers reported include placement on a waiting list, being told a wait list was full/unavailable, and long durations between application and approval.

**GRAPH 1-Housing, 2016**



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *housing*, this analysis shows the following:

- More females than males found the service accessible.
- More African American/black PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more unstably housed and transgender PLWH found the service difficult to access when compared to all participants.

**TABLE 1-Top 5 Reported Barrier Types for Housing, 2016**

	No.	%
1. Education and Awareness (EA)	22	25%
2. Wait (W)	22	25%
3. Eligibility (EL)	12	14%
4. Housing (H)	8	9%
5. Interactions with Staff (S)	7	8%

**TABLE 2-Housing, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	20%	11%	19%	23%	6%	35%	20%	13%
Did not need service	41%	28%	47%	29%	42%	81%	26%	36%	41%
Needed, easy to access	27%	30%	20%	35%	22%	13%	35%	28%	26%
Needed, difficult to access	15%	22%	22%	17%	14%	0%	4%	16%	20%

**TABLE 3-Housing, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	29%	18%	50%	18%	24%	14%
Did not need service	19%	45%	50%	26%	56%	33%
Needed, easy to access	20%	23%	0%	42%	12%	33%
Needed, difficult to access	33%	14%	0%	13%	9%	19%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

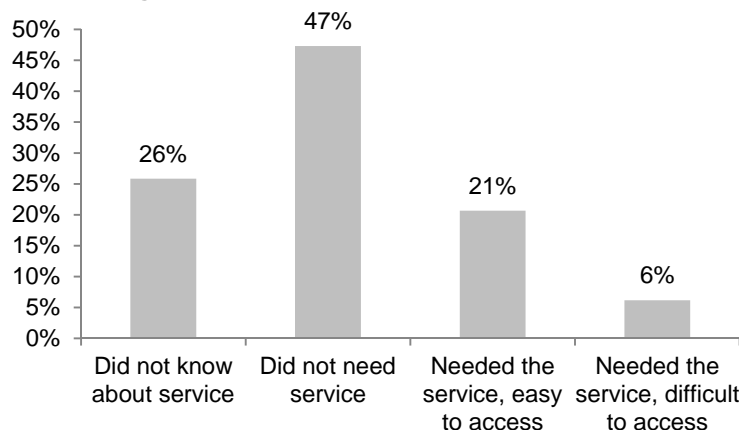
## LEGAL SERVICES

*Legal services* provides licensed attorneys to persons living with HIV (PLWH) to assist with permanency planning and various legal interventions that maintain health and other benefits. This includes estate planning, wills, guardianships, and powers-of-attorney as well as discrimination, entitlement, and insurance disputes.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 27% of participants indicated a need for *legal services* in the past 12 months. 21% reported the service was easy to access, and 6% reported difficulty. 26% stated that they did not know the service was available.

(**Table 1**) When barriers to *legal services* were reported, the most common barrier type was education and awareness (54%). Education and awareness barriers reported include lack of knowledge about service availability, staff contact, definition, and location.

**GRAPH 1-Legal Services, 2016**



**TABLE 1-Top 5 Reported Barrier Types for Legal Service, 2016**

	No.	%
1. Education and Awareness (EA)	13	54%
2. Interactions with Staff (S)	7	29%
3. Administrative (AD)	1	4%
4. Eligibility (EL)	1	4%
5. Financial (F)	1	4%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *legal services*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH than other race/ethnicities found the service accessible.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, recently released PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Legal Services, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	27%	23%	30%	25%	31%	36%	43%	30%	17%
Did not need service	47%	47%	40%	50%	34%	21%	43%	46%	49%
Needed, easy to access	20%	23%	20%	20%	20%	43%	13%	19%	25%
Needed, difficult to access	6%	8%	10%	4%	15%	0%	0%	5%	9%

**TABLE 3-Legal Services, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	31%	26%	50%	27%	17%	23%
Did not need service	43%	47%	50%	43%	48%	65%
Needed, easy to access	22%	22%	0%	19%	31%	6%
Needed, difficult to access	5%	6%	0%	11%	3%	6%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

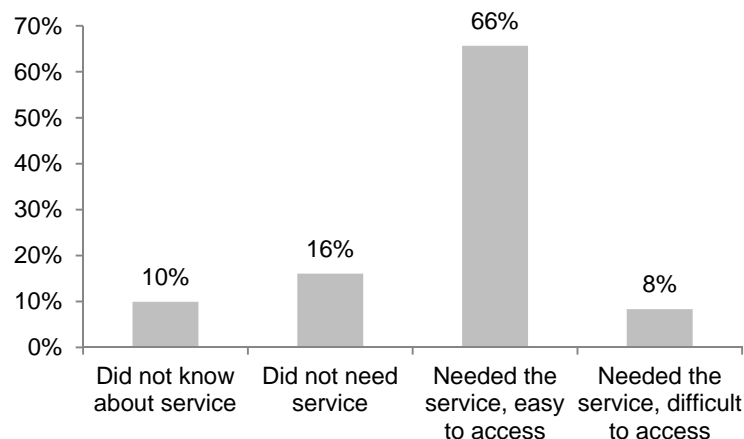
## LOCAL HIV MEDICATION ASSISTANCE

*Local HIV medication assistance*, technically referred to as the *Local Pharmacy Assistance Program (LPAP)*, provides HIV-related pharmaceuticals to persons living with HIV (PLWH) who are not eligible for medications through other payer sources, including the state AIDS Drug Assistance Program (ADAP).

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 74% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 66% reported the service was easy to access, and 8% reported difficulty. 10% stated that they did not know the service was available.

(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was related to health insurance coverage (24%). Health insurance-related barriers reported include having coverage gaps and being uninsured.

**GRAPH 1-Local HIV Medication Assistance, 2016**



**TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2016**

	No.	%
1. Health Insurance Coverage (I)	8	24%
2. Administrative (AD)	4	12%
3. Education and Awareness (EA)	3	9%
4. Eligibility (EL)	3	9%
5. Financial (F)	3	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *local HIV medication assistance*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH than other race/ethnicities found the service accessible.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, rural and recently released PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	10%	9%	7%	12%	9%	0%	5%	11%	8%
Did not need service	18%	11%	16%	17%	11%	53%	14%	14%	20%
Needed, easy to access	65%	68%	71%	62%	73%	33%	76%	66%	64%
Needed, difficult to access	7%	11%	7%	9%	7%	13%	5%	8%	8%

**TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	12%	8%	100%	13%	0%	14%
Did not need service	19%	18%	0%	3%	12%	14%
Needed, easy to access	61%	67%	0%	74%	73%	71%
Needed, difficult to access	8%	8%	0%	11%	15%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

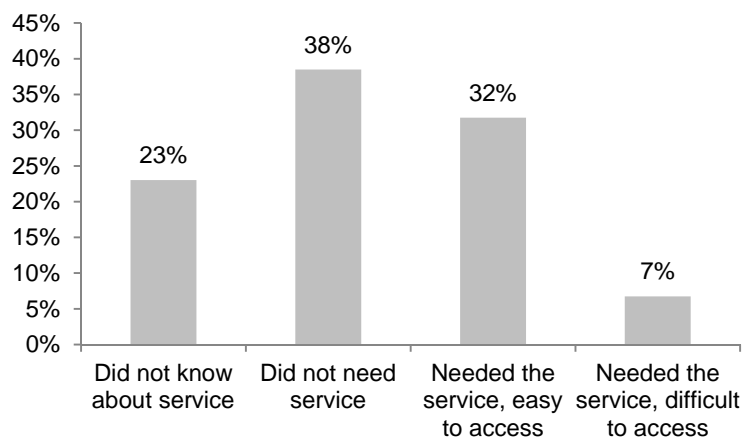
## MEDICAL NUTRITION THERAPY

*Medical nutrition therapy* provides nutrition supplements and nutritional counseling to persons living with HIV (PLWH) outside of a primary care visit by a licensed registered dietician based on physician recommendation and a nutrition plan. The purpose of such services can be to address HIV-associated nutritional deficiencies or dietary needs as well as to mitigate medication side effects.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 38% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 32% reported the service was easy to access, and 7% reported difficulty. 23% stated that they did not know the service was available.

(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common barrier types was education and awareness (34%). Education and awareness barriers reported include lack of knowledge about service availability and location.

**GRAPH 1-Medical Nutrition Therapy, 2016**



**TABLE 1-Top 5 Reported Barrier Types for Medical Nutrition Therapy, 2016**

	No.	%
1. Education and Awareness (EA)	10	34%
2. Administrative (AD)	4	14%
3. Eligibility (EL)	4	14%
4. Interactions with Staff (S)	3	10%
5. Wait (W)	3	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *medical nutrition therapy*, this analysis shows the following:

- More male than females found the service accessible.
- More African American/black PLWH than other race/ethnicities found the service accessible.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more rural and unstably housed PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Medical Nutrition Therapy, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	24%	19%	21%	24%	23%	14%	54%	23%	18%
Did not need service	37%	42%	40%	35%	40%	71%	29%	36%	45%
Needed, easy to access	32%	31%	30%	34%	31%	14%	13%	35%	29%
Needed, difficult to access	6%	8%	9%	7%	5%	0%	4%	6%	8%

**TABLE 3-Medical Nutrition Therapy, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	35%	22%	0%	18%	40%	14%
Did not need service	28%	37%	100%	34%	34%	36%
Needed, easy to access	30%	35%	0%	42%	14%	45%
Needed, difficult to access	8%	7%	0%	5%	11%	5%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

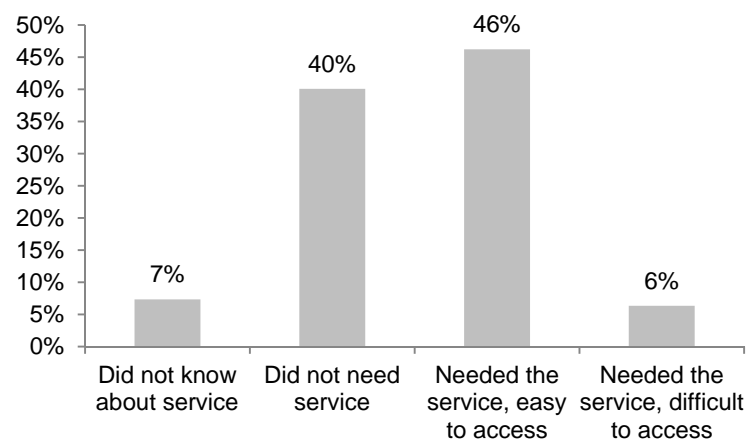
## MENTAL HEALTH SERVICES

*Mental health services*, also referred to as *professional mental health counseling*, provides psychological counseling services for persons living with HIV (PLWH) who have a diagnosed mental illness. This includes group or individual counseling by a licensed mental health professional in accordance with state licensing guidelines.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 53% of participants indicated a need for *mental health services* in the past 12 months. 46% reported the service was easy to access, and 6% reported difficulty. 7% stated that they did not know the service was available.

(**Table 1**) When barriers to *mental health services* were reported, the most common barrier types were administrative (25%) and wait-related barriers (25%). Administrative barriers reported include hours of operation, complex processes, and staff changes without notification to the client. Wait-related barriers reported include placement on a waitlist.

**GRAPH 1-Mental Health Services, 2016**



**TABLE 1-Top 5 Reported Barrier Types for Mental Health Services, 2016**

	No.	%
1. Administrative (AD)	6	25%
2. Wait (W)	6	25%
3. Health Insurance Coverage (I)	2	8%
4. Interactions with Staff (S)	2	8%
5. Resource Availability (R)	2	8%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *mental health services*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more rural and unstably housed PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Mental Health Services, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	6%	4%	8%	9%	0%	13%	8%	6%
Did not need service	40%	39%	29%	41%	47%	40%	33%	39%	43%
Needed, easy to access	46%	48%	57%	45%	39%	60%	54%	47%	44%
Needed, difficult to access	6%	8%	10%	6%	5%	0%	0%	6%	7%

**TABLE 3-Mental Health Services, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	11%	5%	0%	3%	0%	14%
Did not need service	25%	37%	50%	22%	50%	18%
Needed, easy to access	53%	51%	50%	69%	35%	68%
Needed, difficult to access	10%	6%	0%	6%	15%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender



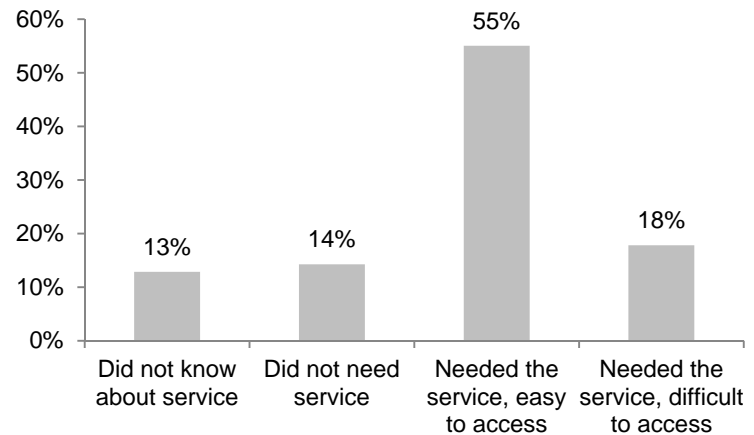
## ORAL HEALTH CARE

*Oral health care, or dental services, refers to the diagnostic, preventative, and therapeutic services provided to persons living with HIV (PLWH) by a dental health care professional (such as a dentist or hygienist). This includes examinations, periodontal services (such as cleanings and fillings), extractions and other oral surgeries, restorative dental procedures, and prosthodontics (or dentures).*

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *oral health care* in the past 12 months. 55% reported the service was easy to access, and 18% reported difficulty. 13% stated that they did not know the service was available.

(**Table 1**) When barriers to *oral health care* were reported, the most common barrier type was wait-related issues (35%). Wait-related barriers reported include placement on a waitlist, long waits at appointments, being told a wait list was full/unavailable, and long durations between application and approval.

**GRAPH 1-Oral Health Care, 2016**



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *oral health care*, this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- In addition, more rural, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

**TABLE 1-Top 5 Reported Barrier Types for Oral Health Care, 2016**

	No.	%
1. Wait (W)	29	35%
2. Interactions with Staff (S)	11	13%
3. Health Insurance Coverage (I)	10	12%
4. Eligibility (EL)	8	10%
5. Administrative (AD)	7	8%

**TABLE 2-Oral Health Care, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	13%	12%	3%	16%	15%	13%	35%	15%	6%
Did not need service	16%	8%	8%	17%	15%	7%	13%	16%	11%
Needed, easy to access	54%	60%	68%	51%	52%	60%	35%	50%	66%
Needed, difficult to access	17%	20%	21%	17%	18%	20%	17%	19%	16%

**TABLE 3-Oral Health Care, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	17%	11%	0%	21%	9%	14%
Did not need service	12%	14%	0%	29%	6%	10%
Needed, easy to access	47%	55%	100%	34%	50%	71%
Needed, difficult to access	25%	19%	0%	16%	35%	5%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

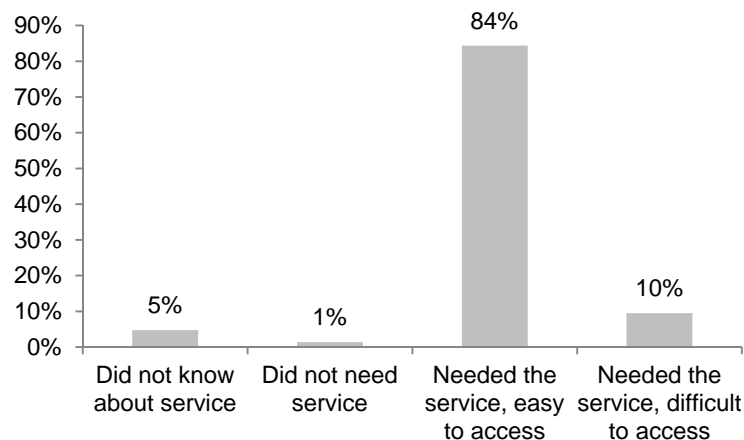
## PRIMARY HIV MEDICAL CARE

*Primary HIV medical care*, technically referred to as *outpatient/ambulatory medical care*, refers to the diagnostic and therapeutic services provided to persons living with HIV (PLWH) by a physician or physician extender in an outpatient setting. This includes physical examinations, diagnosis and treatment of common physical and mental health conditions, preventative care, education, laboratory services, and specialty services as indicated.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 94% of participants indicated a need for *primary HIV medical care* in the past 12 months. 84% reported the service was easy to access, and 10% reported difficulty. 5% stated that they did not know the service was available.

(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was administrative (19%). Administrative barriers reported include complex processes, staff, hours of operation, understaffing, and service changes without client notification.

**GRAPH 1-Primary HIV Medical Care, 2016**



**TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2016**

	No.	%
1. Administrative (AD)	8	19%
2. Interactions with Staff (S)	6	14%
3. Transportation (T)	6	14%
4. Wait (W)	6	14%
5. Education and Awareness (EA)	4	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH and whites found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more out of care, rural, transgender, recently released, and unstably housed PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	5%	3%	5%	4%	6%	0%	0%	6%	4%
Did not need service	1%	2%	0%	2%	2%	0%	0%	2%	2%
Needed, easy to access	84%	86%	83%	85%	85%	87%	83%	83%	86%
Needed, difficult to access	10%	9%	12%	9%	8%	13%	17%	10%	9%

**TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	7%	4%	0%	11%	0%	14%
Did not need service	0%	1%	0%	0%	0%	0%
Needed, easy to access	81%	85%	67%	79%	79%	73%
Needed, difficult to access	12%	10%	33%	11%	21%	14%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

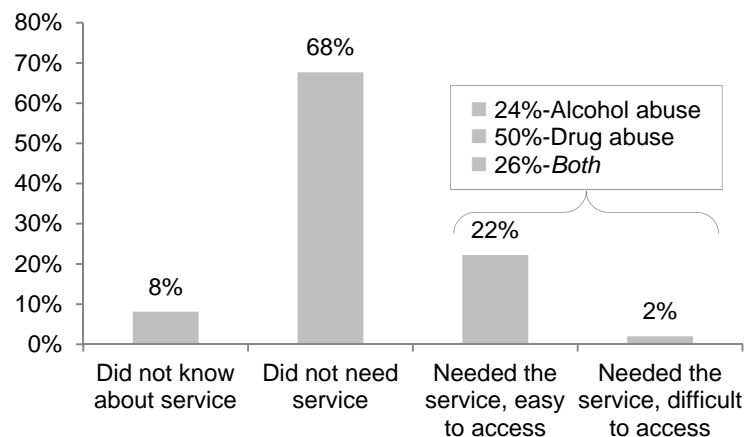
## SUBSTANCE ABUSE SERVICES

*Substance abuse services*, also referred to as *outpatient alcohol or drug abuse treatment*, provides counseling and/or other treatment modalities to persons living with HIV (PLWH) who have a substance abuse concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol abuse and/or abuse of legal or illegal drugs.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 22% reported the service was easy to access, and 2% reported difficulty. 8% stated they did not know the service was available. When analyzed by type of substance concern, 24% of participants cited alcohol, 56% cited drugs, and 26% cited both.

(**Table 1**) When barriers to *substance abuse services* were reported, the most common barrier types were education and awareness (lack of knowledge about location), eligibility (ineligibly), and health-insurance related (being uninsured).

**GRAPH 1-Substance Abuse Services, 2016**



**TABLE 1-Top 3 Reported Barrier Types for Substance Abuse Services, 2016**

	No.	%
1. Education and Awareness (EA)	1	33%
2. Eligibility (EL)	1	33%
3. Health Insurance Coverage (I)	1	33%
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(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *substance abuse services*, this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- In addition, more recently released, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

**TABLE 2-Substance Abuse Services, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	8%	2%	10%	11%	0%	30%	9%	4%
Did not need service	69%	64%	73%	65%	70%	60%	48%	68%	70%
Needed, easy to access	21%	26%	24%	23%	17%	40%	17%	22%	24%
Needed, difficult to access	2%	2%	1%	2%	2%	0%	4%	2%	1%

**TABLE 3-Substance Abuse Services, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	14%	9%	50%	8%	9%	18%
Did not need service	61%	68%	50%	42%	88%	50%
Needed, easy to access	23%	21%	0%	39%	3%	32%
Needed, difficult to access	2%	2%	0%	11%	0%	0%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

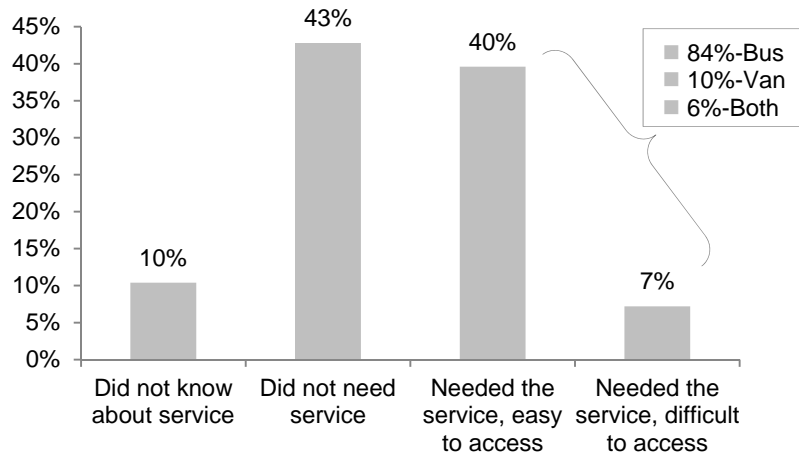
<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender

## TRANSPORTATION

*Transportation services* provides transportation to persons living with HIV (PLWH) to locations where HIV-related care is received, including pharmacies, mental health services, and substance abuse services. The service can be provided in the form of public transportation vouchers (bus passes), gas vouchers (for rural clients), taxi vouchers (for emergency purposes), and van-based services as medically indicated.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 47% of participants indicated a need for *transportation services* in the past 12 months. 40% reported the service was easy to access, and 7% reported difficulty. 10% stated they did not know the service was available. When analyzed by type transportation assistance sought, 84% of participants needed bus passes, 10% needed van services, and 6% needed both forms of assistance.

**GRAPH 1-Transportation Services, 2016**



(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was transportation (28%). Transportation barriers reported include both lack of transportation and difficulty with special transportation providers.

