DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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

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

AGENDA

12 noon, Thursday, March 9, 2017
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

I. Call to Order — Cecilia Ross, Chair, RW Planning Council
- A. Welcome and Moment of Reflection
- B. Adoption of the Agenda
- C. Approval of the Minutes
- D. Training: Council Activities for the 2017 HIV Comprehensive Plan — Amber Harbolt, RW Office of Support
- E. Training: How To Best Meet the Need Process — Robert Noble and Gloria Sierra, Co-Chairs, Quality Improvement Committee

II. Public Comments and Announcements — Carol Suazo, Secretary

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV/AIDS status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV/AIDS status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person with HIV/AIDS", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Committees

A. Quality Improvement Committee — Robert Noble and Gloria Sierra, Co-Chairs

Item: General Committee Orientation

Recommended Action: FYI: The Committee received Committee-specific orientation, which included learning how to review and understand reports routinely prepared by staff.

Item: Reports from Administrative Agent – Part A/MAI
Recommended Action: FYI: See the attached reports:

- FY16 Service Utilization, dated 02/08/17
- FY16 Procurement, dated 02/08/17
- FY15 Chart Reviews
    1. Power Point Summary
    2. Oral Health – Rural
    3. Primary Care
    4. Vision
- Clinical Quality Management Quarterly Committee Report

Item: Reports from Administrative Agent – Part B/SS
Recommended Action: FYI: See the attached reports:

- Schedule of 2017 Reports from The Resource Group
- Service Utilization (3), dated 02/03/17 & 02/06/17
- Procurement (2), dated 02/08/17
- Health Insur. Assist. Program (2), dated 01/10/17 & 02/08/17
- TRG Consumer Interview Results 2016

Item: Proposed Ideas
Recommended Action: **Motion:** Establish a Workgroup to study and recommend action on the two (2) Proposed Idea forms which both relate to the Emergency Financial Assistance service category.

Item: Process for Providing Input into the Part B/SS Standards of Care — Tori Williams, Director RW Office of Support
Recommended Action: FYI: Review the process for providing monthly input into the Ryan White Part B/State Services (SS) proposed Standards of Care. See attached schedule.

Item: Input into the Part B/SS Standards of Care
Recommended Action: **Motion**: The Committee recommends the following input regarding the Ryan White Part B/State Services (SS) standards of care for: Universal, Primary Outpatient Medical Care and Medical Case Management:

The Council noted the difference in formatting, contract vs. standards of care language, and performance measures and recommends that Ryan White Part A/MAI continue to use the current Part A standards of care for Universal, Primary Outpatient Medical Care and Medical Case Management. Some regulations in the Part B/SS standards seem onerous (example: is it beneficial to require agencies to ask clients about their hobbies?). Overall, this recommendation will not result in a difference in the quality of care which clients receive in the Houston EMA verses the rest of the State. In addition, there are some items in the Part B/SS standards that will be considered for adoption into the Part A standards for Medical Case Management in the Fall of 2017.

B. Affected Community Committee — Rodney Mills and Tana Pradia, Co-Chairs

Item: Committee Training
Recommended Action: FYI: See the attached items re: committee training on the purpose of the Council and the role of the committee at public hearings and health fairs.

Item: Road 2 Success Proposal
Recommended Action: FYI: See the attached proposal regarding Road 2 Success. The Committee will make a recommendation regarding this proposal in April 2017. The delay is because the Committee had to postpone their February meeting due to electrical problems at the Office of Support building the day of their meeting.

Item: 2016 Community Events
Recommended Action: FYI: Please see Tori if anyone wishes to help with a water table at the AIDS Walk on Sunday, March 5, 2017.

C. Comprehensive HIV Planning Committee — Isis Torrente and Steven Vargas, Co-Chairs

Item: Speakers Bureau Workgroup
Recommended Action: FYI: John Lazo provided a brief overview of the function and scope of the Speaker's Bureau. Members were encouraged to sign up to participate on the Speaker's Bureau Workgroup. The Workgroup is slated to meet in April, August, and December this year.

Item: 2017 Committee Timetable
Recommended Action: FYI: See the attached 2017 Committee Timetable for 2017 activities and deliverables.

Item: 2016 Needs Assessment: Profile of the Recently Released
Recommended Action: FYI: See the attached 2016 Houston HIV Care Services Needs Assessment: Profile of the Recently Released. Additional profiles detailing needs and barriers encountered among special populations represented in the Needs Assessment will be completed for transgender and gender non-conforming, youth, aging, rural, women of color, MSM, and those who are unstably housed or homeless through August.

D. Operations Committee — Curtis Bellard and Nancy Miertschin, Co-Chairs

Item: 2016 Texas Open Meetings Act Training
Recommended Action: FYI: See the attached list of those who have participated in the Open Meetings Act training.

Item: Council Orientation
Recommended Action: FYI: See the attached evaluation of the 2017 Council evaluation.

Item: Committee Orientation
Recommended Action: FYI: Per Council policy, members of the Operations Committee signed Statements of Confidentiality forms.

Item: 2017 Council Training Topics
Recommended Action: FYI: See the attached list of 2017 Council training topics.

Item: FY 2017 Council Support Budget
Recommended Action: FYI: See the attached, revised FY 2017 Council Support Budget which has been revised to accommodate an increase in the cost of employee health insurance and retirement.

E. Priority and Allocations Committee — Ella Collins-Nelson and Paul Grunenwald, Co-Chairs

Item: FY 2018 Guiding Principles and Criteria
Recommended Action: Motion: Approve the attached FY 2018 Guiding Principles and Decision Making Criteria.

Item: FY 2018 Priority Setting Process
Recommended Action: **Motion:** Approve the attached FY 2018 Priority Setting Process.

Item: FY 2017 Policy for Addressing Unobligated and Carryover Funds
Recommended Action: **Motion**: Approve the attached FY 2017 Policy for Addressing Unobligated and Carryover Funds.

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. HOPWA	Krystal Shultz
B. Community Prevention Group (CPG)	Herman Finley
C. Update from Task Forces:	
• Sexually Transmitted Infections (STI)	Herman Finley
• African American	S. Johnson-Fairley
• Latino	Gloria Sierra
• MSM	Ted Artiaga
• Transgender	Robert Noble
• Hepatitis C	Steven Vargas
• Urban AIDS Ministry	Ella Collins-Nelson
• Youth	John Lazo
D. HIV and Aging	John Lazo
E. Positive Women's Network	Tana Pradia
F. END HIV Houston	Venita Ray
G. Ryan White Part C Urban and Part D	Nancy Miertschin
H. SPNS Grant: HIV and the Homeless Program	Nancy Miertschin
I. Texas HIV Medication Advisory Committee	Nancy Miertschin
J. Texas HIV Syndicate	Amber Harbolt
K. Legislative Updates	
L. Texas HIV/AIDS Coalition	

IX. Announcements

X. Adjournment

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MINUTES

12 noon, Thursday, February 9, 2017
2223 W. Loop South, Room 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
John Lazo, Vice-Chair	Tana Pradia	Willie Barnes, ViiV
Carol Suazo, Secretary	Teresa Pruitt	Mikel Marshall, ViiV
Ted Artiaga	Venita Ray	Shabaura Perryman, BMS
Curtis Bellard	Gloria Sierra	
Skeet Boyle	Krystal Shultz	**STAFF PRESENT**
Bianca Burley	Isis Torrente	*Ryan White Grant Administration*
Ella Collins-Nelson	Steven Vargas	Carin Martin
Amber David	Larry Woods	Heather Keizman
Evelio Salinas Escamilla		*Tasha Traylor*
Herman Finley	**MEMBERS ABSENT**	
Tracy Gorden	Connie Barnes	*The Resource Group*
Angela F. Hawkins	David Benson, excused	Sha'Terra Johnson-Fairley
Denis Kelly	Johnny Deal, excused	Lashunda Robinson, intern
Tom Lindstrom	Denny Delgado, excused	Sharon Rhames, intern
Osaro Mgbere	Paul Grunenwald, excused	Nicole Booker, intern
Nancy Miertschin	Arlene Johnson, excused	
Rodney Mills	J. Hoxi Jones, excused	*Office of Support*
Allen Murray	Peta-gay Ledbetter, excused	Tori Williams
Robert Noble	Shital Patel, excused	Amber Harbolt
John Poole	Cecilia Ross, excused	Diane Beck

Call to Order: John Lazo, Vice Chair, called the meeting to order at 12:05 p.m.
During the welcoming remarks, Lazo welcomed the new Council Members, thanked the Operations Committee for the great job of organizing and hosting the Mentor Luncheon and Orientation and thanked everyone who helped with the Road 2 Success classes and the Physician Conference.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Pruitt, Hawkins) to approve the December 8, 2016 minutes.* **Motion carried.** Abstentions: Finley, Kelly, Lindstrom, Mgbere, Poole, Ray and Shultz.

Training: END HIV Houston and Crosswalk for END HIV Houston and 2017 Houston Area Comprehensive HIV Prevention and Care Services Plan: Ray and Harbolt presented the attached documents.

Public Comment and Announcements: None.

Reports from Committees:
Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following: Comprehensive Plan Kick Off Event: On January 10, 2017 the Office of Support hosted a Kick Off event for the 2017-2021 Houston Area Comprehensive HIV Prevention and Care Services Plan.

Affected Community Committee: No report.

Quality Improvement Committee: No report.

Priority and Allocations Committee: No report

Operations Committee: Curtis Bellard, Co-Chair, reported on the following.
2017 Mentor/Mentee Luncheon: The Operations Committee hosted the 2017 Mentor/Mentee Luncheon on January 19, 2017. Before the luncheon, the Chair of the Council provided training to all mentors.

2017 Council Orientation: The Operations Committee hosted the 2017 Council Orientation on January 26, 2017.

2017 Council Activities: Tori Williams reviewed the attached Petty Cash Memorandum, Timeline of Critical Activities and the Texas Open Meetings Act Training Memorandum.

Report from Office of Support: Tori Williams, Manager, summarized the attached report. She added that Council volunteers were needed to staff a water table at the AIDS Walk. Pruitt volunteered.

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

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

New Business:
HOPWA: Shultz said that they will be releasing an RFP in late March or early April.

Community Prevention Group (CPG): Finley

Updates from Task Forces:
Sexually Transmitted Infections (STI): Noble said that they are still promoting their online survey which has a $20 incentive and also an incentive for the agency that refers the most participants. The STDFree360 website has a PSA running on several local stations.

African American: Johnson-Fairley said the next meeting is tomorrow at noon at the Fifth Ward Multiservice Center located at 4014 Market Street.

Latino: Sierra presented the attached report.

MSM: Artiaga presented the attached report.

Transgender: David said that a transgender focus group was held to give the transgender community a voice and help us learn about the community needs and cultural competency such as the language that is used. There were at least 30 people in attendance.

Hepatitis C: Vargas presented the attached report.

Urban AIDS Ministry: David said that Nelson-Collins should provide this report because he does not attend this meeting. Nelson-Collins said that there was no meeting.

Youth: Lazo presented the attached report.

HIV and Aging: Lazo presented the attached report.

Positive Women's Network: Pradia said that they meet on the second Monday of the month at Legacy. There will be a presentation on February 7 Black HIV Awareness Day *entitled The Truth about HIV in the Black Community* at Reynolds Elementary in the Sunnyside area. They will also join with AAMA for their March 4th event observing Women and Girls HIV Awareness Day.

END HIV Houston: Ray presented at the start of the meeting.

Ryan White Part C Urban and Part D: Miertschin presented the attached report.

SPNS Grant: HIV and the Homeless Program: Miertschin presented the attached report.

Texas HIV Medication Advisory Committee: Miertschin presented the attached report.

Announcements: Gorden has applications for the Poz Living Conference in Florida. Kelly said that Advocacy Day is February 28 in Austin. Ray added that she will have a training for Advocacy Day on Wednesday, February 15th.

Adjournment: The meeting was adjourned at 1:50 p.m.

Respectfully submitted,

_____ _____

Victoria Williams, Director Date

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for February 9, 2017

C = Chaired the meeting ◆ ja = Just arrived at the meeting ◆ lm = Left the meeting

C = Chair of the meeting lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
John Lazo, Vice-Chair				C				C	Tana Pradia		X				X		
Carol Suazo, Secretary		X				X			Teresa Pruitt		X				X		
Ted Artiaga		X				X			Venita Ray		X						X
Curtis Bellard		X				X			Gloria Sierra		X				X		
Skeet Boyle	X				X				Krystal Shultz		X						X
Bianca Burley		X				X			Isis Torrente		X				X		
Ella Collins-Nelson		X				X			Steven Vargas		X				X		
Amber David		X				X			Larry Woods		X			X	X		
Evelio Salinas Escamilla		X				X											
Herman Finley				X				X	**MEMBERS ABSENT**								
Tracy Gorden		X				X			Connie Barnes								
Angela F. Hawkins		X				X			David Benson								
Denis Kelly		X						X	Johnny Deal								
Tom Lindstrom		X						X	Denny Delgado								
Osaro Mgbere		X						X	Paul Grunenwald								
Nancy Miertschin		X				X			Arlene Johnson								
Rodney Mills		X				X			J. Hoxi Jones								
Allen Murray		X				X			Peta-gay Ledbetter								
Robert Noble	X				X				Shital Patel								
John Poole		X						X	Cecilia Ross								

How to Best Meet the Need Process
BKA
HTBMN

Presented by The Chairs of Quality Improvement

Gloria Sierra and Robert Noble

What is the HTBMN Process

- It is a series of workgroups facilitated by the Quality Improvement Committee, that is held annually, to review and/or revise all Ryan White service definitions and determine the financial eligibility for each service.

HTBMN PROCESS CON'T

- The service definitions that will be reviewed are funded by Ryan White Part A, Part B, and State Services funding. The **Bold text indicates that a particular service** is due to be RFP'd (Request for proposal)

WHY ?

- The services are reviewed in order to improve and sometimes bring back a service that has been discontinued , (The Idea Form) or eliminate a particular service.

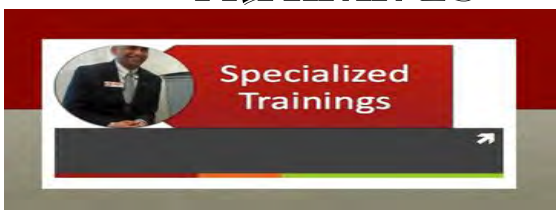
How do I

- In March and April 2017, QI will facilitate two special workgroups to discuss: Emergency Financial Assistance and how to make our services more accessible to transgender individuals.
- In April and May 2017, QI will facilitate three workgroups to review all currently funded services.

CONFLICTS OF INTEREST

- Who must declare a conflict of interest
- Who is going to vote

TRAININGS



- On March 20, 2017, the Affected Community Committee will host a training for consumers and others on the HTBMN process.
- On April 13, 2017, the QI Committee will host a training on the documents being used for decision-making. This training is especially important for anyone interested in participating in a workgroup and those serving on the Priority and Allocations Committee.

QI NEEDS YOU

- Sign up for workgroups
- Come to the trainings
- We need your input


THANK YOU!

FY 2017 How to Best Meet the Need Justification for Each Service Category

Revised: 03/18/16

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2014 Needs Assessment, 2012-2014 Comp Plan, 2013 Outcome Measures, 2013 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-14-15							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ✔ Yes ___No			

‡ Service Category for Part B/State Services only.

PUBLIC COMMENT – 02-20-17

From: Keizman, Heather (PHES)
Sent: Friday, February 17, 2017 1:35 PM
To: Williams, Victoria (County Judge's Office)
Cc: Martin, Carin (PHES)
Subject: Re: Texas DSHS Standards of Care (SOC): DSHS Link to the Draft OAHS Standards of Care and Universal Standards posted for Public Comment

Hi Tori,

I was just reading the DSHS feedback to the comments they received regarding SOC. I wanted to bring the item below to the attention of consumers (on the last page of the comments). Recently at the Sharing Science Symposium, several of our current or former council members also made the request below to the presenters. Please share with them that if they consider this an important issue, to provide their feedback to DSHS. I think it would be particularly helpful for DSHS to hear from consumers on this issue.

19. Replace patient with client everywhere in document. DSHS feedback: Patient will remain within the OAHS standard as this is a clinical standard of care.

Thanks,

Heather Keizman, RN, MSN, WHNP-BC
Project Coordinator, Clinical Quality Improvement
Ryan White Grant Administration
Harris County Public Health and Environmental Services
2223 West Loop South, #431
Houston, TX 77027
Phone: 713.439.6037
Email: hkeizman@hcphes.org

Quality Improvement Committee Report

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

FY 2016 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconciliation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,746,354**	**516,252**	**399,947**	**0**	**0**	**10,662,553**	**49.70%**	**10,662,553**	**0**		**7,325,327**	**69%**	**83%**
1.a	Primary Care - Public Clinic (a)	3,570,049	73,790	0	0		3,643,839	16.99%	3,643,839	0	3/1/2016	$2,545,954	70%	83%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,066,552	148,743	108,329	0		1,323,624	6.17%	1,323,624	0	3/1/2016	$1,090,757	82%	83%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e) (f)	929,215	128,225	108,329	0		1,165,769	5.43%	1,165,769	0	3/1/2016	$830,862	71%	83%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	926,294	78,076	108,329	0		1,112,699	5.19%	1,112,699	0	3/1/2016	$563,504	51%	83%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,143,032	23,626	0	0		1,166,658	5.44%	1,166,658	0	3/1/2016	$792,055	68%	83%
1.f	Primary Care - Women at Public Clinic (a)	1,863,570	38,519	0			1,902,089	8.87%	1,902,089	0	3/1/2016	$1,228,578	65%	83%
1.g	Primary Care - Pediatric (a.1)	15,124	313				15,437	0.07%	15,437	0	3/1/2016	$14,917	97%	83%
1.h	Vision	232,518	24,960	74,960	0		332,438	1.55%	332,438	0	3/1/2016	$258,700	78%	83%
2	**Medical Case Management**	**2,215,702**	**0**	**174,999**	**0**	**0**	**2,390,701**	**11.14%**	**2,390,701**	**0**		**1,713,507**	**72%**	**83%**
2.a	Clinical Case Management	488,656	0		0		488,656	2.28%	488,656	0	3/1/2016	$379,675	78%	83%
2.b	Med CM - Public Clinic (a)	162,622	0	0	0		162,622	0.76%	162,622	0	3/1/2016	$150,055	92%	83%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	58,333	0		379,403	1.77%	379,403	0	3/1/2016	$380,016	100%	83%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	58,333	0		379,405	1.77%	379,405	0	3/1/2016	$154,608	41%	83%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	58,333	0		165,580	0.77%	165,580	0	3/1/2016	$102,348	62%	83%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.63%	348,760	0	3/1/2016	$255,340	73%	83%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.84%	180,311	0	3/1/2016	$118,462	66%	83%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.75%	160,051	0	3/1/2016	$88,038	55%	83%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.37%	80,025	0	3/1/2016	$56,384	70%	83%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2016	$28,582	62%	83%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,581,440**	**53,356**		**0**	**0**	**2,634,796**	**12.28%**	**2,634,796**	**0**	3/1/2016	**$1,964,847**	**75%**	**83%**
4	**Oral Health**	**166,404**	**0**	**30,000**	**0**	**0**	**196,404**	**0.92%**	**196,404**	**0**	3/1/2016	**137,800**	**70%**	**83%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	30,000			196,404	0.92%	196,404	0	3/1/2016	$137,800	70%	83%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,029,422**	**0**	**0**	**0**	**0**	**1,029,422**	**4.80%**	**1,029,422**	**0**	3/1/2016	**$856,356**	**83%**	**83%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.21%**	**45,677**	**0**	3/1/2016	**$29,456**	**64%**	**83%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.59%**	**341,395**	**0**	3/1/2016	**$275,204**	**81%**	**83%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Non-Medical Case Management**	**1,440,385**	**0**	**35,378**	**0**	**0**	**1,475,763**	**6.88%**	**1,475,763**	**0**		**875,399**	**59%**	**83%**
12.a	Service Linkage targeted to Youth	110,793		0			110,793	0.52%	110,793	0	3/1/2016	$52,902	48%	83%
12.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	245,497			0		245,497	1.14%	245,497	0	3/1/2016	$53,570	22%	83%
12.c	Service Linkage at Public Clinic (a)	490,886		0	0		490,886	2.29%	490,886	0	3/1/2016	$273,589	56%	83%
12.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		35,378	0		628,587	2.93%	628,587	0	3/1/2016	$495,338	79%	83%
13	**Medical Transportation**	**527,362**	**0**	**40,000**	**0**	**0**	**567,362**	**2.64%**	**567,362**	**0**		**300,878**	**53%**	**83%**
13.a	Medical Transportation services targeted to Urban	252,680	0	20,000	0		272,680	1.27%	272,680	0	3/1/2016	$229,206	84%	83%
13.b	Medical Transportation services targeted to Rural	97,185	0	20,000	0		117,185	0.55%	117,185	0	3/1/2016	$71,672	61%	83%
13.c	Transportation vouchering (bus passes & gas cards)	177,497	0	0	0		177,497	0.83%	177,497	0	3/1/2016	$0	0%	0%
14	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
15	**Legal Assistance**	**293,406**	**-293,406**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	$0	0%	0%
[illegible]	**Total Service Dollars**	**18,387,547**	**276,202**	**680,324**	**0**	**0**	**19,344,073**	**90.17%**	**19,344,073**	**0**		**13,478,774**	**70%**	**83%**
	Grant Administration	**1,612,704**	**0**	**0**	**0**	**0**	**1,612,704**	**7.52%**	**1,612,704**	**0**	**N/A**	**1,361,266**	**84%**	**83%**
[illegible]	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.34%	1,146,388	0	N/A	$978,485	85%	83%
PC	County Judge & RWPC Support*	466,316	0		0	0	466,316	2.17%	466,316	0	N/A	382,781	82%	83%
[illegible]	**Quality Management**	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.31%**	**495,000**	**0**	**N/A**	**$409**	**0%**	**83%**
		20,495,251	**276,202**	**680,324**	**0**	**0**	**21,451,777**	**100.00%**	**21,451,777**	**0**		**14,840,448**	**69%**	**83%**
								Unallocated	Unobligated					
	Part A Grant Award:	20,771,451	*Carry Over:*	680,325		*Total Part A:*	21,451,776	-1	-1					

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

FY 2016 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
		Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent				
	Core (must not be less than 75% of total service dollars)	16,126,394	569,608	604,946	0	0	17,300,948	89.44%	17,300,948	89.44%				
	Non-Core (may not exceed 25% of total service dollars)	2,261,153	-293,406	75,378	0	0	2,043,125	10.56%	2,043,125	10.56%				
	Total Service Dollars (does not include Admin and QM)	18,387,547	276,202	680,324	0	0	19,344,073		19,344,073					
	Total Admin (must be ≤ 10% of total Part A + MAI)	1,612,704	0	0	0	0	1,612,704	7.52%						
	Total QM (must be ≤ 5% of total Part A + MAI)	495,000	0	0	0	0	495,000	2.31%						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	2,011,206	46,743	334,989	0	0	2,392,938	100.00%	2,011,206	381,732		1,449,800	72%	58%
1.b (MAI)	Primary Care - CBO Targeted to African American	1,016,618	23,627	167,495	0	0	1,207,740	50.47%	1,016,618	191,122	3/1/2016	$791,725	78%	58%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	994,588	23,116	167,494	0	0	1,185,198	49.53%	994,588	190,610	3/1/2016	$658,075	66%	58%
	Total MAI Service Funds	2,011,206	46,743	334,989	0	0	2,392,938	100.00%	2,011,206	381,732		1,449,800	72%	58%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Funds	2,011,206	46,743	334,989	0	0	2,392,938	100.00%	2,011,206	381,732		1,449,800	72%	58%
	MAI Grant Award	2,057,949	*Carry Over:*	577,522		*Total MAI:*	2,635,471							
	Combined Part A and MAI Total	22,506,457												

Footnotes:

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

FY 2016 Ryan White Part A and MAI Service Utilization Report

SUR - 3rd Quarter Cumulative (3/1-11/30)																				
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	Verify	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus	Verify
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	6,467	6,743	73%	27%	100%	49%	15%	2%	34%	100%	0%	1%	6%	26%	27%	14%	25%	2%	100%
1.a	Primary Care - Public Clinic (a)	2,350	3,138	69%	31%	100%	52%	10%	2%	36%	100%	0%	0%	3%	19%	26%	14%	35%	3%	100%
1.b	Primary Care - CBO Targeted to AA (a) (g)	1,060	1,545	70%	30%	100%	99%	0%	1%	0%	100%	0%	1%	11%	36%	26%	11%	15%	1%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (g)	960	1,031	84%	16%	100%	0%	0%	0%	100%	100%	0%	0%	7%	29%	33%	14%	15%	1%	100%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	644	87%	13%	100%	0%	88%	11%	0%	100%	0%	0%	5%	27%	25%	17%	24%	2%	100%
1.e	Primary Care - CBO Targeted to Rural (a)	400	690	74%	26%	100%	47%	18%	2%	33%	100%	0%	1%	8%	33%	27%	12%	18%	2%	100%
1.f	Primary Care - Women at Public Clinic (a)	1,000	956	0%	100%	100%	64%	7%	2%	27%	100%	0%	0%	2%	16%	30%	15%	33%	3%	100%
1.g	Primary Care - Pediatric (a)	7	15	53%	47%	100%	53%	7%	0%	40%	100%	27%	47%	27%	0%	0%	0%	0%	0%	100%
1.h	Vision	1,600	1,644	75%	25%	100%	47%	16%	2%	34%	100%	0%	0%	4%	21%	23%	16%	32%	3%	100%
2	**Local Drug Reimbursement Program (a)**	2,845	3,576	77%	23%	100%	49%	16%	2%	33%	100%	0%	0%	6%	30%	29%	14%	19%	1%	100%
3	**Medical Case Management (f)**	3,075	4,461																	
3.a	Clinical Case Management	600	1,081	73%	27%	100%	60%	23%	2%	16%	100%	0%	0%	7%	25%	23%	12%	31%	3%	100%
3.b	Med CM - Targeted to Public Clinic (a)	280	428	98%	2%	100%	58%	9%	2%	31%	100%	0%	2%	22%	18%	18%	9%	29%	2%	100%
3.c	Med CM - Targeted to AA (a)	550	1,606	68%	32%	100%	99%	0%	1%	0%	100%	0%	1%	10%	31%	25%	12%	20%	1%	100%
3.d	Med CM - Targeted to H/L(a)	550	683	84%	16%	100%	0%	0%	0%	100%	100%	0%	1%	7%	32%	28%	15%	16%	2%	100%
3.e	Med CM - Targeted to White and/or MSM (a)	260	463	88%	12%	100%	0%	90%	10%	0%	100%	0%	0%	2%	24%	22%	16%	33%	2%	100%
3.f	Med CM - Targeted to Rural (a)	150	706	72%	28%	100%	45%	25%	3%	27%	100%	0%	1%	7%	26%	23%	14%	26%	4%	100%
3.g	Med CM - Targeted to Women at Public Clinic (a)	240	223	0%	100%	100%	69%	7%	2%	23%	100%	0%	2%	13%	14%	26%	13%	27%	4%	100%
3.h	Med CM - Targeted to Pedi (a)	125	96	50%	50%	100%	74%	5%	0%	21%	100%	60%	28%	11%	0%	0%	0%	0%	0%	100%
3.i	Med CM - Targeted to Veterans	200	152	95%	5%	100%	76%	14%	1%	9%	100%	0%	0%	0%	3%	3%	5%	70%	20%	100%
3.j	Med CM - Targeted to Youth	120	104	99%	1%	100%	64%	6%	2%	28%	100%	0%	10%	90%	0%	0%	0%	0%	0%	100%
4	**Oral Health**	200	246	68%	32%	100%	40%	34%	0%	26%	100%	0%	0%	6%	23%	25%	14%	30%	3%	100%
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	246	68%	32%	100%	40%	34%	0%	26%	100%	0%	0%	6%	23%	25%	14%	30%	3%	100%
5	**Medical Nutritional Therapy/Nutritional Supplements**	650	464	78%	22%	100%	39%	24%	3%	33%	100%	0%	0%	2%	10%	20%	19%	43%	6%	100%
6	**Mental Health Services (d)**	NA	NA																	
7	**Health Insurance**	1,700	1,121	83%	17%	100%	40%	31%	2%	27%	100%	0%	0%	3%	16%	23%	16%	38%	4%	100%
8	**Substance Abuse Treatment - Outpatient**	40	26	96%	4%	100%	27%	58%	0%	15%	100%	0%	0%	4%	23%	31%	15%	27%	0%	100%
9	**Hospice Services (d)**	NA	NA																	
10	**Home and Community Based Services (d)**	NA	NA																	
11	**Early Medical Intervention Services (d)**	NA	NA																	
12	**Non-Medical Case Management**	7,045	5,819																	
12.a	Service Linkage Targeted to Youth	320	190	78%	22%	100%	59%	8%	3%	31%	100%	0%	14%	86%	0%	0%	0%	0%	0%	100%
12.b	Service Linkage at Testing Sites	260	140	64%	36%	100%	69%	9%	1%	21%	100%	0%	0%	0%	30%	22%	11%	30%	6%	100%
12.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	2,463	68%	32%	100%	62%	11%	1%	26%	100%	0%	0%	0%	20%	24%	13%	39%	4%	100%
12.d	Service Linkage at CBO Primary Care Programs (a)	2,765	3,026	76%	24%	100%	56%	14%	2%	28%	100%	2%	1%	9%	28%	24%	12%	21%	2%	100%
13	**Food Pantry ~~(funded by State Services)~~**	NA	NA																	
14	**Transportation**	2,850	2,407																	
14.a	Transportation Services - Urban	170	384	66%	34%	100%	59%	13%	2%	26%	100%	0%	0%	7%	26%	26%	12%	26%	3%	100%
14.b	Transportation Services - Rural	130	114	76%	24%	100%	34%	41%	2%	23%	100%	0%	0%	7%	22%	18%	16%	32%	4%	100%
14.c.1	Transportation vouchering (bus passes)	2,500	1,849																	
14.c.2	Transportation vouchering (gas vouchers)	50	60																	
15	**Legal Assistance**	390	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
16	**Linguistic Services (d)**	NA	NA																	
	Net unduplicated clients served - all categories*	10,200	11,378	74%	26%	100%	53%	16%	2%	29%	100%	1%	1%	6%	23%	24%	13%	29%	3%	100%
	Living AIDS cases + estimated Living HIV non-AIDS (from FY 14 App) (b)	NA	22,830	74%	26%	100%	49%	23%	3%	25%	100%	0%	6%		18%	27%	30%	18%		100%

**10,200* clients to be served is based on the number of unduplicated clients served in FY 2013 (update per CPCDMS)

FY 2016 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	Verify	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus	Verify
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,433	72%	28%	100%	99%	0%	1%	0%	100%	0%	1%	11%	36%	27%	11%	14%	0%	100%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,060	87%	13%	100%	0%	0%	0%	100%	100%	0%	0%	7%	31%	32%	14%	15%	1%	100%

RW Part A New Client Service Utilization Report

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/12 - 2/28/13)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	Verify	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus	Verify
1	Primary Medical Care	2,100	1,408	78%	22%	100%	55%	13%	3%	29%	100%	0%	2%	11%	36%	23%	11%	17%	1%	100%
2	LPAP	1,200	540	81%	19%	100%	55%	14%	3%	28%	100%	0%	2%	10%	37%	27%	11%	13%	1%	100%
3.a	Clinical Case Management	400	194	81%	19%	100%	60%	20%	3%	18%	100%	0%	2%	14%	37%	21%	11%	15%	0%	100%
3.b-3.h	Medical Case Management	1,600	840	77%	23%	100%	57%	14%	2%	27%	100%	2%	4%	14%	35%	22%	10%	13%	0%	100%
3.i	Medical Case Manangement - Targeted to Veterans	60	39	95%	5%	100%	77%	15%	0%	8%	100%	0%	0%	0%	5%	3%	3%	69%	21%	100%
4	Oral Health	40	23	74%	26%	100%	48%	17%	0%	35%	100%	0%	0%	9%	39%	26%	13%	13%	0%	100%
12.a. 12.c. 12.d.	Non-Medical Case Management (Service Linkage)	3,700	1,595	75%	25%	100%	59%	13%	2%	26%	100%	1%	2%	10%	32%	23%	11%	20%	1%	100%
12.b	Service Linkage at Testing Sites	260	90	70%	30%	100%	61%	10%	1%	28%	100%	0%	3%	14%	39%	19%	7%	14%	3%	100%

Footnotes:

(a)	Bundled Category
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(d)	Funded by Part B and/or State Services
(e)	Not funded in FY 2014
(f)	Total MCM served does not include Clinical Case Management
(g)	CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

Ryan White Part A, Houston EMA FY 2015 Chart Review

Chart Reviews Conducted

- Primary Care
- Vision
- Dental- Rural Target

Chart Review Process

- Review period: 3/1/15-2/28/16
- Sample was representative of the RWPA EMA population, with the exception that women and transgender clients were over sampled
- Data abstraction tool used to collect data
- Data collected for 28 performance measures

Sample Size Selection

- Charts were reviewed from a random sample of 635 clients out of 6,819 primary care clients (9.3%)
- RWGA uses a 90% confidence level with +/- 3.5% confidence interval
  - National Quality Center recommends 90% confidence level with +/- 16% confidence interval
  - DSHS recommends 80% confidence level with +/- 8% confidence interval

Trends

- Over the last few years, gradual increases have been seen in:
  - Gonorrhea/Chlamydia
  - Hepatitis B vaccination
  - Hepatitis C screening and treatment
  - Mental Health screening
  - Cervical cancer screening
- Decreases have been seen in:
  - Documentation of HIV risk counseling

Core Measures

- Viral Load Suppression
  - Houston EMA 86.4% (FY14 92%) HIVQUAL Mean 82%
- ART Prescription
  - Houston EMA 96.5% (FY14 95.3%) HIVQUAL Mean 91%
- PCP Prophylaxis
  - Houston EMA 93% (FY14 100%) HIVQUAL Mean 80%

Ethnic/Racial Disparities

- Ethnic/racial disparities continue to be seen for most measures

Improvement Plans

- Agencies are required to submit improvement plans to RWGA for measures needing improvement

Item	Goal	Interventions	Timeline for Implementation	Evaluation Method	Evaluation Date(s)	Outcome
Hepatitis C Screening	1. Hepatitis C Screening will increase to 98% (current 86%)	1. An alert has been placed in the patient chart to notify provider at future appointments that that Hepatitis C screening is needed. 2. Continue to provide Hepatitis Panel screening at all initial HIV primary care visits.	1/4/16	CPCDMS report will be run to monitor this performance measure	April 2016	

Vision

- Charts were reviewed from a random sample of 150 clients out of 2,066 vision clients (7.3%)
- Sample was representative of the RWPA EMA population
- Review period: 3/1/15-2/28/16

Vision

- Overall, performance is high and is consistent with quality vision care
- Findings:
  - 15/18 (83.3%) measures had at least 95% performance
  - Increases in CD4 and VL documentation to 64% (48% in 2014)
  - Eleven clients had documented eye disease and all were managed appropriately

Oral Heath Care- Rural Target

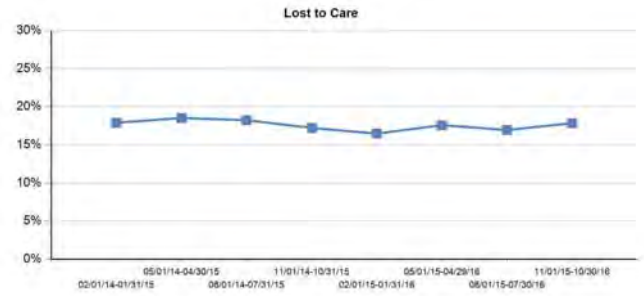
- Charts were reviewed from a random sample of 75 clients out of 288 dental clients (26%)
- Sample was representative of the RWPA EMA population
- Review period: 3/1/15-2/28/16

Oral Heath Care- Rural Target

- Overall, performance is high
- 88% of clients received an intraoral and an extraoral exam
- 92% received periodontal screening
- One client had documented oral disease and had not yet returned for evaluation

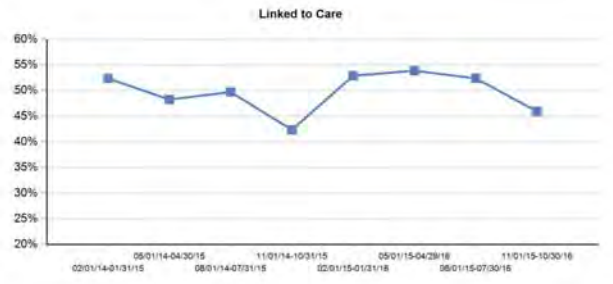
Quarterly Report

- Lost to Care
  - Percentage of *uninsured* patients who had no medical visit and a detectable or missing viral load test in the last 6 months of the measurement year
  - Has been stable over the past year



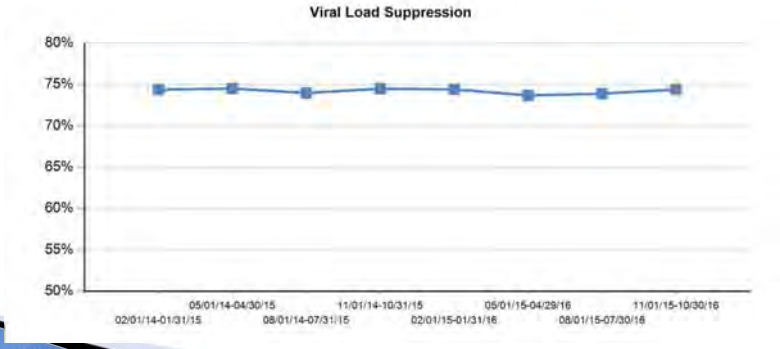
Quarterly Report

- Linked to Care
  - Percentage of newly enrolled *uninsured* patients who had a medical visit in each of the 4-month periods of the measurement year
  - Generally hovered around 50% for the last few years



Quarterly Report

- Viral Load Suppression
  - Percentage of clients with a viral load of <200 copies/ml at last HIV viral load test in the measurement year



Any Questions?

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Oral Health Care-Rural Target Chart Review FY 2015

Ryan White Part A Quality Management Program–Houston EMA

January 2017

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

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health & Environmental Services. During FY 15, a comprehensive review of client dental records was conducted for services provided between 3/1/15 to 2/28/16. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 15 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

Table 1. Data Collection Parameters

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

The Sample Selection Process

The sample population was selected from a pool of 288 unduplicated clients who accessed Part A oral health care between 3/1/15 and 2/28/16. The medical charts of 75 of these clients were used in the review, representing 26% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/15 and 2/28/16 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 15 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	29	38.7%	110	38.2%
White	44	58.7%	172	59.7%
Asian	1	1.3%	2	.7%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	0	0%	1	.4%
Multi-Race	1	1.3%	3	1.4%
	75		**288**	
Hispanic Status				
Hispanic	18	24%	78	27.1%
Non-Hispanic	57	76%	210	72.9%
	75		**288**	
Gender				
Male	49	65.3%	197	68.4%
Female	26	34.7%	90	31.3%
Transgender	0	0%	1	.4%
	75		**288**	
Age				
18 – 24	4	5.3%	16	5.6%
25 – 34	14	18.7%	64	22.2%
35 – 44	23	30.7%	90	31.3%
45 – 54	21	28%	78	27.1%
55 – 64	11	14.7%	33	11.5%
65+	2	2.7%	7	2.4%
	75		**288**	

Findings

Clinic Visits

Information gathered during the 2015 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

A complete and thorough assessment of a patient's medical history is essential among individuals infected with HIV or anyone who is medically compromised. Such information, such as current medication or any history of alcoholism for example, offers oral health care providers key information that may determine the appropriateness of prescriptions, oral health treatments and procedures. The form that is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will focus on the assessment of information that is of particular importance among HIV/AIDS patients compared to patients in the general population.

Assessment of Medical History

	2013	2014	2015
Primary Care Provider	79%	67%	88%
Dental Health History*	73%	97%	93%
Medical Health History*	72%	81%	83%
Medical History 6 month Update	57%	59%	94%
Medication Review	85%	61%	91%
Allergies Recorded	87%	81%	93%
Documentation of HIV Status	92%	6%	71%
Documentation of Opportunistic Infection Status	71%	53%	93%
Tobacco Use	88%	81%	95%
Substance Abuse	87%	80%	95%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2013	2014	2015
Vital Signs	99%	96%	99%
CBC documented	80%	59%	63%
Screening for Antibiotic Prophylaxis	91%	83%	91%

Prevention and Detection of Oral Disease

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

	2013	2014	2015
Oral Health Education*	85%	87%	80%
Clinical Tooth Chart	99%	100%	99%
Intraoral Exam	95%	92%	88%
Extraoral Exam	95%	91%	88%
Periodontal screening*	91%	91%	92%
X-rays present	95%	94%	92%
Treatment plan*	93%	89%	81%

*HIV/AIDS Bureau (HAB) Performance Measures

One client presented with oral pathology, but had not yet returned for evaluation by the dentist.

Procedures Performed

	2014	2015
Extractions	32%	29%
Fillings	59%	60%
Root Canals	7%	11%
Dentures	13%	11%
Crowns	11%	17%

Conclusions

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

Appendix A – Resources

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

HIV/AIDS Bureau. (2013). *HIV Performance Measures*. Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

Mountain Plains AIDS Education and Training Center. (2013). Oral Health Care for the HIV-infected Patient. Retrieved from: http://aidsetc.org/resource/oral-health-care-hiv-infected-patient.

New York State Department of Health AIDS Institute. (2004). *Promoting Oral Health Care for People with HIV Infection*. Retrieved from: http://www.hivdent.org/_dentaltreatment_/pdf/oralh-bp.pdf.

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

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Primary Care Chart Review Report FY 2015

Ryan White Part A Quality Management Program – Houston EMA

December 2016

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

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2015 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Medical Services to five organizations. Approximately 7,800 unduplicated-HIV positive individuals are serviced by these organizations.

Harris County Public Health (HCPH) must ensure the quantity, quality and cost effectiveness of primary medical care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

Introduction

On April 13, 2015, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV/AIDS. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/15 and 2/28/16. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents: May 1, 2014*, were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Management (CQM) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, 2014* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

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

If documentation on a particular element was not found a "no data" response was entered into the database. Some elements require that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was it repeated at the prescribed interval? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to get at quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider? For some data elements, the primary issue was not the final report per se, but more of whether the requisite test/exam was performed or not, i.e., STD screening or whether there was an updated history and physical.

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

Tale 1. Data Collection Parameters

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

Tale 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	CD4, Viral Load Assays, and CBCs are recommended every 3-6 months. Clients on ART should have a Liver Function Test and a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Annual screening is recommended, either PPD, IGRA or chest X-ray
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the study period
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV/AIDS Education	Documentation of topics covered including disease process, staging, exposure, transmission, risk reduction, diet and exercise
Pneumocystis carinii Pneumonia Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis

The Sample Selection Process

The sample population was selected from a pool of 6,819 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/15 and 2/28/16. The medical charts of 635 clients were used in this review, representing 9.3% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV/AIDS health issues, women were over-sampled, comprising 46.6% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/15-2/28/16

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	315	49.6%	5,010	73.47%
Female	296	46.6%	1,742	25.55%
Transgender Male to Female	24	3.8%	64	.94%
Transgender Female to Male	0	0%	3	.04%
TOTAL	**635**		**6,819**	
Race				
Asian	5	.8%	86	1.26%
African-Amer.	309	48.7%	3,440	50.45%
Pacific Islander	0	0%	8	.12%
Multi-Race	2	.3%	44	.65%
Native Amer.	4	.6%	24	.35%
White	315	49.6%	3,217	47.18%
TOTAL	**635**		**6,819**	
Hispanic				
Non-Hispanic	400	63%	4,407	64.63%
Hispanic	235	37%	2,412	35.37%
TOTAL	**635**		**6,819**	
Age				
18-24	38	6%	519	7.61%
25-34	150	23.6%	1,854	27.19%
35-44	189	29.8%	1,986	29.12%
45-54	181	28.5%	1,711	25.09%
55-64	69	10.9%	675	9.9%
65 and older	**8**	1.3%	74	1.09%
Total	**635**		**6,819**	

Report Structure

In November 2013, the Health Resource and Services Administration's (HRSA), HIV/AIDS Bureau (HAB) revised its performance measure portfolio[1]. The categories included in this report are: Core, All Ages, and Adolescents/Adult. These measures are intended to serve as indicators for use in monitoring the quality of care provided to patients receiving Ryan White funded clinical care. In addition to the HAB measures, several other primary care performance measures are included in this report. When available, data and results from the 2 preceding years are provided, as well as comparison to national benchmarks. Performance measures are also depicted with results categorized by race/ethnicity.

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

Findings

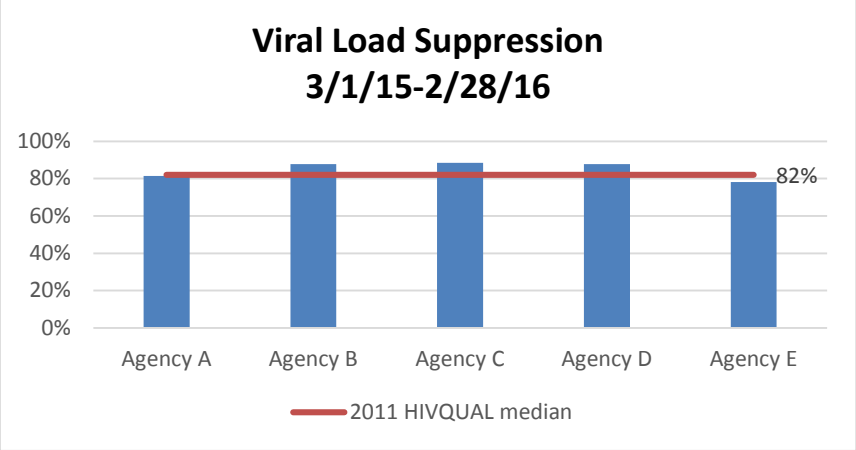
Core Performance Measures

Viral Load Suppression

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

	2013	2014	2015
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	509	539	519
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	579	586	601
Rate	**87.9%**	**92%**	**86.4%**
	1.6%	**4.1%**	**-5.6%**

2015 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	210	202	105
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	253	228	117
Rate	**83%**	**88.6%**	**89.7%**



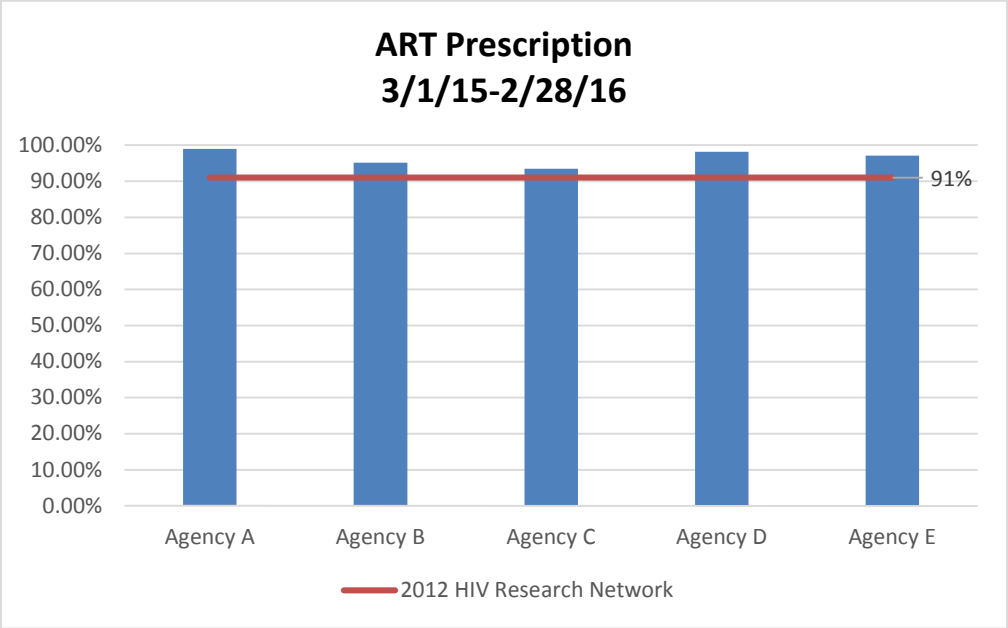
ART Prescription

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

	2013	2014	2015
Number of clients who were prescribed an ART regimen within the measurement year	609	605	613
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**95.9%**	**95.3%**	**96.5%**
Change from Previous Years Results	**2.6%**	**-.6%**	**1.2%**

- Of the 22 clients not on ART, none had a CD4 <200

2015 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	260	231	118
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	275	235	121
Rate	**94.5%**	**98.3%**	**97.5%**



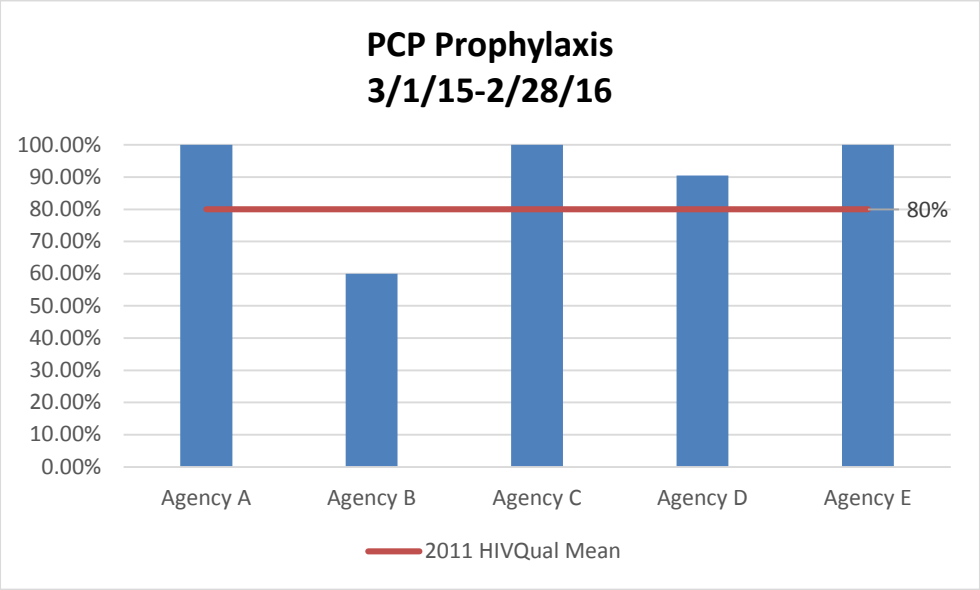
PCP Prophylaxis

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

	2013	2014	2015
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	75	45	53
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	76	45	57
Rate	**98.7%**	**100%**	**93%**
Change from Previous Years Results	**.9%**	**1.3%**	**-7%**

*Two clients refused PCP prophylaxis

2015 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	29	15	8
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	31	17	8
Rate	**93.5%**	**88.2%**	**100%**



All Ages Performance Measures

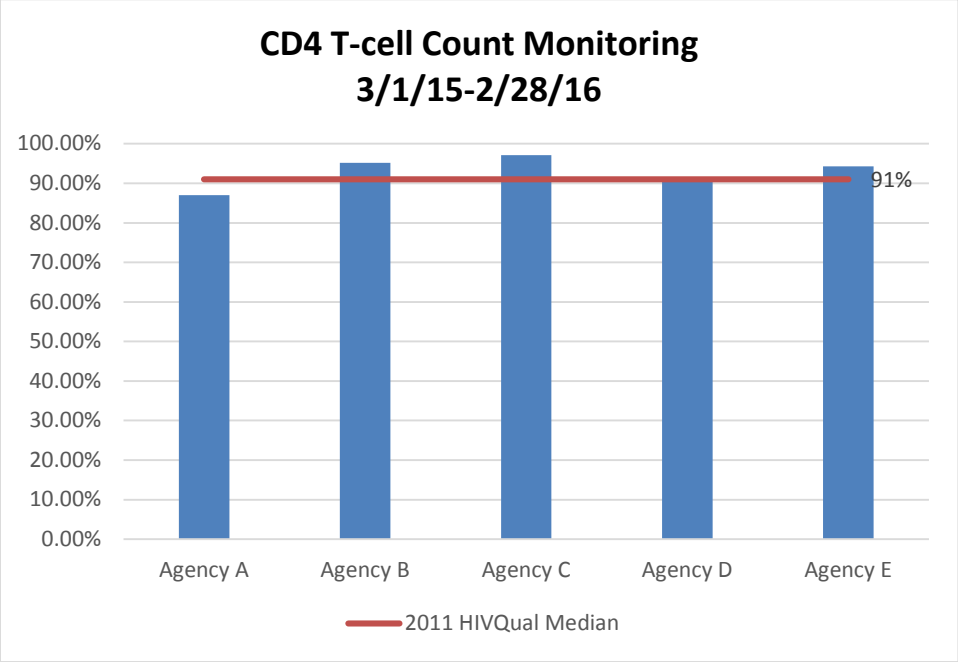
CD4 T-Cell Count

- Percentage of clients with HIV infection who had a CD4 T-cell count performed at least every six months during the measurement year

	2013	2014	2015
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	575	581	590*
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**90.6%**	**91.5%**	**92.9%**
Change from Previous Years Results	**18.1%**	**.9%**	**1.4%**

*Includes 5 clients for whom only 1 CD4 count test was indicated.