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *transportation services*, this analysis shows the following:

- More females than males found the service accessible..
- More African American/black PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more transgender, recently released, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

**TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2016**

	No.	%
1. Transportation (T)	9	28%
2. Education and Awareness (EA)	6	19%
3. Eligibility (EL)	4	13%
4. Accessibility (AC)	3	9%
5. Resource Availability (R)	3	9%

**TABLE 2-Transportation Services, by Demographic Categories, 2016**

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	11%	8%	7%	9%	15%	13%	22%	10%	9%
Did not need service	47%	31%	55%	36%	41%	87%	43%	44%	40%
Needed, easy to access	35%	55%	27%	48%	38%	0%	30%	38%	44%
Needed, difficult to access	8%	6%	10%	8%	5%	0%	4%	8%	7%

**TABLE 3-Transportation Services, by Selected Special Populations, 2016**

Experience with the Service	Unstably Housed <sup>a</sup>	MSM <sup>b</sup>	Out of Care <sup>c</sup>	Recently Released <sup>d</sup>	Rural <sup>e</sup>	Transgender <sup>f</sup>
Did not know about service	17%	13%	50%	8%	6%	14%
Did not need service	27%	49%	50%	22%	72%	18%
Needed, easy to access	46%	31%	0%	59%	16%	50%
Needed, difficult to access	10%	8%	0%	11%	6%	18%

<sup>a</sup>Persons reporting housing instability <sup>b</sup>Men who have sex with men <sup>c</sup>Persons with no evidence of HIV care for 12 mo.

<sup>d</sup>Persons released from incarceration in the past 12 mo. <sup>e</sup>Non-Houston/Harris County residents <sup>f</sup>Persons with discordant sex assigned at birth and current gender





**2016 Houston Area HIV Care Services Needs Assessment**

**Approved: PENDING**

**For more information, contact:**

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**2016 QUARTERLY REPORT  
COMPREHENSIVE HIV PLANNING COMMITTEE**

**Status of Committee Goals and Responsibilities (\*means mandated by HRSA):**

1. \*Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Plan.

*ongoing*

2. \*Determine the size and demographics of the estimated population of individuals who are unaware of their HIV status.

*done*

3. \*Work with the community and other committees to develop a strategy for identifying those with HIV who do not know their status, make them aware of their status, and link and refer them into care.

*ongoing*

4. \*Explore and develop on-going needs assessment and comprehensive planning activities including the identification and prioritization of special studies.

*ongoing*

5. \*Review and disseminate the most current Joint Epidemiological Profile.

*ongoing*

*Nancy Meertschin*  
\_\_\_\_\_  
Committee Chairperson

*11/10/16*  
\_\_\_\_\_  
Date

# **Quality Improvement Committee Report**





# Ryan White Grant Administration

## Consumer Feedback for FY 2016 Standard of Care and Outcome Measures

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### General Standards

- There are issues with the telephone system. When calling-in one is prompted for a number, yet nothing happens. The caller is placed in a loop being bounced back-and-forth. The issue has been occurring for a year.
  - The AA will ask the agencies to test their phone systems, as clients have been experiencing problems reaching agency staff directly.
  - RWGA recommended the providers' test their phone system by calling and try to contact someone to understand what clients' experience.
- Consumers wanted to know why are Case Managers unable to be trained on providing bus vouchers.
  - QMD will remind CM/SLWs about bus vouchers and review the AA's internal process.
- The consumers noted there is an issue with getting beyond the front desk in the agencies. There were instances where consumers felt ignored/unaddressed. Consumers want the agencies to understand that consumers are a vital part of the agencies' bottom line.
  - The agencies were informed and have agreed to try and incorporate customer service training into their current training curricula and/or orientation.
- Consumers raised an issue with the supervision of staff. While RWGA cannot oversee all of the aspects that touch employees' in each agency, the General Standards covering Staff Requirements - 1.0 of the SOC, outline the general guidelines of employment.
- Concerns over confidentiality in clinics were raised again and RWGA will make a point to cover this issue with applicable agencies.
  - General Standard 3.2 addresses this concern. We will work with our providers to make sure appropriate procedures are in place.

- **Consumers raised the issue around case management, assignments and closures.**
  - **RWGA will make a concerted effort to ensure communication of case management assignments and case closure is covered at the agency and consumer level (in conjunction with the Office of Support).**

#### **Wait Time (Positive Feedback)**

- **A consumer witnessed an experience where another consumer was able to be seen immediately.**
- **Another consumer noted that he has been able to navigate within the system utilizing the technology available.**

# RWGA Summary of Recommended Changes FY 2017 Standards of Care

## 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)' 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*<sup>2</sup>. Specific requirements for each of the models are discussed under each case management service category.

1.0	<b>Staff Training</b>
1.1	<p><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.</p> <ul style="list-style-type: none"> <li>• Agency will maintain verification of attendance (RWGA will also maintain sign-in logs)              During the consumer workgroup meeting, it was asked if customer service training could be included for staff training.</li> </ul>

<sup>1</sup> 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

<sup>2</sup> 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](http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp)

# RWGA Summary of Recommended Changes FY 2017 Standards of Care

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<p>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)</p>	<p>Sub-recipients asked if the number of meetings can be reduced however the amount of meetings will remain.</p>

## Primary Medical Care

<p>1.2</p>	<p><u>Licensing, Knowledge, Skills and Experience</u></p> <ul style="list-style-type: none"> <li>• All staff maintain current organizational licensure (and/or applicable certification) and professional licensure</li> <li>• The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc.</li> <li>• Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (<a href="http://www.hivma.org">www.hivma.org</a>):</li> <li>• Clinical management of at least 25 HIV-infected patients within the last year</li> <li>• 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.</li> <li>• Physician extenders must obtain this experience within six months of hire</li> <li>• All staff receive professional supervision</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in personnel record</li> </ul> <p>Legacy has asked if the standards can align with the Medical Board:  <u>The Texas Medical Board requires 48 hours per every 24 months, HIVMA requires 40 hours per 36 months, and RW SOC (SOC Primary Medical Care – Section 1.2) requires 15 hours per year. The TMB standard is more rigorous, the one that most providers would normally follow in order to maintain their licenses, and the standard we would prefer to adhere to. Of course, content requirements (certain number of HIV-specific CMEs) are not at issue, merely the timing required. Please let me know if I can be of any assistance, and I appreciate the opportunity to work with you on the SOC.</u></p>
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## RWGA Summary of Recommended Changes FY 2017 Standards of Care

1.3	<ul style="list-style-type: none"> <li>Staff show training and/or experience with the medical care of adults with HIV</li> </ul> <p><b>Peer Review</b> Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).</p>	<ul style="list-style-type: none"> <li>Provider will document peer review has occurred annually</li> </ul>
1.4	<p><b>Standing Delegation Orders (SDO)</b> 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).</p>	<ul style="list-style-type: none"> <li>Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider.</li> <li>Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually.</li> <li>Use of standing delegation orders will be documented in patient's primary record system.</li> </ul>
1.5	<p><b>Primary Care Guidelines</b> Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (<a href="http://www.aidsinfo.nih.gov/guidelines/">http://www.aidsinfo.nih.gov/guidelines/</a>) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines.</p>	<ul style="list-style-type: none"> <li>Documentation in client's record</li> <li>Exceptions noted in client's record</li> </ul>
1.6	<p><b>Medical Evaluation/Assessment</b> 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 (<a href="http://www.hivma.org">www.hivma.org</a>) within 3 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and</p>	<ul style="list-style-type: none"> <li>Completed assessment in client's record</li> </ul>

# RWGA Summary of Recommended Changes FY 2017 Standards of Care

	<p>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:</p> <ul style="list-style-type: none"> <li>• Psychosocial history</li> <li>• HIV treatment history and staging</li> <li>• Most recent CD4 counts and VL test results</li> <li>• Resistance testing and co receptor tropism assays as clinically indicated</li> <li>• Medication adherence history</li> <li>• History of HIV related illness and infections</li> <li>• History of Tuberculosis</li> <li>• History of Hepatitis and vaccines</li> <li>• Psychiatric history</li> <li>• Transfusion/blood products history</li> <li>• Past medical care</li> <li>• Sexual history</li> <li>• Substance abuse history</li> <li>• Review of Systems</li> </ul>
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### 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.~~

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**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 position 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	<b>Staff Requirements</b>	
1.1	<p><u>Minimum Qualifications</u>                  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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
2.0	<b>Timeliness of Services/Documentation</b>	
2.1	<p><u>Client Eligibility</u> 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</p>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> <li>• Documentation of “not in care” status</li> </ul>

	<p>following in order to be eligible for non-medical case management services:</p> <ul style="list-style-type: none"> <li>• HIV+ and not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or</li> <li>• Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or</li> <li>• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS</li> </ul>	through the CPCDMS
2.2	<p><u>Outreach and Reengagement/Re-linkage Specialist</u></p> <p>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.</p> <p>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 housing issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager. <b><u>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.</u></b></p>	<ul style="list-style-type: none"> <li>• Documentation in client record on the brief assessment form, signed and dated</li> <li>• A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate</li> </ul>
2.3	<p><u>Outreach and Reengagement/Re-linkage Specialist –Reassessment</u></p> <p>Clients on <b><u>open status</u></b> will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.</p>	<ul style="list-style-type: none"> <li>• Documentation in RWGA approved client reassessment form or agency’s equivalent form, signed and dated</li> </ul>
2.4	<p><u>Transfer of Not-in-Care and Newly Diagnosed Clients (COH Only)</u></p> <p>outreach and reengagement/re-linkage specialist – s targeting their services to Not-in-Care and newly diagnosed clients will work with</p>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the CPCDMS</li> </ul>



	<p>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.</p> <p>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.</p>	
2.5	<p><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:</p> <ul style="list-style-type: none"> <li>• Methods of routine communication with testing sites regarding newly diagnosis and referred individuals</li> <li>• Description of service linkage worker job duties conducted in the field</li> <li>• Process for re-engaging agency patients lost to care (no primary care visit in 6 months)</li> </ul>	<ul style="list-style-type: none"> <li>○ Review of Agency's Policies and Procedures Manual indicates compliance.</li> </ul>
3.0	<p><b>Supervision and Caseload</b></p>	
3.1	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation in supervision notes, which must include: <ul style="list-style-type: none"> <li>➤ date</li> <li>➤ name(s) of case manager(s) present</li> <li>➤ topic(s) covered and/or client(s) reviewed</li> <li>➤ plan(s) of action</li> <li>➤ supervisor's signature</li> </ul> </li> <li>• Supervision notes are never maintained in the client record</li> </ul>
3.2	<p><u>Caseload Coverage – Outreach and Reengagement/Re-linkage</u></p>	<ul style="list-style-type: none"> <li>• Documentation of all client encounters in</li> </ul>

	<p><b>Specialist</b>  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.</p>	<p>client record and in the Centralized Patient Care Data Management System</p>
<p>3.3</p>	<p><u>Case Reviews</u> – 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.</p>	<ul style="list-style-type: none"> <li>• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and ORRS</li> </ul>

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## 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	<b>Services are part of the coordinated continuum of HIV/AIDS services:</b>	
1.1	<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.	<ul style="list-style-type: none"> <li>• Documentation of referrals received</li> </ul>
2.0	<b>Tax Preparation services adhere to professional standards and regulations.</b>	
2.1	<u>Licensure</u> 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.	<ul style="list-style-type: none"> <li>• Staff records indicate compliance</li> </ul>
2.2	<u>Non-Licensed Staff</u> Non-licensed staff members are supervised by tax preparers and or supervisors	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>
3.0	<b>Service providers are knowledgeable, accepting and respectful of the needs of individuals with HIV/AIDS.</b>	
3.1	<u>Ongoing Staff Training</u> 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	<ul style="list-style-type: none"> <li>• Staff has attended and has continued access to training activities</li> <li>• Staff has access to manuals and regulations</li> <li>• Documentation of training on current applicable tax laws</li> <li>• Staff have access to updated HIV/AIDS information</li> <li>• Agency maintains system for dissemination of HIV/AIDS information relevant to the tax assistance needs of PLWH to paid staff and volunteers</li> <li>• Staff interviews indicate compliance</li> </ul>

	tax training.	
<b>4.0</b>	<b>Client is kept informed and participates in decisions about his/her case.</b>	
4.1	<u>Service Agreement</u> Clients are kept informed and work together with staff to determine the objective of the tax preparation and to achieve goals.	<ul style="list-style-type: none"> <li>• Copy of service agreement between client and agency is in client record</li> </ul>
4.2	<u>Case Closure</u> Agency will develop case closure criteria and procedures. Cases may be closed: <ul style="list-style-type: none"> <li>• when the client's tax issue has been resolved, or when the client:</li> <li>• has become ineligible</li> <li>• has had no direct program contact for over six months</li> <li>• is deceased</li> <li>• no longer needs the service</li> <li>• discontinues the service</li> <li>• improperly utilizes the service</li> <li>• has not complied with the client services agreement</li> </ul> Agency will attempt to notify clients about case closure.	<ul style="list-style-type: none"> <li>• Case closure criteria and procedures on file at provider agency</li> <li>• Client chart will include attempts at notification and reason for case closure</li> </ul>

DRAFT

**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)**

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## Introduction

According to the Joint Commission on Accreditation of Healthcare Organization (JCAHO) 2008)<sup>1</sup>, 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.

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<sup>1</sup> 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
<b>1.0</b>	<b>Staff Requirements</b>	
1.1	<p><u>Staff Screening (Pre-Employment)</u>            Staff providing services to clients shall be screened for appropriateness by provider agency as follows:</p> <ul style="list-style-type: none"> <li>• Personal/Professional references</li> <li>• Personal interview</li> <li>• Written application</li> </ul> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Review of personnel and/or volunteer files indicates compliance</li> </ul>
1.2	<p><u>Initial Training: Staff/Volunteers</u>            Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire &amp; 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.</p>	<ul style="list-style-type: none"> <li>• Documentation of all training in personnel file.</li> <li>• Specific training requirements are specified in Agency Policy and Procedure</li> <li>• Materials for staff training and continuing education are on file</li> <li>• Staff interviews indicate compliance</li> </ul>
1.3	<p><u>Staff Performance Evaluation</u>            Agency will perform annual staff performance evaluation.</p>	<ul style="list-style-type: none"> <li>• Completed annual performance evaluation kept in employee’s file</li> <li>• Signed and dated by employee and supervisor (includes electronic signature)</li> </ul>
1.4	<p><u>Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers</u>            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.</p>	<ul style="list-style-type: none"> <li>• Documentation of training is maintained by the agency in the personnel file</li> </ul>

	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	<p><u>Staff education on eligibility determination and fee schedule</u></p> <p>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 &amp; intake staff annually.</p> <p>All new employees must complete within ninety (90) days of hire.</p>	Documentation of training in employee's record
<b>2.0</b>	<b>Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.</b>	
2.1	<p><u>Service Evaluation</u></p> <p>Agency has a process in place for the evaluation of client services.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Staff interviews indicate compliance.</li> </ul>
2.2	<p><u>Subcontractor Monitoring</u></p> <p>Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include:</p> <ul style="list-style-type: none"> <li>• Fiscal monitoring</li> <li>• Program</li> <li>• Quality of care</li> <li>• Compliance with guidelines and standards</li> </ul> <p>Reviewed Annually</p>	<ul style="list-style-type: none"> <li>• Documentation of subcontractor monitoring</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
2.3	<p><u>Staff Guidelines</u></p> <p>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.</p> <p>Reviewed Annually</p>	<ul style="list-style-type: none"> <li>• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures</li> </ul>

2.4	<u>Work Conditions</u> Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	<ul style="list-style-type: none"> <li>• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply</li> <li>• Staff interviews indicate compliance</li> </ul>
2.5	<u>Staff Supervision</u> Staff services are supervised by a paid coordinator or manager.	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
2.6	<u>Professional Behavior</u> Staff must comply with written standards of professional behavior.	<ul style="list-style-type: none"> <li>• Staff guidelines include standards of professional behavior</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency's complaint and grievance files</li> </ul>
2.7	<u>Communication</u> There are procedures in place regarding regular communication with staff about the program and general agency issues.	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Documentation of regular staff meetings</li> <li>• Staff interviews indicate compliance</li> </ul>
2.8	<u>Accountability</u> There is a system in place to document staff work time.	<ul style="list-style-type: none"> <li>• Staff time sheets or other documentation indicate compliance</li> </ul>
2.9	<u>Staff Availability</u> Staff are present to answer incoming calls during agency's normal operating hours.	<ul style="list-style-type: none"> <li>• Published documentation of agency operating hours</li> <li>• Staff time sheets or other documentation indicate compliance</li> </ul>
<b>3.0</b>	<b>Clients Rights and Responsibilities</b>	

3.1	<p><u>Clients Rights and Responsibilities</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>• Informed consent</li> <li>• Confidentiality</li> <li>• Grievance procedures</li> <li>• Duty to warn or report certain behaviors</li> <li>• Scope of service</li> <li>• Criteria for end of services</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client's record</li> </ul>
3.2	<p><u>Confidentiality</u></p> <p>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.</p> <p>There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Clients interview indicates compliance</li> <li>• Agency's structural layout and information management indicates compliance</li> <li>• Signed confidentiality statement in each employee's personnel file</li> </ul>
3.3	<p><u>Consents</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Agency Policy and Procedure and signed and dated consent forms in client record</li> </ul>
3.4	<p><u>Up to date Release of Information</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>• Name of the person or entity permitted to make the disclosure</li> </ul>	<ul style="list-style-type: none"> <li>• Current Release of Information form with all the required elements signed by client or authorized person in client's record</li> </ul>

	<ul style="list-style-type: none"> <li>• Name of the client</li> <li>• The purpose of the disclosure</li> <li>• The types of information to be disclosed</li> <li>• Entities to disclose to</li> <li>• Date on which the consent is signed</li> <li>• The expiration date of client authorization (or expiration event) no longer than two years</li> <li>• Signature of the client/or parent, guardian or person authorized to sign in lieu of the client.</li> <li>• Description of the <i>Release of Information</i>, its components, and ways the client can nullify it</li> </ul> <p>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.</p>	
3.5	<p><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:</p> <ul style="list-style-type: none"> <li>• to whom complaints can be made</li> <li>• steps necessary to complain</li> <li>• form of grievance, if any</li> <li>• time lines and steps taken by the agency to resolve the grievance</li> <li>• documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client</li> <li>• all complaints or grievances initiated by clients are documented on the Agency's standardized form</li> <li>• resolution of each grievance/complaint is documented on the Standardized form and shared with client</li> <li>• confidentiality of grievance</li> <li>• addresses and phone numbers of licensing authorities and funding sources</li> </ul>	<ul style="list-style-type: none"> <li>• Signed receipt of agency Grievance Procedure, filed in client chart</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Review of Agency's Grievance file indicates compliance,</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2</li> </ul>

3.6	<p><u>Conditions Under Which Discharge/Closure May Occur</u></p> <p>A client may be discharged from Ryan White funded services for the following reasons.</p> <ul style="list-style-type: none"> <li>• Death of the client</li> <li>• At the client’s or legal guardian request</li> <li>• Changes in client’s need which indicates services from another agency</li> <li>• Fraudulent claims or documentation about HIV diagnosis by the client</li> <li>• 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.</li> <li>• 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).</li> <li>• Client service plan is completed and no additional needs are identified.</li> </ul> <p>Client must be provided a written notice prior to involuntary termination of services (e.g. due to dangerous behavior, fraudulent claims or documentation, etc.).</p>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the Centralized Patient Care Data Management System</li> <li>• A copy of written notice and a certified mail receipt for involuntary termination</li> </ul>
3.7	<p><u>Client Closure</u></p> <p>A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including:</p> <ul style="list-style-type: none"> <li>• Date and reason for discharge/closure</li> <li>• Summary of all services received by the client and the client’s response to services</li> <li>• Referrals made and/or</li> <li>• Instructions given to the individual at discharge (when applicable)</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the Centralized Patient Care Data Management System</li> </ul>
3.8	<p><u>Client Feedback</u></p> <p>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</p>	<ul style="list-style-type: none"> <li>• Documentation of clients’ evaluation of services is maintained</li> <li>• Documentation of CAB and public meeting minutes</li> </ul>

	<p>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).</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of existence and appropriateness of a suggestion box or other client input mechanism</li> <li>• Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1</li> </ul>
3.9	<p><u>Patient Safety (Core Services Only)</u>  Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation <i>for Ambulatory Care</i> (<a href="http://www.jointcommission.org">www.jointcommission.org</a>) to ensure patients' safety. The NPSG to be addressed include the following as applicable:</p> <ul style="list-style-type: none"> <li>• "Improve the accuracy of patient identification</li> <li>• Improve the safety of using medications</li> <li>• Reduce the risk of healthcare-associated infections</li> <li>• Accurately and completely reconcile medications across the continuum of care</li> <li>• Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (<a href="http://www.jointcommission.org">www.jointcommission.org</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
3.10	<p><u>Client Records</u>  Provider shall maintain all client records.</p>	<ul style="list-style-type: none"> <li>• Review of agency's policy and procedure for records administration indicates compliance</li> </ul>
<b>4.0</b>	<b>Accessibility</b>	
4.1	<p><u>Cultural Competence</u>  Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals.</p>	<ul style="list-style-type: none"> <li>• Agency has procedures for obtaining translation services</li> <li>• Client satisfaction survey indicates compliance</li> </ul>

		<ul style="list-style-type: none"> <li>• Policies and procedures demonstrate commitment to the community and culture of the clients</li> <li>• Availability of interpretive services, bilingual staff, and staff trained in cultural competence</li> <li>• Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record</li> </ul>
4.2	<p><u>Client Education</u> Agency demonstrates capacity for client education and provision of information on community resources</p>	<ul style="list-style-type: none"> <li>• Availability of the blue book and other educational materials</li> <li>• Documentation of educational needs assessment and client education in clients' records</li> </ul>
4.3	<p><u>Special Service Needs</u> Agency demonstrates a commitment to assisting individuals with special needs</p>	<ul style="list-style-type: none"> <li>• Agency compliance with the Americans with Disabilities Act (ADA).</li> <li>• Review of Policies and Procedures indicates compliance</li> <li>• Environmental Review shows a facility that is handicapped accessible</li> </ul>
4.4	<p><u>Provision of Services for low-Income Individuals</u> 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.</p>	<ul style="list-style-type: none"> <li>• Facility is accessible by public transportation</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4</li> </ul>
4.5	<p><u>Proof of HIV Diagnosis</u> Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03</li> </ul>



	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.	<ul style="list-style-type: none"> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3</li> </ul>
4.6	<p><u>Provision of Services Regardless of Current or Past Health Condition</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of Policies and Procedures indicates compliance</li> <li>• A file containing information on clients who have been refused services and the reasons for refusal</li> <li>• Source Citation: HAB Program Standards; Section D: #1</li> </ul>
4.7	<p><u>Client Eligibility</u></p> <p>In order to be eligible for services, individuals must meet the following:</p> <ul style="list-style-type: none"> <li>• HIV+</li> <li>• Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.)</li> <li>• Income no greater than 300% of the Federal Poverty level (unless otherwise indicated)</li> <li>• Proof of identification</li> <li>• Ineligibility for third party reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> <li>• Documentation of ineligibility for third party reimbursement</li> <li>• 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</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1</li> </ul>
4.8	<p><u>Re-certification of Client Eligibility</u></p> <p>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</p>	<ul style="list-style-type: none"> <li>• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every six (6) months</li> <li>• Review of Policies and Procedures indicates compliance</li> <li>• Information in client's files that includes proof of screening for insurance</li> </ul>