2015 CD4 by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	255	215	116
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	275	235	121
Rate	**92.7%**	**91.5%**	**95.9%**

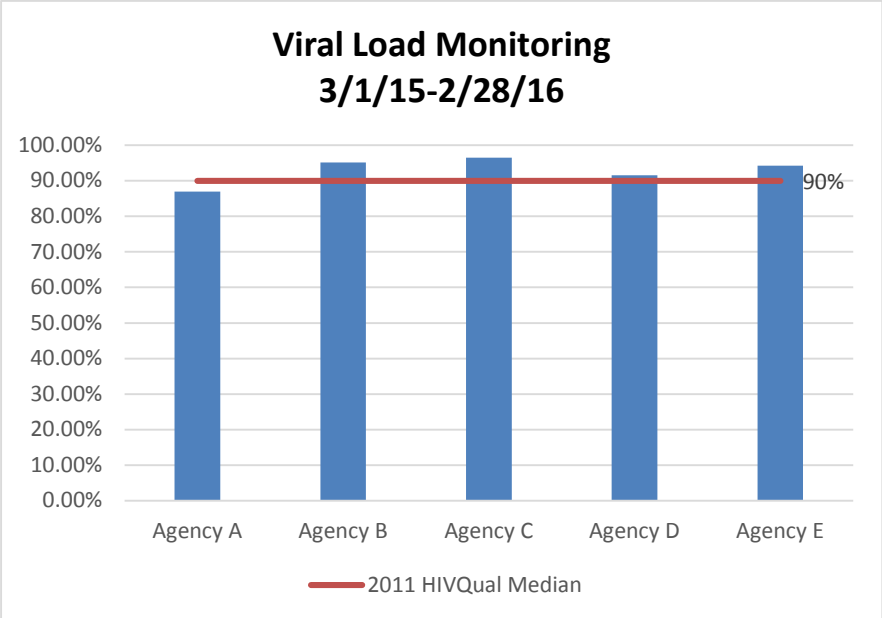


Viral Load Monitoring

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

	2013	2014	2015
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year*	573	580	590
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**90.2%**	**91.3%**	**92.9%**
Change from Previous Years Results	**17.3%**	**1.1%**	**1.4%**

2015 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year	255	215	116
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	275	235	121
Rate	**92.7%**	**91.5%**	**95.9%**

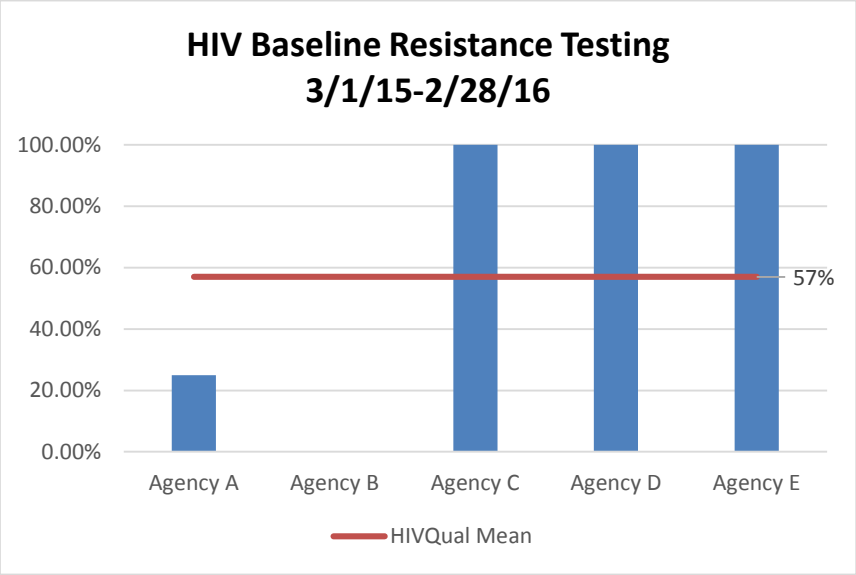


HIV Drug Resistance Testing Before Initiation of Therapy

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

	2013	2014	2015
Number of patients who had an HIV drug resistance test performed at any time before initiation of HIV ART	14	17	7
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	21	20	10
Rate	**66.7%**	**85%**	**70%**
Change from Previous Years Results		**18.3%**	**-15%**

2015 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of patients who had an HIV drug resistance test performed at any time before initiation of HIV ART	3	2	2
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	4	3	3
Rate	**75%**	**66.7%**	**66.7%**



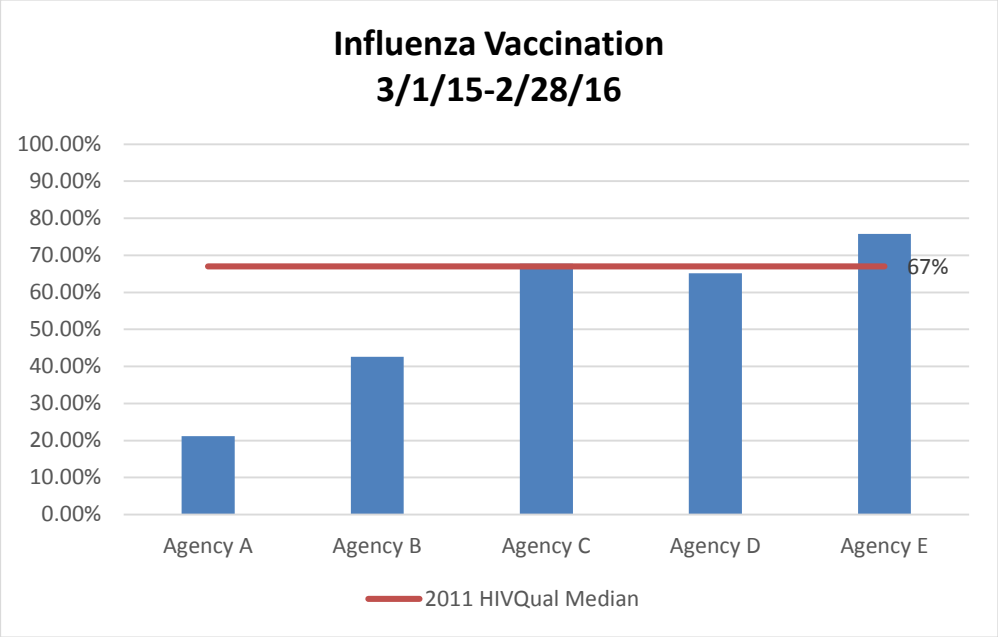
Influenza Vaccination

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

	2013	2014	2015
Number of HIV-infected clients who received influenza vaccination within the measurement year	383	404	326
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	615	607	579
Rate	**62.3%**	**66.6%**	**56.3%**
Change from Previous Years Results	**3.2%**	**4.3%**	**-10.3%**

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

2015 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who received influenza vaccination within the measurement year	132	125	67
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	248	217	110
Rate	**53.2%**	**57.6%**	**60.9%**

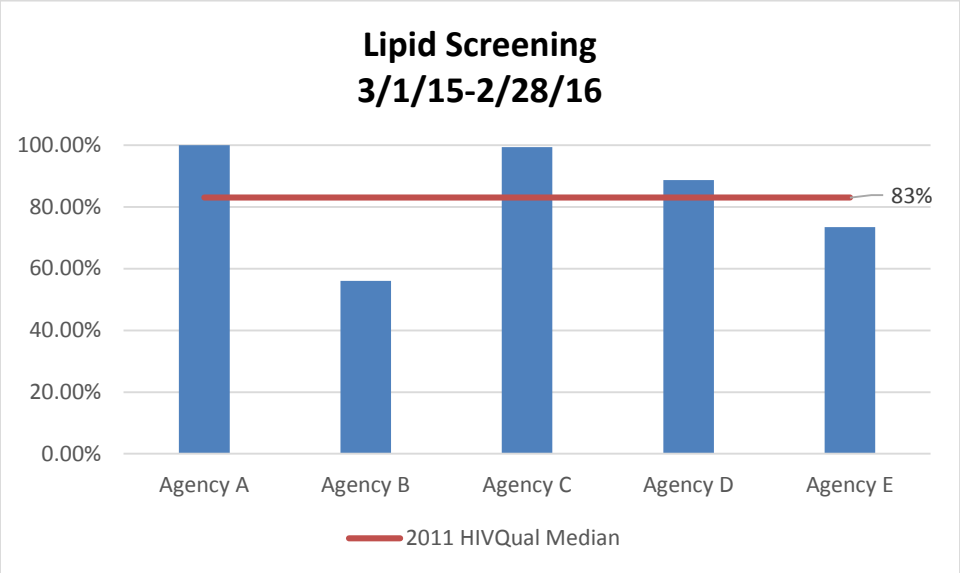


Lipid Screening

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

	2013	2014	2015
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	562	563	542
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	609	605	613
Rate	**92.3%**	**93.1%**	**88.4%**
Change from Previous Years Results	**5.2%**	**.8%**	**-4.7%**

2015 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	219	210	110
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	260	231	118
Rate	**84.2%**	**90.1%**	**93.2%**

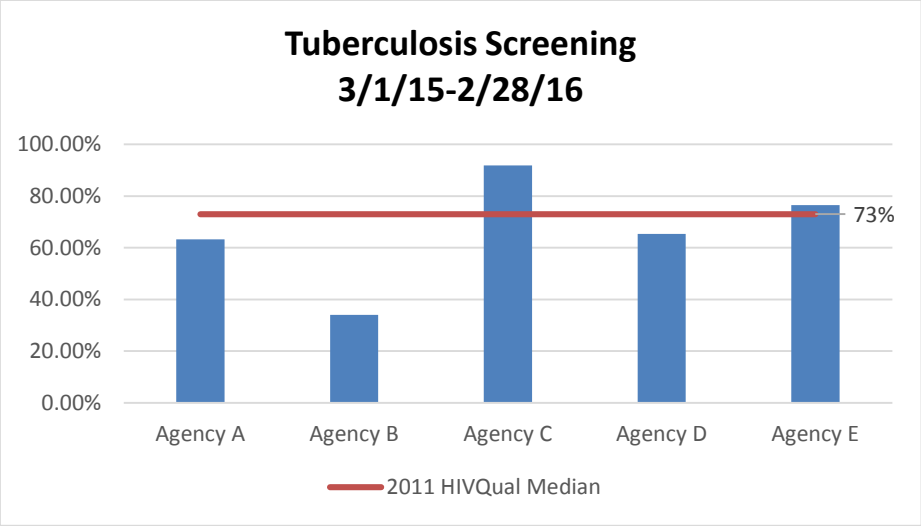


Tuberculosis Screening

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

	2013	2014	2015
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	355	404	376
Number of HIV-infected clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	573	568	560
Rate	**62%**	**71.1%**	**67.1%**
Change from Previous Years Results	**5.6%**	**9.1%**	**-4%**

2015 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	157	144	72
Number of HIV-infected clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	245	206	105
Rate	**64.1%**	**69.9%**	**68.6%**



Adolescent/Adult Performance Measures

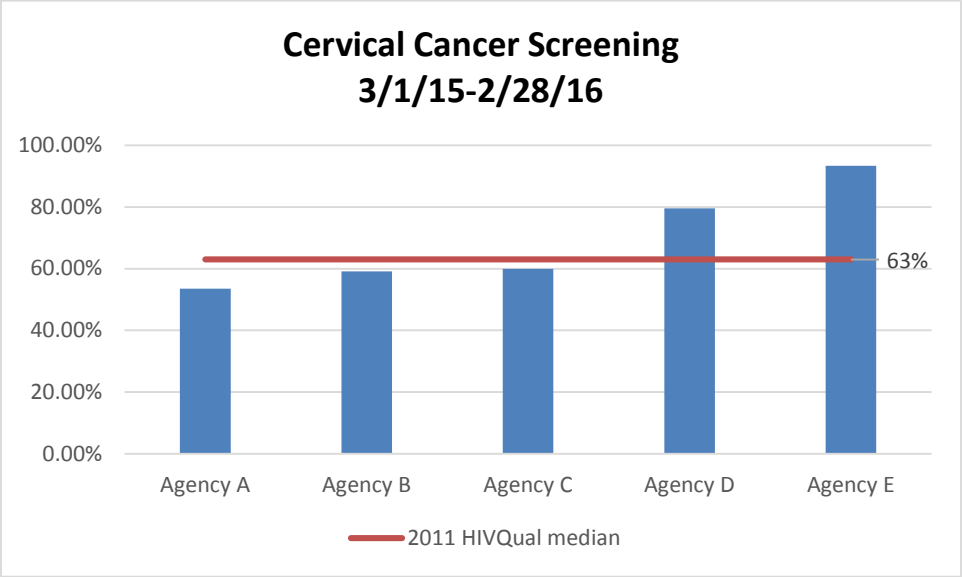
Cervical Cancer Screening

- Percentage of women with HIV infection who have Pap screening results documented in the measurement year

	2013	2014	2015
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	167	183	197*
Number of HIV-infected female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	273	288	289
Rate	**61.2%**	**63.5%**	**68.2%**
Change from Previous Years Results	**6.7%**	**2.3%**	**5.3%**

- 20.3% (40/197) of pap smears were abnormal
- *Includes 30 women who had screening within 3 years as indicated

2015 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	133	56	8
Number of HIV-infected female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	189	74	24
Rate	**70.4%**	**75.7%**	**33.3%**



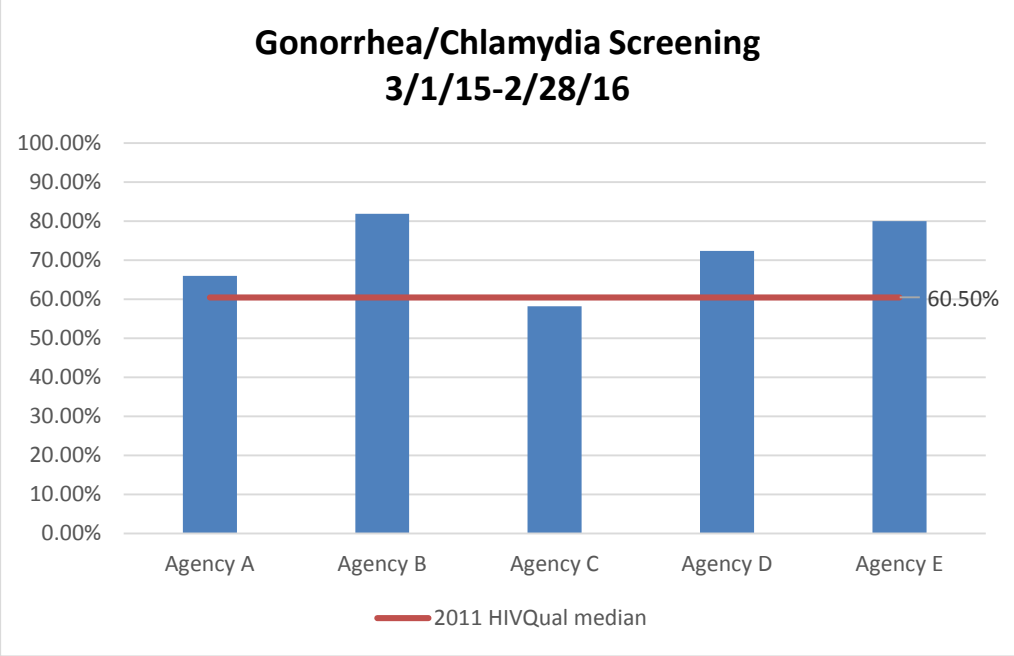
Gonorrhea/Chlamydia Screening

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

	2013	2014	2015
Number of HIV-infected clients who had a test for Gonorrhea/Chlamydia	396	424	442
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	631	635
Rate	**62.4%**	**67.2%**	**69.6%**
Change from Previous Years Results	**8.1%**	**4.8%**	**2.4%**

- 19 cases of CT and 13 cases of GC were identified

2015 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	198	160	83
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**72%**	**68.1%**	**68.6%**



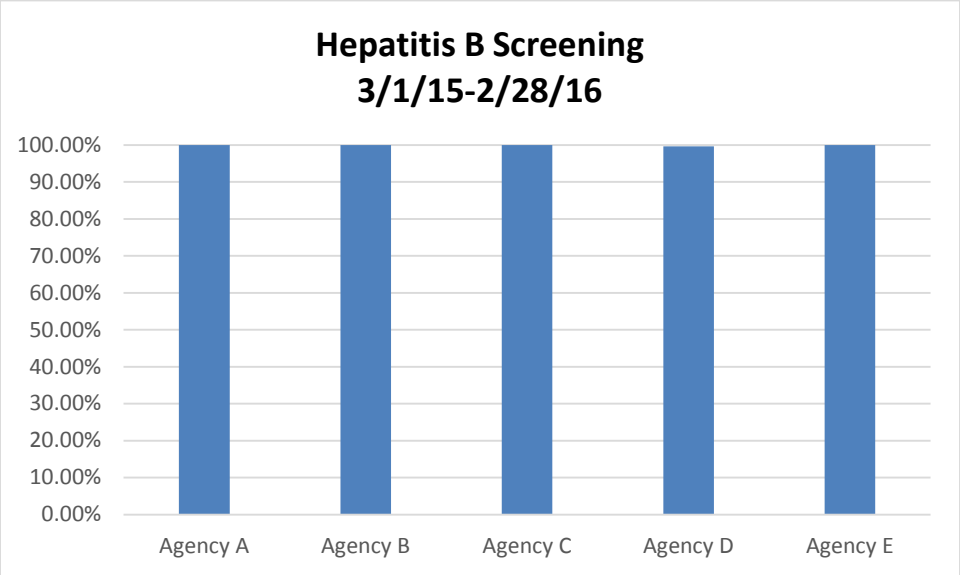
Hepatitis B Screening

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

	2013	2014	2015
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	620	627	634
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**97.6%**	**98.7%**	**99.8%**
Change from Previous Years Results	**-.4%**	**1.1%**	**1.1%**

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

2015 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	274	235	121
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**99.6%**	**100%**	**100%**

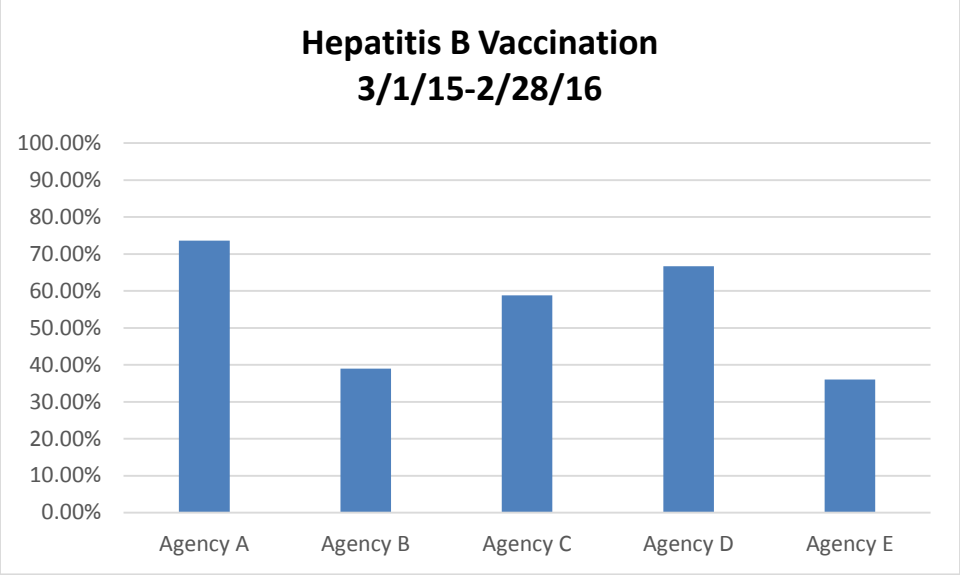


Hepatitis B Vaccination

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

	2013	2014	2015
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	165	179	184
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	328	322	307
Rate	**50.3%**	**55.6%**	**59.9%**
Change from Previous Years Results	**7.4%**	**5.3%**	**4.3%**

2015 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	63	90	31
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	124	132	50
Rate	**50.8%**	**68.2%**	**62%**