	<p>status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS.</p> <p>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</p> <ul style="list-style-type: none"> <li>Agency must verify 3<sup>rd</sup> party payment coverage for eligible services at every visit or monthly (whichever is less frequent)</li> </ul>	<p>coverage (i.e. hard/scanned copy of results)</p> <ul style="list-style-type: none"> <li>Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2</li> <li>Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02</li> </ul>
4.9	<p><u>Charges for Services</u></p> <p>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 <math>\leq 100\%</math> 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:</p> <ul style="list-style-type: none"> <li>101%-200% of FPL---5% or less of GIL</li> <li>201%-300% of FPL---7% or less of GIL</li> <li>&gt;300% of FPL -----10% or less of GIL</li> </ul> <p>Additionally, agency must implement the following:</p> <ul style="list-style-type: none"> <li>Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.)</li> <li>Tracking of charges</li> <li>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.</li> <li><u>Documentation of fees</u></li> </ul>	<ul style="list-style-type: none"> <li>Review of Policies and Procedures indicates compliance</li> <li>Review of system for tracking patient charges and payments indicate compliance</li> <li>Review of charges and payments in client records indicate compliance with annual cap</li> <li>Sliding fee application forms on client record is consistent with Federal guidelines</li> </ul>
4.10	<p><u>Information on Program and Eligibility/Sliding Fee Schedule</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>Agency has a written substantiated annual plan to targeted populations</li> <li>Zip code data show provider is reaching clients throughout service</li> </ul>

	<p>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.</p>	<p>area (as applicable to specific service category).</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Signed receipt for client education/information regarding eligibility and sliding fees on client record</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5</li> </ul>
4.11	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation of client referral is present in client record</li> <li>• Review of agency's policies &amp; procedures' manual indicates compliance</li> </ul>
4.12	<p><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.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Documentation of compliance with TRG's Policy SG-19 Client Wait Lists</li> <li>• Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted</li> </ul>

	<p>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:</p> <ul style="list-style-type: none"> <li>• Action steps to be taken Agency to resolve the service shortfall; and</li> <li>• Projected date that services will resume.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>• Number of clients on the wait list.</li> <li>• Progress toward completing the plan for resumption of service.</li> <li>• A revised plan for resumption of service, if necessary.</li> </ul>	
4.13	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> </ul>
<b>5.0</b>	<b>Quality Management</b>	
5.1	<p><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:</p> <ul style="list-style-type: none"> <li>• The Agency’s QM Plan</li> <li>• Meeting agendas and/or notes (if applicable)</li> <li>• Project specific CQI Plans</li> <li>• Root Cause Analysis &amp; Improvement Plans</li> <li>• Data collection methods and analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Up to date QM Manual</li> <li>• Source Citation: HAB Universal Standards; Section F: #2</li> </ul>

	<ul style="list-style-type: none"> <li>• Work products</li> <li>• QM program evaluation</li> <li>• Materials necessary for QM activities</li> </ul>	
5.2	<u>Data Collection and Analysis</u> 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.	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Up to date QM Manual</li> <li>• Supervisors log on record reviews signed and dated</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2</li> </ul>
<b>6.0</b>	<b>Point Of Entry Agreements</b>	
6.1	<u>Points of Entry (Core Services Only)</u> 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.	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Documentation of formal agreements with appropriate Points of Entry</li> <li>• Documentation of referrals and their follow-up</li> </ul>
<b>7.0</b>	<b>Emergency Management</b>	
7.1	<u>Emergency Preparedness</u> 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	<ul style="list-style-type: none"> <li>• Emergency Preparedness Plan</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> </ul>

	response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	<p><u>Emergency Management Training</u>  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:</p> <ul style="list-style-type: none"> <li>• IS -100.HC – Introduction to the Incident command system for healthcare/hospitals</li> <li>• IS-200.HC- Applying ICS to Healthcare organization</li> <li>• IS-700.A-National Incident Management System (NIMS) Introduction</li> <li>• IS-800.B National Response Framework (management)</li> </ul> <p>The above courses may be accessed at:<a href="http://www.training.fema.gov">www.training.fema.gov</a>.  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.</p>	<ul style="list-style-type: none"> <li>• Documentation of all training including certificate of completion in personnel file</li> </ul>
7.3	<p><u>Emergency Preparedness Plan</u>  The emergency preparedness plan shall address the six critical areas for emergency management including</p> <ul style="list-style-type: none"> <li>• Communication pathways</li> <li>• Essential resources and assets</li> <li>• patients' safety and security</li> <li>• staff responsibilities</li> <li>• Supply of key utilities such as portable water and electricity</li> <li>• Patient clinical and support activities during emergency situations.  (<a href="http://www.jointcommission.org">www.jointcommission.org</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Emergency Preparedness Plan</li> </ul>
7.4	<p><u>Emergency Management Drills</u>  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.</p>	<ul style="list-style-type: none"> <li>• Emergency Management Plan</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>

<b>8.0</b>	<b>Building Safety</b>	
8.1	<u>Required Permits</u> All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	<ul style="list-style-type: none"><li>• Current required permits on file</li></ul>

## 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)<sup>2</sup> 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*<sup>3</sup>. Specific requirements for each of the models are discussed under each case management service category.

1.0	Staff Training	
1.1	<p><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.</p> <p>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)</p>	<ul style="list-style-type: none"> <li>Agency will maintain verification of attendance (RWGA will also maintain sign-in logs)</li> </ul>

<sup>2</sup> 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

<sup>3</sup> 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](http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp)



1.2	<p><u>Required Training for New Employees</u></p> <p>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 (<a href="https://tx.train.org">https://tx.train.org</a>) 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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Certificates of completion for applicable trainings in the case manager’s file</li> <li>• Sign-in sheets for agency based trainings maintained by Agency</li> <li>• RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum</li> </ul>
1.3	<p><u>Certified Application Counselor (CAC) Training &amp; Certification</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Certificates of completion in case manager’s file</li> </ul>
1.4	<p><u>Case Management Supervisor Peer-led Training</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of attendance sign-in sheet indicates compliance</li> </ul>
1.5	<p><u>Child Abuse Screening, Documenting and Reporting Training</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation of staff training</li> </ul>
<b>2.0</b>	<b>Timeliness of Services</b>	

2.1	<p><u>Initial Case Management Contact</u>  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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>
2.2	<p><u>Acuity</u>  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).</p>	<ul style="list-style-type: none"> <li>• Completed acuity scale in client's records</li> </ul>
2.3	<p><u>Progress Notes</u>  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.</p>	<ul style="list-style-type: none"> <li>• Legible, signed and dated documentation in client record.</li> <li>• Documentation of time expended with or on behalf of patient in progress notes</li> </ul>
2.4	<p><u>Client Referral and Tracking</u>  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:</p> <ul style="list-style-type: none"> <li>• Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager</li> <li>• Work with the Client to determine barriers to referrals and facilitate access to referrals</li> <li>• Utilize a tracking mechanism to monitor completion of all case management referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Documentation of follow-up tracking activities in clients records</li> <li>• A current list of agencies that provide services including availability of the Blue Book</li> </ul>
2.5	<p><u>Client Notification of Service Provider Turnover</u></p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>

	Client must be provided notice of assigned service provider's cessation of employment within 30 days of the employee's departure.	
2.6	<p><u>Client Transfers between Agencies: Open or Closed less than One Year</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>
2.7	<p><u>Caseload</u></p> <p>Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.</p>	<ul style="list-style-type: none"> <li>• Review of the agency's policies and procedures for Staffing ratios</li> </ul>

## 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	<p><u>Minimum Qualifications</u> 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).</p>	<ul style="list-style-type: none"> <li>• A file will be maintained on each clinical case manager</li> <li>• 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</li> </ul>
1.2	<p><u>Scope of Services</u> 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.</p>	<ul style="list-style-type: none"> <li>• Review of client records indicates compliance</li> <li>• Agency Policy and Procedures indicates compliance</li> </ul>
1.3	<p><u>Ongoing Education/Training for Clinical Case Managers</u> After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of</p>	<ul style="list-style-type: none"> <li>• Certificates of completion are maintained by the agency</li> <li>• Current License on case manager’s file</li> </ul>

	continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	
<b>2.0</b>	<b>Timeliness of Services/Documentation</b>	
2.1	<p><u>Client Eligibility</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>● 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.</li> <li>● Clinical criteria for admission into clinical case management must include one of the following: <ul style="list-style-type: none"> <li>➢ 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.</li> <li>➢ 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.</li> <li>➢ Client is in mental health counseling or chemical dependency treatment.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record</li> </ul>
2.2	<p><u>Discharge/Closure from Clinical Case Management Services</u></p> <p>In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons.</p> <ul style="list-style-type: none"> <li>● Client has achieved a sustainable level of stability and independence.</li> </ul>	<ul style="list-style-type: none"> <li>● Documentation in client record.</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program.</li> <li>➤ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.</li> </ul>	
2.3	<p><u>Coordination with Primary Medical Care and Medical Case Management Provider</u></p> <p>Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White <b>Part A/B</b>-funded Medical Case Management programs.</p> <p>Clinical Case Management services provided to clients accessing primary medical care from a Ryan White <b>Part A/B</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.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Case conferences are documented in the client record</li> </ul>
2.4	<p><u>Assessment</u></p> <p>Assessment begins at intake.</p> <p>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.</p> <p>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</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate</li> </ul>

	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	<p><u>Reassessment</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated</li> <li>• Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)</li> </ul>
2.6	<p><u>Service Plan</u></p> <p>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.</p> <p>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,</p>	<ul style="list-style-type: none"> <li>• Documentation in client record on the clinical case management service plan or agency's equivalent form</li> <li>• Service plan signed by client and the case manager</li> </ul>

	mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	
<b>3.0</b>	<b>Supervision and Caseload</b>	
3.1	<p><u>Clinical Supervision and Caseload Coverage</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of the agency’s Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files.</li> <li>• Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision</li> </ul>



## 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.

<b>1.0</b>	<b>Staff Requirements</b>	
1.1	<p><u>Minimum Qualifications</u>            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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>2.0</b>	<b>Timeliness of Services/Documentation</b>	
2.1	<p><u>Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (COH Only)</u>            In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services:</p> <ul style="list-style-type: none"> <li>• HIV+ and not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> <li>• Documentation of “not in care” status through the CPCDMS</li> </ul>

	<ul style="list-style-type: none"> <li>• Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or</li> <li>• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS</li> </ul>	
2.2	<p><u>Service Linkage Worker Assessment</u></p> <p>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.</p> <p>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. <b><u>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.</u></b></p>	<ul style="list-style-type: none"> <li>• Documentation in client record on the brief assessment form, signed and dated</li> <li>• A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate</li> </ul>
2.3	<p><u>Service Linkage Worker Reassessment</u></p> <p>Clients on <b><u>open status</u></b> will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.</p>	<ul style="list-style-type: none"> <li>• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated</li> </ul>
2.4	<p><u>Transfer of Not-in-Care and Newly Diagnosed Clients (COH Only)</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the CPCDMS</li> </ul>

	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	<p><u>Primary Care Newly Diagnosed and Lost to Care Clients</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>• Methods of routine communication with testing sites regarding newly diagnosis and referred individuals</li> <li>• Description of service linkage worker job duties conducted in the field</li> <li>• Process for re-engaging agency patients lost to care (no primary care visit in 6 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance.</li> </ul>
<b>3.0</b>	<b>Supervision and Caseload</b>	
3.1	<p><u>Service Linkage Worker Supervision</u></p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in supervision notes, which must include: <ul style="list-style-type: none"> <li>➤ date</li> <li>➤ name(s) of case manager(s) present</li> <li>➤ topic(s) covered and/or client(s) reviewed</li> <li>➤ plan(s) of action</li> <li>➤ supervisor’s signature</li> </ul> </li> <li>• Supervision notes are never maintained in the client record</li> </ul>
3.2	<p><u>Caseload Coverage – Service Linkage Workers</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System</li> </ul>

3.3	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW</li> </ul>
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## 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	<p><u>Qualifications/Training</u>            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.</p>	<ul style="list-style-type: none"> <li>• Documentation of credentials and job description in medical case manager’s file</li> </ul>
1.2	<p><u>Scope of Services</u>            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.</p>	<ul style="list-style-type: none"> <li>• Review of clients’ records indicates compliance</li> </ul>
1.3	<p><u>Ongoing Education/Training for Medical Case Managers</u>            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.</p>	<ul style="list-style-type: none"> <li>• Attendance sign-in sheets and/or certificates of completion are maintained by the agency</li> </ul>

2.0	<p><b>Timeliness of Service/Documentation</b></p> <p>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.</p>	
2.1	<p><u>Screening Criteria for Medical Case Management</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>i. Newly diagnosed</li> <li>ii. New to ART</li> <li>iii. CD4&lt;200</li> <li>iv. VL&gt;100,000 or fluctuating viral loads</li> <li>v. Excessive missed appointments</li> <li>vi. Excessive missed dosages of medications</li> <li>vii. Mental illness that presents a barrier to the patient’s ability to access, comply or adhere to medical treatment</li> <li>viii. Substance abuse that presents a barrier to the patient’s ability to access, comply or adhere to medical treatment</li> <li>ix. Housing issues</li> <li>x. Opportunistic infections</li> <li>xi. Unmanaged chronic health problems/injury/Pain</li> <li>xii. Lack of viral suppression</li> <li>xiii. Positive screening for intimate partner violence</li> <li>xiv. Clinician’s referral</li> </ul> <p>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.</p> <p>The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services.</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency’s screening criteria for medical case management</li> </ul>

	<p>psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders;</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• Client is in mental health counseling or chemical dependency treatment.</li> </ul>	
2.2	<p><u>Assessment</u> Assessment begins at intake.</p> <p>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.</p> <p><u>Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter.</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.</li> </ul>
2.3	<p><u>Reassessment</u></p> <p>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</p>	<ul style="list-style-type: none"> <li>• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated</li> </ul>

	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.	<ul style="list-style-type: none"> <li>• Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)</li> </ul>
2.4	<p><u>Service Plan</u></p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record on the medical case management service plan or agency’s equivalent form</li> <li>• Service Plan signed by the client and the case manager</li> </ul>
2.5	<p><u>Brief Interventions</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in the progress notes reflects a brief re-assessment and plan (referral)</li> <li>• Documentation in client record on the brief re-assessment form</li> <li>• Documentation of referrals and their outcomes in the progress notes</li> <li>• Documentation of brief interventions in the progress notes.</li> </ul>
<b>3.0</b>	<b>Supervision and Caseload</b>	



3.1	<p><u>Clinical Supervision and Caseload Coverage</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of the agency’s Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files.</li> <li>• Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision</li> </ul>
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## 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 an insurance policy.

<b>1.0</b>	<b>Staff/Training</b>	
<b>1.1</b>	<u>Ongoing Training</u> 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.	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Staff interviews indicate compliance</li> </ul>
<b>1.2</b>	<u>Staff Experience</u> A minimum of one year documented HIV/AIDS work experience is preferred.	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
<b>2.0</b>	<b>Client Eligibility</b>	
<b>2.1</b>	<u>Comprehensive Intake/Assessment</u> 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.	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of client intake/assessment for service indicates compliance</li> </ul>
<b>2.2</b>	<u>Advance Premium Tax Credit Reconciliation</u> Agency will ensure all clients receiving assistance for Marketplace QHP premiums:	<ul style="list-style-type: none"> <li>• Review of client record</li> </ul>

	<ul style="list-style-type: none"> <li>• Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment</li> <li>• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods</li> <li>• Submit prior year tax information no later than May 31st. Tax information must include: <ul style="list-style-type: none"> <li>○ Federal Marketplace Form 1095-A</li> <li>○ IRS Form 8962</li> <li>○ IRS Form 1040 (excludes 1040EZ)</li> </ul> </li> <li>• Reconciliation of APTC credits or liabilities</li> </ul>	
<b>3.0</b>	<b>Client Access.</b>	
<b>3.1</b>	<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.	<ul style="list-style-type: none"> <li>• Documentation of referrals received</li> <li>• Documentation of referrals out</li> <li>• Staff reports indicate compliance</li> </ul>
<b>3.2</b>	<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.  <b>Priority Ranking of Cost Sharing Assistance (in descending order):</b> <ol style="list-style-type: none"> <li>1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary)</li> <li>2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications)</li> <li>3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments)</li> </ol> Medicare Part D (Rx) premiums	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of agency's monthly reimbursement indicates compliance</li> </ul>
<b>3.3</b>	<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	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance.</li> </ul>

	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.)	<ul style="list-style-type: none"><li>• Review of client intake/assessment for service indicates compliance</li></ul>
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## 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.

<b>1.0</b>	<b>Services are part of the coordinated continuum of HIV/AIDS services.</b>	
1.1	<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.	<ul style="list-style-type: none"> <li>• Documentation of referrals received</li> </ul>
<b>2.0</b>	<b>Legal services adhere to professional standards and regulations.</b>	
2.1	<u>Licensure</u> Attorneys are licensed to practice law in the state of Texas and have a minimum educational level of a doctorate in Jurisprudence.	<ul style="list-style-type: none"> <li>• Staff records indicate compliance</li> </ul>
2.2	<u>Non-Licensed Staff</u> Non-licensed staff members are supervised by attorneys.	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>
<b>3.0</b>	<b>Service providers are knowledgeable, accepting and respectful of the needs of individuals with HIV/AIDS.</b>	
3.1	<u>Ongoing Staff Training</u> 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	<ul style="list-style-type: none"> <li>• Staff has attended and has continued access to training activities</li> <li>• Staff has access to manuals and regulations</li> <li>• Documentation of training on current applicable laws through the State Bar</li> <li>• Staff have access to updated HIV/AIDS information</li> <li>• Agency maintains system for dissemination of HIV/AIDS information</li> </ul>

	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 <ul style="list-style-type: none"> <li>• Staff interviews indicate compliance</li> </ul>
<b>4.0</b>	<b>Client is kept informed and participates in decisions about his/her case.</b>	
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.	<ul style="list-style-type: none"> <li>• Copy of service agreement between client and agency is in client record</li> </ul>
4.2	<u>Case Closure</u> Agency will develop case closure criteria and procedures. Cases may be closed: <ul style="list-style-type: none"> <li>• when the client's legal or benefit issue has been resolved, or when the client: <ul style="list-style-type: none"> <li>• has become ineligible</li> <li>• has had no direct program contact for over six months</li> <li>• is deceased</li> <li>• no longer needs the service</li> <li>• discontinues the service</li> <li>• improperly utilizes the service</li> <li>• has not complied with the client services agreement</li> </ul> </li> </ul> Agency will attempt to notify clients about case closure.	<ul style="list-style-type: none"> <li>• Case closure criteria and procedures on file at provider agency</li> <li>• Client chart will include attempts at notification and reason for case closure</li> </ul>

## 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.

<b>1.0</b>	<b>Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV/AIDS.</b>	
1.1	<p><u>Client Eligibility</u></p> <p>In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of income in the client record.</li> </ul>
1.2	<p><u>Timeliness of Service Provision</u></p> <ul style="list-style-type: none"> <li>• Agency will process prescription for approval within two (2) business days</li> <li>• Pharmacy will fill prescription within one (1) business day of approval</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in the client record and review of pharmacy summary sheets</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>
1.3	<p><u>LPAP Medication Formulary</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Review of billing history indicates compliance</li> <li>• Documentation in client's record</li> </ul>
<b>2.0</b>	<b>Staff HIV/AIDS knowledge is based on documented training.</b>	

2.1	<p><u>Orientation</u> 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.</p>	<ul style="list-style-type: none"> <li>• Review of training curriculum indicates compliance</li> <li>• Documentation of all training in personnel file</li> <li>• Specific training requirements are specified in the staff guidelines</li> </ul>
2.2	<p><u>Ongoing Training</u> Eight (8) hours annually of continuing education in HIV/AIDS related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.</p>	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Staff interviews indicate compliance</li> </ul>
2.3	<p><u>Pharmacy Staff Experience</u> A minimum of one year documented HIV/AIDS work experience is preferred.</p>	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
2.4	<p><u>Pharmacy Staff Supervision</u> Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.</p>	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present</li> </ul>



## 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

<b>1.0</b>	<b>Services are individualized and tailored to client needs.</b>	
1.1	<u>Education/Counseling – Clients Receiving New Supplements</u> 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.	<ul style="list-style-type: none"> <li>• Client record indicates compliance</li> </ul>
1.2	<u>Education/Counseling – Follow-Up</u> Clients receive education/counseling regarding supplement(s) again at: <ul style="list-style-type: none"> <li>• follow-up</li> <li>• when there is a change in supplements</li> <li>• at the discretion of the registered dietician if clinically indicated</li> </ul>	<ul style="list-style-type: none"> <li>• Client record indicates compliance</li> </ul>
<b>2.0</b>	<b>Services adhere to professional standards and regulations.</b>	
2.1	<u>Nutritional Supplement Formulary</u> 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	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Review of billing history indicates compliance</li> <li>• Documentation in client's record</li> </ul>

	and Human Services guidelines for ART and treatment of opportunistic infections.	
2.2	<p><u>Inventory</u></p> <p>Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.</p>	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Staff interviews</li> </ul>
2.3	<p><u>Licensure</u></p> <p>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</p>	<ul style="list-style-type: none"> <li>• Documentation of current licensure</li> <li>• Nutritional plan in client's record</li> </ul>
2.4	<p><u>Protocols</u></p> <p>Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV/AIDS including the <i>American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care</i>.</p>	<ul style="list-style-type: none"> <li>• Chart Review shows compliance</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>

## 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.

<b>1.0</b>	<b>Staff HIV/AIDS knowledge is based on documented training.</b>	
1.1	<u>Continuing Education</u> <ul style="list-style-type: none"> <li>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)</li> <li>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)</li> </ul>	<ul style="list-style-type: none"> <li>Materials for staff training and continuing education are on file</li> <li>Documentation of continuing education in personnel file</li> </ul>
1.2	<u>Experience – HIV/AIDS</u> A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	<ul style="list-style-type: none"> <li>Documentation of work experience in personnel file</li> </ul>
1.3	<u>Staff Supervision</u> 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.	<ul style="list-style-type: none"> <li>Review of personnel files indicates compliance</li> <li>Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> </ul>
<b>2.0</b>	<b>Patient Care</b>	
2.1	<u>HIV Primary Care Provider Contact Information</u> Agency obtains and documents HIV primary care provider contact information for each client.	<ul style="list-style-type: none"> <li>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</li> </ul>
2.2	<u>Consultation for Treatment</u>	<ul style="list-style-type: none"> <li>Documentation of communication in the client record</li> </ul>

	Agency consults with client's medical care providers when indicated.	
2.3	<p><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:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated</li> <li>• Client's chief complaint, where applicable</li> <li>• Medication names</li> <li>• Sexually transmitted diseases</li> <li>• HIV-associated illnesses</li> <li>• Allergies and drug sensitivities</li> <li>• Alcohol use</li> <li>• Recreational drug use</li> <li>• Tobacco use</li> <li>• Neurological diseases</li> <li>• Hepatitis</li> <li>• Usual oral hygiene</li> <li>• Date of last dental examination</li> <li>• Involuntary weight loss or weight gain</li> <li>• Review of systems</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of health history information in the client record. Reasons for missing health history information are documented</li> </ul>
2.4	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation of health history update in the client record</li> </ul>
2.5	<p><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</p>	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Review of client records indicate compliance</li> </ul>

2.6	<p><u>Treatment Plan</u></p> <ul style="list-style-type: none"> <li>• A comprehensive, multi disciplinary Oral Health treatment plan will be developed in conjunction with the patient.</li> <li>• Patient's primary reason for dental visit should be addressed in treatment plan</li> <li>• Patient strengths and limitations will be considered in development of treatment plan</li> <li>• Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions</li> <li>• Treatment plan will be updated as deemed necessary</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment plan dated and signed by both the provider and patient in patient file</li> <li>• Updated treatment plan dated and signed by both the provider and patient in patient file</li> </ul>
2.7	<p><u>Annual Hard/Soft Tissue Examination</u></p> <p>The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record:</p> <ul style="list-style-type: none"> <li>• Charting of caries;</li> <li>• X-rays;</li> <li>• Periodontal screening;</li> <li>• Written diagnoses, where applicable;</li> <li>• Treatment plan.</li> </ul> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>
2.8	<p><u>Oral Hygiene Instructions</u></p> <p>Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>

## 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 taking, 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	<b>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</b>	
1.1	<u>Minimum Qualifications</u> 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.	<ul style="list-style-type: none"> <li>• Credentials on file</li> </ul>
1.2	<u>Licensing, Knowledge, Skills and Experience</u> <ul style="list-style-type: none"> <li>• All staff maintain current organizational licensure (and/or applicable certification) and professional licensure</li> <li>• The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc.</li> <li>• Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (<a href="http://www.hivma.org">www.hivma.org</a>):</li> <li>• Clinical management of at least 25 HIV-infected patients within the last year</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in personnel record</li> </ul>

	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Physician extenders must obtain this experience within six months of hire</li> <li>• All staff receive professional supervision</li> <li>• Staff show training and/or experience with the medical care of adults with HIV</li> </ul>	
1.3	<p><u>Peer Review</u> Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).</p>	<ul style="list-style-type: none"> <li>• Provider will document peer review has occurred annually</li> </ul>
1.4	<p><b>Standing Delegation Orders (SDO)</b> 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).</p>	<ul style="list-style-type: none"> <li>• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider.</li> <li>• Standing Delegation Orders will be reviewed , updated as needed and signed by the physician annually.</li> <li>• Use of standing delegation orders will be documented in patient's primary record system.</li> </ul>
1.5	<p><u>Primary Care Guidelines</u> Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (<a href="http://www.aidsinfo.nih.gov/guidelines/">http://www.aidsinfo.nih.gov/guidelines/</a>).</p>	<ul style="list-style-type: none"> <li>• Documentation in client's record</li> <li>• Exceptions noted in client's record</li> </ul>
1.6	<p><u>Medical Evaluation/Assessment</u> 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 (<a href="http://www.hivma.org">www.hivma.org</a>) within 3 weeks of initial contact with the client.</p>	<ul style="list-style-type: none"> <li>• Completed assessment in client's record</li> </ul>

	<p>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:</p> <ul style="list-style-type: none"> <li>• Psychosocial history</li> <li>• HIV treatment history and staging</li> <li>• Most recent CD4 counts and VL test results</li> <li>• Resistance testing and co receptor tropism assays as clinically indicated</li> <li>• Medication adherence history</li> <li>• History of HIV related illness and infections</li> <li>• History of Tuberculosis</li> <li>• History of Hepatitis and vaccines</li> <li>• Psychiatric history</li> <li>• Transfusion/blood products history</li> <li>• Past medical care</li> <li>• Sexual history</li> <li>• Substance abuse history</li> <li>• Review of Systems</li> </ul>	
1.7	<p><u>Medical Records</u></p> <p>Medical Records should clearly document the following components, separate from progress notes:</p> <ul style="list-style-type: none"> <li>• A central “Problems List” which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable)</li> <li>• A vaccination record, including dates administered</li> <li>• The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies)</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>
1.8	<p><u>Plan of Care</u></p>	<ul style="list-style-type: none"> <li>• Plan of Care documented in client’s record</li> </ul>



	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	<p><u>Follow- Up Visits</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>• Measure vital signs including height and weight</li> <li>• Perform physical examination and update client history</li> <li>• Measure CBC, CD4 and VL levels every 3-6 months or in accordance with current treatment guidelines,</li> <li>• Evaluate need for ART</li> <li>• Resistance Testing if clinical indicated</li> <li>• Evaluate need for prophylaxis of opportunistic infections</li> <li>• Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan</li> <li>• Update problem list</li> <li>• Refer client for ophthalmic examination by an ophthalmologist every six months when CD4 count falls below 50CU/MM</li> <li>• Refer Client for dental evaluation or care every 12 months</li> <li>• Incorporate HIV prevention strategies into medical care for of persons living with HIV</li> <li>• Screen for risk behaviors and provide education on risk reduction</li> <li>• Assess client comprehension of treatment plan and provide education/referral as indicated</li> <li>• Refer for other clinical and social services where indicated</li> </ul>	<ul style="list-style-type: none"> <li>• Content of Follow-up documented in client’s record</li> <li>• Documentation of specialist referral including dental in client’s records</li> </ul>
1.10	<p><u>Yearly Surveillance Monitoring and Vaccinations</u></p> <ul style="list-style-type: none"> <li>• All HIV–infected women should have regular pap tests</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>

	<ul style="list-style-type: none"> <li>➤ An initial negative pap test should be followed with another pap test in 6-12 months and if negative, annually thereafter.</li> <li>➤ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years</li> <li>➤ Women 30 years old and older may have pap test and HPV co-testing, and if normal, repeated every 3 years</li> <li>➤ A pap test showing abnormal results should be managed per guidelines</li> <li>• Screening for anal cancer, if indicated</li> <li>• Resistance Testing if clinical indicated</li> <li>• Chem. panel with LFT and renal function test</li> <li>• Influenza vaccination</li> <li>• Annual Mental Health Screening with standardized tool</li> <li>• 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. <i>Guidelines for preventing opportunistic infections among HIV-infected persons</i>) (Available at <a href="http://aidsinfo.nih.gov/Guidelines/">aidsinfo.nih.gov/Guidelines/</a>))</li> <li>• Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated</li> </ul>	
1.11	<p><u>Preconception Care for HIV Infected Women of Child Bearing Age</u>  In accordance with the US Department of Health and Human Services recommendations (<a href="http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf">http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf</a>), 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:</p> <ul style="list-style-type: none"> <li>• Assess women’s pregnancy intentions on an ongoing basis and discuss reproductive options</li> <li>• Offer effective and appropriate contraceptive methods to women who wish to prevent unintended pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of preconception counseling and care at initial visit and annual updates in Client’s record as applicable</li> </ul>

	<ul style="list-style-type: none"> <li>• Counsel on safe sexual practices</li> <li>• Counsel on eliminating of alcohol, illicit drugs and smoking</li> <li>• 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</li> <li>• Inform women of interventions to prevent sexual transmission of HIV when attempting conception with an HIV-uninfected partner</li> </ul> <p>Other preconception care consideration should include:</p> <ul style="list-style-type: none"> <li>• The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur</li> <li>• Maximum suppression of viral load prior to conception</li> </ul>	
1.12	<p><u>Obstetrical Care for HIV Infected Pregnant Women</u></p> <p>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 <a href="http://www.aidsinfo.nih.gov/Guidelines">http://www.aidsinfo.nih.gov/Guidelines</a>.</p>	<ul style="list-style-type: none"> <li>• Documentation in client's record</li> </ul>
1.13	<p><u>Coordination of Services in Prenatal Care</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client's records.</li> </ul>
1.14	<p><u>Care of HIV-Exposed and HIV- Infected Infants, Children and Pre-pubertal Adolescents</u></p> <p>Care and monitoring of HIV-exposed children must be done in accordance to the HHS guidelines.</p> <p>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</p>	<ul style="list-style-type: none"> <li>• Documentation in client's record</li> </ul>

	<p>of Antiretroviral Agents in Pediatric HIV Infection (<a href="http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf">http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf</a>) 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.</p> <p>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.</p>	
1.15	<p><u>Patient Medication Education</u></p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
1.16	<p><u>Adherence Assessment</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Completed adherence tool in client's record</li> <li>• Documentation of counseling in client records</li> </ul>

1.17	<p><u>Documented Non-Compliance with Prescribed Medication Regimen</u>  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.</p>	<ul style="list-style-type: none"> <li>• Review of Policies and Procedures Manual indicates compliance.</li> </ul>
1.18	<p><u>Client Mental Health and Substance Use Policy</u>  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.</p>	<ul style="list-style-type: none"> <li>• Review of Policies and Procedures Manual indicates compliance.</li> </ul>
1.19	<p><u>Intimate Partner Violence Screening Policy</u>  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:</p> <ul style="list-style-type: none"> <li>• process for ensuring clients are screened for IPV no less than annually</li> <li>• intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management</li> <li>• State reporting requirements associated with IPV</li> <li>• Description of required medical record documentation</li> <li>• Procedures for patient referral including available resources, procedures for follow-up and responsible personnel</li> <li>• Plan for training all appropriate staff (including non-RW funded staff)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Policies and Procedures Manual indicates compliance.</li> <li>• Documentation in patient record</li> </ul>
1.20	<p><u>Patient Retention in Care</u>  The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include:</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>

	<ul style="list-style-type: none"> <li>• process for client appointment reminders (e.g. timing, frequency, position responsible)</li> <li>• process for contacting clients after missed appointments (e.g. timing, frequency, position responsible)</li> <li>• measures to promote retention in care</li> <li>• process for re-engaging those lost to care (no primary care visit in 6 months)</li> </ul>	
<b>2.0</b>	<b>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</b>	
2.1	<u>Psychiatric Guidelines</u> Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines ( <a href="http://www.txpsych.org">www.txpsych.org</a> ) and the American Psychiatric Association ( <a href="http://www.psych.org/aids">www.psych.org/aids</a> ) guidelines.	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
<b>3.0</b>	<b>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.</b>	
3.1	<u>Access to Care</u> 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: <ul style="list-style-type: none"> <li>• Mechanisms for urgent care evaluation and/or triage</li> <li>• Mechanisms for in-patient care</li> <li>• Mechanisms for information/referral to: <ul style="list-style-type: none"> <li>➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry</li> <li>➢ Social work and case management services</li> <li>➢ Mental health services</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Agency Policy and Procedure regarding continuity of care.</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Substance abuse treatment services</li> <li>➤ Anti-retroviral counseling/therapy for pregnant women</li> <li>➤ Local federally funded hemophilia treatment center for persons with inherited coagulopathies</li> <li>➤ Clinical investigations</li> </ul>	
3.2	<p><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.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
3.3	<p><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 &amp; c, cervical cancer screening, etc., for follow-up).</p>	<ul style="list-style-type: none"> <li>• Documentation of referrals out</li> <li>• Staff interviews indicate compliance</li> <li>• Established tracking systems</li> </ul>
3.4	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
3.5	<p><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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>

## 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	<b>Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV/AIDS.</b>	
1.1	<p><u>Comprehensive Assessment</u></p> <p>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.</p> <ul style="list-style-type: none"> <li>• Presenting Problem</li> <li>• Developmental/Social history</li> <li>• Social support and family relationships</li> <li>• Medical history</li> <li>• Substance abuse history</li> <li>• Psychiatric history</li> <li>• Complete mental status evaluation (including appearance and behavior, talk, mood, self attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks)</li> <li>• Cognitive assessment (level of consciousness, orientation, memory and language)</li> </ul> <p>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.</p>	<ul style="list-style-type: none"> <li>• Completed assessment in client’s record</li> </ul>
1.2	<p><u>Psychosocial History</u></p> <p>A psychosocial history will be completed and must include:</p> <ul style="list-style-type: none"> <li>• Education and training</li> <li>• Employment</li> <li>• Military service</li> </ul>	<ul style="list-style-type: none"> <li>• Completed assessment in client’s record</li> </ul>



	<ul style="list-style-type: none"> <li>• Legal history</li> <li>• Family history and constellation</li> <li>• Physical, emotional and/or sexual abuse history</li> <li>• Sexual and relationship history and status</li> <li>• Leisure and recreational activities</li> <li>• General psychological functioning</li> </ul>	
1.3	<p><u>Treatment Plan</u></p> <p>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:</p> <ul style="list-style-type: none"> <li>• Statement of the goal(s) of counseling</li> <li>• The plan of approach</li> <li>• Mechanism for review</li> </ul> <p>The plan must also address full range of substances the patient is abusing</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Completed treatment plan in client's record</li> <li>• Treatment Plan review documented in client's records</li> </ul>
1.4	<p><u>Treatment Plan Review</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of agency's Policy and Procedure Manual indicates compliance</li> <li>• Updated treatment plan in client's record</li> </ul>
<b>2.0</b>	<b>Services are part of the coordinated continuum of HIV/AIDS services.</b>	

2.1	<p><u>Clients Referral and Tracking</u>  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.</p>	<ul style="list-style-type: none"> <li>• Documentation of referrals received</li> <li>• Documentation of referrals out</li> <li>• Staff interviews indicate compliance</li> <li>• Collaborative agreements demonstrate that these services are offered on an off-site</li> </ul>
2.2	<p><u>Facility License</u>  Agency is appropriately licensed by the Texas Department of State Health Services – Substance Abuse Services (TDSHS/SAS) with outpatient treatment designations.</p>	<ul style="list-style-type: none"> <li>• Documentation of current agency licensure</li> </ul>
2.3	<p><u>Minimum Qualifications</u>  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.</p>	<ul style="list-style-type: none"> <li>• Documentation of current licensure in personnel files</li> </ul>
<b>3.0</b>	<b>Staff HIV/AIDS knowledge is based on documented training and experience.</b>	
3.1	<p><u>Staff Training</u>  All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance to the Texas Administrative Code, rule §448.603 (a), (c) &amp; (d).</p>	<ul style="list-style-type: none"> <li>• Review of training curriculum indicates compliance</li> <li>• Documentation of all training in personnel file</li> <li>• Specific training requirements are specified in the staff guidelines</li> <li>• Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b)</li> </ul>
3.2	<p><u>Experience – HIV/AIDS</u>  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.</p>	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
<b>4.0</b>	<b>Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV/AIDS. Staff efforts are compassionate and sensitive to client needs.</b>	

4.1	<p><u>Staff Supervision</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency's Policy and Procedure Manual indicates compliance</li> </ul>
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## 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	<b>Transportation services are offered to eligible clients to ensure individuals most in need have access to services.</b>	
1.1	<p><u>Client Eligibility</u> In order to be eligible for services, individuals must meet the following:</p> <ul style="list-style-type: none"> <li>• HIV+</li> <li>• Residence in the Houston EMA/HSDA</li> <li>• Part A Urban Transportation limited to Harris County</li> <li>• Part A Rural/Part B Transportation are limited to Houston EMA/HSDA, as applicable</li> <li>• Income no greater than 300% of the Federal Poverty level</li> <li>• Proof of identification</li> <li>• Documentation of ineligibility for Third Party Reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, identification, residence and income in the client record</li> </ul>
1.2	<p><u>Voucher Guidelines (Distribution Sites)</u></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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 <ul style="list-style-type: none"> <li>➤ In order for an existing bus card client to <u>renew</u> their bus card (i.e. obtain another bus card voucher</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Client record indicates guidelines were followed; if not, an explanation is documented</li> <li>• Documentation of the type of voucher(s) issued</li> <li>• Emergency necessitating taxi voucher is documented</li> <li>• Ongoing current (<b>within the last 180 days</b>) medical care is documented in the CPCDMS OR</li> <li>• A current (within the last 180 days) copy of client’s Viral Load and/or CD4 lab work</li> </ul>

	<p>for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV disease, or</p> <ul style="list-style-type: none"> <li>➤ Documentation that the bus voucher is needed to ensure an out-of-care client is re-engaged in primary medical care</li> <li>• 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</li> <li>• Taxi Voucher: for emergencies, to access emergency shelter vouchers and to attend Social Security disability hearings only</li> </ul>	<p>(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</p> <ul style="list-style-type: none"> <li>• Engagement/re-engagement in medical care is documented in client's case management assessment and service plan, OR</li> <li>•</li> </ul>
1.3	<p><u>Eligibility for Van-Based Transportation (Urban Transportation Only)</u></p> <p>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.</p> <p>All clients may receive a maximum of 4 non-certified round trips per year (includes taxi vouchers).</p>	<ul style="list-style-type: none"> <li>• Client record indicates compliance</li> </ul>
<b>2.0</b>	<p><b>ACCESSIBILITY</b></p> <p><b>Transportation services are offered in such a way as to overcome barriers to access and utilization.</b></p>	
2.1	<p><u>Notification of Service Availability</u></p> <p>Prospective and current clients are informed of service availability, prioritization and eligibility requirements.</p>	<ul style="list-style-type: none"> <li>• Program information is clearly publicized</li> <li>• Availability of services, prioritization policy and eligibility requirements are defined in the information publicized</li> </ul>
2.2	<p><u>Access</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Agency's policies and procedures for transportation services describe how the client can access the service</li> <li>• Review of agency's complaint and grievances log</li> <li>• Signed agreement in client's records</li> </ul>

	<p>Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle.</p> <p>This statement should include the consequences of violating the agreement.</p>	
2.3	<p><u>Handicap Accessibility</u></p> <p>Transportation services are handicap accessible.</p> <p>Agency/Driver may refuse service to client with open sores/wounds or real exposure risk.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Agency compliance with the Americans with Disabilities Act (ADA)</li> <li>• Agency documentation of reason for refusal of service</li> <li>• Documentation of training in personnel records</li> </ul>
2.4	<p><u>EMA Accessibility</u></p> <p>Services are available throughout the Houston EMA as contractually defined in the RFP.</p>	<ul style="list-style-type: none"> <li>• Review of agency's Transportation Log and Monthly Activity Reports for compliance</li> </ul>
2.5	<p><u>Service Availability</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of Transportation Logs</li> <li>• Transportation services shall be available on Saturdays, by pre-scheduled appointment for core services</li> <li>• Review of agency policy and procedure</li> </ul>
2.6	<p><u>Service Capacity</u></p> <p>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.</p> <p>* Maximized means the agency will not be able to provide service to client within the next 72 hours.</p>	<ul style="list-style-type: none"> <li>• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized</li> <li>• Agency will document all clients who were denied transportation or a voucher</li> </ul>
<b>3.0</b>	<b>Timeliness and Delays: Transportation services are provided in a timely manner</b>	
3.1	<p><u>Timeliness</u></p> <p>There is minimal waiting time for vehicles and vans; appointments are kept</p> <ul style="list-style-type: none"> <li>• Waiting times longer than 2 hours will also be documented in the client record</li> </ul>	<ul style="list-style-type: none"> <li>• Waiting times longer than 60 minutes will be documented in Delay Incident Log.</li> <li>• Review of Delay incident log</li> <li>• Review of client's record</li> </ul>

	<ul style="list-style-type: none"> <li>• 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</li> <li>• Review of agency's complaint and grievance logs</li> </ul> <p>Client interviews and client satisfaction survey</p>	
3.2	<p><u>Immediate Service Problems</u></p> <p>Clients are made aware of problems immediately (e.g. vehicle breakdown) and notification documented.</p>	<ul style="list-style-type: none"> <li>• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance</li> <li>• Review of agency's complaint and grievance logs</li> <li>• Client interviews and client satisfaction survey</li> </ul>
3.3	<p><u>Future Service Delays</u></p> <p>Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur.</p>	<ul style="list-style-type: none"> <li>• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance</li> <li>• Review of agency's complaint and grievance logs</li> <li>• Client interviews and client satisfaction survey</li> <li>• Documentation exists in the client record</li> </ul>
3.4	<p><u>Confirmation of Appointments</u></p> <p>Agency must allow clients to confirm appointments at least 48 hours in advance.</p>	<ul style="list-style-type: none"> <li>• Review of agency's transportation policies and procedures indicates compliance</li> <li>• Review of agency's complaint and grievance logs</li> <li>• Client interviews and client satisfaction survey.</li> </ul>
3.5	<p><u>"No Shows"</u></p> <p>"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 <i>may be</i> 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</p>	<ul style="list-style-type: none"> <li>• Review of agency's transportation policies and procedures indicates compliance</li> <li>• Documentation on Transportation Log</li> <li>• Documentation in client record</li> </ul>

	services. One additional no show and the client can be suspended from service for one (1) year.	
3.6	<p><u>System Abuse</u></p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client record of verification that an appointment did not exist</li> <li>• Documentation in the client record of client cancellation of van/vehicle appointments</li> <li>• Availability of agency's published rules</li> <li>• Written documentation in the client record of specific instances of system abuse</li> </ul>
3.7	<p><u>Documentation of Service Utilization</u></p> <p>Transportation Provider must ensure:</p> <ul style="list-style-type: none"> <li>• Follow-up verification between transportation provider and destination service program confirming use of eligible service(s) <u>or</u></li> <li>• Client provides proof of service documenting use of eligible services at destination agency on the date of transportation <u>or</u></li> <li>• Scheduling of transportation services by receiving agency's case manager or transportation coordinator</li> <li>• 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.</li> </ul> <p>The content of the proof of service will include:</p> <ul style="list-style-type: none"> <li>• Agency's letter head</li> <li>• Date/Time</li> <li>• CPCDMS client code</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of confirmation from destination agency in agency/client record</li> <li>• Client's original receipt from destination agency in agency/client record</li> <li>• Documentation in Case Manager's progress notes</li> <li>• Documentation in agency/client record of the one (1) allowable one-way trip per year without proof of service documentation</li> </ul>



	<ul style="list-style-type: none"> <li>Name and signature of Agency's staff who attended to client</li> <li>Agency's stamp</li> </ul>	
<b>4.0</b>	<b>Safety/Vehicle Maintenance: Transportation services are safe</b>	
4.1	<p><u>Vehicle Maintenance and Insurance</u></p> <p>Vehicles are in good repair and equipped for adverse weather conditions.</p> <p>All vehicles will be equipped with both a fire extinguisher and first aid and CPR kits.</p> <p>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.</p> <p>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.</p> <p>Driver must have radio or cell phone capability.</p>	<ul style="list-style-type: none"> <li>Inspection of First Aid/CPR kits indicates compliance</li> <li>Review of vehicle file</li> <li>Current vehicle State Inspection sticker.</li> <li>Fire extinguisher inspection date must be current</li> <li>Proof of current automobile liability and personal injury insurance in the amount of at least \$300,000.00</li> </ul>
4.2	<p><u>Emergency Procedures</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>A copy of each in-service and sign-in roster with names both printed and signed and maintained in the driver's personnel file</li> </ul>
4.3	<p><u>Transportation of Children</u></p> <p>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</p>	<ul style="list-style-type: none"> <li>Review of Transportation Log indicates compliance</li> </ul>

	<p><a href="http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm">http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm</a>. 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.</p>	<ul style="list-style-type: none"> <li>• Review of client records indicates compliance</li> <li>• Review of agency policies and procedures</li> </ul>
4.4	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation in vehicle</li> <li>• Documentation in personnel file</li> </ul>
<b>5.0</b>	<b>Records Administration: Transportation services are documented consistently and appropriately</b>	
5.1	<p><u>Transportation Consent</u> Prior to receiving transportation services, clients must read and sign the Transportation Consent.</p>	<ul style="list-style-type: none"> <li>• Review of client records indicates compliance</li> </ul>
5.2	<p><u>Van/Vehicle Transportation</u> Agency must document daily transportation services on the Transportation Log.</p>	<ul style="list-style-type: none"> <li>• Review of agency files indicates compliance</li> <li>• Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.</li> </ul>
5.3	<p><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.</p>	<ul style="list-style-type: none"> <li>• Map is printed out and filed in client chart</li> </ul>

## 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.

<b>1.0</b>	<b>Staff HIV/AIDS knowledge is based on documented training.</b>	
1.1	<u>Ongoing Training</u> Four (4) hours of continuing education in vision-related or other specific topics is required annually.	<ul style="list-style-type: none"> <li>• Documentation of all training in personnel file</li> <li>• Staff interviews indicate compliance</li> </ul>
1.2	<u>Staff Experience/Qualifications</u> <u>Minimum of one (1) year HIV/AIDS work experience for paid staff (optometry interns exempt) is preferred.</u> 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.	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
1.3	<u>Staff Supervision</u> 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.	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency's Policy and Procedure Manual indicates compliance</li> </ul>
<b>2.0</b>	<b>Patient Care</b>	
2.1	<u>Physician Contact Information</u> Agency obtains and documents primary care physician contact information for each client. At minimum, agency should collect the physician's name and telephone number.	<ul style="list-style-type: none"> <li>• Documentation of physician contact information in the client record</li> </ul>
2.2	<u>Client Intake</u> Agency collects the following information for all new clients: Health history;	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>

	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.	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>
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.	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>
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.	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>

Harris County

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# HCPHES

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Public Health & Environmental Services

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**FY 2015 PERFORMANCE MEASURES HIGHLIGHTS**

**RYAN WHITE GRANT ADMINISTRATION**

**HARRIS COUNTY**

**PUBLIC HEALTH & ENVIRONMENTAL SERVICES**

**(HCPHES)**

2223 West Loop South. Houston, Texas 77027

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[www.hcphes.org](http://www.hcphes.org)

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## **Highlights from FY 2015 Performance Measures**

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### **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.