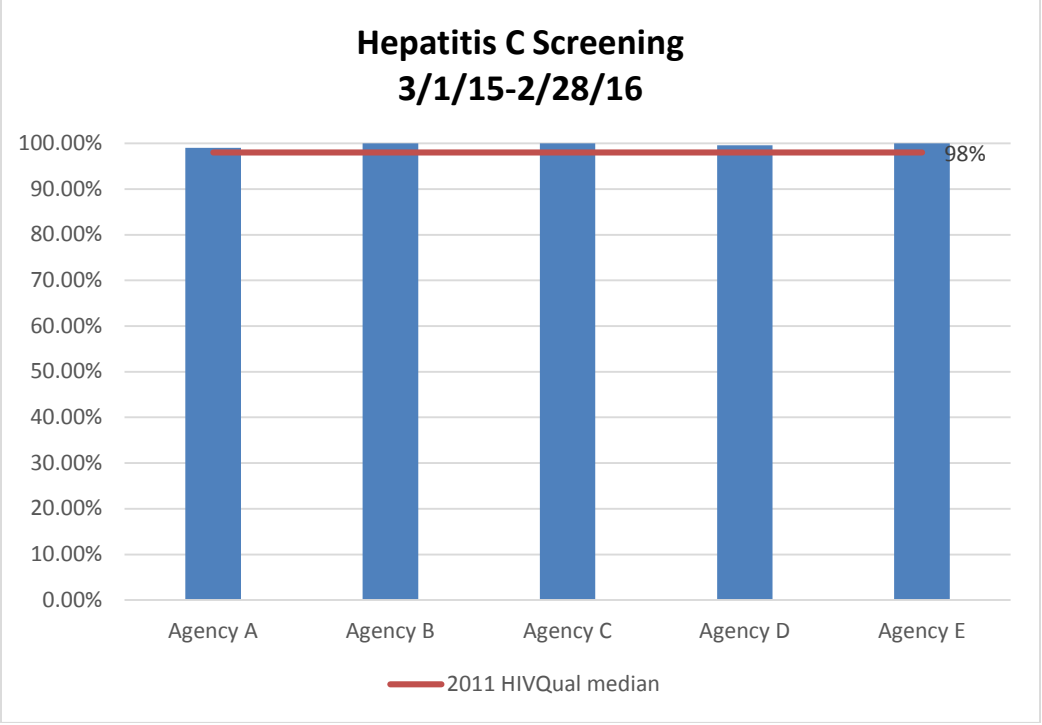
Hepatitis C Screening

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

	2013	2014	2015
Number of HIV-infected clients who have documented HCV status in chart	607	626	633
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**95.6%**	**98.6%**	**99.7%**
Change from Previous Years Results	**-2.9%**	**3%**	**1.1%**

- 6% (38/635) were Hepatitis C positive, including 6 acute infections only and 13 cures

2015 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who have documented HCV status in chart	273	235	121
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**99.3%**	**100%**	**100%**

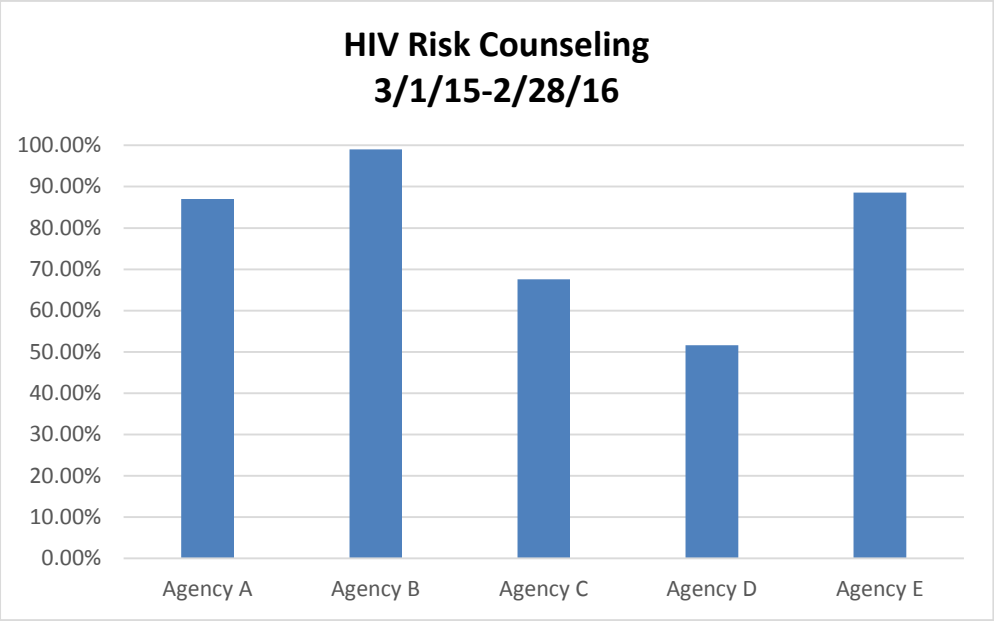


HIV Risk Counseling

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

	2013	2014	2015
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	526	489	453
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**82.8%**	**77%**	**71.3%**
Change from Previous Years Results	**-2.6%**	**-5.8%**	**-5.7%**

2015 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	204	170	76
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**74.2%**	**72.3%**	**62.8%**

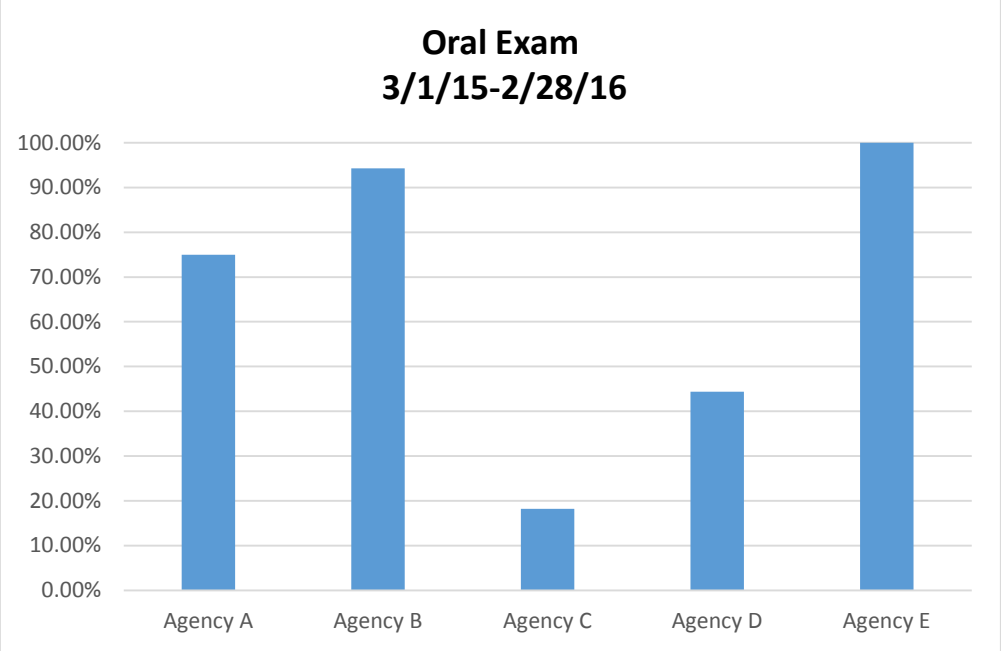


Oral Exam

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

	2013	2014	2015
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	364	356	340
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**57.3%**	**56.1%**	**53.5%**
Change from Previous Years Results	**2.9%**	**-.8%**	**-2.6%**

2015 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	153	125	60
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	275	235	121
Rate	**55.6%**	**53.2%**	**49.6%**



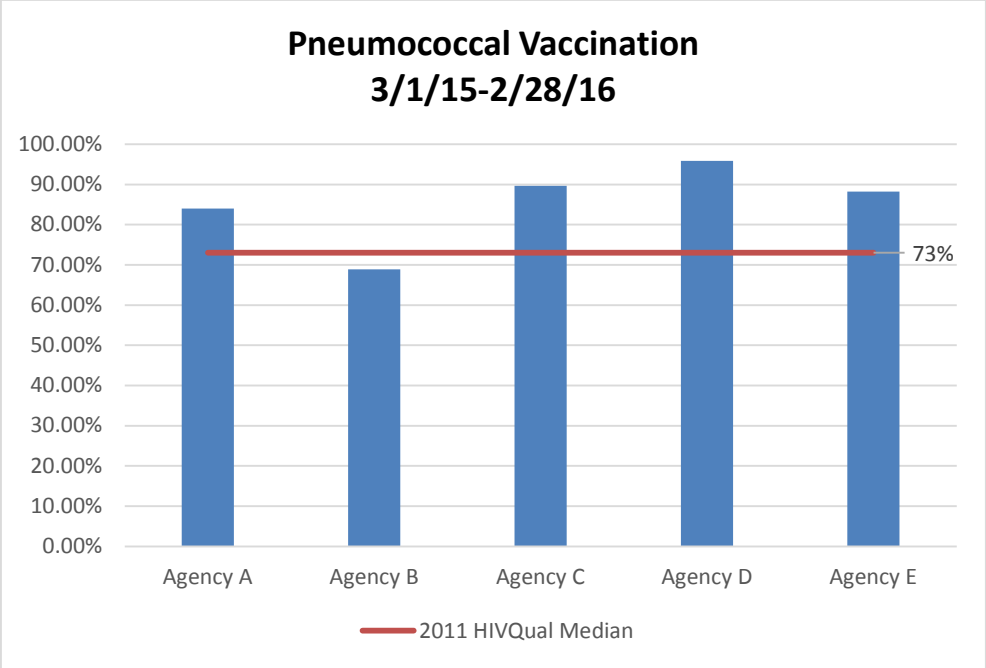
Pneumococcal Vaccination

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

	2013	2014	2015
Number of HIV-infected clients who received pneumococcal vaccination	470	556	546
Number of HIV-infected clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	555	623	622
Rate	**84.7%**	**89.2%**	**87.8%**
Change from Previous Years Results	**1.6%**	**4.5%**	**-1.4%**

- 275/635 clients (43.3%) received both PPV13 and PPV23 (FY14-36.9%,FY13-13.7%)

2015 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who received pneumococcal vaccination	230	213	100
Number of HIV-infected clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	269	231	118
Rate	**85.5%**	**92.2%**	**84.7%**



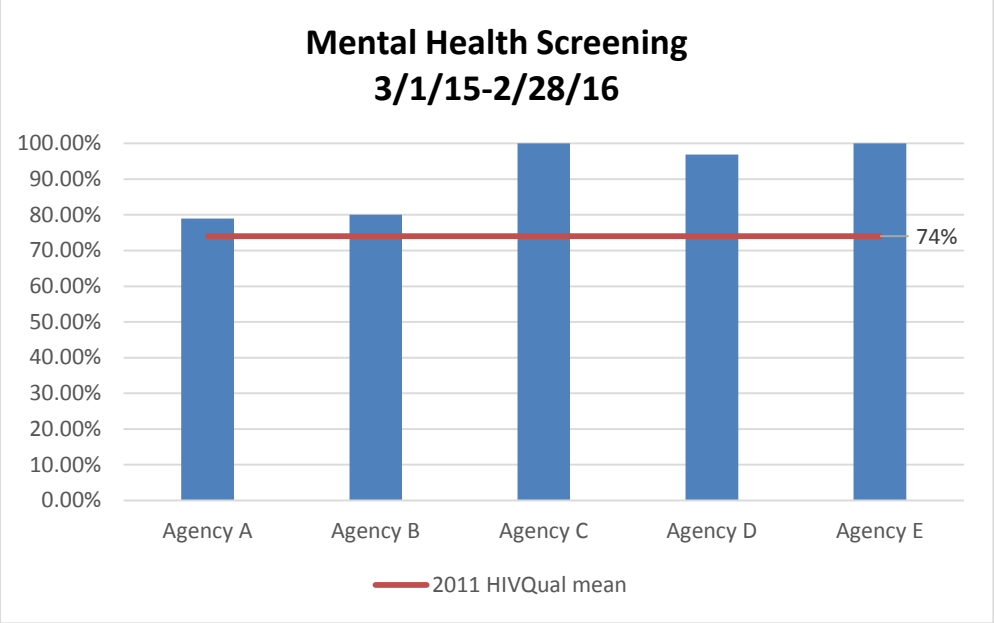
Preventative Care and Screening: Mental Health Screening

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

	2013	2014	2015
Number of HIV-infected clients who received a mental health screening*	520	567	586
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**81.9%**	**89.3%**	**92.3%**
Change from Previous Years Results	**-5.5%**	**7.4%**	**3%**

*The 2014 & 2015 definition only includes those who had a mental health screening using a standardized tool

- 31% (197/635) had mental health issues. Of the 98 who needed additional care, 75 (76.5%) were either managed by the primary care provider or referred; 12 clients refused a referral.

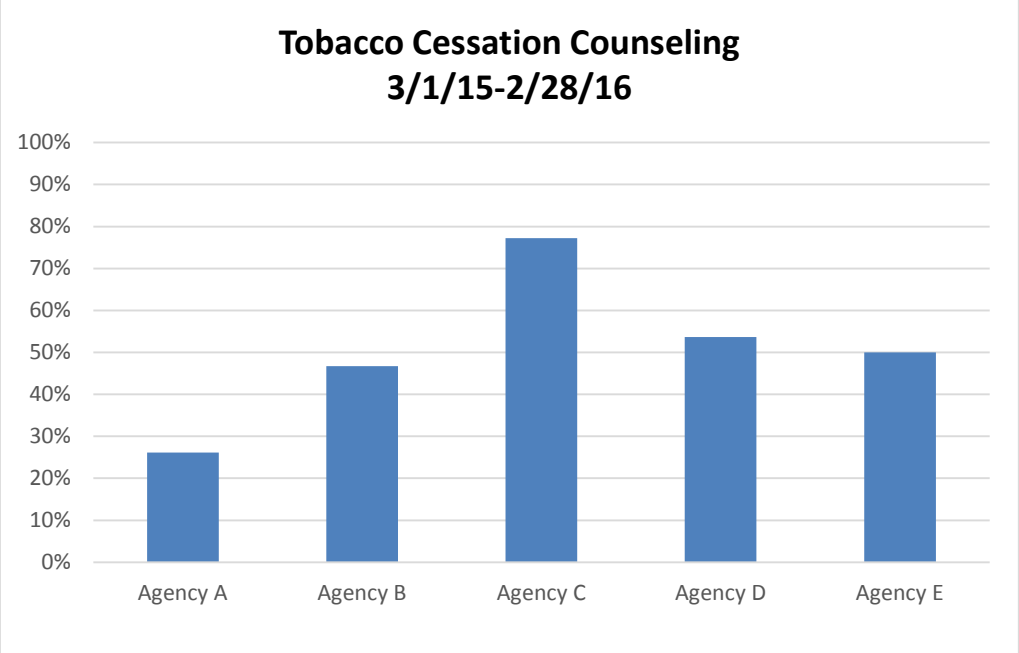


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

	2013	2014	2015
Number of HIV-infected clients who were screened for tobacco use in the measurement period	633	631	635
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.7%**	**99.4%**	**100%**
Change from Previous Years Results	**15.1%**	**-.3%**	**6%**

- **HIVQUAL-US Mean 86%**
- Of the 635 clients screened, 185 (29.1%) were current smokers.
- Of the 185 current smokers, 104 (56.2%) received smoking cessation counseling, and 24 (13%) refused smoking cessation counseling



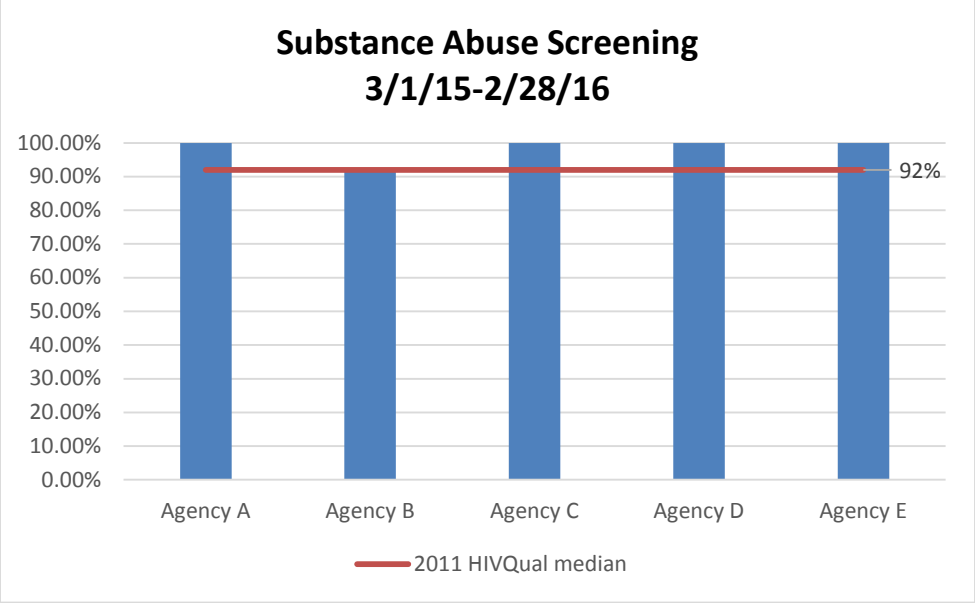
Substance Abuse Screening

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

	2013	2014	2015
Number of new HIV-infected clients who were screened for substance use within the measurement year	620	624	627
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**97.6%**	**98.3%**	**98.7%**
Change from Previous Years Results	**22.6%**	**.7%**	**.4%**

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

- 5% (32/635) had substance abuse issues. Of the 32 clients who needed referral, 17 (53%) received one, and 12 (37.5%) refused.

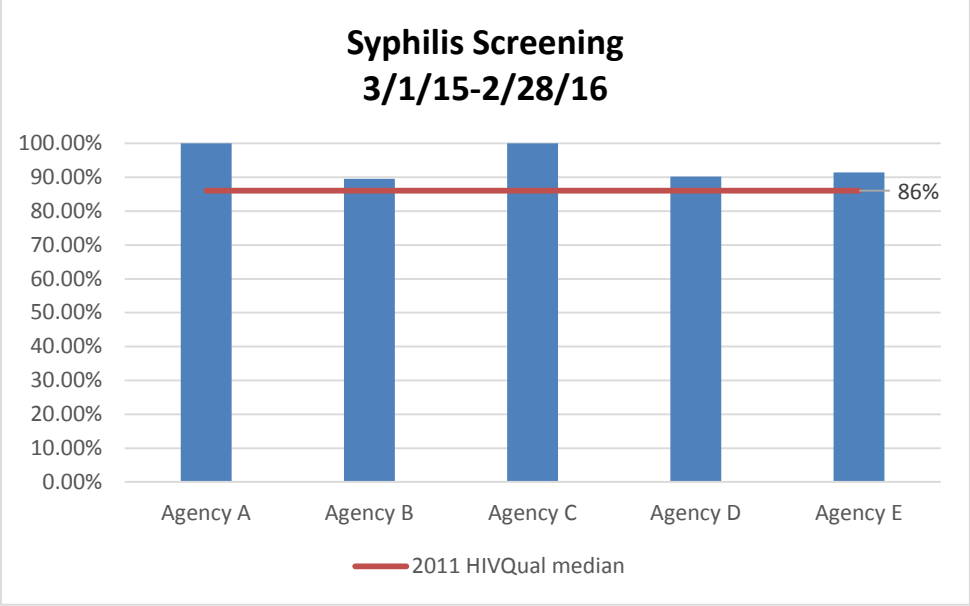


Syphilis Screening

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

	2013	2014	2015
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	591	594	599
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	632	635	635
Rate	**93.5%**	**93.5%**	**94.3%**
Change from Previous Years Results	**9.9%**	**0%**	**.8%**

- 6.2% (37/599) new cases of syphilis diagnosed

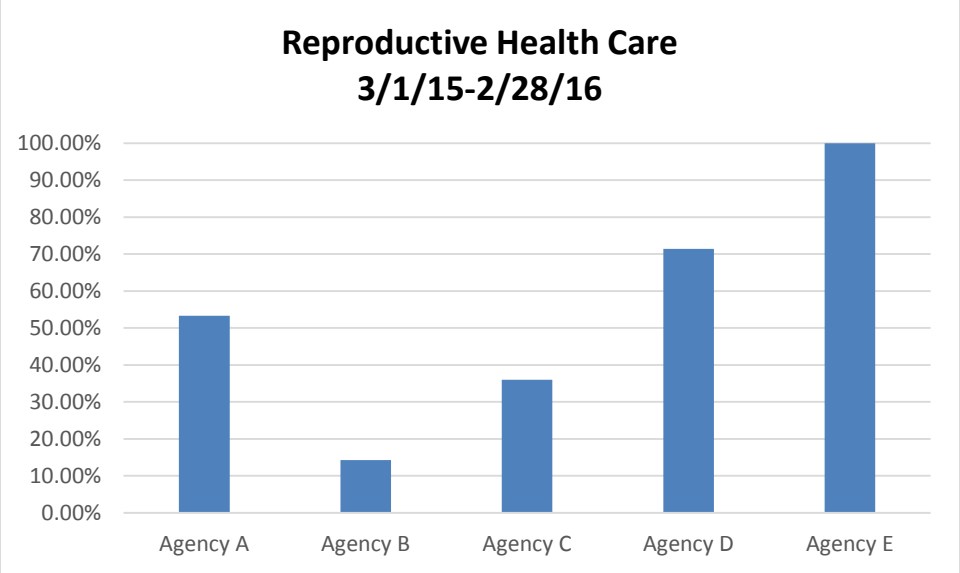


Other Measures

Reproductive Health Care

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

	2013	2014	2015
Number of HIV-infected reproductive-age women who received reproductive health assessment and care	32	30	34
Number of HIV-infected reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	67	73	69
Rate	**47.8%**	**41.7%**	**49.3%**
Change from Previous Years Results	**15.7%**	**-6.1%**	**7.6%**

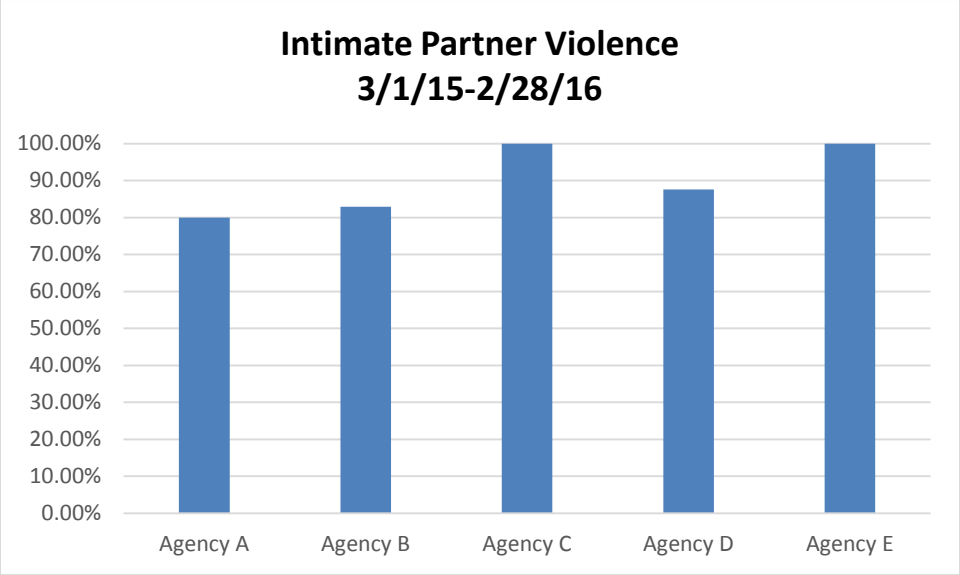


Intimate Partner Violence Screening

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

	2013	2014	2015
Number of HIV-infected clients who received screening for current intimate partner violence	462	570	569
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**72.8%**	**89.8%**	**89.6%**
		17%	**-.2%**

*7/635 (1.1%) screened positive



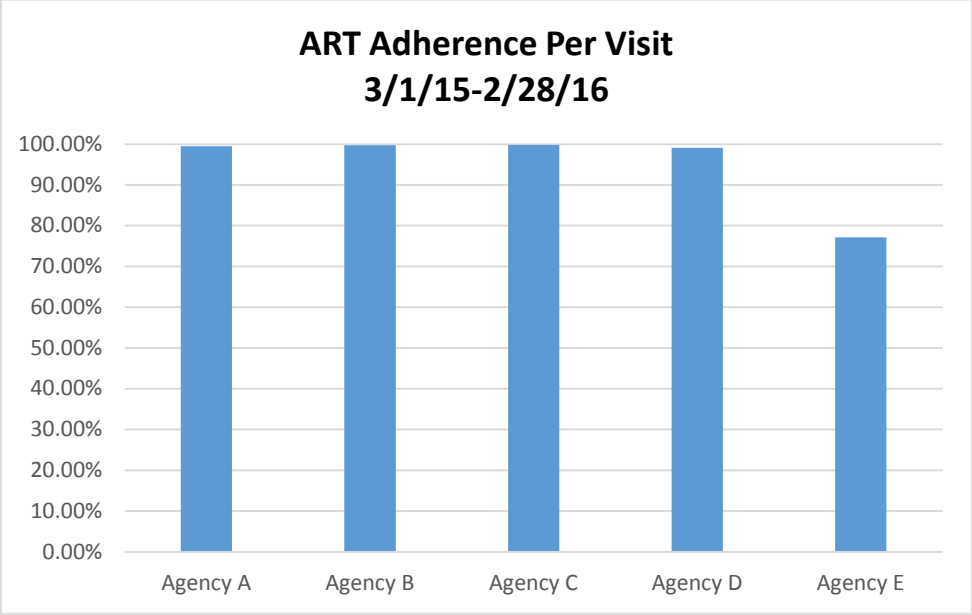
Adherence Assessment & Counseling

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

	Adherence Assessment		
	2013	2014	2015
Number of HIV-infected clients, as part of their primary care, who were assessed for adherence at least once per year	541	599	607
Number of HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	573	605	613
Rate	**94.4%**	**99%**	**99%**
Change from Previous Years Results	**-4.2%**	**4.6%**	**0%**

- **HIVQUAL-US Mean 96%, 75th percentile 100%**

Adherence Assessment Per Visit	
	2015
Number of primary care visits where ART adherence was assessed	1,940
Number of primary care visits for HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	1,981
Rate	**97.9%**



ART for Pregnant Women

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

	2013	2014	2015
Number of HIV-infected pregnant women who were prescribed ART during the 2nd and 3rd trimester	4	4	5
Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	4	4	5
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0**

Primary Care: Diabetes Control

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

	2013	2014	2015
Number of HIV-infected diabetic clients whose last HbA1c in the measurement year was <8%	34	41	27
Number of HIV-infected diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	53	68	47
Rate	**64.2%**	**60.3%**	**57.4%**
Change from Previous Years Results		**-3.9%**	**-2.9%**

- 634/635 (99.8%) of clients where screened for diabetes and 47/634 (7.4%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2013	2014	2015
Number of HIV-infected hypertensive clients whose last blood pressure of the measurement year was <140/90	123	125	131
Number of HIV-infected hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	172	173
Rate	**68.3%**	**72.7%**	**75.7%**
Change from Previous Years Results		**4.4%**	**3%**

- 173/635 (27.2%) of clients where were diagnosed with hypertension

Primary Care: Breast Cancer Screening

- Percentage of women with HIV infection, over the age of 41, who had a mammogram documented in the previous two years

	2013	2014	2015
Number of HIV-infected women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	136	138	140
Number of HIV-infected women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	163	158	168*
Rate	**83.4%**	**87.3%**	**83.3%**
Change from Previous Years Results		**3.9%**	**-4%**

*The denominator excluded three clients who refused a mammogram

Conclusions

The Houston EMA demonstrates performance rates at or above national averages for nearly all performance measures. Overall, performance rates were comparable to the previous year. There have been several positive trends over the past 2 years: cervical cancer screening, sexually transmitted infection screening, and Hepatitis B vaccination rates have continued to improve. However, viral load suppression has slightly decreased, as well as influenza vaccination, and HIV risk counseling. RWGA will continue to monitor these measures closely and initiate quality improvement initiatives as needed. In addition, racial and ethnic disparities continue to be seen for most measures, with African-Americans having lower rates than White and Hispanic clients. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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Vision Care Chart Review Report FY 2015

Ryan White Part A Quality Management Program–Houston EMA

January 2017

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health & Environmental Services. During FY 15, a comprehensive review of client vision records was conducted for services provided between 3/1/15 to 2/28/16.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 15 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

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

The Sample Selection Process

The sample population was selected from a pool of 2,066 unduplicated clients who accessed Part A vision care between 3/1/15 and 2/28/16. The medical charts of 150 of these clients were used in the review, representing 7.3% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/15 and 2/28/16 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 15 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	75	50%	1,013	49%
White	74	49.3%	1,006	49%
Asian	1	.7%	19	1%
Native Hawaiian/Pacific Islander	0	0%	3	<1%
American Indian/Alaska Native	0	0%	11	<1%
Multi-Race	0	0%	24	<1%
TOTAL	**150**		**2,066**	**100%**
Hispanic Status				
Hispanic	48	32%	699	34%
Non-Hispanic	102	68%	1,367	66%
TOTAL	**150**		**2,066**	**100%**
Gender				
Male	109	72.7%	1,533	74%
Female	38	25.3%	520	25%
Transgender Male to Female	3	2%	13	<1%
Transgender Female to Male	0	0%	0	0
TOTAL	**150**		**2,099**	**100%**
Age				
<= 24	7	4.7%	116	6%
25 – 34	36	24%	451	22%
35 – 44	34	22.7%	497	24%
45 – 54	46	30.7%	630	30%
55 – 64	23	15.3%	309	15%
65+	4	2.7%	63	3%
TOTAL	**150**		**2,066**	**100%**

Findings

Laboratory Tests

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

Patient chart records should provide documentation of the most recent CD4 and VL information. Ideally this information should be updated in coordination with an annual complete eye exam. As noted in the table below, significant decreases were noted in lab documentation compared to previous years.

	2012	2013	2014	2015
CD4	90%	49%	48%	64%
VL	89%	49%	48%	64%

Client Intake Form (CIF)

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

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

	2012	2013	2014	2015
Primary Care Provider	99%	51%	52%	50%
Medication Allergies	100%	93%	100%	100%
Medical History	100%	99%	100%	100%
Current Medications	99%	96%	100%	100%
Reason for Visit	100%	99%	100%	100%
Ocular History	97%	99%	100%	100%

Eye Examinations (Including CEE/DFE) and Exam Findings

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

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

	2012	2013	2014	2015
Complete Eye Exam	96%	100%	99%	100%
Dilated Fundus Exam	76%	53%	94%	95%
Internal Eye Exam	100%	100%	100%	100%
Documentation of Diagnosis	100%	100%	99%	100%
Documentation of Treatment Plan	100%	100%	99%	100%
Visual Acuity	100%	100%	100%	100%
Refraction Test	96%	99%	98%	100%
Observation of External Structures	97%	56%	100%	100%
Glaucoma Test	100%	99%	100%	100%
Cytomegalovirus (CMV) screening	78%	55%	94%	95%

Ocular Disease

Eleven clients (7.3%) demonstrated ocular disease, including hypertensive retinopathy, diabetic retinopathy, cataracts, glaucoma, and upper chalazion. One client received treatment for ocular disease, 2 clients were referred to a specialty eye clinic, and 8 clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 97% (95%-FY14, 97%-FY13 reviews) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 15 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 15-Vision Chart Review Data Collection Tool

Mar 1, 15 to Feb 28, 16

Pt. ID # _____ Site Code:_____

CLIENT INTAKE FORM (CIF)

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

CD4 & VL

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

EYE CARE:

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

Revised March, 2013

Appendix B – Resources

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

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

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

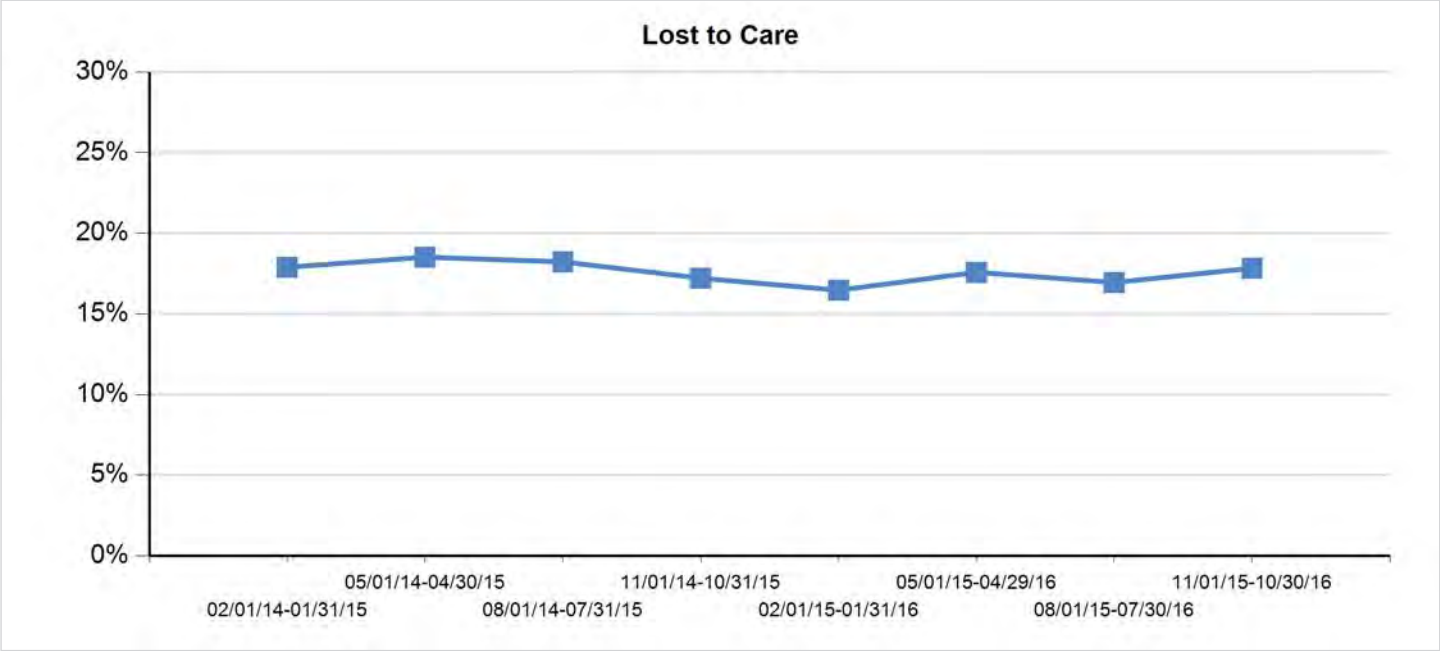
4. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed July 25, 2013.

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

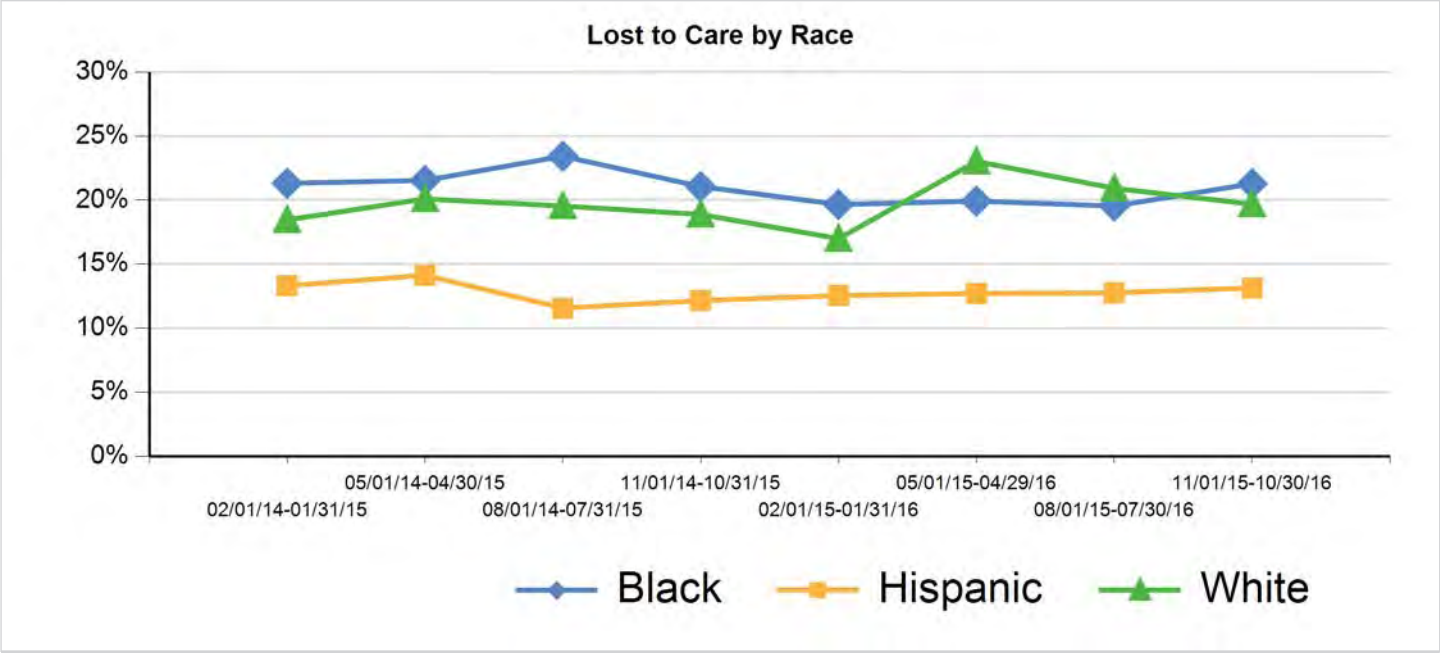
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **11/1/2015**

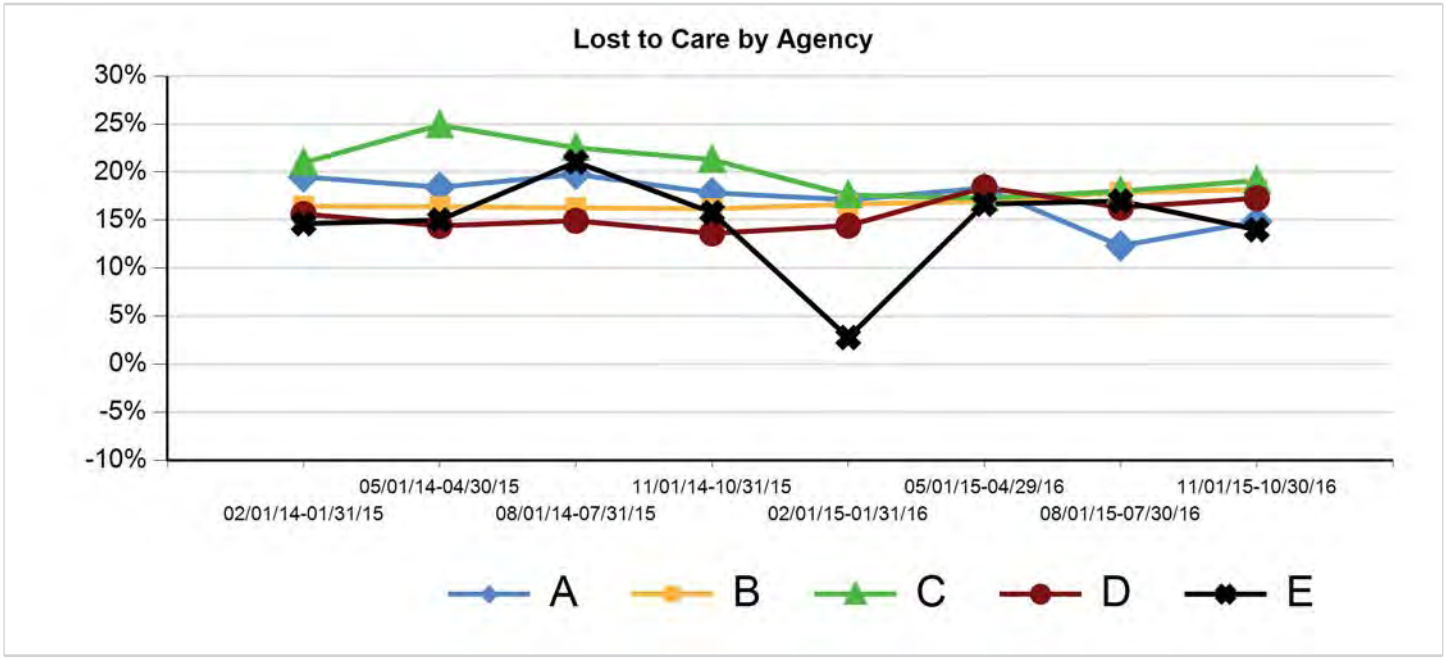
Lost to Care				
In+Care Campaign Gap Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	776	845	821	892
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	4,712	4,807	4,845	5,001
Percentage	16.5%	17.6%	16.9%	17.8%
Change from Previous Quarter Results	-0.7%	1.1%	-0.6%	0.9%



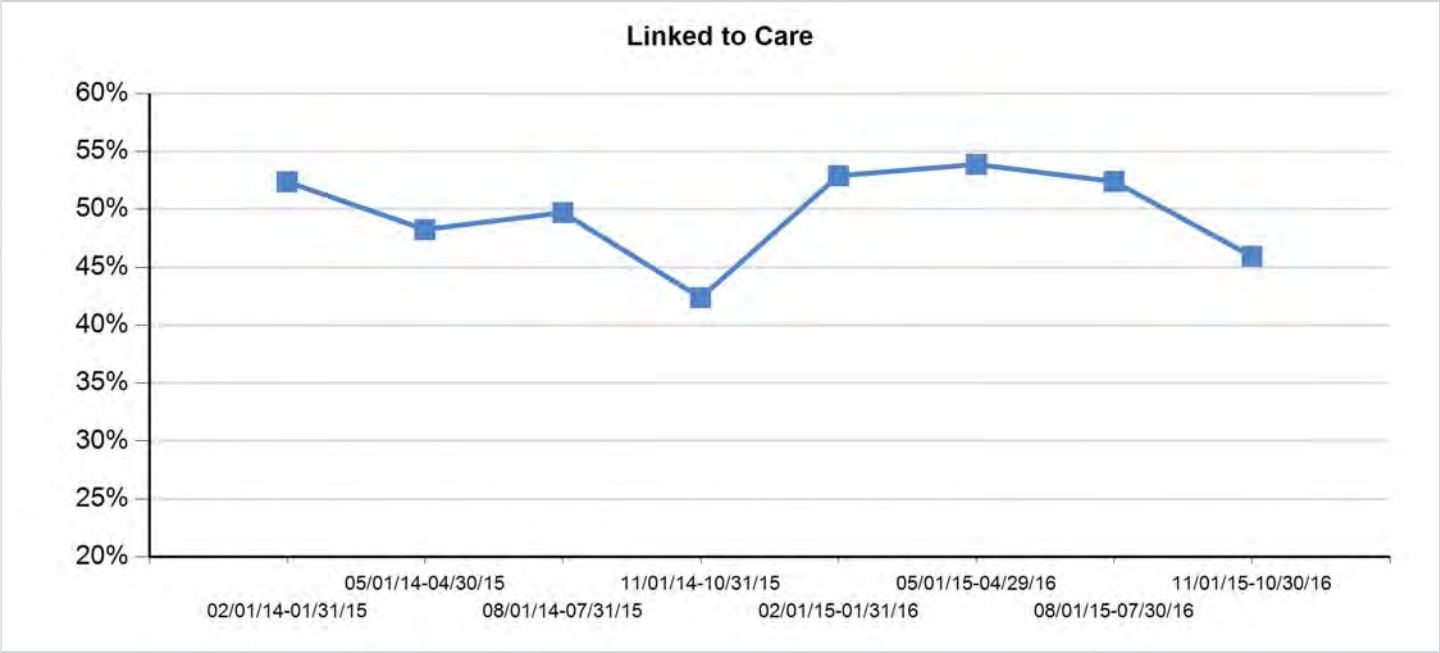
Lost to Care by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	452	229	148	446	235	132	506	249	124
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,269	1,803	643	2,283	1,842	631	2,378	1,895	630
Percentage	19.9%	12.7%	23.0%	19.5%	12.8%	20.9%	21.3%	13.1%	19.7%
Change from Previous Quarter Results	0.3%	0.2%	6.0%	-0.4%	0.1%	-2.1%	1.7%	0.4%	-1.2%



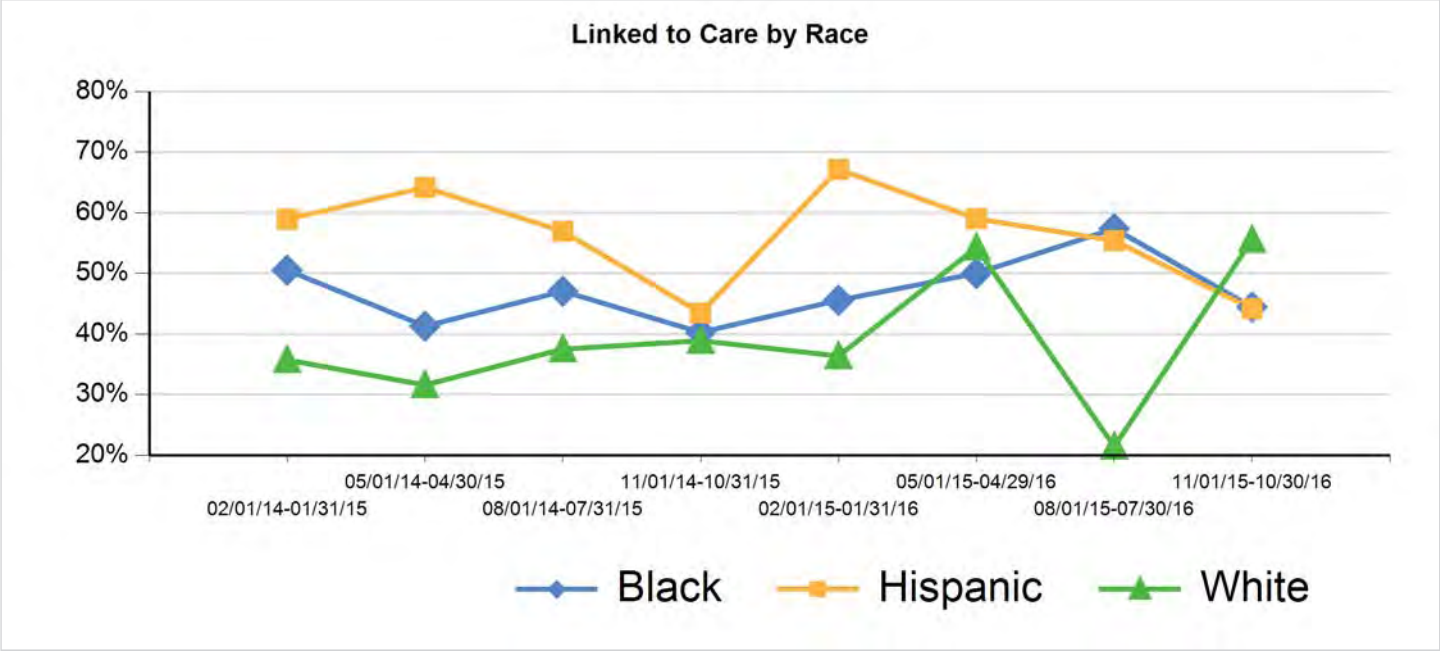
Lost to Care by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	79	346	225	163	9	97	346	261	185	7
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	641	1,935	1,249	999	53	653	1,902	1,366	1,071	50
Percentage	12.3%	17.9%	18.0%	16.3%	17.0%	14.9%	18.2%	19.1%	17.3%	14.0%
Change from Previous Quarter Results	-6.0%	0.9%	0.7%	-2.1%	0.3%	2.5%	0.3%	1.1%	1.0%	-3.0%



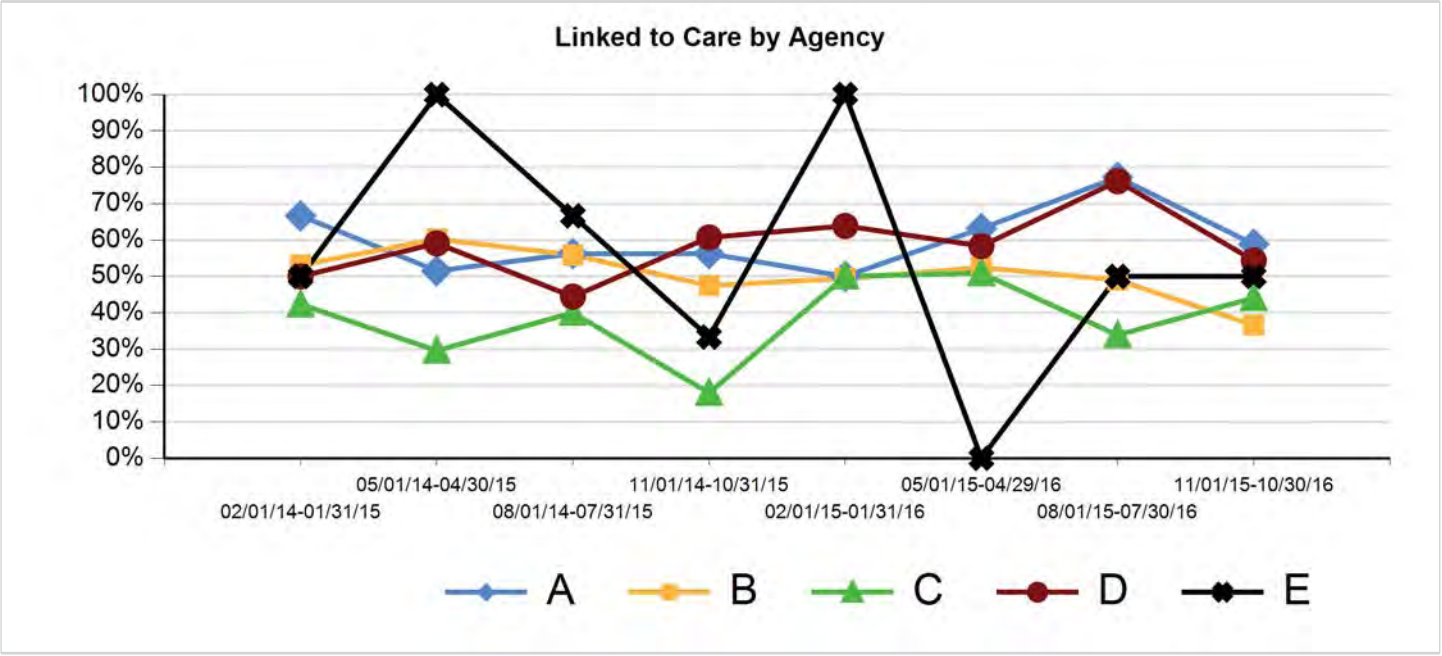
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of newly enrolled HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	91	111	120	96
Number of newly enrolled HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	172	206	229	209
Percentage	52.9%	53.9%	52.4%	45.9%
Change from Previous Quarter Results	10.5%	1.0%	-1.5%	-6.5%
* exclude if vl<200 in 1st 4 months				