<b>HIV Performance Measures</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>-11.1%</b>
Percentage of clinical case management clients who utilized mental health services	298 (23.5%)	247 (24.3%)	<b>0.8%</b>
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	491 (74.6%)	382 (73.0%)	<b>-1.6%</b>
Percentage of clients identified with an active substance abuse condition who received Ryan White funded substance abuse treatment	0 (0.0%)	0 (0.0%)	<b>0.0%</b>
Percentage of clients who were homeless or unstably housed	411 (32.5%)	327 (32.1%)	<b>-0.4%</b>

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.

<b>Clinical Chart Review Measures</b>	<b>FY 2014</b>
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%)	<b>1.8%</b>

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%
<b>Total</b>	<b>93</b>	<b>44</b>	<b>47%</b>

Ryan White Part A  
HIV Performance Measures  
FY 2015 Report

**Local Pharmacy Assistance**  
All Providers

<b>HIV Performance Measures</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>-0.5%</b>

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.

<b>HIV Performance Measures</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>-3.5%</b>
Percentage of medical case management clients who utilized mental health services	548 (10.8%)	599 (11.9%)	<b>1.1%</b>
Increase in the percentage of clients who have 3 <sup>rd</sup> party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	2,060 (40.8%)	2,078 (41.2%)	<b>0.4%</b>
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%)	<b>-0.9%</b>
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%)	<b>-1.6%</b>
Percentage of clients who were homeless or unstably housed	1,751 (34.7%)	1,879 (37.2%)	<b>2.5%</b>

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.

<b>Clinical Chart Review Measures</b>	<b>FY 2014</b>
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**

<b>HIV Performance Measures</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	395 (80.1%)	396 (79.7%)	<b>-0.4%</b>
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%)	<b>N/A</b>

Ryan White Part A  
HIV Performance Measures  
FY 2015 Report

**Oral Health Care**  
All Providers

<b>HIV Performance Measures</b>	<b>FY 2015</b>
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

<b>Clinical Chart Review Measures*</b>	<b>FY 2013</b>	<b>FY 2014</b>
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										
<b>Total</b>	<b>0</b>	<b>0</b>								

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.

<b>HIV Performance Measures</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>1.4%</b>
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%)	<b>0.6%</b>
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%)	<b>-5.0%</b>
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%)	<b>-0.5%</b>
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%)	<b>-3.5%</b>
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%)	<b>-2.9%</b>
95% of clients with HIV infection will be screened for Hepatitis B virus infection status (ever)	5,114 (72.8%)	5,211 (74.8%)	<b>2.0%</b>
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%)	<b>-8.6%</b>
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%)	<b>0.8%</b>
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%)	<b>-2.1%</b>



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

<b>Clinical Chart Review Measures*</b>	<b>FY 2013</b>	<b>FY 2014</b>
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.hcphe.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.

<b>HIV Performance Measures</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>-3.8%</b>
Percentage of clients who utilized primary medical care for the first time after accessing service linkage	345 (4.9%)	336 (5.4%)	<b>0.5%</b>
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	43	29	<b>-32.6%</b>
Median	19	14	<b>-26.3%</b>
Mode	7	7	<b>0.0%</b>
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%)	<b>-5.3%</b>

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%)	<b>6.2%</b>
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	8 (57.1%)	11 (57.9%)	<b>0.8%</b>
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**

<b>Van-Based Transportation</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>0.6%</b>
35% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	353 (57.8%)	345 (51.2%)	<b>-6.6%</b>

<b>Bus Pass Transportation</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>Change</b>
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%)	<b>-7.6%</b>
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	600 (21.6%)	440 (16.8%)	<b>-4.8%</b>
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%)	<b>-10.2%</b>

Ryan White Part A  
HIV Performance Measures  
FY 2015 Report

**Vision Care**  
All Providers

<b>HIV Performance Measures</b>	<b>FY 2015</b>
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

<b>Clinical Chart Review Measures*</b>	<b>FY 2013</b>	<b>FY 2014</b>
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										
Keratoconjunctivitis										
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										
<b>Total</b>	<b>1</b>	<b>0</b>								



1718 HOUSTON HSDA STANDARDS OF CARE  
SUMMARY OF CHANGES

COMMUNITY-BASED HEALTH SERVICES

9.2	<p><u>Licensure</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation of license and/or certification posted in a <del>conspicuous highly-visible</del> place at the site where services are provided to clients.</li> </ul>
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HEALTH INSURANCE ASSISTANCE

Service Category Name Changed

9.2	<p><del>Compliance with Regional Health Insurance Assistance Policy</del></p> <p><del>The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1601).</del></p>	<ul style="list-style-type: none"> <li>• <del>Annual Review of agency shows compliance with established policy.</del></li> </ul>
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1718 Standard of Care  
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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
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Services</u>                      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: <b>Skilled Nursing</b> 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; <b>Other Therapeutic Services</b> including recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation; <b>Nutrition</b> including evaluation and counseling, supplemental nutrition, and daily nutritious meals; and <b>Education</b> 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.</p>	<ul style="list-style-type: none"> <li>• Program's Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>
9.2	<p><u>Licensure</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Documentation of license and/or certification posted in a <b>conspicuous highly-visible</b> place at the site where services are provided to clients.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.3	<p><u>Services Requiring Licensed Personnel</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation of qualification in personnel file</li> </ul>
9.4	<p><u>Staff Qualifications</u></p> <p>All personnel providing care shall have (or receive training) in the following minimum qualifications:</p> <ul style="list-style-type: none"> <li>• Ability to work with diverse populations in a non-judgmental way</li> <li>• Working knowledge of: <ul style="list-style-type: none"> <li>➢ HIV and its diverse manifestations</li> <li>➢ HIV transmission and effective methods of reducing transmission</li> <li>➢ current treatment modalities for HIV and co-morbidities</li> <li>➢ HIV/AIDS continuum of care</li> <li>➢ diverse learning and teaching styles</li> <li>➢ the impacts of mental illness and substance use on behaviors and adherence to treatment</li> <li>➢ crisis intervention skills</li> <li>➢ the use of individualized plans of care in the provision of services and achievement of goals</li> </ul> </li> <li>• Effective crisis management skills</li> <li>• Effective assessment skills</li> </ul>	<ul style="list-style-type: none"> <li>• Personnel Qualification on file</li> <li>• Documentation of orientation of file</li> </ul>
9.5	<p><u>Doctor's Order</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of client files indicates compliance.</li> </ul>
9.6	<p><u>Billing Requirement</u></p> <p>Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third party payers.</p>	<ul style="list-style-type: none"> <li>• Provider will provide evidence of third-party billing.</li> </ul>

#	STANDARD	MEASURE
9.7	<p><b><u>Comprehensive Client Assessment</u></b>  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.</p> <p>A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment should be completed to include:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Review of client files indicates compliance.</li> <li>• Acuity levels documented as part of assessment.</li> </ul>
9.8	<p><b><u>Nutritional Evaluation</u></b>  Each client shall receive a nutritional evaluation within 15 days of initiation of care.</p>	<ul style="list-style-type: none"> <li>• Documentation is on file.</li> </ul>
9.9	<p><b><u>Meal Plan</u></b>  Staff will maintain signed and approved meal plans.</p>	<ul style="list-style-type: none"> <li>• Written documentation of plans is on file and posted in serving area.</li> </ul>
9.10	<p><b><u>Plan of Care</u></b>  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.</p>	<ul style="list-style-type: none"> <li>• Review of client files indicates compliance</li> </ul>
9.11	<p><b><u>Implementation of Care Plan</u></b>  In coordination with the medical care coordination team, professional staff will:</p> <ul style="list-style-type: none"> <li>• Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider.</li> <li>• 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.</li> <li>• Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services).</li> <li>• Monitor changes in client's physical and mental health, and level of functionality.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in the client chart indicates services provided were consistent with the treatment plan.</li> </ul>

#	STANDARD	MEASURE
9.11	<p><u>Implementation of Care Plan (Cont'd)</u></p> <ul style="list-style-type: none"> <li>• Participate in the development of individualized care plan with members of the care team.</li> <li>• Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.</li> <li>• Provide attendant care services which include taking vital signs if medically indicated</li> <li>• Assist with client's self administration of medication.</li> <li>• Promptly report any problems or questions regarding the client's adherence to medication.</li> <li>• Report any changes in the client's condition and needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in the client chart indicates services provided were consistent with the treatment plan.</li> </ul>
9.12	<p><u>Refusal of referral</u></p> <p>The home or community-based health service agency may refuse a referral for the following reasons only:</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p>The agency must document the situation in writing and immediately contact the client's primary medical care provider.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client chart will indicate the reason for refusal</li> </ul>
9.13	<p><u>Completion of Services/Discharge</u></p> <p>Services will end when one or more of the following takes place:</p> <ul style="list-style-type: none"> <li>• Client acuity indicates self-sufficiency and care plan goals completed;</li> <li>• Client expresses desire to discontinue services;</li> <li>• Client is not seen for ninety (90) days or more; and</li> <li>• Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility)</li> <li>• Client is unable or unwilling to adhere to agency policies.</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client chart of specific criteria indicating appropriateness of discharge</li> </ul>

**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
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><b>Scope of Service</b> 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.</p> <p>The provision of EIS includes:</p> <ul style="list-style-type: none"> <li>• HIV Testing and Targeted counseling**</li> <li>• Referral services</li> <li>• Linkage to care</li> <li>• Health education and literacy training that enable clients to navigate the HIV system of care</li> </ul> <p>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.</p> <p>**Limitation: Ryan White Part B funds can only be used for HIV testing as necessary to supplement, <u>not supplant</u>, existing funding.</p>	<ul style="list-style-type: none"> <li>• Program’s Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.2	<u>Agency License</u> The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.	<ul style="list-style-type: none"> <li>Review of agency</li> </ul>
9.3	<u>Program Policies and Procedures</u> Agency will have a policy that: <ul style="list-style-type: none"> <li>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</li> <li>Specifies that services shall be provided at specific points of entry</li> <li>Specifies required coordination with HIV prevention efforts and programs</li> <li>Requires coordination with providers of prevention services</li> <li>Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found</li> <li>Requires monitoring of referrals into care and treatment</li> </ul>	<ul style="list-style-type: none"> <li>Program's Policies and Procedures indicate compliance with expectations.</li> </ul>
9.4	<u>Staff Qualifications</u> All agency staff that provide direct-care services shall possess: <ul style="list-style-type: none"> <li>Advanced training/experience in the area of HIV/infectious disease</li> <li>HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment</li> <li>Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel.</li> </ul> Supervisors must possess a degree in a health/social service field or equivalent experience.	<ul style="list-style-type: none"> <li>Review of personnel files indicates compliance</li> </ul>
9.5	<u>Continuing Education</u> Each staff will complete a minimum of 12 hours of training annually to remain current on HIV care.	<ul style="list-style-type: none"> <li>Evidence of training will be documented in the staff personnel records.</li> </ul>



#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.6	<p><u>Supervision</u> 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:</p> <ul style="list-style-type: none"> <li>• Date, time, and content of the supervisory sessions</li> <li>• Results of the supervisory case review addressing at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service.</li> </ul>	<ul style="list-style-type: none"> <li>• Program's Policies and Procedures indicate compliance with expectations.</li> <li>• Review of documentation indicates compliance.</li> </ul>
9.7	<p><u>Client Eligibility</u> In order to be eligible for services, individuals must meet the following:</p> <ul style="list-style-type: none"> <li>• HIV-positive status</li> <li>• Language(s) spoken and Literacy level (client self-report)</li> </ul> <p><i>Due to client's state of incarceration, this service is excluded from the requirement to document income and residency.</i></p>	<ul style="list-style-type: none"> <li>• Documentation of HIV status is present in the client file.</li> <li>• Documentation in compliance with TRG Policies for Documentation of HIV Status.</li> </ul>
9.8	<p><u>CPCDMS Update/Registration</u> As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.</p>	<ul style="list-style-type: none"> <li>• Current registration of client is present in CPCDMS.</li> </ul>
9.9	<p><u>Assessment of Client</u> 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.</p>	<ul style="list-style-type: none"> <li>• Intake assessment form is present in the client file.</li> </ul>
9.10	<p><u>Provision of Client Education</u> Staff provide client with education regarding the disease and its management, risk reduction, medication adherence and other health-related education.</p>	<ul style="list-style-type: none"> <li>• Documentation of client education is present in the client file.</li> </ul>
9.11	<p><u>Increase Health Literacy</u> Staff assesses client ability to navigate medical care systems and provides education to increase client ability to advocate for themselves in medical care systems.</p>	<ul style="list-style-type: none"> <li>• Documentation of health literacy evaluation and education is present in the client file.</li> </ul>

#	STANDARD	MEASURE
9.12	<u>Coordination of Care</u> Staff assists in the coordination of client medical care while incarcerated including, but not limited to, medical appointments and medications.	<ul style="list-style-type: none"> <li>Documentation of coordination of care is present in the client file.</li> </ul>
9.13	<u>Medication Regimen Establishment/Transition</u> 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.	<ul style="list-style-type: none"> <li>Documentation of THMP/ADAP application and its submission is present in client file.</li> <li>Documentation of connection/referral to outside pharmacy.</li> </ul>
9.14	<u>Transitional Team Multidisciplinary (TTMD) Review</u> Staff creates opportunities for MDT review with all involved agencies to discuss client's case.	<ul style="list-style-type: none"> <li>Schedule of available times for TTMD reviews with involved agencies available for review.</li> <li>Documentation of TTMD reviews present in client file.</li> </ul>
9.15	<u>Discharge Planning</u> Staff conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: <ul style="list-style-type: none"> <li>Review of core medical and other supportive services available upon release, and</li> <li>Creation of a discharge plan.</li> </ul>	<ul style="list-style-type: none"> <li>Documentation of review of services present in client file.</li> <li>Documentation of client discharge plan is present in client file.</li> </ul>
9.16	<u>HIV Testing and Targeted Counseling</u> 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. <ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Review of monthly expenses indicates compliance</li> <li>Waiver are present when funds are utilized for testing</li> </ul>
9.17	<u>Referral Process</u> Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral will include a packet with <ol style="list-style-type: none"> <li>A copy of the Harris County Jail Intake/Assessment Form,</li> <li>Proof of HIV diagnosis,</li> <li>A list of current medications, and</li> <li>Provide client ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community.</li> </ol>	<ul style="list-style-type: none"> <li>Documentation of referral present in client file</li> <li>Documentation of referral feedback present in client file.</li> <li>Copy of "known to me as" letter present in client file.</li> </ul>

#	STANDARD	MEASURE
9.18	<p><u>MOUs with Core Medical Services</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Review of MOUs at annual quality compliance reviews.</li> <li>• Documentation of communication and referrals with agencies covered by MOUs is present in client file.</li> </ul>



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

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Service</u>  <b>Health Insurance Assistance:</b> 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.</p> <p><u>Co-Payment:</u> A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. <u>Co-Insurance:</u> A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription. <u>Deductible:</u> 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. <u>Premium:</u> The amount paid by the insured to an insurance company to obtain or maintain an insurance policy. <u>Tax Reconciliation:</u> A refundable credit will be given on an individual's federal income tax return if the amount of advance-credit payments is <i>less</i> 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 <i>more</i> than the credit amount. <u>Advance Premium Tax Credit (APTC) Tax Liability:</u> Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of \$500.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Program's Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.2	<p><u>Compliance with Regional Health Insurance Assistance Policy</u>                      The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1601).</p>	<ul style="list-style-type: none"> <li>• Annual Review of agency shows compliance with established policy.</li> </ul>
9.3	<p><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.</p> <p>Agencies must maintain referral relationships with organizations or individuals who can provide income tax preparation assistance.</p>	<ul style="list-style-type: none"> <li>• Documentation of referrals received</li> <li>• Documentation of referrals out</li> <li>• Staff reports indicate compliance</li> </ul>
9.4	<p><u>Ongoing Training</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Staff interviews indicate compliance</li> </ul>
9.5	<p><u>Staff Experience</u>                      A minimum of one year documented HIV/AIDS work experience is preferred.</p>	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
9.6	<p><u>Staff Supervision</u>                      Staff services are supervised by a paid coordinator or manager.</p>	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.7	<p><u>Program Policies</u>                      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&amp;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.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Review of personnel files indicates training on the policies.</li> </ul>
9.8	<p><u>Prioritization of Cost-Sharing Service</u>                      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.</p> <p><b>Priority Ranking of Cost Sharing Assistance (in descending order):</b></p> <ol style="list-style-type: none"> <li>1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary)</li> <li>2. Non-HIV medication co-pays and deductibles</li> <li>3. Co-payments for provider visits (e.g. physician visit and/or lab copayments)</li> <li>4. Medicare Part D (Rx) premiums</li> <li>5. APTC Tax Liability</li> <li>6. Out of Network out-of-pocket expenses</li> </ol>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of agency’s monthly reimbursement indicates compliance.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.9	<p><u>Allowable Use of Funds</u></p> <ol style="list-style-type: none"> <li>1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)*</li> <li>2. Deductibles</li> <li>3. Medical/Pharmacy co-payments</li> <li>4. Co-insurance, and</li> <li>5. Tax reconciliation up to of 50% of the tax due up to a maximum of \$500</li> <li>6. Only Medical, Dental and Vision plans are covered. Life insurance and other elective policies are not covered</li> </ol>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of agency’s monthly reimbursement indicates compliance.</li> </ul>
9.10	<p><u>Restricted Use of Funds</u></p> <ol style="list-style-type: none"> <li>1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period.</li> <li>2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage.</li> <li>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.</li> <li>4. Payment can never be made directly to clients.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ol>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of agency’s monthly reimbursement indicates compliance.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.11	<p><u>Health Insurance Premium Assistance</u>                      The following criteria must be met for a health plan to be eligible for HIP assistance:</p> <ol style="list-style-type: none"> <li>1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested</li> <li>1. Health Insurance coverage must be evaluated for cost effectiveness</li> <li>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.</li> <li>3. COBRA plans must be evaluated based on cost effectiveness and client benefit.</li> </ol> <p>Additional Requirements for ACA plans:</p> <ol style="list-style-type: none"> <li>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).</li> <li>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).</li> <li>3. All clients who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL).</li> </ol> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of client records indicates compliance.</li> </ul>
9.12	<p><u>Comprehensive Intake/Assessment</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of client intake/assessment for service indicates compliance.</li> </ul>
9.13	<p><u>Decreasing Barriers to Service</u>                      Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for client to physically present to Health Insurance provider.)</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of client intake/assessment for service indicates compliance</li> </ul>



#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.14	<p><u>Waiver Process</u>                      In order to ensure proper program delivery, a waiver from the AA is required for the following circumstances:</p> <ol style="list-style-type: none"> <li>1. HIC payment assistance will exceed benchmark for directly delivered services,</li> <li>2. Providing payment assistance for out of network providers,</li> <li>3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary,</li> <li>4. Discontinuing HIC payment assistance due to client conduct or fraud,</li> <li>5. Refusing HIC assistance for a client who is eligible and whom HIC provides a cost advantage over direct service delivery,</li> <li>6. Services being postponed, denied, or a waitlisted and;</li> <li>7. Assisting an eligible client with the entire cost of a group policy that includes coverage for persons not eligible for HIC payment assistance.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> </ul>
9.15	<p><u>Payer of Last Resort</u>                      Agencies must assure that all clients are screened for potential third party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist clients in enrollment.</p>	<ul style="list-style-type: none"> <li>•</li> </ul>
9.16	<p><u>Vigorous Pursuit</u>                      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 “<i>vigorously pursue</i>”, all clients receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must:</p> <ol style="list-style-type: none"> <li>1. Designate premium tax credit be taken in advance during enrollment</li> <li>2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal</li> <li>3. Submit prior year tax information no later than May 31<sup>st</sup>.</li> <li>4. Reconciliation of advance premium tax credits or liabilities.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> </ul>