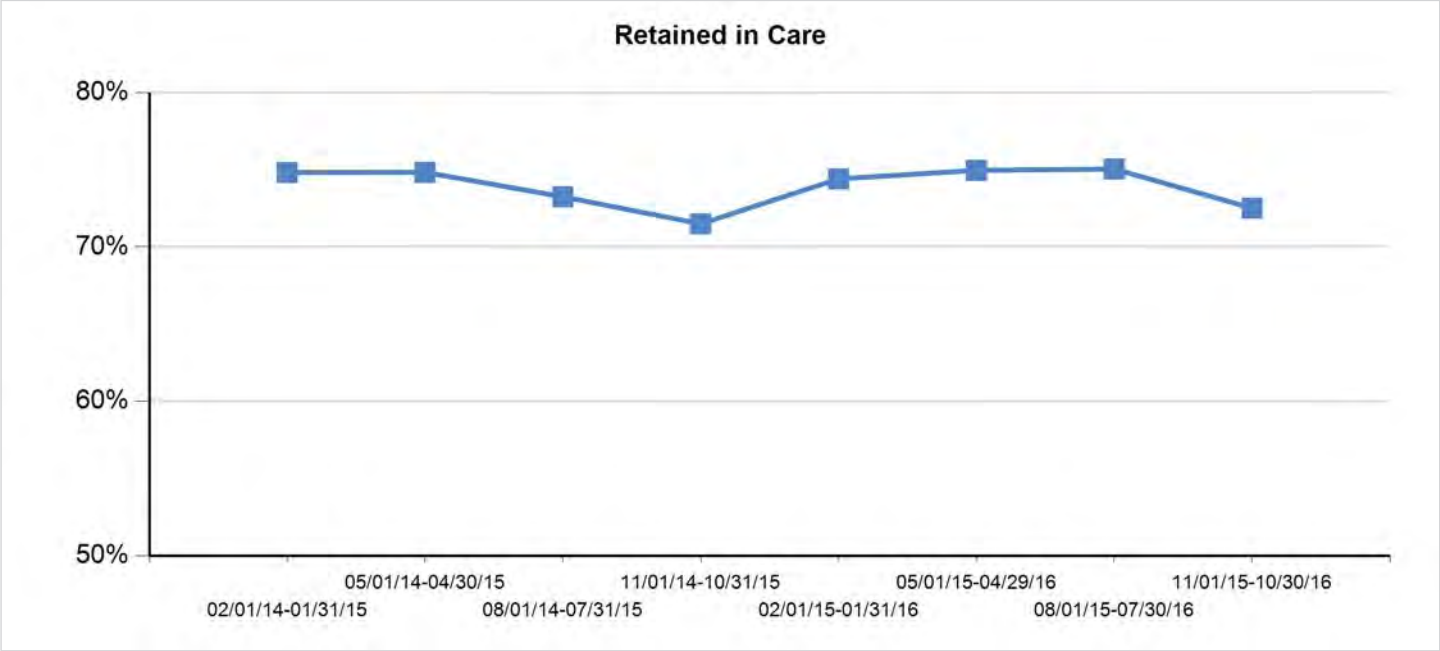
Linked to Care by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	53	36	19	70	41	6	48	34	10
Number of newly enrolled HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	106	61	35	122	74	28	108	77	18
Percentage	50.0%	59.0%	54.3%	57.4%	55.4%	21.4%	44.4%	44.2%	55.6%
Change from Previous Quarter Results	4.4%	-8.1%	17.9%	7.4%	-3.6%	-32.9%	-12.9%	-11.2%	34.1%
* exclude if vl<200 in 1st 4 months									



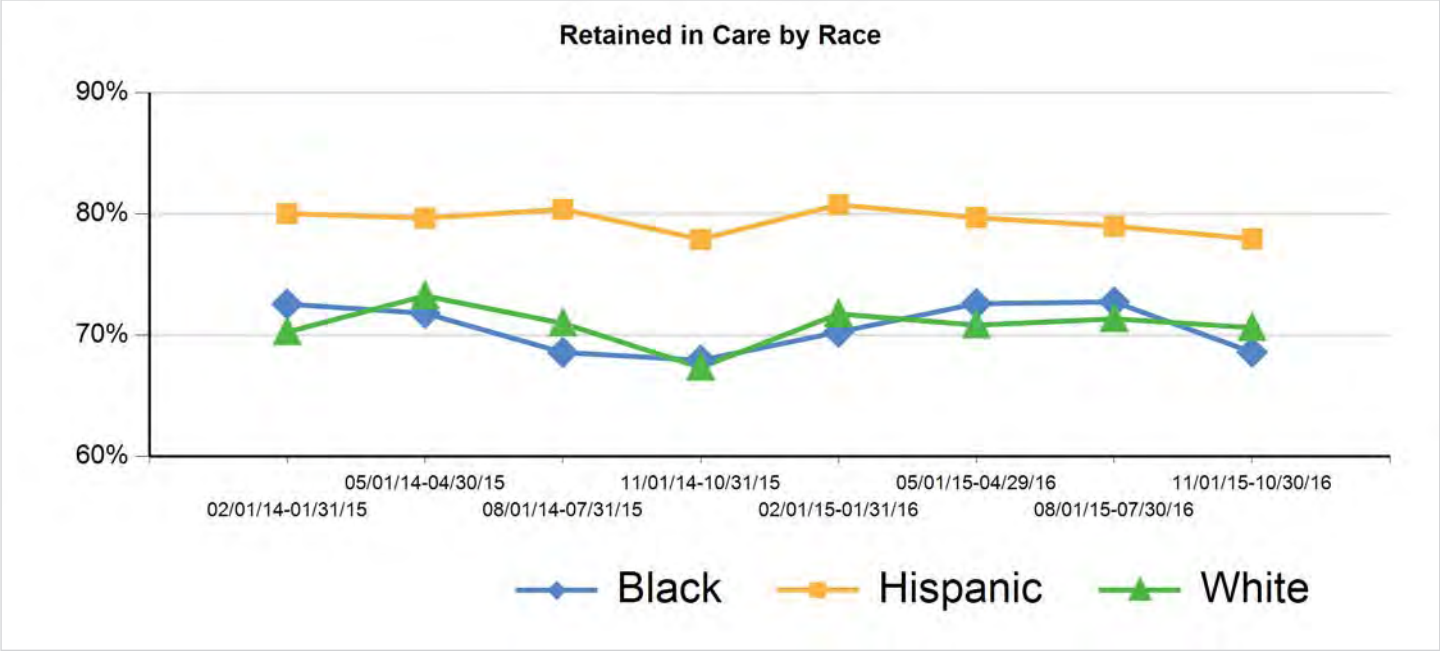
Linked to Care by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of newly enrolled HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	17	49	21	32	2	10	26	26	31	3
Number of newly enrolled HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	22	100	62	42	4	17	71	59	57	6
Percentage	77.3%	49.0%	33.9%	76.2%	50.0%	58.8%	36.6%	44.1%	54.4%	50.0%
Change from Previous Quarter Results	14.1%	-3.4%	-17.0%	17.9%	50.0%	-18.4%	-12.4%	10.2%	-21.8%	0.0%
* exclude if vl<200 in 1st 4 months										



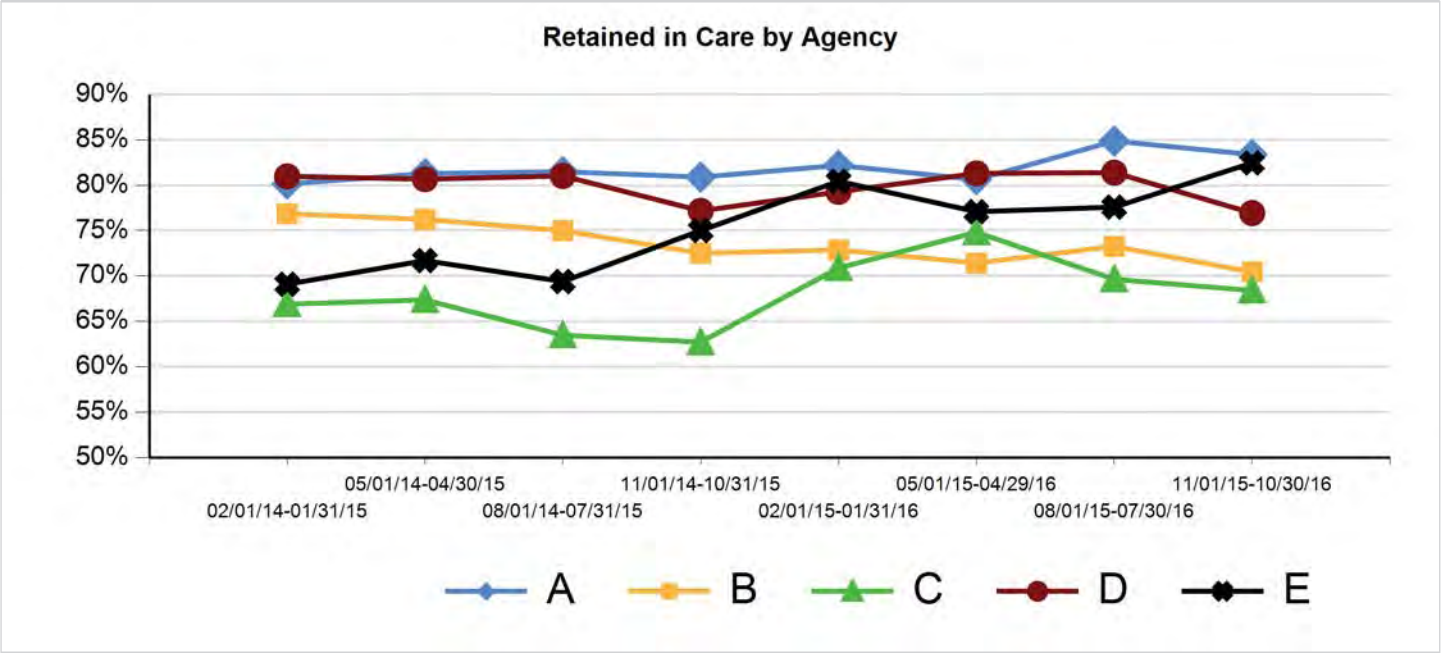
Retained in Care				
Houston EMA Medical Visits Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year*	3,946	4,015	4,103	4,063
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	5,303	5,356	5,467	5,603
Percentage	74.4%	75.0%	75.1%	72.5%
Change from Previous Quarter Results	2.9%	0.6%	0.1%	-2.5%
* Not newly enrolled in care				



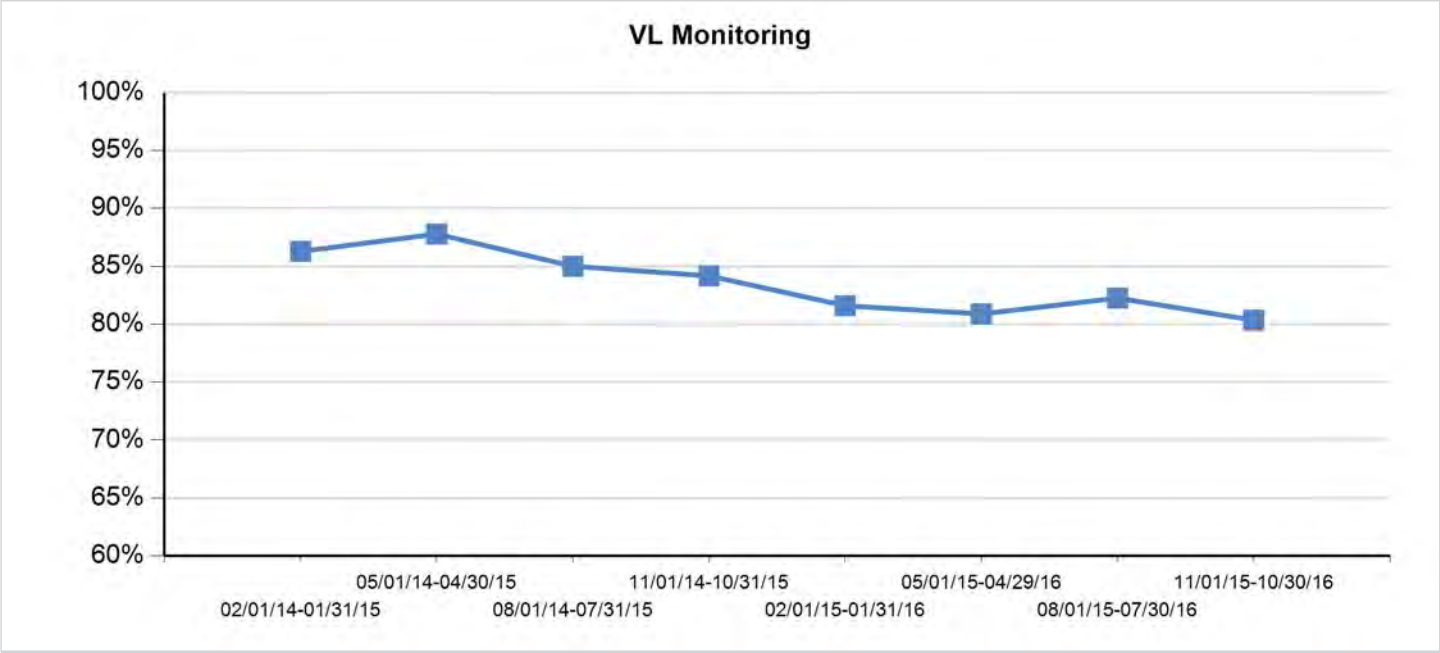
Retained in Care by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	1,853	1,561	524	1,904	1,581	530	1,853	1,606	514
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	2,553	1,959	740	2,618	2,002	743	2,702	2,061	728
Percentage	72.6%	79.7%	70.8%	72.7%	79.0%	71.3%	68.6%	77.9%	70.6%
Change from Previous Quarter Results	2.3%	-1.1%	-0.9%	0.1%	-0.7%	0.5%	-4.1%	-1.0%	-0.7%



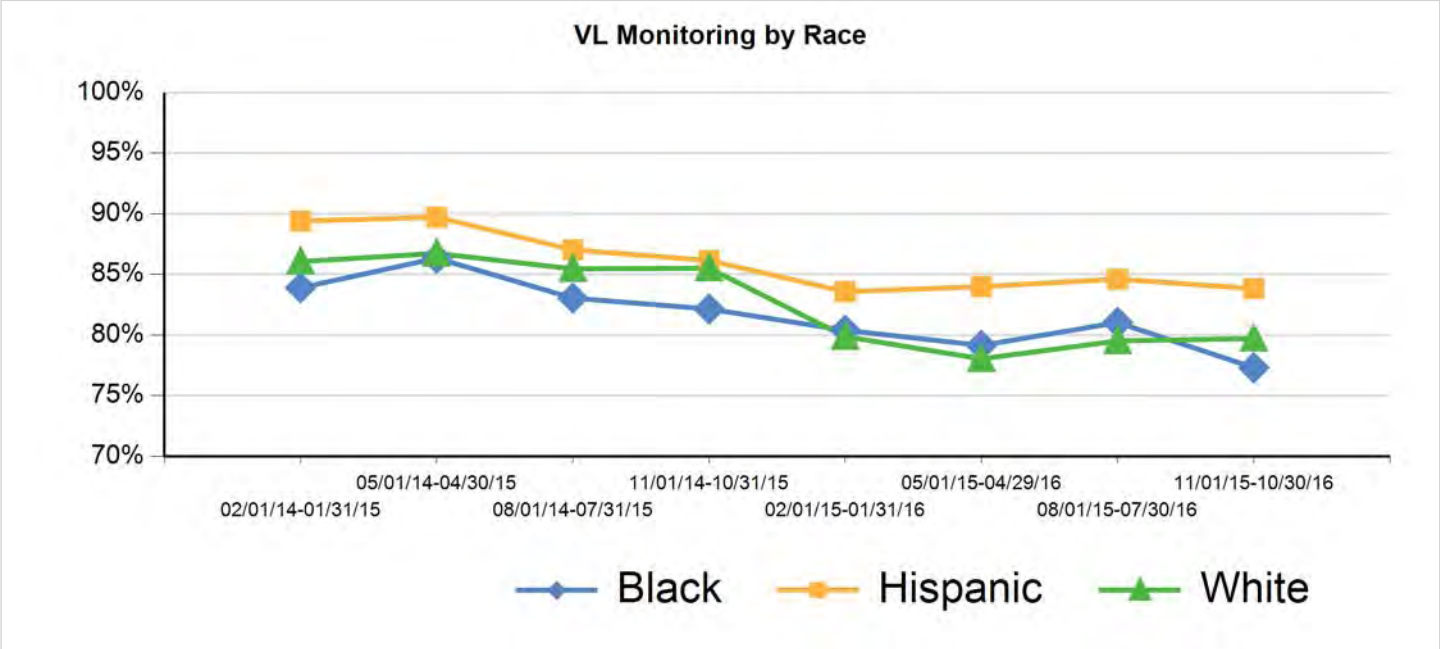
Retained in Care by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	600	1,559	1,064	940	45	592	1,468	1,117	947	47
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	707	2,128	1,528	1,155	58	710	2,084	1,633	1,231	57
Percentage	84.9%	73.3%	69.6%	81.4%	77.6%	83.4%	70.4%	68.4%	76.9%	82.5%
Change from Previous Quarter Results	4.3%	1.8%	-5.2%	0.1%	0.5%	-1.5%	-2.8%	-1.2%	-4.5%	4.9%



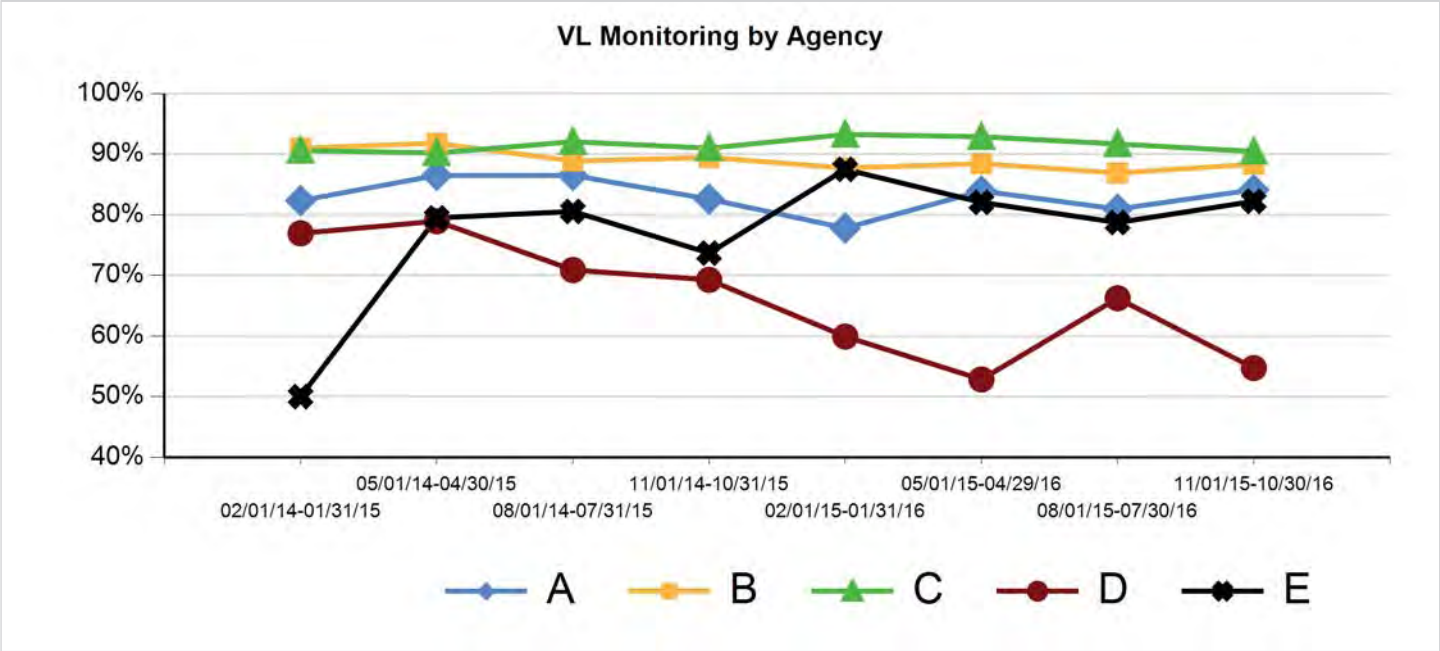
Viral Load Monitoring				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	3,493	3,470	3,628	3,514
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	4,281	4,290	4,411	4,374
Percentage	81.6%	80.9%	82.2%	80.3%
Change from Previous Quarter Results	-2.6%	-0.7%	1.4%	-1.9%



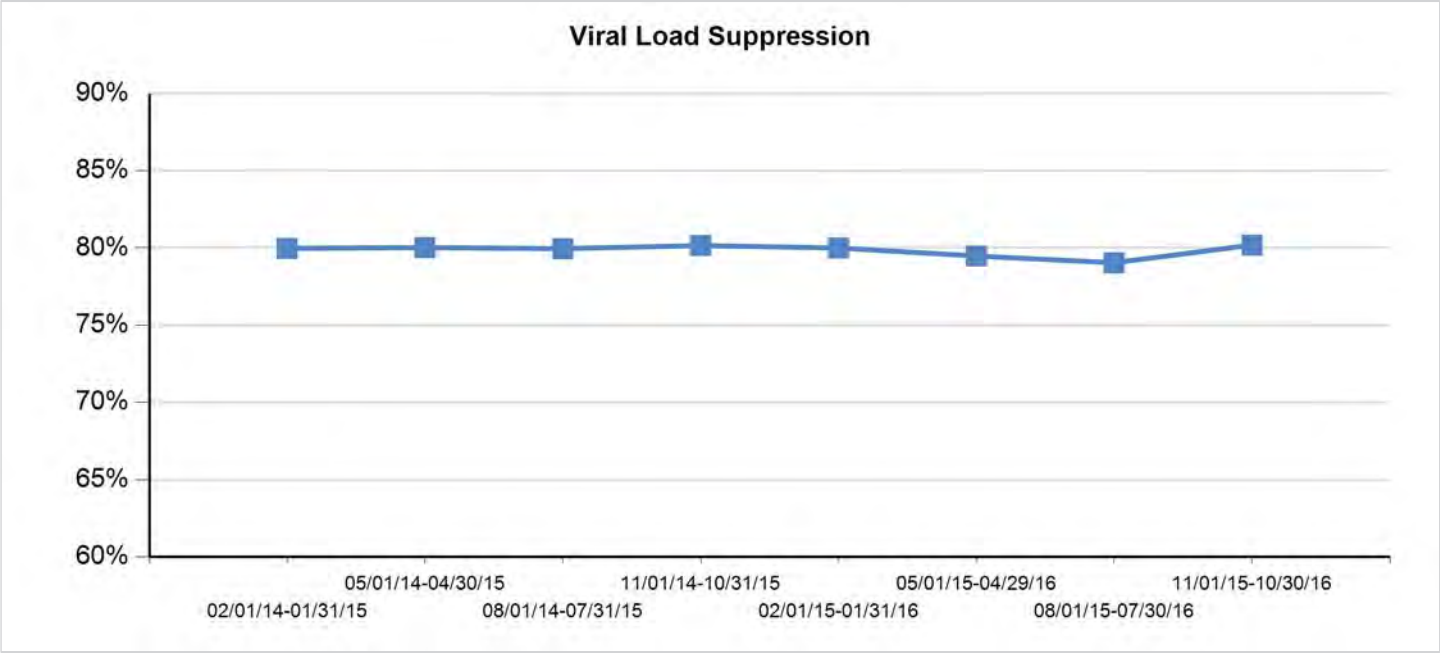
VL Monitoring Data by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	1,574	1,390	437	1,670	1,429	450	1,560	1,425	444
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	1,989	1,655	560	2,061	1,689	566	2,018	1,700	557
Percentage	79.1%	84.0%	78.0%	81.0%	84.6%	79.5%	77.3%	83.8%	79.7%
Change from Previous Quarter Results	-1.3%	0.4%	-1.8%	1.9%	0.6%	1.5%	-3.7%	-0.8%	0.2%