**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
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Service</u> 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.</p> <p>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.</p> <p>Allowable Ryan White/State Services funded services are:</p> <ul style="list-style-type: none"> <li>• Room</li> <li>• Board</li> <li>• Nursing care</li> <li>• Mental health counseling, to include bereavement counseling</li> <li>• Physician services</li> <li>• Palliative therapeutics</li> </ul>	<ul style="list-style-type: none"> <li>• Program’s Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.2	<p><u>Scope of Service (Cont'd)</u>                      Services NOT allowed under this category:</p> <ul style="list-style-type: none"> <li>• HIV medications under hospice care unless paid for by the client.</li> <li>• Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.</li> <li>• Funeral, burial, cremation, or related expenses.</li> <li>• Nutritional services,</li> <li>• Durable medical equipment and medical supplies.</li> <li>• Case management services.</li> </ul>	
9.3	<p><u>Client Eligibility</u>                      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.</p> <ul style="list-style-type: none"> <li>• Referred by a licensed physician</li> <li>• 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</li> <li>• Must be reassessed by a physician every six (6) months.</li> <li>• Must first seek care from other facilities and denial must be documented in the resident's chart.</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record.</li> <li>• Documentation in client's chart that an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.</li> </ul>
9.4	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation of referrals received.</li> <li>• Documentation of referrals out</li> <li>• Staff reports indicate compliance</li> </ul>
9.5	<p><u>Staff Education</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Staff will attend and has continued access to training activities:</li> <li>• Staff has access to updated HIV/AIDS information</li> <li>• Agency maintains system for dissemination of HIV/AIDS information relevant to the needs of PLWHA to paid staff and volunteers.</li> <li>• Agency will document provision of in-service education to staff regarding current treatment methodologies and promising practices.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.6	<u>Ongoing Staff Training</u> <ul style="list-style-type: none"> <li>• 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).</li> <li>• One (1) hour of training in HIV/AIDS is required annually for all other staff (in addition to training required in General Standards).</li> </ul>	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Documentation of training in personnel file</li> </ul>
9.7	<u>Staff Credentials &amp; Experience</u> 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.	<ul style="list-style-type: none"> <li>• Personnel files reflect requisite licensure or certification.</li> <li>• Documentation of work experience in personnel file</li> </ul>
9.8	<u>Staff Requirements</u> Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	<ul style="list-style-type: none"> <li>• Review of personnel file indicates compliance</li> <li>• Staff interviews indicate compliance.</li> </ul>
9.9	<u>Volunteer Assistance</u> 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: <ul style="list-style-type: none"> <li>• Be provided with clearly defined roles and written job descriptions</li> <li>• Conform to policies and procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation of all training in volunteer files</li> <li>• Signed compliance by volunteer</li> </ul>
9.10	<u>Volunteer Training</u> 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.	<ul style="list-style-type: none"> <li>• Review of training curriculum indicates compliance</li> <li>• Documentation of all training in volunteer files</li> </ul>
9.11	<u>Staff Supervision</u> 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	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance.</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance.</li> <li>• Review of documentation that supervisory provider or advanced practice registered nurse provided supervision over other staff members</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.12	<p><u>Facility Licensure</u>                      Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation.</p>	<ul style="list-style-type: none"> <li>• License and/or certification will be posted in a conspicuous place at the site where services are provided to patients.</li> <li>• Documentation of license and/or certification is available at the site where services are provided to clients</li> </ul>
9.13	<p><u>Denial of Service</u>                      The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• There are no beds available</li> <li>• Level of patient’s acuity and staffing limitations</li> <li>• Patient is aggressive and a danger to the staff</li> <li>• Patient is a “no show”</li> </ul> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation of notification is available for review.</li> </ul>
9.14	<p><u>Multidisciplinary Team Care</u>                      Agency must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation in client’s records</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.15	<p><u>Medication Administration Record</u>                      Agency documents each patient’s scheduled medications. Documentation includes patient’s name, date, time, medication name, dose, route, reason, result, and signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>
9.16	<p><u>PRN Medication Record</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>
9.17	<p><u>Physician Orders</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>
9.18	<p><u>Intake and Service Eligibility</u>                      Agency will receive referrals from a broad range of HIV/AIDS service providers. Information will be obtained from the referral source and will include:</p> <ul style="list-style-type: none"> <li>• Contact and identifying information (name, address, phone, birth date, etc.)</li> <li>• Language(s) spoken</li> <li>• Literacy level (client self-report)</li> <li>• Demographics</li> <li>• Emergency contact</li> <li>• Household members</li> <li>• Pertinent releases of information</li> <li>• Documentation of insurance status</li> <li>• Documentation of income (including a “zero income” statement)</li> <li>• Documentation of state residency</li> <li>• Documentation of proof of HIV positivity</li> <li>• Photo ID or two other forms of identification</li> <li>• Acknowledgement of client’s rights</li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation in client’s records</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.19	<p><u>Comprehensive Health Assessment</u>                      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:</p> <ul style="list-style-type: none"> <li>• History of HIV infection and other co morbidities</li> <li>• Current symptoms</li> <li>• Systems review</li> <li>• Past history of other medical, surgical or psychiatric problems</li> <li>• Medication history</li> <li>• Family history</li> <li>• Social history</li> <li>• Identifies the patient’s need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care.</li> <li>• A review of current goals of care</li> </ul> <p>Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>
9.20	<p><u>Plan of Care</u>                      Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient’s priorities.</p> <p>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 ( <a href="http://hab.hrsa.gov/tools/palliative/contents.html">http://hab.hrsa.gov/tools/palliative/contents.html</a>) and professional guidelines                      Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.21	<p><u>Counseling Services</u> 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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client’s record</li> </ul>
9.22	<p><u>Bereavement Counseling</u> 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:</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• 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;</li> <li>• 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;</li> <li>• ensure that bereavement services reflect the needs of the bereaved.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment present in the client’s record.</li> <li>• Referral and/or service provision documented.</li> </ul>
9.23	<p><u>Dietary Counseling</u> 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.</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment present in the client’s record.</li> <li>• Referral and/or service provision documented.</li> </ul>



#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.24	<p><u>Mental Health Counseling</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Assessment present in the client’s record.</li> <li>• Referral and/or service provision documented.</li> </ul>
9.25	<p><u>Spiritual Counseling</u>                      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:</p> <ul style="list-style-type: none"> <li>• Provide an assessment of the client's and family's spiritual needs;</li> <li>• 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</li> <li>• Advise the client and family of the availability of spiritual counseling services.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment present in the client’s record.</li> <li>• Referral and/or service provision documented.</li> </ul>
9.26	<p><u>Palliative Therapy</u>                      Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.</p>	<ul style="list-style-type: none"> <li>• Assessment present in the client’s record.</li> <li>• Documentation in client’s records.</li> </ul>
9.27	<p><u>Medical Social Services</u>                      Medical social services must be provided by a qualified social worker. and is based on:</p> <ul style="list-style-type: none"> <li>• The patient's and family's needs as identified in the patient's psychosocial assessment</li> <li>• The patient's and family's acceptance of these services.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment present in the client’s record.</li> <li>• Documentation in client’s records.</li> </ul>
9.28	<p><u>Discharge</u>                      An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met:</p> <ul style="list-style-type: none"> <li>• Patient expires.</li> <li>• Patient’s medical condition improves and hospice care is no longer necessary.</li> <li>• Patient elects to be discharged.</li> <li>• Patient is discharged for cause.</li> <li>• Patient is transferred out of provider’s facility.</li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation in client’s records.</li> </ul>

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
<b>9.0</b>	<b>Services are part of the coordinated continuum of HIV/AIDS and social services</b>	
9.1	<p><u>Scope of Service</u> 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.</p>	<ul style="list-style-type: none"> <li>• Program’s Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>
9.2	<p><u>Staff Qualifications and Training</u></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Interpreter staff/agency will be trained and experienced in the health care setting</li> </ul>	<ul style="list-style-type: none"> <li>• Program Policies and Procedures will ensure the contracted agency is in compliance with legislation/regulations</li> <li>• Legislation and Regulations                             <ul style="list-style-type: none"> <li>• (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</li> </ul> </li> </ul>
9.3	<p><u>Program Policies</u> 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.</p>	<ul style="list-style-type: none"> <li>• Review of Program Policies.</li> </ul>

#	STANDARD	MEASURE
<b>9.0</b>	<b>Services are part of the coordinated continuum of HIV/AIDS and social services</b>	
9.4	<u>Provision of Services</u> <ul style="list-style-type: none"> <li>• Agency/providers will offer services to the client only in connection with other HRSA approved services (such as clinic visits).</li> <li>• 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 or friends of the client</li> <li>• Based on provider need, agency shall provide the following types of linguistic services in the client's preferred language: <ul style="list-style-type: none"> <li>• Oral interpretation</li> <li>• Written translation</li> <li>• Sign language</li> </ul> </li> <li>• 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</li> <li>• Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Program's Policies and Procedures indicate compliance.</li> <li>• Documentation of provision of services present in client files indicates compliance.</li> </ul>
9.5	<u>Timeliness of Scheduling</u> Agency will schedule service within one (1) business day of the request.	<ul style="list-style-type: none"> <li>• Review of client files indicates compliance.</li> </ul>
9.6	<u>Interpreter Certifications</u> All American Sign Language interpreters will be certified in the State of Texas. Level II and III interpreters are recommended for medical interpretation.	<ul style="list-style-type: none"> <li>• Agency contracts with companies that maintain certified ASL interpreters on staff.</li> <li>• Agency requests denote appropriate levels of interpreters are requested.</li> </ul>
9.7	<u>Subcontractor Exclusion:</u> 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.	<ul style="list-style-type: none"> <li>• No Measure</li> </ul>

**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
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Work</u> Agency will provide the following services: <b>Individual Therapy/counseling</b> 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. <b>Support Groups</b> 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.</p>	<ul style="list-style-type: none"> <li>• Program’s Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.2	<p><u>Licensure</u>                      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.</p>	<ul style="list-style-type: none"> <li>• A file will be maintained on each professional counselor. Supportive documentation of credentials is maintained by the agency in each counselor’s personnel file.</li> <li>• Review of Agency Policies and Procedures Manual indicates compliance.</li> <li>• Review of personnel files indicates compliance</li> </ul>
9.3	<p><u>Staff Orientation and Education</u>                      Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum:</p> <ul style="list-style-type: none"> <li>• Referral for crisis intervention policy/procedures</li> <li>• Standards of Care</li> <li>• Confidentiality</li> <li>• Consumer Rights and Responsibilities</li> <li>• Consumer abuse and neglect reporting policies and procedures</li> <li>• Professional Ethics</li> <li>• Emergency and safety procedures</li> <li>• Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable)</li> </ul> <p>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.</p>	<ul style="list-style-type: none"> <li>• Personnel record will reflect all orientation and required continuing education training.</li> <li>• Review of Agency Policies and Procedures Manual indicates compliance.</li> <li>• Review of personnel files indicates compliance</li> </ul>
9.4	<p><u>Family Counseling Experience</u>                      Professional counselors must have two years experience in family counseling if providing services to families.</p>	<ul style="list-style-type: none"> <li>• Experience is documented via resume or other method. Exceptions noted in personnel files.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.5	<p><u>Professional Liability Insurance</u> Professional liability coverage of at least \$300,000 for the individual or \$1,000,000 for the agency is required.</p>	<ul style="list-style-type: none"> <li>• Documentation of liability insurance coverage is maintained by the agency.</li> </ul>
9.6	<p><u>Substance Abuse Assessment Training</u> 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.</p>	<ul style="list-style-type: none"> <li>• Documentation of training is maintained by the agency in each counselor’s personnel file.</li> </ul>
9.7	<p><u>Crisis Situations and Behavioral Emergencies</u> 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:</p> <ul style="list-style-type: none"> <li>• verbal intervention</li> <li>• non-violent physical intervention</li> <li>• emergency medical contact information</li> <li>• incident reporting</li> <li>• voluntary and involuntary inpatient admission</li> <li>• follow-up contacts</li> </ul> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of Agency Policies and Procedures Manual indicates compliance.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.8	<p><u>Other Policies and Procedures</u>                      The agency must develop and implement Policies and Procedures that include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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)</li> <li>• Changing therapists</li> <li>• Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, time line for referrals.</li> <li>• Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months.</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency Policies and Procedures Manual indicates compliance.</li> </ul>
9.9	<p><u>In-Home Services</u>                      Therapy/counseling and/or bereavement counseling may be conducted in the client’s home.</p>	<ul style="list-style-type: none"> <li>• Program Policies and Procedures address the provision of home visits.</li> </ul>
9.10	<p><u>Client Orientation</u>                      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:</p> <ul style="list-style-type: none"> <li>• Services available</li> <li>• Clinic hours and procedures for after-hours emergency situations</li> <li>• How to reach staff member(s) as appropriate</li> <li>• Scheduling appointments</li> <li>• Client responsibilities for receiving program services and the agency's responsibilities for delivering them</li> <li>• Patient rights including the grievance process</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client record indicates compliance.</li> <li>• Annual Client Interviews indicates compliance.</li> </ul>



#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.11	<p><u>Comprehensive Assessment</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I.</li> <li>• 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.</li> </ul>
9.12	<p><u>Treatment Plan</u>                      Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including:</p> <ul style="list-style-type: none"> <li>• Statement of the goal(s) of counseling and description of the mental health issue</li> <li>• Goals and objectives</li> <li>• The plan of approach and treatment modality (group or individual)</li> <li>• Start date for mental health services</li> <li>• Recommended number of sessions</li> <li>• Date for reassessment</li> <li>• Projected treatment end date</li> <li>• Any recommendations for follow up</li> <li>• Mechanism for review</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client record.</li> <li>• Exceptions noted in client file.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.12	<p><u>Treatment Plan (Cont'd)</u>                      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.</p>	
9.13	<p><u>Treatment Plan Review</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Review of Agency Policies and Procedures Manual indicates compliance.</li> <li>• Client's records</li> <li>• Exceptions noted in client files.</li> </ul>
9.14	<p><u>Progress Notes</u>                      Progress notes are completed for every professional counseling session and must include:</p> <ul style="list-style-type: none"> <li>• Client name</li> <li>• Session date</li> <li>• Observations</li> <li>• Focus of session</li> <li>• Interventions</li> <li>• Progress on treatment goals</li> <li>• Newly identified issues/goals</li> <li>• Assessment</li> <li>• Duration of session</li> <li>• Counselor signature and counselor authentication</li> <li>• Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence</li> </ul>	<ul style="list-style-type: none"> <li>• Legible, signed and dated documentation in client record.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.15	<u>Discharge</u> Services may be discontinued when the client has: <ul style="list-style-type: none"> <li>• Reached goals and objectives in their treatment plan</li> <li>• Missed three (3) consecutive appointments in a six (6) month period</li> <li>• Continual non-adherence to treatment plan</li> <li>• Chooses to terminate services</li> <li>• Unacceptable patient behavior</li> <li>• Death</li> </ul>	<ul style="list-style-type: none"> <li>• Agency will develop discharge criteria and procedures.</li> </ul>
9.16	<u>Discharge Summary</u> Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: <ul style="list-style-type: none"> <li>• Circumstances of discharge</li> <li>• Summary of needs at admission</li> <li>• Summary of services provided</li> <li>• Goals completed during counseling</li> <li>• Discharge plan</li> <li>• Counselor authentication,</li> <li>• Date</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client record.</li> </ul>
9.17	<u>Supervisor Qualifications</u> 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.	<ul style="list-style-type: none"> <li>• Documentation of supervisor credentials is maintained by the agency.</li> </ul>
9.18	<u>Clinical Supervision</u> 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.	<ul style="list-style-type: none"> <li>• Documentation in supervision notes.</li> <li>• Each mental health service agency must have and implement a written policy for regular supervision of all licensed staff.</li> </ul>

**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
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Work</u> 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.</p> <p>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.</p> <p>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.</p> <p>Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.</p>	<ul style="list-style-type: none"> <li>• Program’s Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
	<p><u>Staff Qualifications</u>                      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</p>	<ul style="list-style-type: none"> <li>• Documentation of qualifications for each dental provider present in personnel file.</li> </ul>
9.2	<p><u>Continuing Education</u></p> <ul style="list-style-type: none"> <li>• 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)</li> <li>• 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)</li> </ul>	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Documentation of continuing education in personnel file</li> </ul>
9.3	<p><u>Experience – HIV/AIDS</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
9.4	<p><u>Confidentiality</u>                      Confidentiality statement signed by dental employees.</p>	<ul style="list-style-type: none"> <li>• Signed statement in personnel file.</li> </ul>
9.5	<p><u>Universal Precautions</u>                      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:</p> <ul style="list-style-type: none"> <li>• Health care workers who perform exposure-prone procedures should know their HIV antibody status</li> <li>• 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.</li> <li>• Tuberculosis tests at least every 12 months for all staff.</li> <li>• OSHA guidelines must be met to ensure staff and patient safety.</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of review in personnel file.</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.6	<p><u>Staff Supervision</u>                      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.</p>	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> </ul>
9.7	<p><u>Annual Cap On Services</u>                      Maximum amount that may be funded by Ryan White/State Services per patient is \$3,000/year.</p> <ul style="list-style-type: none"> <li>• In cases of emergency, the maximum amount may exceed the above cap</li> <li>• In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap.</li> </ul> <p>Dental providers must document <i>via approved waiver</i> the reason for exceeding the yearly maximum amount.</p>	<ul style="list-style-type: none"> <li>• Annual review of reimbursements indicates compliance</li> <li>• Signed waiver present in patient record for each patient.</li> </ul>
9.8	<p><u>HIV Primary Care Provider Contact Information</u>                      Agency obtains and documents HIV primary care provider contact information for each client.</p>	<ul style="list-style-type: none"> <li>• 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</li> </ul>
9.9	<p><u>Consultation for Treatment</u>                      Agency consults with client’s medical care providers when indicated.</p>	<ul style="list-style-type: none"> <li>• Documentation of communication in the client record</li> </ul>
9.10	<p><u>Dental and Medical History Information</u>                      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:</p> <ul style="list-style-type: none"> <li>• A baseline current (within in last 12 months) CBC laboratory test</li> <li>• Current (within the last 12 months) CD4 and Viral Load laboratory test results or more frequent when clinically indicated</li> <li>• Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level (e.g., Factor VIII activity) and inhibitor titer (e.g., BIA)</li> <li>• Tuberculosis screening result</li> <li>• Patient’s chief complaint, where applicable</li> <li>• Current Medications</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of health history information in the client record. Reasons for missing health history information are documented</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
	<p><u>Dental and Medical History Information (Cont'd)</u>                      This information should include, but not be limited to, the following:</p> <ul style="list-style-type: none"> <li>• Sexually transmitted diseases</li> <li>• HIV-associated illnesses</li> <li>• Allergies and drug sensitivities</li> <li>• Alcohol use</li> <li>• Recreational drug use</li> <li>• Tobacco use</li> <li>• Neurological diseases</li> <li>• Hepatitis A, B, C status</li> <li>• Usual oral hygiene</li> <li>• Date of last dental examination</li> <li>• Involuntary weight loss or weight gain</li> <li>• Review of systems</li> </ul> <p>Any predisposing conditions that may affect the prognosis, progression and management of oral health condition</p>	<ul style="list-style-type: none"> <li>•</li> </ul>
9.11	<p><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.</p>	<ul style="list-style-type: none"> <li>• Documentation of health history update in the client record</li> </ul>
9.12	<p><u>Limited Physical Examination</u>                      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.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Review of client records indicate compliance</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.13	<p><u>Oral Examination</u>                      Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as:</p> <ul style="list-style-type: none"> <li>• D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established patient</li> <li>• D0120-Periodic Oral Evaluation to include bitewing x-rays, established patient,</li> <li>• D0160-Detailed and Extensive Oral Evaluation</li> <li>• D0170-Re-evaluation, limited, problem focused (established patient; not post-operative visit)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of client records indicate compliance</li> </ul>
9.14	<p><u>Comprehensive Periodontal Examination</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.</p> <p>Patient must have a periodontal screening once per year. A periodontal screen should include:</p> <ul style="list-style-type: none"> <li>• Assessment of medical and dental histories</li> <li>• Quantity and quality of attached gingival</li> <li>• Bleeding</li> <li>• Tooth mobility</li> <li>• Radiological review of the status of the periodontium and dental implants.</li> </ul> <p>Comprehensive periodontal examination (ADA CDT D0180) includes:</p> <ul style="list-style-type: none"> <li>• Evaluation of periodontal conditions</li> <li>• Probing and charting</li> <li>• Evaluation and recording of the patient’s dental and medical history and general health assessment.                             <ul style="list-style-type: none"> <li>• It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Review of client records indicate compliance</li> </ul>



#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.15	<p><u>Treatment Plan</u>                      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:</p> <ul style="list-style-type: none"> <li>• Provision for the relief of pain</li> <li>• Elimination of infection</li> <li>• Preventive plan component</li> <li>• Periodontal treatment plan if necessary</li> <li>• Elimination of caries</li> <li>• Replacement or maintenance of tooth space or function</li> <li>• Consultation or referral for conditions where treatment is beyond the scope of services offered</li> <li>• Determination of adequate recall interval.</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment plan dated and signed by both the provider and patient in patient file</li> <li>• Annually updated treatment plan dated and signed by both the provider and patient in patient file</li> </ul>
9.16	<p><u>Phase 1 Treatment Plan</u>                      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:</p> <ul style="list-style-type: none"> <li>• Restorative treatment</li> <li>• Basic periodontal therapy (non-surgical)</li> <li>• Basic oral surgery (simple extractions and biopsy)</li> <li>• Non-surgical endodontic therapy</li> <li>• Maintenance of tooth space</li> <li>• Tooth eruption guidance for transitional dentition</li> </ul>	<ul style="list-style-type: none"> <li>• Phase 1 Treatment plan dated and signed by both the provider and patient in patient file</li> <li>• Annually updated Phase 1 treatment plan dated and signed by both the provider and patient in patient file</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.17	<p><u>Annual Hard/Soft Tissue Examination</u> The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record:</p> <ul style="list-style-type: none"> <li>• Charting of caries;</li> <li>• X-rays;</li> <li>• Periodontal screening;</li> <li>• Written diagnoses, where applicable;</li> <li>• Treatment plan.</li> </ul> <p>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.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>
9.18	<p><b>Oral Health Education</b> Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager.</p> <p>Provider must provide patient oral health education once each year which includes but is not limited to the following:</p> <ul style="list-style-type: none"> <li>• D1330 Oral hygiene instructions</li> <li>• D1320 Smoking/tobacco cessation counseling as indicated</li> <li>• Additional areas for instruction may include Nutrition ( D1310).</li> <li>• For pediatric patients, oral health education should be provided to parents and caregivers and be age appropriate for pediatric patients.</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
9.19	<p><u>Oral Hygiene Instructions</u> Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>
9.20	<p><u>Referrals</u> 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.</p>	<ul style="list-style-type: none"> <li>• Documentation in the client record</li> </ul>

### 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](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](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>



**2016 Quarterly Report**  
**Quality Improvement Committee**  
(November 2016)

**Status of Committee Goals and Responsibilities (\*means mandated by HRSA)**

1. Conduct the "How to Best Meet the Needs" (HTBMN) process, with particular attention to the continuum of care with respect to HRSA identified core services.

Done

2. Develop a process for including consumer input that is proactive and consumer friendly for the Standards of Care and Performance Measures review process.