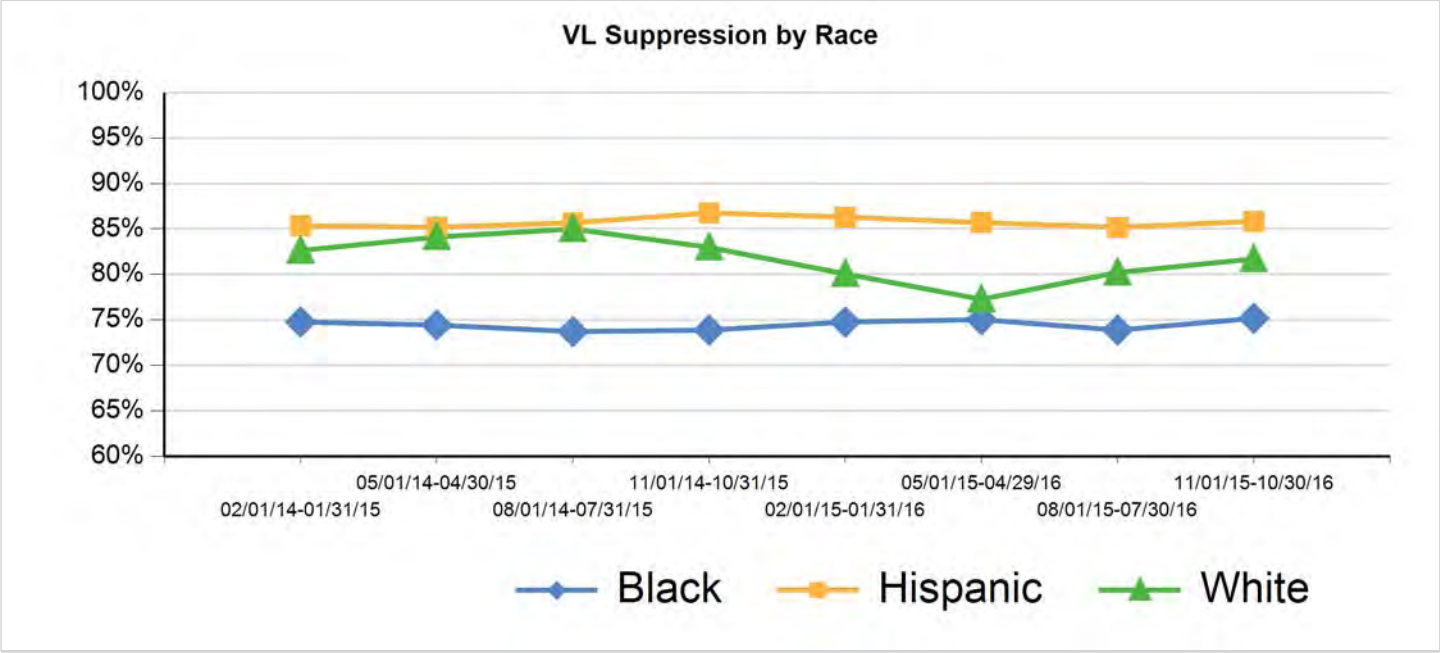
VL Monitoring by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	497	1,418	1,015	653	37	509	1,365	1,041	545	37
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	614	1,632	1,107	986	47	605	1,545	1,151	996	45
Percentage	80.9%	86.9%	91.7%	66.2%	78.7%	84.1%	88.3%	90.4%	54.7%	82.2%
Change from Previous Quarter Results	-3.0%	-1.6%	-1.2%	13.4%	-3.3%	3.2%	1.5%	-1.2%	-11.5%	3.5%



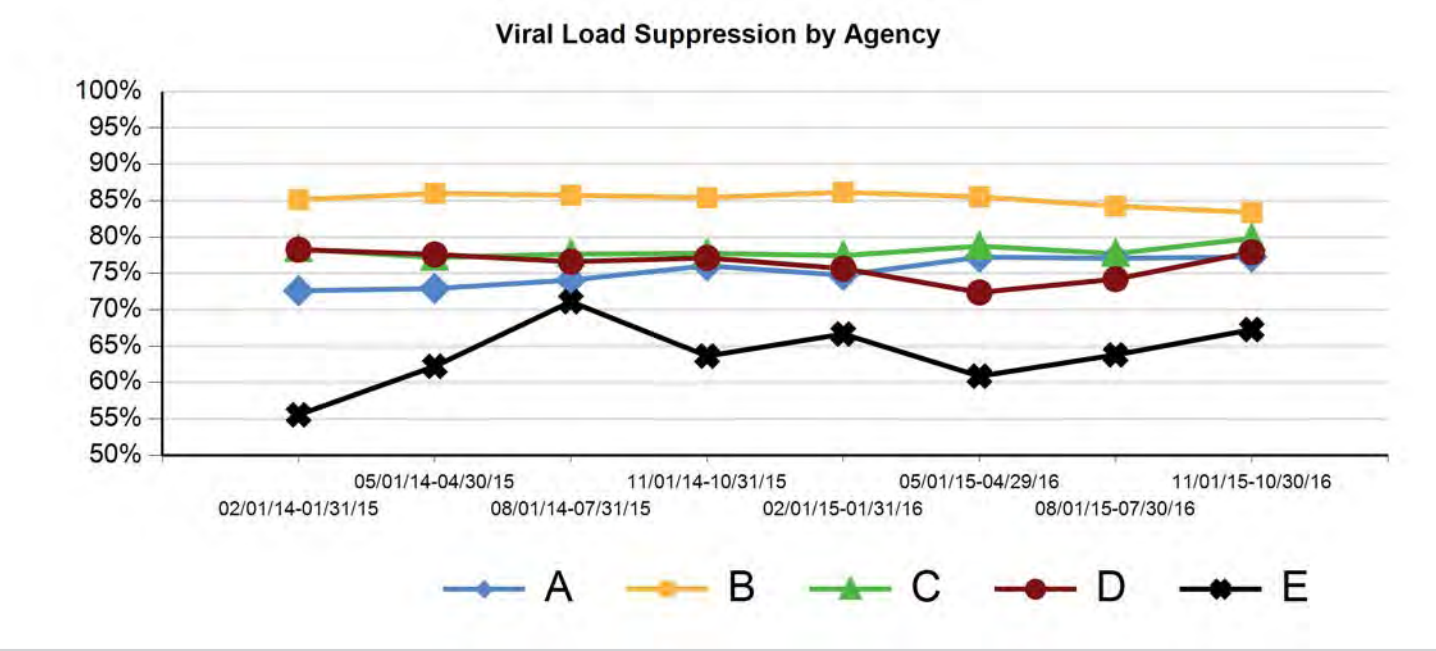
Viral Load Suppression				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	3,956	3,997	4,051	4,148
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,945	5,029	5,125	5,173
Percentage	80.0%	79.5%	79.0%	80.2%
Change from Previous Quarter Results	-0.2%	-0.5%	-0.4%	1.1%



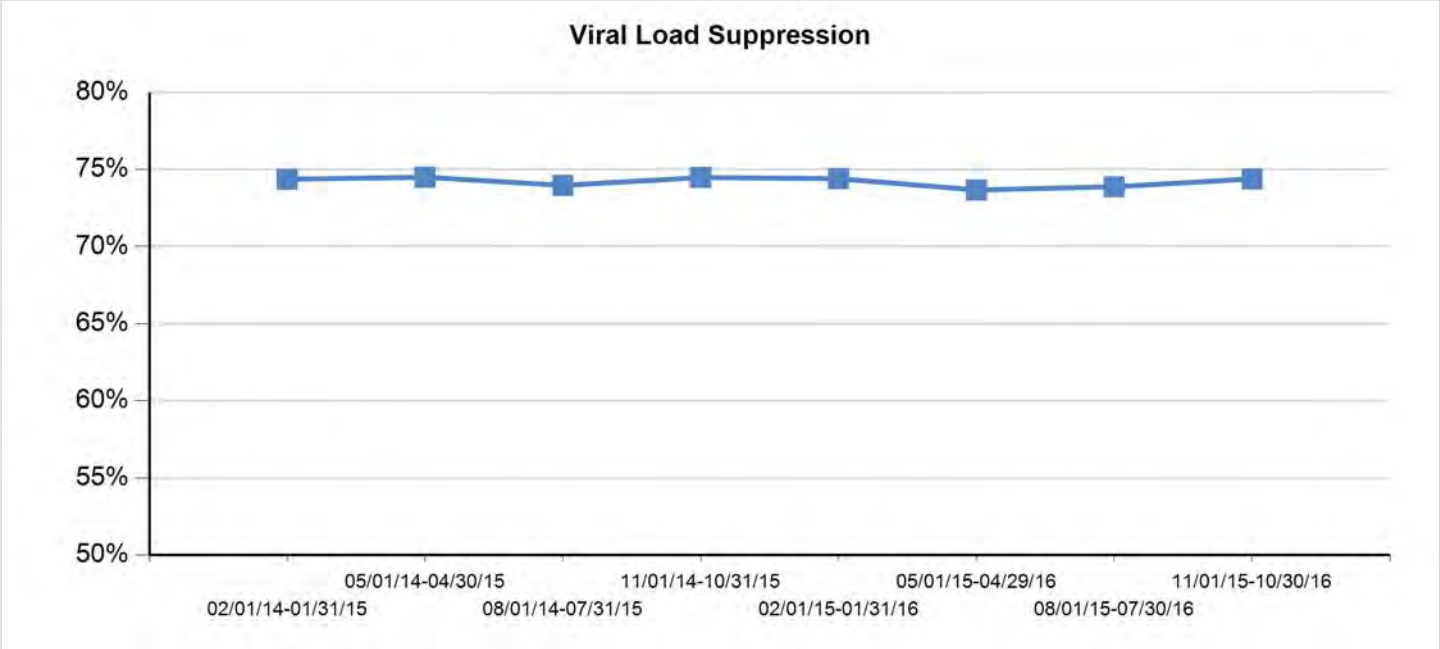
VL Suppression by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	1,811	1,576	530	1,835	1,598	531	1,864	1,642	549
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,414	1,839	686	2,484	1,876	662	2,480	1,913	672
Percentage	75.0%	85.7%	77.3%	73.9%	85.2%	80.2%	75.2%	85.8%	81.7%
Change from Previous Quarter Results	0.3%	-0.6%	-2.8%	-1.1%	-0.5%	3.0%	1.3%	0.7%	1.5%



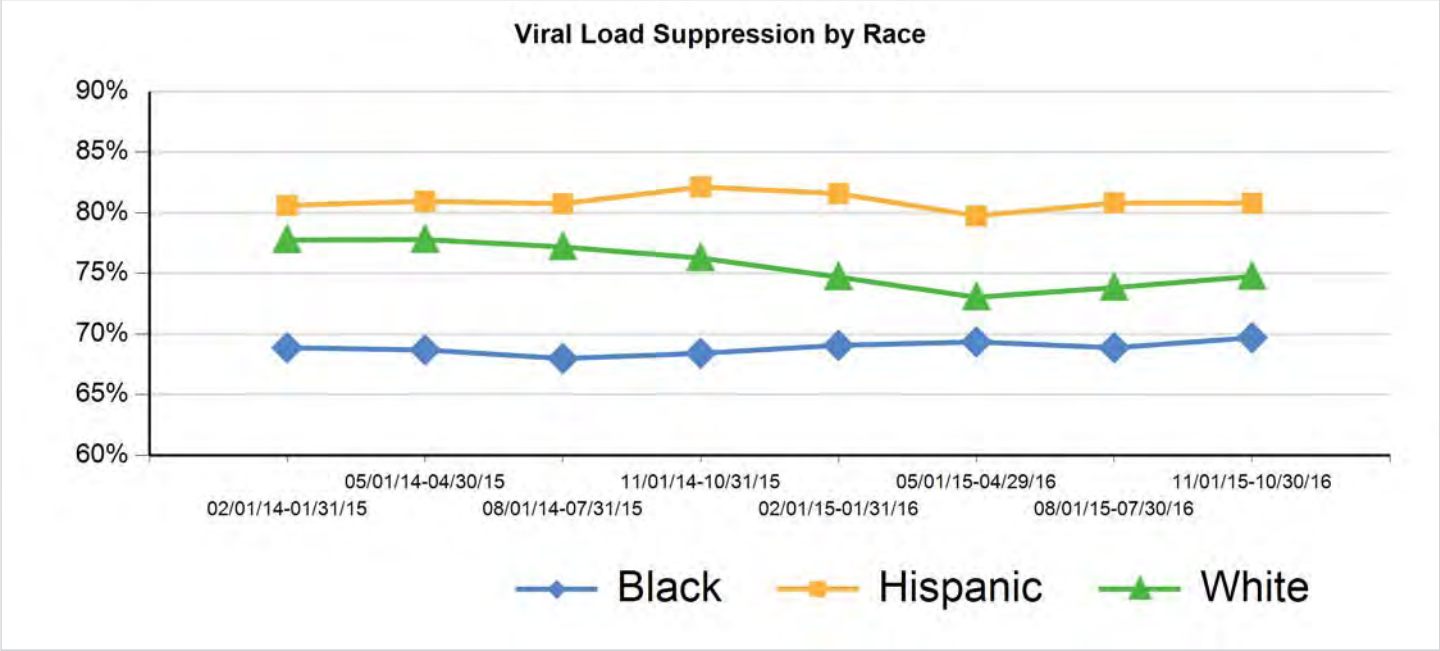
VL Suppression by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	538	1,625	1,036	849	37	547	1,524	1,115	938	37
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	698	1,929	1,333	1,144	58	708	1,828	1,397	1,204	55
Percentage	77.1%	84.2%	77.7%	74.2%	63.8%	77.3%	83.4%	79.8%	77.9%	67.3%
Change from Previous Quarter Results	-0.2%	-1.3%	-1.0%	1.8%	2.9%	0.2%	-0.9%	2.1%	3.7%	3.5%



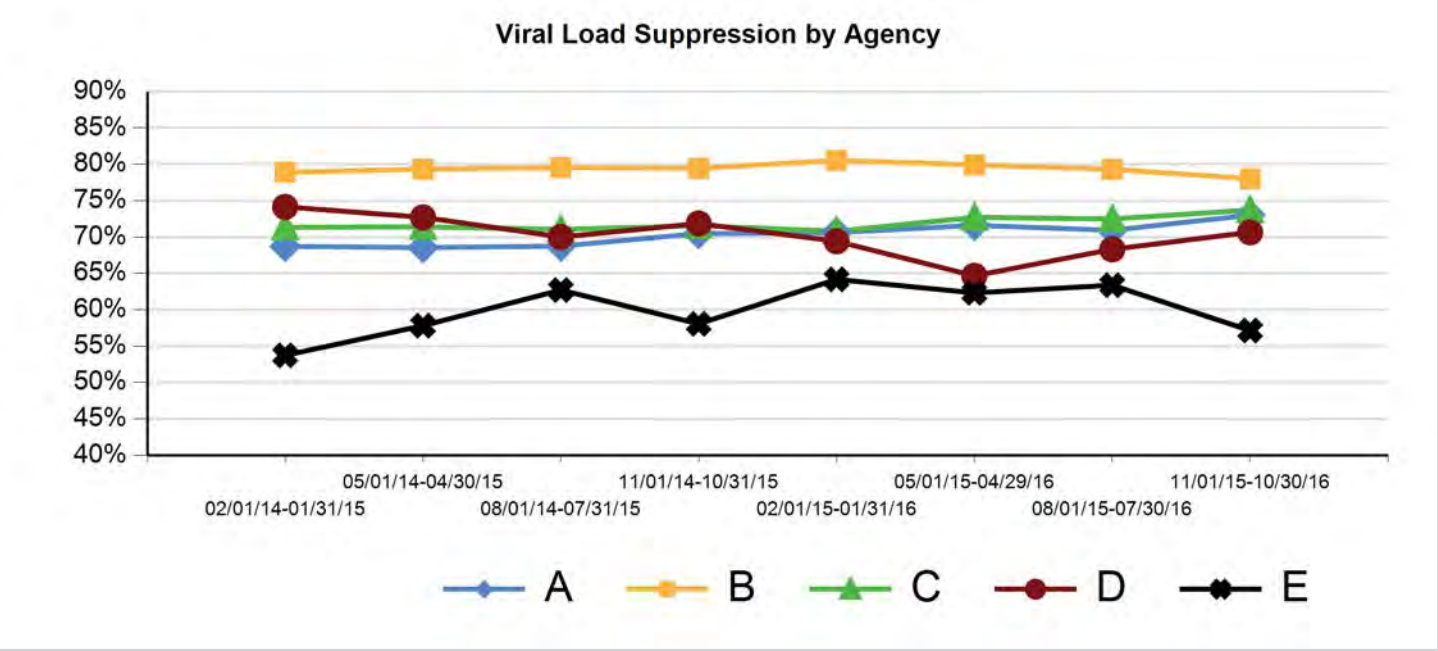
Viral Load Suppression 2- HAB Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	5,192	5,220	5,310	5,502
Number of HIV-infected clients who have had at least 1 medical visit with a provider with prescribing privileges	6,978	7,085	7,187	7,396
Percentage	74.4%	73.7%	73.9%	74.4%
Change from Previous Quarter Results	-0.1%	-0.7%	0.2%	0.5%



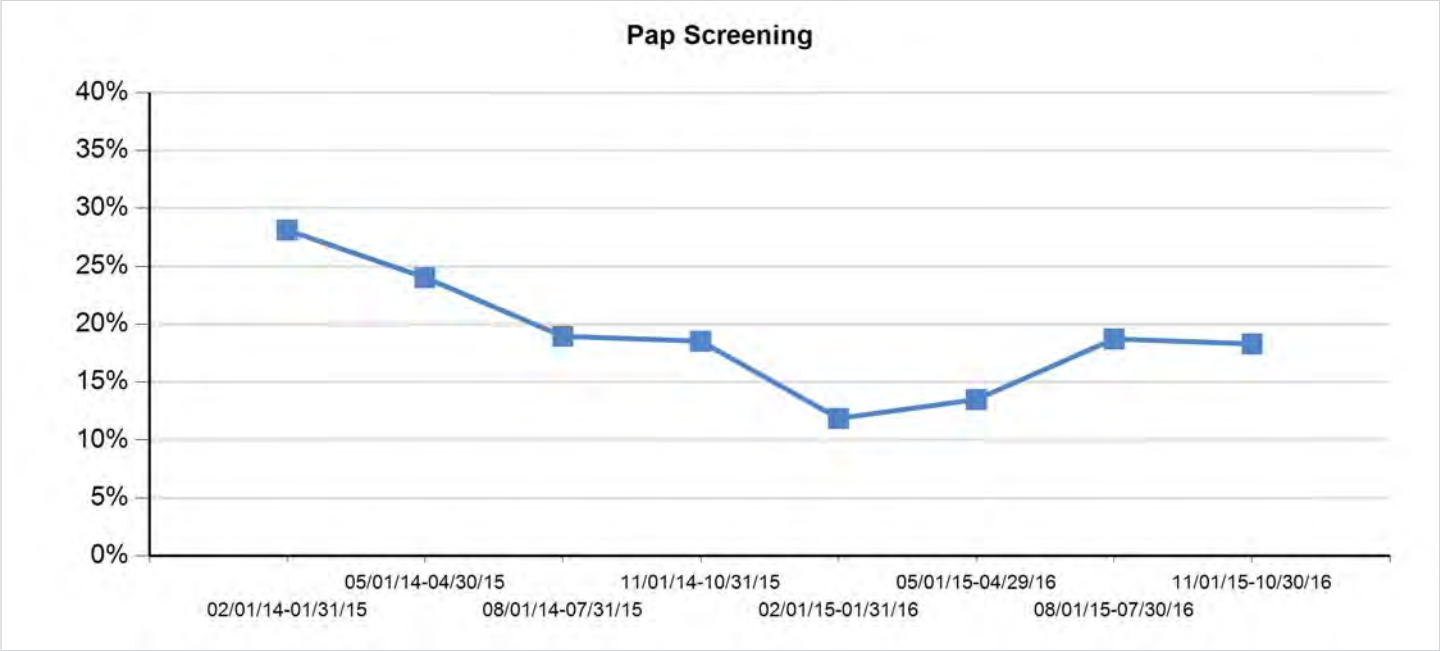
VL Suppression by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	2,416	1,992	704	2,457	2,017	722	2,569	2,082	731
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	3,484	2,498	964	3,568	2,496	978	3,686	2,577	978
Percentage	69.3%	79.7%	73.0%	68.9%	80.8%	73.8%	69.7%	80.8%	74.7%
Change from Previous Quarter Results	0.3%	-1.8%	-1.7%	-0.5%	1.1%	0.8%	0.8%	0.0%	0.9%



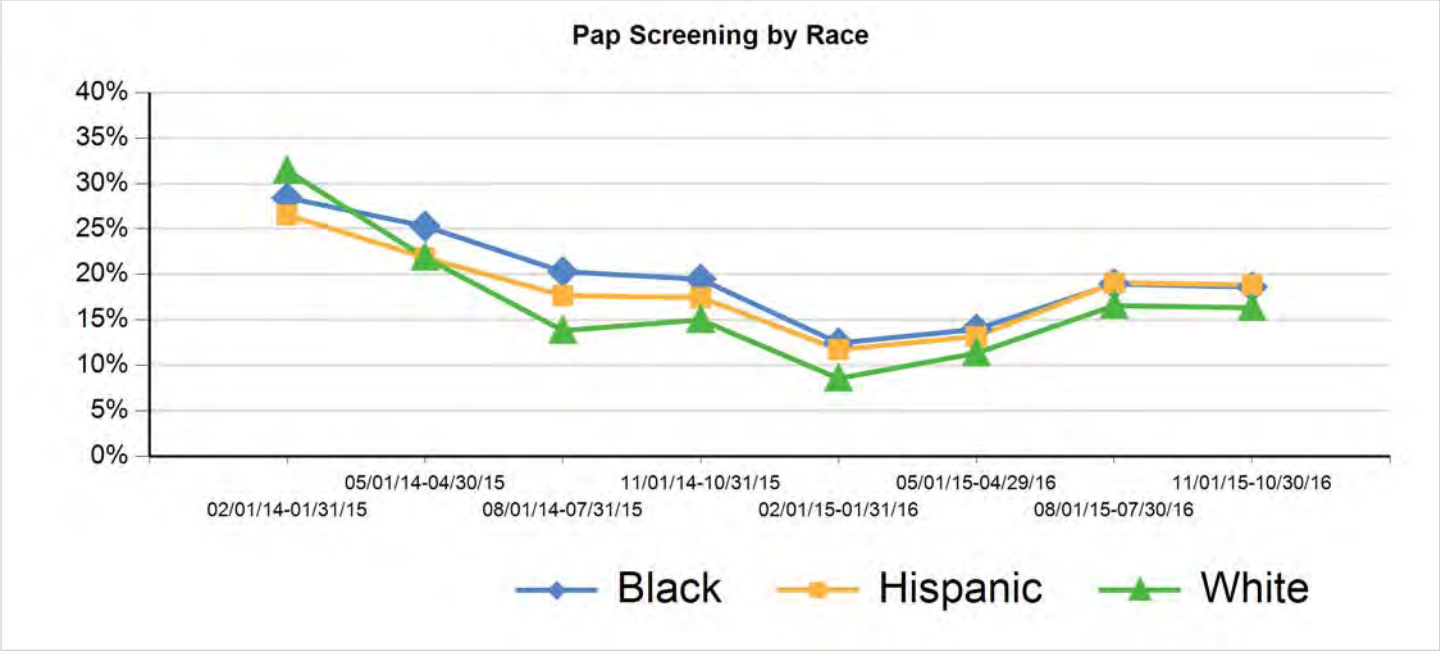
Viral Load Suppression by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	610	2,158	1,533	1,052	45	641	2,120	1,637	1,156	40
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	860	2,721	2,115	1,540	71	878	2,717	2,221	1,636	70
Percentage	70.9%	79.3%	72.5%	68.3%	63.4%	73.0%	78.0%	73.7%	70.7%	57.1%
Change from Previous Quarter Results	-0.7%	-0.6%	-0.2%	3.6%	1.1%	2.1%	-1.3%	1.2%	2.3%	-6.2%



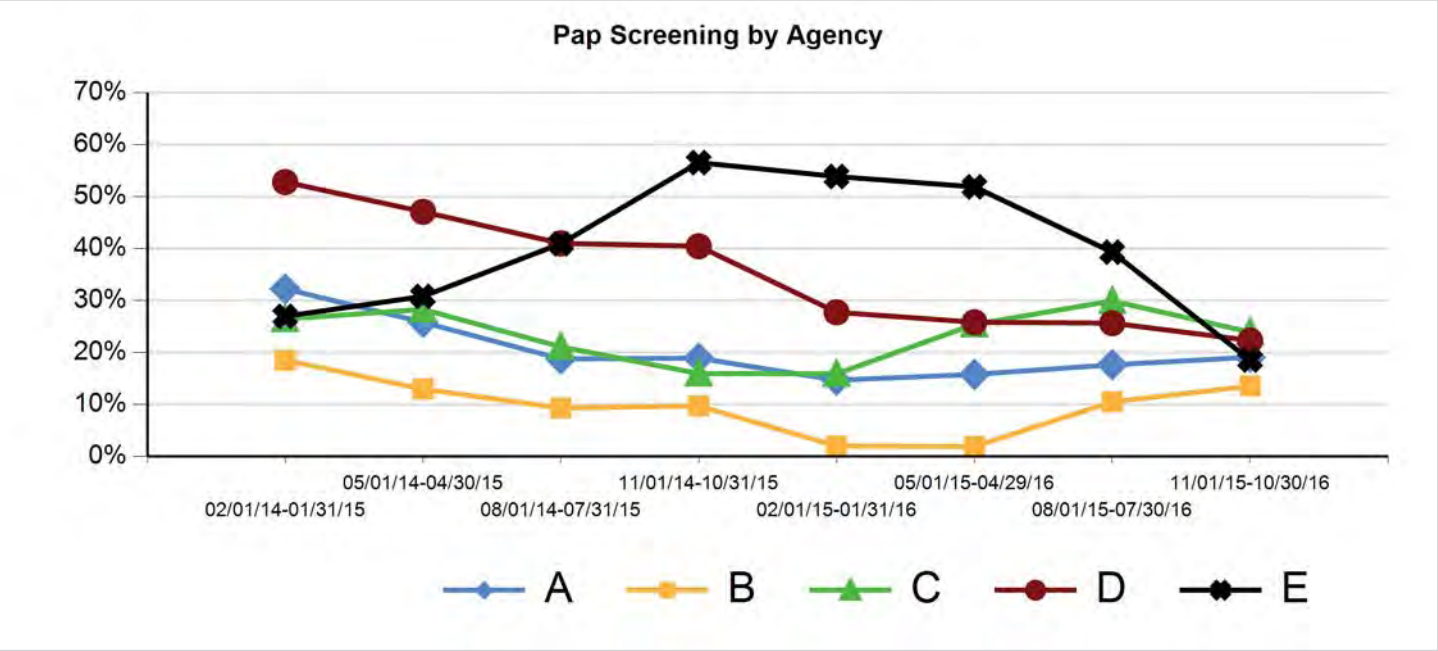
Cervical Cancer Screening				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	213	245	343	340
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,796	1,816	1,832	1,858
Percentage	11.9%	13.5%	18.7%	18.3%
Change from Previous Quarter Results	-6.7%	1.6%	5.2%	-0.4%



Cervical Cancer Screening Data by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	161	64	17	222	91	25	222	91	24
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,153	486	150	1,171	477	151	1,193	483	147
Percentage	14.0%	13.2%	11.3%	19.0%	19.1%	16.6%	18.6%	18.8%	16.3%
Change from Previous Quarter Results	1.5%	1.4%	2.8%	5.0%	5.9%	5.2%	-0.3%	-0.2%	-0.2%



Pap Smear Screening by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	44	88	104	103	11	48	112	87	94	5
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	250	841	348	402	28	252	829	364	422	27
Percentage	17.6%	10.5%	29.9%	25.6%	39.3%	19.0%	13.5%	23.9%	22.3%	18.5%
Change from Previous Quarter Results	1.9%	8.6%	4.5%	-0.2%	-12.6%	1.4%	3.0%	-6.0%	-3.3%	-20.8%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v3.3.1 9/2/15", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

2016 RWPC Service Utilization Report Due

State Services Contract Years	Ryan White Part B Contract Years
Year 1: 9/1/15 - 8/31/16 Year 2: 9/1/16 - 8/31/17	Year 1: 9/1/15 - 3/31/16 Year 2: 4/1/16 - 3/31/17

2015 Annual Chart Review Reports
Delivered to QI Committee

March 2016

All Monthly & Quarterly Reports delivered on a one-month delay to allow the finalization of data.