Done

3. Continue to improve the information, processes and reporting (within the committee and also thru collaboration with other Planning Council committees) needed to:

a. Identify "The Un-met Need"; Done

b. Determine "How to Best Meet the Needs"; Done

c. \*Strengthen and improve the description and measurement of medical and health related outcomes. Done

4. \*Identify and review the required information, processes and reporting needed to assess the "Efficiency of the Administrative Mechanism". Focus on the status of specific actions and related time-framed based information concerning the efficiency of the administrative mechanism operation in the areas of:

Done  
5


a. Planning fund use (meeting RWPC identified needs, services and priorities);

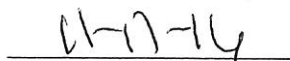
b. Allocating funds (reporting the existence/use of contract solicitation, contract award and contract monitoring processes including any time-frame related activity);

c. Distributing funds (reporting contract/service/re-imbursement expenditures and status, as well as, reporting contract/service utilization information).

5. Annually, review the status of committee activities identified in the current Comprehensive Plan. will do in Feb. 2017

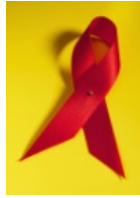
**Status of Tasks on the Timeline:**

  
\_\_\_\_\_  
Committee Chairperson

  
\_\_\_\_\_  
Date

# Operations Committee Report

**DRAFT**



**Houston Area HIV Services Ryan White Planning Council  
Office of Support**

# **2016 Project LEAP Final Report**

October 2016

Prepared by:  
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**Office of Support**  
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**Houston Area HIV Services Ryan White Planning Council  
Office of Support  
2016 Project LEAP Final Report**

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- FY16 Project LEAP Service Definition (approved 10-12-15)
- 2016 Project LEAP Course Overview
- 2016 Pre/Post-Training Evaluation Forms

## Introduction

“Project LEAP” (*Learning, Empowerment, Advocacy and Participation*) is a locally-defined HRSA-funded Service Category for the Houston EMA. Its purpose is to “increase the number and effectiveness of HIV infected individuals and affected others who can participate in organizations, councils, and committees dealing with the allocation of public funds for HIV-related prevention and care services,” with an emphasis on increasing participation in the EMA’s two local Planning Bodies, the Ryan White Planning Council (RWPC) and the Houston HIV Prevention Community Planning Group (CPG).

Project LEAP is currently designed as a weekly class spanning 16 weeks including classroom training, out-of-class time observation, and experiential community-based learning. Annually, the RWPC reviews and makes recommendations for the Project LEAP Service Definition based on program results and student needs. An External Advisory Panel consisting of representatives from the RWPC, CPG, and Project LEAP alumni also advises Project LEAP.

Beginning in 2012, the RWPC Office of Support (OS) assumed responsibility for planning, implementing, and evaluating Project LEAP, including student recruitment, syllabus design, and course facilitation. In its pilot year as an Office of Support project, 29 students were enrolled in the program, and 24 students graduated (for an 83% graduation rate). Of graduates, 63% were HIV consumers, and 63% applied for either RWPC or CPG membership. The pilot was also conducted at a savings of over \$38,000 compared to prior contracted providers.

This report summarizes results from the 2016 Project LEAP cohort, including the ways in which the 2016 syllabus met the objectives outlined in the RWPC-approved Service Definition, the extent of the program’s achievement in increasing the knowledge and skills of HIV infected and affected individuals, and lessons learned for future program implementation.



## Obj. 1: Contact Hours Requirements

### From the FY16 Project LEAP Service Definition:

Since 2013, Project LEAP has been designed to include multiple experiential community-based learning opportunities, including direct observations of Planning Body activities. To ensure each Project LEAP student has the same opportunity for community-based learning activities, the FY16 Project LEAP Service Definition requires contact hours for out-of-class time and service learning. The approved contact hours for Project LEAP are as follows:

- A minimum of one day class will be provided during the term of this [program]. If a minimum of five (5) HIV+, non-conflicted individuals apply for, and are accepted into, an evening class, then day and evening classes will be provided during the term of this agreement. Each class will include graduation and at least:
  1. 44 contact hours of classroom training;
  2. Twelve (12) hours of participation in RWPC or CPG meetings or activities; and participation in HIV-related community activities

Only three (3) non-conflicted PLWH a preference for an evening class applied and were accepted into 2016 Project LEAP. As this number did not meet the minimum threshold per the FY16 Project LEAP Service Definition, an evening class was not conducted in 2016. All three (3) applicants stated that they would attend the day class.

### From the 2016 Project LEAP Syllabus:

- One class was held each week from April 6, 2016 – July 20, 2016 (**Figure 1**), including:
  1. 48 hours of classroom training;
  2. 12 hours of participation in RWPC or CPG meetings or activities; and participation in HIV-related community activities;
- For a total of 60 hours of instruction. This is 3 hours *more per class* than the Service Definition requirement.
- A graduation dinner and ceremony was held on July 27, 2016.

**Figure 1: Project LEAP Contact Hours, 2016**

	<b>FY16 Service Definition</b> (approved 10-12-15)	<b>2016 Project LEAP Syllabus</b> (conducted 4-6-16 through 7-20-16)	
<b>Requirement</b>	Number of Hours	Number of Hours	Method
Graduation	n/a	n/a	Graduation ceremony held 7-27-16
Classroom training	44	48	11 weekly classroom sessions conducted at 4 hours/session; 4 hours of classroom sessions before RWPC, CPG, and P&A Committee mtgs
PC/CPG/Community participation	12	12	Student attendance at 1 RWPC mtg (2 hrs), 1 CPG mtg (2 hrs), 1 P&A Committee mtg (2 hrs), 1 community mtg (2 hrs), and participation in 1 volunteer shift at an HIV testing event (4 hrs)
<b>Total per class</b>	56	60	
<i>Number of classes</i>	1 / 2	1	
<b>Total contact hours</b>	56/112	60	

## Obj. 1: Curriculum Requirements

### **FY16 Project LEAP Service Definition curriculum requirements met by the 2016 Project LEAP syllabus:**

#### 1. Information on the sources & purposes of HIV service funds in the Houston EMA/HSDA

- Week #2 (4/13/16): Panel – Barriers to Reaching, Linking, & Retention in Care (Epidemiology Overview & Special Populations (Meyer, Blue, Cantu & Johnson)
- Week #3 (4/20/16): Overview of HIV/AIDS Care Funds & RW Program: HRSA to Council (Williams)
- Week #4 (4/27/16): HIV Prevention Program: CDC to CPG (Wiley)
- Week #9 (6/1/16): Overview of Housing Opportunities for People with HIV/AIDS (Barr)
- Week #12 (6/22/16): Attendance at Priorities & Allocations (P&A) Committee meeting (Williams)

#### 2. Structure, functions, & procedures of the RWPC/CPG

- Week #1 (4/6/16): History of HIV in Houston Panel (Leonard, Vargas, Ray & Williams)
- Week #3 (4/20/16): Designing HIV Care Services: HTBMN (Williams)
- Week #3 (4/20/16): PB & Jelly Exercise (Function of Policies & Procedures) (Harbolt)
- Week #4 (4/27/16): Robert's Rules of Order Exercise (Lazo)
- Week #6 (5/11/16): Community Needs Assessment (Harbolt)
- Week #8 (5/25/16): Attendance at Community Planning Group (CPG) meeting
- Week #10 (6/8/16): Attendance at Ryan White Planning Council (RWPC) meeting
- Week #11 (6/15/16): Training and Exercise on the P&A Process (Williams)
- Week #12 (6/22/16): Organizing Graduation/Robert's Rules of Order Practice (Williams)
- Week #15 (7/13/16): Project LEAP to Planning Body (Ross, Gorden, Escamilla, Blue, & Kelly)

#### 3. Training & skills building in needs assessments, parliamentary procedures & meeting management, presentation skills, accessing & utilizing resources and role models, & organizational participation & conduct

- Week #1 (4/6/16): Introduction to Robert's Rules of Order, Part 1 (Williams)
- Week #2 (4/13/16): LEAP Special Study Project Survey Development (Harbolt)
- Week #3 (4/20/16): LEAP Special Study Project – Survey Skills Training (Harbolt)
- Week #4 (4/27/16): Robert's Rules of Order Exercise (Lazo)
- Week #6 (5/11/16): Community Needs Assessment (Harbolt)
- Week #7 (5/18/16): LEAP Special Study Project – Analyze Survey Data (Harbolt)
- Week #7 (5/18/16): Training on HIV Resources/Blue Book Treasure Hunt (Beck)
- Week #9 (6/1/16): LEAP Special Study Project –Presentation Practice (Harbolt)
- Week #10 (6/8/16): Presentation of LEAP Special Study Project to RWPC
- Week #13 (6/29/16) Leadership Skills and Team Building (Alexander)
- Week #15 (7/13/16): Advocacy 101 (Ray)
- Week #16 (7/20/16): Community Meeting Report-Backs (Harbolt)  
*Ongoing: Weekly designation of meeting chairs, weekly practice with Robert's Rules and following meeting agendas, regular in-class small/large-group activities requiring student presentations*

#### 4. Training on HIV-related Standards of Care, quality assurance methods, & HRSA service category definitions

- Week #3 (4/20/16): Designing HIV Care Services: HTBMN (Williams)
- Week #4 (4/27/16): Comprehensive HIV Planning (Harbolt)
- Week #4 (4/27/16): HIV Continuum of Care (Harbolt)
- Week #15 (7/13/16): Training on Standards of Care and Performance Measures (Harbolt)

**Obj. 2: Class Composition vs. Current HIV Prevalence**

From the FY16 Project LEAP Service Definition:

- Enroll at least 12 (20 if evening class) HIV-infected individuals and no more than six (6) (10 if evening class) affected others in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA.
- The race, ethnicity, and gender composition of the classes must reflect current local HIV prevalence data to the extent feasible.
- Endeavor to enroll individuals from groups that are disproportionately affected by HIV disease, including youth and transgender PLWH.
- 

From the 2016 Project LEAP Cohort (Figure 2):

- 10 HIV diagnosed individuals and five (5) affected others were enrolled in Project LEAP in 2016 at the beginning of the program.
- Of graduating students, four (57%) were HIV positive, and three (43%) were affected.
- Compared to HIV prevalence proportions for the Houston EMA, a greater proportion of black (73%) and Hispanic (35%) students enrolled in the program, and a greater proportion of black students graduated from the program (86%).
- Two youth enrolled in the program, and one graduated.
- No transgender students enrolled in the program in 2016.

**Figure 2: Project LEAP Class Composition, 2016**

	EMA HIV Prevalence (as of 12/31/15)		2016 Project LEAP Enrollees (as of 4/6/16)		2016 Project LEAP PLWH Enrollees (as of 4/6/16)		2016 Project LEAP Graduates (as of 7/27/16)	
	#	%	#	%	#	%	#	%
<b>Race/Ethnicity</b>								
White, not Hispanic	5,341	20.5	2	13.3	2	20.0	1	14.3
Black, not Hispanic	12,721	48.8	11	73.3	7	70.0	6	85.7
Hispanic	7,001	26.9	2	35.3	1	10.0	0	0
Other/Unknown	978	3.8	0	0	0	0	0	0
Total	26,041	100	15	100	10	100	7	100
<b>Sex</b>								
Male	19,479	74.8	9	60.0	7	70.0	5	71.4
Female	6,562	25.2	6	40.0	3	30.0	2	28.6
Transgender	n/a	n/a	0	0	0	0	0	0
Total	26,041	100	15	100	10	100	7	100
<b>Age</b>								
13 – 24 years	1,375	5.2	2	13.3	*	*	1	14.3
Total	1,375	5.2	2	13.3	*	*	7	100

\*Data suppressed to maintain confidentiality

## Obj. 2: Course Completion

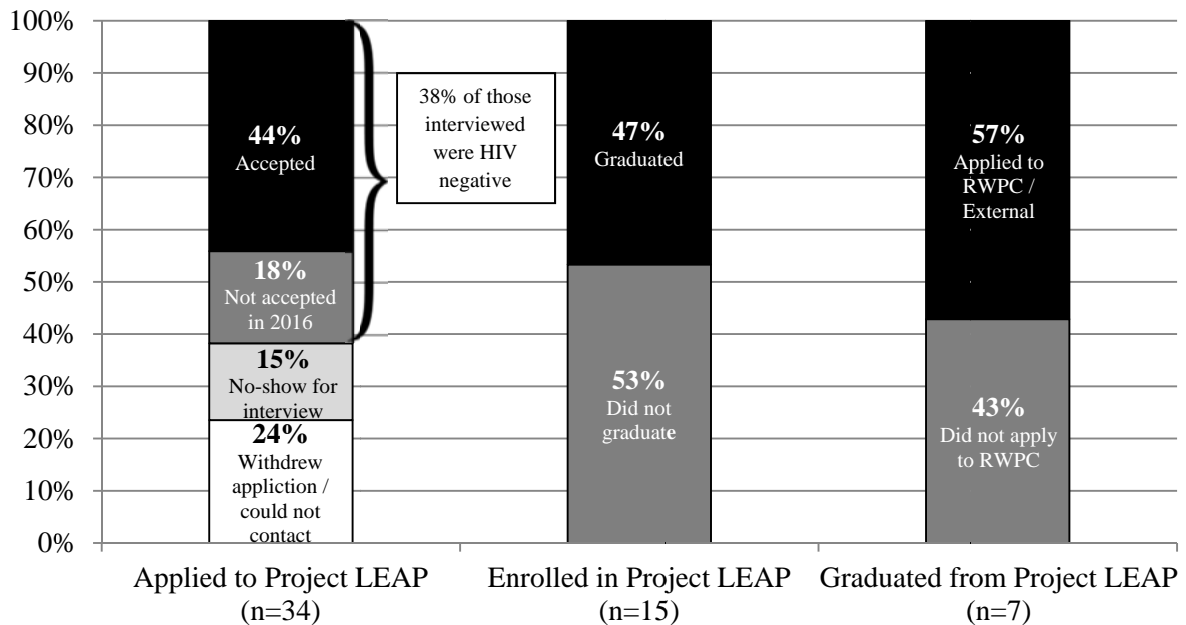
### From the FY16 Project LEAP Service Definition:

- Enroll at least 12 (20 if evening class) HIV-infected individuals and no more than six (6) (10 if evening class) affected others prior to the commencement of the training program.
- Establish realistic training schedules that accommodate varying health situations of participants.

### From the 2016 Project LEAP Cohort (Figures 3):

- 34 individuals applied for the 2016 class of Project LEAP; 8 applicants withdrew from the interview process or could not be contacted after their application was submitted. Interviews were scheduled with the remaining 26 applicants. Five (5) applicants did not show up for their interviews, six (6) applicants were interviewed but not accepted into the program, and 15 applicants were interviewed and enrolled into the program.
- Out of the 15 students enrolled, seven (7) graduated from the program, for a graduation rate of nearly 47%. When a reason was given, primary reasons for attrition were conflicts with school or new employment. Three (3) students enrolled, but never attended class. Two (2) students attended classes early in the course, but did not complete the course. Three (3) students withdrew from the class for the aforementioned reasons.
- Average weekly class size was 6 students. Weeks involving off-site locations, alternate days/times, or with inclement weather correlated with higher absences. Two students had perfect attendance.
- Four (4) students (or 57% of the graduating class) submitted applications to RWPC for PC (3) and/or External Committee (3) membership. As of October 2016, it was unknown how many 2016 Project LEAP Graduated applied to CPG.

**Figure 3: Project LEAP Application, Enrollment, and Course Completion, 2016**



## Obj. 2: Pre/Post-Training Evaluation

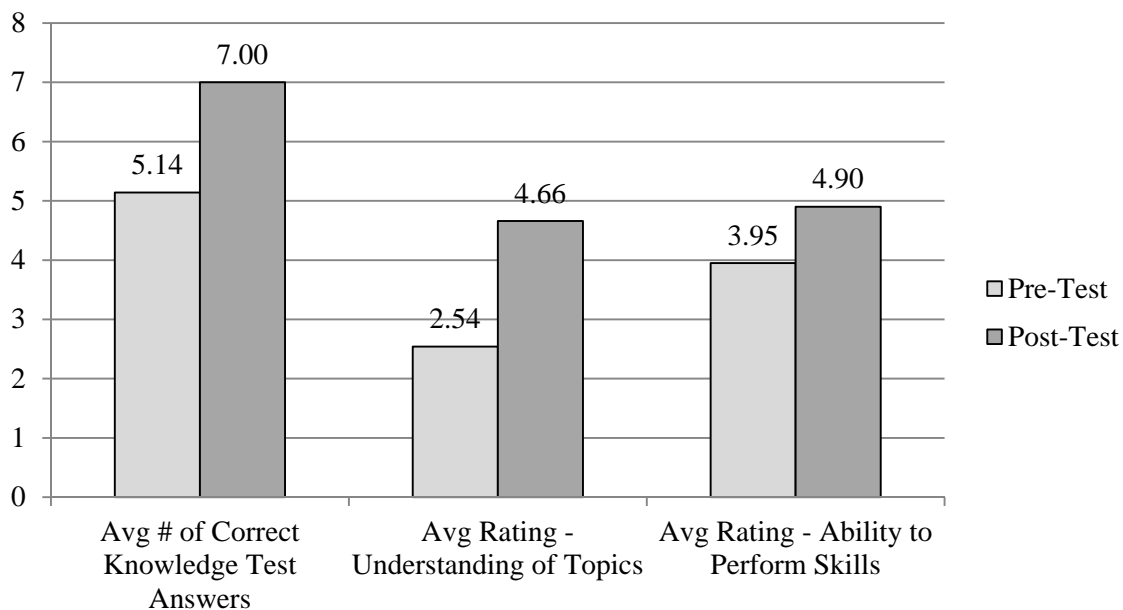
### From the FY16 Project LEAP Service Definition:

- Conduct a pre-training evaluation to determine knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes.
- Conduct a post-training evaluation to measure change.

### From the 2016 Project LEAP Cohort:

- A matched pre-training and post-training evaluation was conducted at Weeks 1 and 16. The evaluation tool (**See Attachment**) included the following:
  1. A 10-item fact-based multiple choice quiz specific to Service Definition topics measuring change in knowledge;
  2. A self-assessment of understanding of Service Definition topics (1 = “not well”; 5 = “very well”) measuring self-assessed change in understanding; and
  3. A self-assessment of ability to perform the skills or activities required by the Service Definition (1 = “not well”; 5= “very well”) measuring self-assessed change in skills.
- 100% of the graduating class was evaluated at both pre and post with the following results (**Figure 4**):
  1. The average number of correct answers to the fact-based multiple choice questions increased from 5.14 to 7.00, or a 36% increase in average knowledge test scores.
  2. The average self-assessment rating of understanding increased from 2.54 to 4.66 (out of 5), or a 55% increase in self-assessed understanding.
  3. The average self-assessment rating of ability to perform skills or activities increased from 3.95 to 4.90 (out of 5), or a 23% increase in self-assessed skills.
  4. As in previous years, the greatest improvements occurred in: knowledge of the purpose of the RW program and RWPC activities; understanding of the structure and function of the RWPC; and ability to effectively use Robert’s Rules of Order.

**Figure 4: Project LEAP Pre/Post-Training Evaluation Results, 2016**



## Obj. 2: Process Evaluation and Lessons Learned

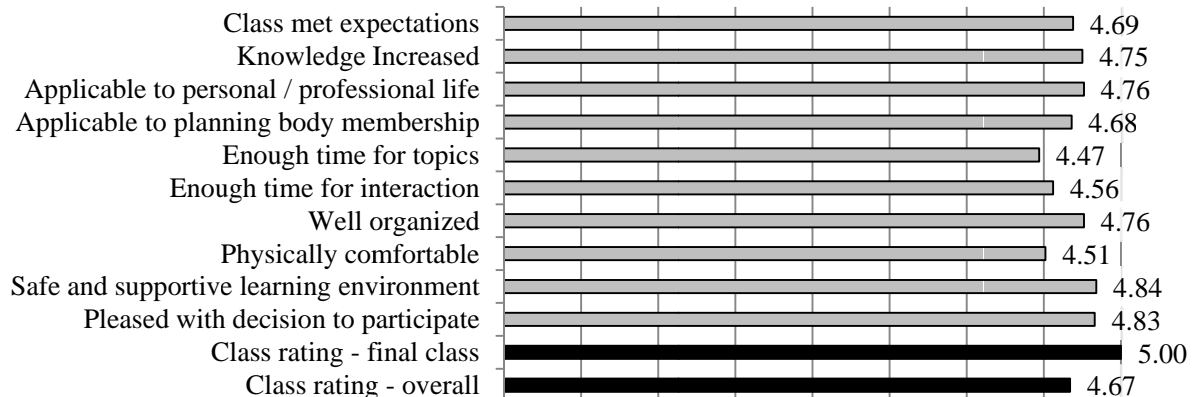
From the FY16 Project LEAP Service Definition:

- Enhance the participation of the HIV-infected and affected persons participating in this project.
- Provide both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning.

From the 2016 Project LEAP Syllabus and Cohort:

- A variety of teaching methods was employed to meet the Service Definition:
  1. *Lectures*: included 20 guest speakers (in addition to three Office of Support staff/facilitators)
  2. *Hands-on activities*: 100% of classroom sessions included an interactive activity (e.g., Robert’s Rules practice, team-building activities, group discussion, and report-back)
  3. *Experiential activities*: Graduation requirements included a special study project, attendance at a community meeting, and a volunteer shift at an HIV testing event. Three weeks of class occurred at a RWPC, Committee, or CPG related function.
- Course instruction quality was assessed weekly. **(Figure 5)**
  1. In general, average ratings were highly favorable, with an average rating heavily skewed toward “Strongly Agree” in all quality measures assessed.
  2. The highest ratings indicate that, generally, students felt the Project LEAP class was a safe and supportive learning environment (4.84/5), were pleased with their decision to participate in Project LEAP (4.83/5), found the information covered applicable to their personal and/or professional life, (4.76/5), and found the class to be well organized and facilitated (4.76/5).
  3. Though still very high, lower ratings indicate students thought there was not always enough time to fully address topics (4.47/5) or interact with classmates (4.56/5), and found the classroom to be physically uncomfortable (4.51/5). Several students commented about the classroom being too cold throughout the course.
  4. Overall, classes received an average rating of 4.67/5. The final class received an average rating of 5/5.

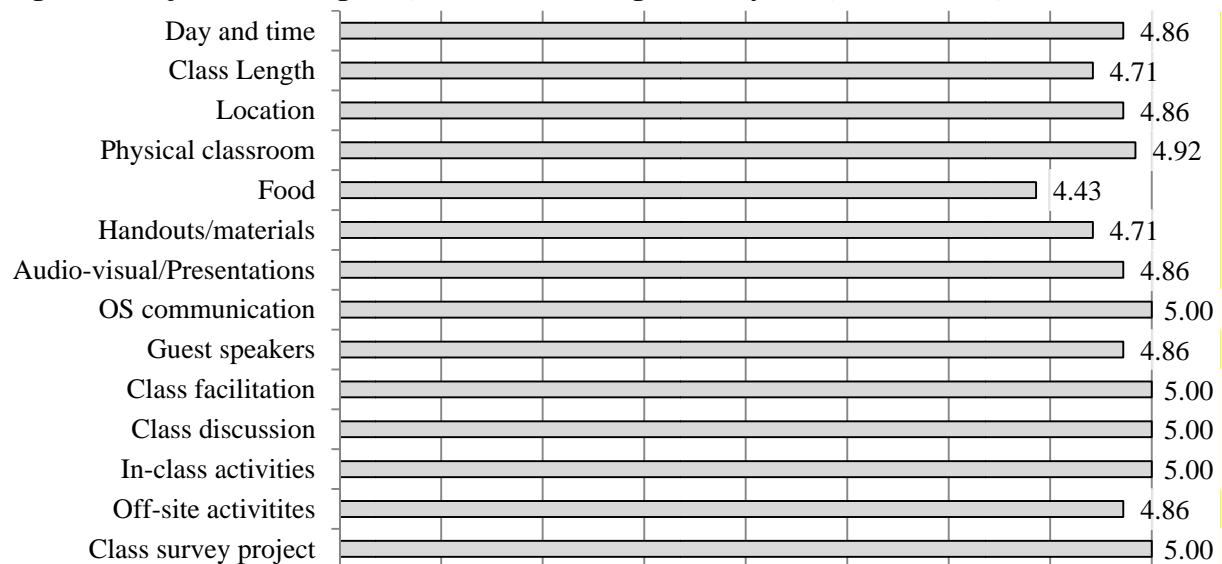
**Figure 5: Project LEAP Weekly Evaluation Results, Average Ratings (1=Strongly Disagree, 5=Strongly Agree; Class Rating, 1=Poor, 5=Excellent), 2016**



## Obj. 2: Process Evaluation and Lessons Learned (Con't)

- Course logistics quality was assessed at the mid-point and end of the course. **(Figure 6)**
  1. Most course logistics elements showed improvement between the mid-point (not shown) and end-point evaluations. Improvement was observed in all elements except handouts/materials provided and the physical classroom.
  2. Average ratings were highly favorable, with all course logistics elements rated “Very Good” (64%) or “Excellent” (36%).

**Figure 6: Project LEAP Logistics, Evaluation Ratings (1=Very Poor, 5=Excellent), 2016**



- General impressions of course quality were measured at the mid-point and end-point. As of the final Project LEAP 2016 class:
  1. 100% of students felt better able to be productive planning body members following Project LEAP.
  2. 100% of students were pleased with their decision to participate in Project LEAP and would recommend Project LEAP to someone else.
  3. 100% of students agreed or strongly agreed that Project LEAP made them more knowledgeable about HIV prevention and care services planning.
- Qualitative data were collected at the mid-point and end-point with an open-ended question inviting students to suggest ways of making Project LEAP even better in the future:
  1. Invite a guest speaker to discuss the intersections and challenges of HIV, substance abuse, and recovery.
  2. Increase variety in the food provided; consider offering an evening class, and add more outside assignments like the community meeting requirement.

Most responses complemented the quality of the class and course content.

**“Project LEAP has Left Me with the Knowledge to be a Better Advocate for My Community”: The Life-Changing Impact of Project LEAP**

Near the end of the course, the 2016 Project LEAP students were asked to share the impact of the program had on their lives. The quotes were displayed in a presentation that played during the graduation ceremony. The following quotes convey sentiments shared by many of the students:

- “I have been prescribed a new pair of glasses. I can see clearly! I am able to assist people that are HIV+ and their families while leading them to a path that comforts them, while reminding them that they are not alone. We can get through this together. I now have the resources and the knowledge to touch people’s lives while serving as an advocate. I am on the front line with a better prescription to fight while giving others hope. Thank you Project LEAP for an inspirational opportunity that I will never forget.”
- “Project LEAP has taught me about advocacy and getting involved, challenging education, and self-discovery. It has taught me so many great things. Thank you, Project LEAP.”
- “Project LEAP has provided a single stream opportunity to learn about the historical and current HIV epidemic and the planning of treatment and prevention. It has provided experts to learn from, practical experience, as well as ‘textbook’ knowledge. Going forward, I am more capable of being a benefit to the RWPC and CPG. Thanks for the learning experience. - Freshly Inspired HIV Activist”
- “Project LEAP has given me a family. A family that supports and encourages each other, all while enjoying our own diversity.”
- “I learned about the resources that help in assisting and servicing the HIV/AIDS clients of our community. I also learned from where the funds are received, and how they are allocated. I received a much better understanding of the role the City of Houston plays in the HIV community. I have a better understanding of the specifics of the Ryan White Planning Council. Project LEAP has left me with the knowledge to be a better advocate for my community.
- “I have grown tremendously since attending the classes. I have been given the opportunity to utilize some of my skills that have been lying dormant for years, and learn so much about the Ryan White Planning Council.”
- “Project LEAP encourages and reminds me that we all have purpose here on Earth, and to take the information learned, share it with others, to be a voice that helps better us all.”



## Budget Information and Comparison

Original Cost of the Program:     \$ 52,000  
 2016 Cost of the Program:         \$ 7,240  
**Total Savings:             \$ 44,760**

2016 Expenses:\*

Supplies	\$ 493
Facilities Rental	1,158
Speaker Fees	100
Student Reimbursement (mileage only – no dependent care needed in 2016)	1,242
Meals and Snacks	3,734
Staff Mileage	20
Miscellaneous (graduation shirts)	494

**TOTAL                             \$7240**

### Project LEAP Budget Comparison, 2012 – 2016

Item	2012 Expenses	2013 Expenses	2014 Expenses	2015 Expenses	2016 Expenses
Personnel & Fringe	\$ 0	\$ 0	\$ 0	\$0	\$ 0
Supplies	1,182	1,159	522.72	638.47	493.44
Facilities Rental	268	875	317.50	273.75	1157.50
Speaker Fees	0	0	0	0	100
Student Reimbursement					
Transportation	3,294	3,178	4,878.35	1,030.72	1,242.06
Dependent Care	560	705	0	0	0
Food	7,844	5,897	7,553.03	4090.90	3,733.56
Staff Mileage	200	25	20.00	20.00	20
Miscellaneous	630	858	808.90	300.50	493.82
<b>TOTAL</b>	<b>\$13,978</b>	<b>\$12,697</b>	<b>\$14,100.50</b>	<b>\$6,354.34*</b>	<b>\$7,240.38*</b>

**\*IMPORTANT:** Please note that 2015 and 2016 expenses are significantly less than in previous years because there were no evening classes.

## Acknowledgments

Project LEAP 2016 was a collaboration of the:

**Houston Area HIV Services Ryan White Planning Council and the  
Houston Health Department Bureau of HIV/STD & Viral Hepatitis Prevention**

Project LEAP 2016 was made possible by the following individuals:

### Project LEAP Advisory Committee

Cecilia Ross, Chair

Curtis Bellard  
Denny Delgado  
Herman Finley  
Morénike Giwa  
Tracy Gorden  
Kelvin Harris  
Angela F. Hawkins  
Denis Kelly  
Michael Kennedy

Osaro Mgbere  
Rodney Mills  
Alex Moses  
Robert Noble  
Tana Pradia  
Teresa Pruitt  
Viviana Santibanez  
Robert Smith  
Isis Torrente

### Guest Speakers

Mike Alexander  
*MLA Consulting*

Melody Barr  
*Houston Department of Housing & Community Development*

Nike Blue  
*AIDS Foundation Houston*

Evelio Salinas Escamilla  
*Houston Area Community Service, Inc.*

Gerry Cantu  
*Latino HIV/AIDS Task Force*

Tracy Gorden  
*Vice Chair, Ryan White Planning Council*

Annette Johnson  
*Baylor College of Medicine, Teen Health Clinic*

Heather Keizman  
*Ryan White Grant Administration*

Denis Kelly  
*CPG, Member;*  
*External Committee Member, Ryan White Planning Council*

John Lazo  
*Houston Metropolitan Chamber of Commerce*

Amy Leonard  
*Legacy Community Health*

Jeffrey Meyer  
*Houston Health Department*

Scot More  
*Coalition for the Homeless of Houston/Harris County*

John Nechman  
*Katine & Nechman L.L.P.*

Venita Ray  
*Legacy Community Health*

Cecilia Ross  
*Living Without Limits Living Large Inc.*

Paul Simmons  
*Legacy Community Health*

Steven Vargas  
*Chair, Ryan White Planning Council*

Lou Weaver  
*Equality Texas*

Cathy Wiley  
*Houston Health Department*

### Office of Support Staff

Tori Williams, Director  
Amber Harbolt, Health Planner  
Diane Beck, Council Coordinator  
Eric Moreno, Assistant Coordinator

### HHD Bureau Staff

Marlene McNeese, Bureau Chief  
Cathy Wiley, Training Administrator

## Attachments

- FY16 Project LEAP Service Definition (approved 10-12-15)
- 2016 Project LEAP Course Overview
- 2016 Pre/Post-Training Evaluation Forms

**SERVICE DEFINITION**  
**2016 Project L.E.A.P.**  
**Houston Ryan White Planning Council**  
**www.rwpcHouston.org**

<b>Service Category Title:</b>	<b>Grant Administration - Project LEAP</b>
<b>Unit of Service Definition:</b>	1 unit of service = 1 class hour of training to Project L.E.A.P. participants. No other costs may be billed to the contract issued for Project LEAP.
<b>Program Goals:</b>	<p>Contractor will increase the number and effectiveness of HIV-infected individuals and affected others who can participate in organizations, councils and committees dealing with the allocation of public funds for HIV-related prevention and care services, through an effort known as “Project LEAP” (Learning, Empowerment, Advocacy and Participation). <del>A minimum of 20 and a maximum of 30 HIV-infected individuals must be enrolled prior to the commencement of the training program. A maximum of 10 affected others may be included in the training program in addition to the minimum number of HIV-infected individuals.</del></p> <p><b>A minimum of 12 (20 if evening class) HIV-infected individuals and no more than 6 (10 if evening class) affected others must be enrolled prior to the commencement of the training program.</b></p> <p>The race, ethnicity and gender composition of the classes must reflect current local HIV/AIDS prevalence data to the extent feasible. Contractor must endeavor to enroll individuals from groups that are disproportionately affected by HIV disease, including youth and transgender PLWHA, in Project LEAP.</p> <p>Project LEAP will increase the knowledge and participation of HIV-infected and affected participants through a training program specifically developed to provide HIV-infected and affected persons with the knowledge and skills necessary to become active, informed, and empowered members of HIV planning bodies and other groups responsible for the assessment of HIV-related prevention and service needs in the Houston EMA/HSDA. The primary focus of training is to prepare participants to be productive members of local HIV/AIDS planning bodies, with an emphasis on planning activities conducted under the auspices of the Houston Ryan White Planning Council (RWPC) and the HIV Prevention Community Planning Group (CPG).</p>
<b>Program Requirements:</b>	<p>A minimum of one day class will be provided during the term of this agreement. If a minimum of 5 HIV+, non-conflicted individuals apply for, and are accepted into, an evening class, then day and evening classes will be provided during the term of this agreement. Each class will include graduation and at least:</p> <ul style="list-style-type: none"> <li>• 44 contact hours of classroom training;</li> <li>• 12 hours of participation in RWPC or CPG meetings or activities;</li> </ul>

	<p>and participation in HIV-related community meetings and activities.</p> <p>The Council-approved minimum outline for the training curriculum includes: HIV funding sources, general and specific operational procedures of HIV-related planning bodies, information regarding assessment of the needs of HIV-infected persons in the Houston EMA/HSDA, presentation skills, knowledge related to accessing services, overview of HIV-related quality improvement processes and parliamentary procedure/meeting management skills.</p> <p>Contractor will provide reimbursement of eligible expenses to participants during the period of enrollment to reimburse these participants for out of pocket costs related to their participation, limited to transportation, childcare, and meals. Contractor agrees to provide HCPHES/ Ryan White Grant Administration and the Houston RWPC with written reports and project summaries as requested by Harris County and in a form acceptable to Harris County, regarding the progress and outcome of the project.</p> <p><b>Contractor will provide Harris County with a written report summarizing the activities accomplished before the end of the calendar year.</b></p>
<p><b>Program Objectives:</b></p>	<p><b>Objective 1: Contractor will identify and provide training to at least 12 (20 if evening class) HIV-infected individuals and no more than 6 (10 if evening class) affected others in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA. The following training curriculum shall be provided:</b></p> <ol style="list-style-type: none"> <li>1. Information on the sources and purposes of HIV service funds in the Houston EMA/HSDA;</li> <li>2. The structure, functions, and procedures of the RWPC and the CPG;</li> <li>3. Specific training and skills building in needs assessments, parliamentary procedures and meeting management procedures, presentation skills, accessing and utilizing support resources and role models, and competence in organizational participation and conduct.</li> <li>4. Specific training on HIV-related Standards of Care, quality improvement methods and HRSA service category definitions.</li> </ol> <p><b>Objective 2: Contractor will enhance the participation of the HIV-infected and affected persons participating in this project by the following documented activities:</b></p> <ol style="list-style-type: none"> <li>1. Establishing realistic training schedules which accommodate varying health situations of participants;</li> <li>2. Conducting a pre-training evaluation of participants to determine their knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston</li> </ol>

area. Contractor must incorporate responses from this pre-training evaluation in the final design of the course curriculum to ensure that, to the extent reasonably possible, the specific training needs of the selected participants are addressed in the curriculum;

3. Conducting a post-training evaluation to measure the change in participants knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area;
4. Providing reimbursement of allowable expenses to help defray costs of the individual's participation, limited to transportation, child care, and meals;
5. Providing both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning.

**Objective 3: Contractor will encourage cooperation and coordination among entities responsible for administering public funds for HIV-related services by:**

1. Involving HCPHES/RWGA, The Houston Regional HIV/AIDS Resource Group and other administrative agencies for public HIV/AIDS care and prevention funds in curriculum development and training activities;
2. Ensuring representatives from the RWPC, the CPG and Project LEAP alumni are members of the Project LEAP External Advisory Panel. The responsibility of the Project LEAP External Advisory Panel is to:
  - Assist in curriculum development
  - Provide input into criteria for selecting Project LEAP participants
  - Help with the development of a recruitment strategy
  - If the Contractor finds it difficult to find individuals that meet the criteria for participation in the Project, assist with student recruitment
  - Review the final report for the Project in order to highlight the successes and brainstorm/problem solve around issues identified in the report. The results of the review will be sent to the RWPC Operations Committee and the next Project LEAP External Advisory Panel.
3. Collaborating with the Project LEAP External Advisory Panel during the initial 60 days of the Contract term. The criteria developed and utilized will, to the maximum extent possible, ensure participants selected represent the groups most affected by HIV disease, consistent with current HIV/AIDS epidemiological data in the Houston EMA/HSDA, including youth (ages 18-24) and transgender PLWHA.

<b>Special Requirements:</b>	Contractor will provide HCPHES/RWGA with the attached matrix and chart 21 and 14 days before the first class and again the day after the first class demonstrating that the criteria established by the Project LEAP External Advisory Panel was met. The matrix must be approved by RWGA 14 days before the first class.
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## EXAMPLES: Matrix and Chart

### Recommended Project LEAP Class of 2013

Candidate	M	F	T	HIV+	Non-Aligned HIV+	W	B	H	Youth Age 13 -19	Youth Age 20-24
1	X			X	X	X				
2		X		X			X		X	
3		X					X			X
4		X		X	X			X		X
5	X					X				
6	X			X	X		X			
7			X	X	X	X				
<b>Totals</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>2</b>

	EMA HIV/AIDS prevalence as of 12/31/10*		PC Members as of 09/01/11		Non-Aligned Consumers on PC	
Race/Ethnicity	#	%	#	%	#	%
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
Black, not Hispanic	10,225	48.98%	19	52.78%	8	50.00%
Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
<b>Total*</b>	<b>20,875</b>	<b>100.00%</b>	<b>36</b>	<b>100.00%</b>	<b>16</b>	<b>100.00%</b>
Gender	#	%	#	%	#	%
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
<b>Total*</b>	<b>20,875</b>	<b>100.00%</b>	<b>36</b>	<b>100.00%</b>	<b>16</b>	<b>100.00%</b>

\*Data are estimated cases adjusted for reporting delay. The sum total of estimates for each category may not match the EMA totals due to rounding.



## **2017 Project LEAP Student Selection Guidelines**

The following guidelines will be used by the Office of Support to select students for the 2016 Project LEAP cohort. They are presented in order of priority:

1. As outlined in the Service Definition for Project LEAP:
  - a. The Office of Support shall enroll at least 12 (20 if evening class) HIV-infected individuals and no more than 6 (10 if evening class) affected others. Preference will be given to non-aligned (non-conflicted) consumers of Ryan White HIV/AIDS Program services in the Houston EMA and high risk applicants.
  - b. Selected students shall be representative of the demographics of current HIV/AIDS prevalence in the Houston EMA, with particular attention to sex/gender, race/ethnicity, and the special populations of youth (age 18 - 24) and transgender.
2. Not be a prior Project LEAP graduate.
  - a. If the applicant is a prior LEAP graduate, they may be selected for the 2017 cohort if they have not been appointed to the Planning Council following LEAP participation and if space in the class is available.
3. Be available for the 2017 Project LEAP class schedule.
4. Have the ability to commit to Project LEAP expectations in regards to class participation, activities, and homework assignments.
5. Demonstrate an interest in planning HIV services in the Houston EMA. Students should have an understanding of the expected roles of Project LEAP graduates in local HIV prevention and care services planning.
6. Demonstrate an interest in volunteerism, advocacy, and other types of community involvement. If possible, have a history of past volunteerism, advocacy, and/or community involvement.
7. Demonstrated interpersonal skills consistent with successful participation in Project LEAP, such as ability/willingness to work in a team, effective communication skills, etc.

## SLATE OF NOMINEES

As of Friday, September 30, 2016, the following people have been nominated as officers for the 2017 Ryan White Planning Council:

### Chair:

Tracy Gorden

Cecilia Ross

### Vice Chair:

John Lazo

Teresa Pruitt

### Secretary:

Teresa Pruitt

Carol Suazo

# 2016 QUARTERLY REPORT OPERATIONS COMMITTEE

(submit November 2016)

## Status of Committee Goals and Responsibilities (\* means mandated by HRSA):

1. Design and implement Orientation for Council members and new external committee members in January and February 2017.  
Status: *Done*
2. When necessary, address member needs for additional orientation and training, including through the Committee Mentoring Program. (Example: create more training for mentors and a "Frequently Asked Questions" form. The information for this document can be gathered from Project LEAP and others.)  
Status: *Done, as needed*
3. \*When necessary, review and revise the bylaws, policies, and procedures of the Ryan White Planning Council.  
Status: *Done, as needed.*
4. When necessary, review and revise policies and procedures for the Council support staff.  
Status: *Done, as needed*
5. \*Investigate and make recommendations regarding complaints and grievances brought before the committee in order to assure member/staff compliance with bylaws, policies, and procedures.  
Status: *Done, as needed*
6. \*Resolve any grievances brought forward.  
Status: *Done, as needed.*
7. \*Make nominations to the CEO, which ensure the reflectiveness and representativeness of the Council.  
Status: *Done, as needed.*
8. Evaluate the performance of the Manager in conjunction with the Planning Council Chair and CEO.  
Status: *Done, as needed*
9. Ensure that the Council is complying with HRSA, County and other open meeting requirements.  
Status: *Done, as needed*
10. Annually, review the status of Committee activities identified in the Comprehensive Plan.

## Status of Tasks on the Timeline:

*Leresa Pruitt*  
Committee Chairperson

*11/15/16*  
Date

# Affected Community Committee Report

**2016 QUARTERLY REPORT**  
**AFFECTED COMMUNITY COMMITTEE**  
 (To be submitted November 2016)

**Status of Committee Goals and Responsibilities (\* indicates a HRSA mandate):**

1. Educate consumers so they understand how to access HIV/AIDS treatment, medication and clinical trials. Provide information that can be understood by consumers of diverse educational backgrounds on client-centered issues such as: medication side effects, toxicities, adherence and more.

Status: *Road to Success being done*

2. Continue to meet 4 – 6 times a year in locations throughout the Houston EMA/HSDA in order to make the Council more accessible to people living with HIV/AIDS.

Status: *done*

3. Distribute information about committee meetings and Council sponsored, educational opportunities to local service providers.

Status: *done*

4. Assure participation by people living with HIV/AIDS in all Council work products.

Status:

5. \*Work with other committees to coordinate Public Hearings regarding the FY 2017 How to Best Meet the Need Results & Priorities and Allocations for Ryan White Parts A and B and State Services.

Status: *done*

6. Continue marketing the activities of the committee and Council through health fairs and other appropriate activities so that people living with HIV/AIDS can attend committee meetings and give input to the Council.

Status: *done*

7. Recruit Council applicants throughout the year.

Status: *done*

8. Annually, review the status of committee activities identified in the current Comprehensive Plan.

Status:

*Jana Pradua*  
 Committee Chairperson

Date *11/22/2016*

*More imfarations Trans Committee*

**FYI**



## TEXAS DEPARTMENT OF STATE HEALTH SERVICES

JOHN HELLERSTEDT, M.D.  
COMMISSIONER

P.O. Box 149347  
Austin, Texas 78714-9347  
1-888-963-7111  
TTY: 1-800-735-2989  
www.dshs.state.tx.us

Date: \_\_\_\_\_

Dear THMP Client:

Thank you for your participation in the THMP program. The program is in the process of updating client recertification. **You will need to reapply for the program and return completed application by: \_\_\_\_\_ in order to continue to receive your medications through the program.** During this process, you may continue to order your medications as usual.

You will be asked to update and submit your current household income and insurance status information as part of this process. **Proof of income and residency will be required**; please take some time now to identify how you will get these documents and begin saving paystubs or award letters that you will submit as documentation.

You will receive your application **at this address**. If you want to receive mail at a different address, please contact us and give us your new address. In the future, you will be asked to reapply to the program every 6 to 12 months.

If you have questions about what needs to be submitted, please contact your local agency or the THMP program with questions **BEFORE** you submit the application. The THMP can help you identify a local agency that can help you complete your application.

**If we do not receive your application by the due date, you will be unable to order medications through the THMP until we receive your information.** If you submit incomplete information, you may not be eligible to order medications through the THMP until the information in question has been received and you are recertified.

If you have any questions please call the THMP at 1-800-255-1090 and ask to speak with Eric (ext. 3013) or Jack (ext. 3012).

Sincerely,

*Rachel Sanor, LMSW, MBA*

Rachel Sanor, LMSW, MBA  
Manager, THMP

Information may be faxed to (512) 533-3178 or mailed to:

Texas Department of State Health Services  
Attn: MSJA MC 1873  
P.O. Box 149347  
Austin, TX 78714-9347

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### Problems or Questions?

Call 1-800-255-1090 or call to speak with Eric (512-533-3013) or Jack (512-533-3012)