Health Insurance Assistance (HIA) Reports
Delivered to QI Committee

Monthly

Service Utilization Reports
Delivered to QI Committee

State Services Service Utilization Reports	
Months Covered	Month Due
September – November	January
September – February	April
September – May	July
September – August	October
Ryan White Part B Service Utilization Reports	
Months Covered	Month Due
September – November	January
September – March	May
April – June	August
April – September	November

Procurement Reports
Delivered to QI Committee

Monthly

2016 - 2017 DSHS State Services Service Utilization Report
9/1/2016 thru 11/30/2016 Houston HSDA (4816)
1st Quarter

Revised 2/6/2017

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Early Intervention Services	*850*	456	81.6%	16.7%	0.0%	1.8%	71.7%	15.6%	12.3%	0.4%	0.0%	1.3%	6.1%	27.6%	24.3%	13.6%	25.4%	1.5%
Health Insurance Premiums & Cost Sharing Assistance	*1,200*	4	100.0%	0.0%	0.0%	0.0%	25.0%	50.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%
Hospice	*35*	10	80.0%	20.0%	0.0%	0.0%	50.0%	20.0%	30.0%	0.0%	0.0%	0.0%	0.0%	20.0%	10.0%	0.0%	70.0%	0.0%
Linguistic/Interpreter Services	*40*	38	50.0%	47.4%	0.0%	2.6%	52.6%	5.3%	5.3%	36.8%	0.0%	0.0%	0.0%	13.2%	42.1%	28.9%	13.2%	2.6%
Mental Health Services	*250*	180	94.4%	3.3%	0.0%	2.2%	24.4%	50.0%	25.0%	0.6%	0.0%	0.0%	1.7%	16.7%	18.3%	15.6%	42.2%	5.6%
Group:		14																
Individual:		172																
Unduplicated Clients Served By State Services Funds:	*NA*	690	83.3%	14.9%	0.0%	1.7%	57.5%	24.5%	15.5%	2.5%	0.0%	0.9%	4.5%	23.5%	23.8%	14.8%	30.0%	2.6%

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1617 DSHS State Services
Procurement Report
September 1, 2016 - August 31, 2017

Chart reflects spending through December 2016

Spending Target: 33%

Revised 2/8/2017

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Mental Health Services	$300,000	15%		$300,000	15%	9/1/2016	$82,248	27%
7	Health Insurance Premiums and Cost Sharing*	$1,043,312	53%		$1,043,312	53%	9/1/2016	$0	0%
9	Hospice	$414,832	21%		$414,832	21%	9/1/2016	$111,980	27%
11	EIS - Incarcerated	$166,211	8%		$166,211	8%	9/1/2016	$51,585	31%
16	Linguistic Services	$48,000	2%		$48,000	2%	9/1/2016	$20,400	43%
	Total Houston HSDA	1,972,355	100%	$0	$1,972,355	100%		266,213	13%

* HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date
Ending date: Part A 02/2/17, Part B 03/31/17, State Services 08/31/17

2016-2017 Ryan White Part B Service Utilization Report
4/1/2016 - 12/31/2016
3rd Quarter

Revised 2/3/2017

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*945*	1,024	82.1%	17.5%	0.0%	0.4%	41.0%	30.1%	26.3%	2.6%	0.1%	0.0%	1.8%	14.1%	21.9%	16.5%	41.7%	4.0%
Home & Community Based Health Services	*55*	31	61.3%	35.5%	0.0%	3.2%	67.7%	12.9%	16.1%	3.2%	0.0%	0.0%	0.0%	3.2%	25.8%	19.4%	41.9%	9.7%
Oral Health Care	*3,810*	2,681	72.4%	27.2%	0.0%	0.5%	49.9%	17.6%	30.9%	1.6%	0.0%	0.1%	2.1%	15.1%	20.9%	14.1%	40.9%	6.8%
Unduplicated Clients Served By RW Part B Funds:	*NA*	3,483	74.5%	25.0%	0.03%	0.5%	47.9%	20.5%	29.9%	1.8%	0.0%	0.1%	2.0%	15.2%	21.5%	14.5%	40.7%	6.0%

NOTE: Missing data for December 2016; Missing data for Age Group (1 client)

2016 - 2017 Ryan White Part B Service Utilization Report
9/1/2016 thru 11/30/2016 Houston HSDA (4816)
1st Quarter

Revised 2/6/2017

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*945*	939	82.1%	17.6%	0.0%	0.3%	40.2%	29.9%	27.1%	2.9%	0.1%	0.0%	1.9%	13.5%	21.5%	17.1%	41.7%	4.1%
Home & Community Based Health Services	*55*	26	57.7%	38.5%	0.0%	3.9%	73.1%	7.7%	19.2%	0.0%	0.0%	0.0%	0.0%	3.8%	23.1%	15.4%	46.2%	11.5%
Oral Health Care	*3,810*	1,590	73.0%	26.5%	0.0%	0.6%	47.3%	17.9%	33.0%	1.8%	0.0%	0.1%	1.3%	14.1%	20.6%	13.5%	43.1%	7.3%
Unduplicated Clients Served By RW Part B Funds:	*NA*	2,409	76.0%	23.5%	0.00%	0.5%	45.2%	21.9%	30.8%	2.0%	0.0%	0.0%	1.6%	14.2%	21.3%	14.8%	42.2%	5.9%

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1617 Ryan White Part B
Procurement Report
April 1, 2016 - March 31, 2017

Reflects spending through November 2016

Spending Target: 67%

Revised 2/8/2017

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Oral Health Care	$2,120,346	64%	($34,781)	$2,085,565	64%	4/1/2016	$1,272,667	60%
7	Health Insurance Premiums and Cost Sharing **	$976,885	29%	($16,122)	$960,763	29%	4/1/2016	$841,172	86%
9	Home and Community Based Health Services	$232,000	7%	($3,840)	$228,160	7%	4/1/2016	$136,880	59%
	Total Houston HSDA	3,329,231	100%	($54,743)	$3,274,488	100%		2,250,719	68%

* Amendment-Reduction in award amount and each service category has been reduced proportionately

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: State Services 08/31/17, Part A 02/29/17, Part B 03/31/17,

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-11/30/2016

Revised: 1/10/2017

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	Dollar Amount of Requests	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	203	$26,232.10				*0*
Medical Deductible	90	$20,845.80				*0*
Medical Premium	1797	$524,068.69				*0*
Pharmacy Co-Payment	962	$82,650.96				*0*
APTC Tax Liability	1	$213.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	3053	$654,010.55	0	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-12/30/2016

Revised: 2/8/2017

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	Dollar Amount of Requests	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	274	$38,119.33	160			*0*
Medical Deductible	133	$30,716.77	95			*0*
Medical Premium	2466	$742,649.90	784			*0*
Pharmacy Co-Payment	1160	$104,449.81	539			*0*
APTC Tax Liability	1	$213.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	4034	$916,148.81	1578	0	$0.00	

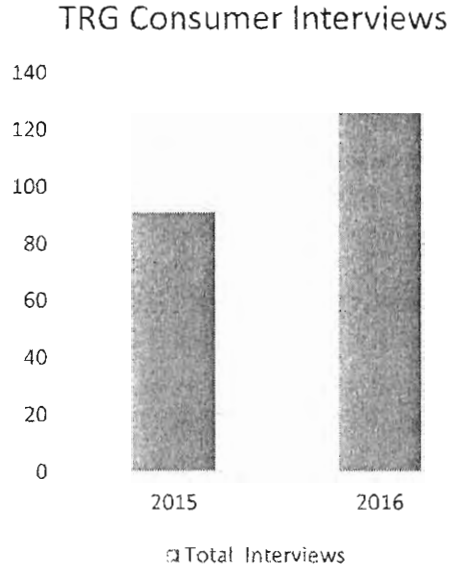
Comments: This report represents services provided under all grants.

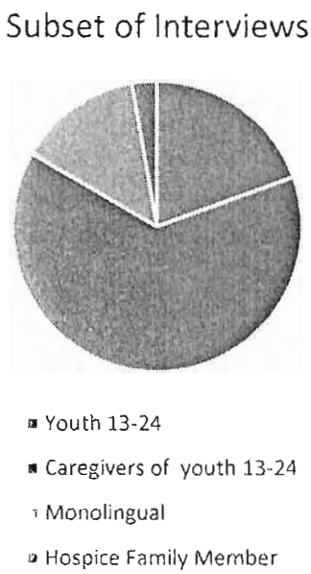
TRG Consumer Interview Results 2016

Interview and feedback Period April-2016-December 2016

OVERVIEW

The Consumer Interview Process is used by The Resource Group (TRG) to determine client satisfaction and collect additional feedback from consumers. Client interviews are required as part of the Quality Compliance Reviews (QCR) at each agency in Houston and the fifty-one county areas of East Texas. During the 2016 QCR season one hundred and twenty-six (126) client participated in the interview process including monolingual Spanish clients, youth as young as 13 with caregivers/guardians. HIV positive clients have been in care ranging from two months though thirty years. The majority of sessions conducted were individual based interviews, while a few were conducted as group interviews. Below is a comparison between the 2015 and 2016 reporting process showing an increase in participation. Four agencies had an increase in the participation of their clients, while three agencies did not reach the requested ten (10) clients for interviews. Youth participation had an increase while, monolingual was the same as the previous year. The total interviews include a new perspective of feedback not collected or documented in this process. The before mentioned perspective was from a hospice client's family member.





CROSS-SERVICE TRENDS

Overall, Clients reported satisfaction with the services they are receiving. Clients, who are in care, feel comfortable and satisfied with their medical team and care process. A high percentage of clients felt they were leaders on their health care team or an important team member of their team. Clients continue to become more descriptive in their roles with their medical team. Clients stated the medical staff answer questions and explain the things the client does not understand. Case managers were described as "good at helping and explaining things".
Statements included;

- One client's statement would like to addressed "the decision makers related to funding" is as follows "You will never know how much the funding helps people out and access to the services provides hope to us"
- "A list of private doctors who accept insured HIV + patients would be helpful as a reasonable clinic alternative."

Clients in Houston and throughout East Texas mentioned general communication between staff and consumers at most service agencies needs improvement. Clients continue to become more open about discussing concerns and reporting dissatisfaction for improvement purposes. There is an ongoing disconnection between clients and the agency complaint process or how concerns are resolve at some agencies. Some clients continue to report they were not aware of the complaint process for problems with services. Some clients were familiar with the agency process and complaint forms. In general, the clients' responses included;

- "The medical staff has an expertise in my ID (infectious disease) needs."
- The compassion and willingness to listen is bigger than anything medically that they could have to offer. I struggle with HIV stigma. The compassion helps me know that HIV did not define me as a person."
- "I needed help and it was made available to me. The staff treats everyone the same."
- "The medical staff keeps their word and they explain everything to me."
- "I like that the medical staff here slows down to talk to me. I would be concerned if they rushed me. My questions could be missed if they did that.
- "Once the nurse helped get my prescriptions filled when I had trouble getting them."
- "The services are convenient and affordable"

Services which received the most detailed comments were Mental Health Services, Oral Health Care, Home and Community-Based Health Care Services and Ryan White Part D services. There was an increase in statements and conversations related to services each year in the TRG Client Interview Process. Most clients were comfortable offering suggestions and recommendation as to how more clients can be reached. In previous years, having online surveys available for clients who may not have the time during their day to complete a survey has been suggested.

Clients who had complaints expressed their complaints have been addressed and resolved. While a few clients worried that if they complained, it may affect their service or that it may take them longer to get an appointment. Clients expressed an explanation of "why they are waiting" was a good way to communicate. In instances, such as the doctor is running late or when calling letting clients know if some is out for the day or for a week. One client stated "I don't mind the waiting, but communication would be helpful so I can decide if I am willing to wait or if I need to

reschedule and appointment. I would like my time respected." Phone system problems such as getting a live person and getting medication refills were discussed as problems. One client suggests an exit survey to ask about any complaints or comments at the end of a visit.

The lessons learned and questions which will be added to the questionnaire for 2017 include:

- "What topics or service would you like to learn more about?"

The client satisfaction questions are reviewed by TRG consumers and feedback is utilized to improve the evaluation process. The Client Interview Process has identified the need for Ryan White agencies to create and facilitate agency specific/ customized trainings for their consumers which may include but are not limited to:

- Consumers reviewing and providing feedback on agency policies and procedures
- Consumer trainings on each service which the agency provides and details to help clients understand the length of processes for specific procedures or service.

SERVICE-SPECIFIC TRENDS

Part D Specific

Individual/ family Interviews clients ranged 1 year to 8 years of receiving services (specific comments are listed below) Statements used to describe what keeps them coming back to the service and what is important about the services included;

- The service & personal relationship and being treated with dignity
- The care is top of the line.
- The phone calls and the return calls are great feels like someone is always there for us.
- The staff does a good job helping the family. I like having a case manager and how the staff handles HIV.
- The staff and medical team keeps up with my child's needs and health.

Group Interviews -The participants ranged from eight (8) to twenty- two (22) years of service with this agency.

- Thirteen caregiver/parents and children/ youth were present during the discussion. Participants represented the youth Consumer Advisory Board (CAB), have been associated with clinical trials, and care or treatment.
- The participants identified that the group serves as a extended family for them when it comes to support for living with HIV.
- Statements used to describe what keeps them coming back to the service and what is important about the services included;
  - The love and care given by the staff
  - The resources
  - The information,
  - "They make me feel human"
  - The staff is very responsive to concerns, needs, and helpful with problems.
- Participants expressed high levels of comfort addressing problems. Participants gave specific examples where problems had been encountered within hospital system and the Ryan White program staff addressed and resolved the problem.

Mental Health Services

Clients were satisfied with this service. Many clients expressed satisfaction with the selection process of pairing a client with an appropriate therapist through this service.

Individual Interviews- clients ranged in years receiving services from 2 weeks to 26 years (specific comments are listed below) Statements included:

- "The staff is really good at matching clients and therapist." One client stated "a staff member called me and said there was someone she thought could better fit my needs. I had not met or talked to the therapist yet. Whatever their process is it is great because I have the best therapist for me. My therapist helps me grow."
- Mental health services clients commented on wanting to have longer sessions to vent their frustration because having a therapist challenged and empowered them. "My therapist is thorough and helps me face my past"
- Clients commented on the ease of changing therapist when needed.
- One client mentioned a desire to have more communication between the therapist and case management staff.

Group Interviews - The members of ranged from six (6) months to ten (10) or more years since diagnosis.

- Consumers were interviewed during a therapeutic session for a peer support group. Once a month, the support group has a licensed therapist attend the group.
- The members identified that the group serves as a surrogate family for them when it comes to support for living with HIV.

Oral Health Care

Clients continued to be concerned with multiple appointments to receive dental care. While some clients did not think, multiple visits were an issue, an equal amount had concerns for their jobs, time and transportation to return and complete necessary dental work. Some described appointments quick and easy to get. Others expressed difficulties or being asked to call back for appointments.

Individual Interviews clients ranged 10 year to 15 years of receiving services (specific comments are listed below) Statements used to describe what keeps them coming back to the service and what is important about the services included;

- "The staff is thorough and polite. I like the atmosphere."
- "I trust the doctors because they are familiar with HIV care. They explain what they are doing. It's important."
- "I am a former dental patient here. I had dental insurance for 5 years. After the loss of my insurance, I had to stabilize my health and return to dental care here. I would not be able to afford dental care without this service."
- "The time to complete some of the procedures or process can take long. One process took 6 months."
- "They ask me my opinion and they explain things to me if I have questions."
- "Have been on the waiting list for three years for a porcelain crown"
- "the dentist here are very warm and friendly. Traditional dentist are not very friendly."
- As a recommendation one client commented "I miss distractions in the lobby like TV. Lobby conversations can be heard too clearly."

Home and Community-Based Health Care Services

Clients were satisfied with this service. Clients expressed satisfaction with the socialization and activities available through this service. Day treatment clients understanding of the service they are receiving has continued to improve from the previous years. The TRG recommends service education is continually administered to day treatment consumers.

Individual Interviews clients ranged 1 year to 8 years of receiving services (specific comments are listed below) Statements used to describe what keeps them coming back to the service and what is important about the services included;

- "Outreach came and told me about the program and provided transportation. I was a volunteer before but I like getting out and meeting new people."
- "The merger was a big change but things are moving forward. There was no program for about two weeks but they worked it out."
- "I like that someone checks on me on a regular basis about my health. They try to keep my mind active. I enjoy it and I feel useful."
- "The front desk is helpful and treats me like family. I have a drug history and the y keep my mind focused on the positive parts of life. They help me with life skill of the things I didn't know and have prior to getting help here."
- "I'm learning about boosting my immune system. The program is helping me grow and develop with taking my meds, going to the doctor, take care of my health and see more clearly the value of it."
- "I like the socialization and meeting people. There are no buses where I live to get around. I felt isolated. The nurse encourages me and that helps me want to do better."
- "the nurse is the best and good at encouraging to everyone. The nurse has no favorites"
- "It use to be wonderful. With staff changes, some new people did not have experience"
- "I get bored and my mind does not feel stimulated. I like movies but I can do that at home. Use our mind and hands to create things. We need more mind stimulating activities. I miss art therapy"
- "I like to feel useful. Sometimes I bring thing to the table for people who can't walk or do the things I still can."
- As a recommendation one client commented "I am diabetic. They should take my blood sugar 1x per week"

Group Interviews -The participants ranged from Three (3) to twenty –two (22) years of service in this program.

- The participants in the group have been living with HIV between four (4) to twenty- six (26) years with service.
- The participants identified that the group serves as a extended family for them when it comes to support for living with HIV.
- Statements used to describe what keeps them coming back to the service and what is important about the services included;
  - The staff works as a team
  - They help with personal hygiene items which is very helpful.
  - Eric is easy to talk to. He is professional and listens and he does what he says he will. He cares and goes the extra mile. He will stop what he is doing and you see results."

- "It feels like family hear and we worry about each other. It is a healthy support away from home."
- "The activity director is good she is new from January but she has grown a lot."
- Recommendations for improvements included; remodeling the space- new paint for the walls, new furniture.
- Recommendations for trip ideas include; fishing, going to Galveston, Kemah
- Other recommendations included more educational and professional speakers and bible study.

Early Intervention Services – Incarcerated (EIS)

EIS clients seem to be very knowledgeable and appreciative of access to service. Statements used to describe what keeps them coming back to the service and what is important about the services included;

- One statement from an incarcerated client said "The staff is nice and discreet. They remember me and that makes it easier for me".
- "I was seen within three days of getting here (referring to being incarcerated)".
- " The doctor takes his time and seems like he cares."

Linguistic Services

There were no issues related to this service and due to the nature of the service delivered, there are no consumer interviews conducted for this service.

Hospice Care Services

There were no issues of note related to this service and due to the nature of the service delivered; consumer interviews were not conducted for this service. 2016 was the first time a family member has given feedback in the client interview process for hospice care. The family is satisfied and grateful for the hospice service.

Health Insurance Premium (HIP)

HIP clients were satisfied and appreciative for the availability of the service. Clients stated that HIP was simple to get and easy to use.

2016 Proposed Idea

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

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

#1 Control Number Date Received 02/13/17

Proposal will be reviewed by the: Quality Assurance Committee on: 02/16/17 (date)
Priority & Allocation Committee on: 02/23/17 (date)

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

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

This will provide 200 clients with 200 units of service.

2. ADDRESS THE FOLLOWING:

A. DESCRIPTION OF SERVICE: Bridge payment To get new patients HIV medications immediately upon presentation of prescription

B. TARGET POPULATION (Race or ethnic group and/or geographic area): NO

C. SERVICES TO BE PROVIDED (including goals and objectives): one time HIV medication payment To eliminate wait time for approval by CCP, LPAP or ADAP. elimination of Complex Administrative process

D. ANTICIPATED HEALTH OUTCOMES (Related to Knowledge, Attitudes, Practices, Health Data, Quality of Life, and Cost Effectiveness): 1. Drop in % of patients lost.
2. stress - importance of Treatment by immediate start.
3. earlier Treatment starts The better the outcome.

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

✓	Current Needs Assessment (Year: 2016)	Page(s): 66 Paragraph: ___
___	Current HIV Comprehensive Plan (Year: ____)	Page(s): ___ Paragraph: ___
___	Health Outcome Results: Date: _____	Page(s): ___ Paragraph: ___
___	Other Ryan White Planning Document:	
	Name & Date of Document: _____	Page(s): ___ Paragraph: ___

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

REASON FOR RECOMMENDATION:

(Continue on Page 2 of this application form)

DRAFT

Proposed Idea

THIS PAGE IS FOR THE PRIORITY AND ALLOCATIONS COMMITTEE
(See Criteria and Principles to Guide Decision Making)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY AND INCLUDE A BRIEF HISTORY OF RELATED SERVICE CATEGORY, IF AVAILABLE.

CURRENTLY APPROVED RELATED SERVICE CATEGORY ALLOCATION/UTILIZATION:
Allocation: $ Ø
Expenditure: $ Ø Year-to-Date

Utilization: Ø Unduplicated Clients Served Year-to-Date
Ø Units of Service Provided Year-to-Date

AMOUNT OF FUNDING REQUESTED:
$ 125,000 This will provide funding for the following purposes which will further the objectives in this service category: (describe how): medication purchases

PLEASE STATE HOW THIS IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS: A comprehensive system STARTS with diagnosis and early Treatment. Getting gaps in medical & Treatment delivery Filled assure better results (principle A+B)
1 CRITERIA - A. consumer getting immediate CARE.
2 CRITERIA A. B. -C, D. E. F. G. H. I - all criteria met.

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

___ Recommended for Funding in the Amount of: $_____
___ Not Recommended for Funding
___ Other:

REASON FOR RECOMMENDATION:

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

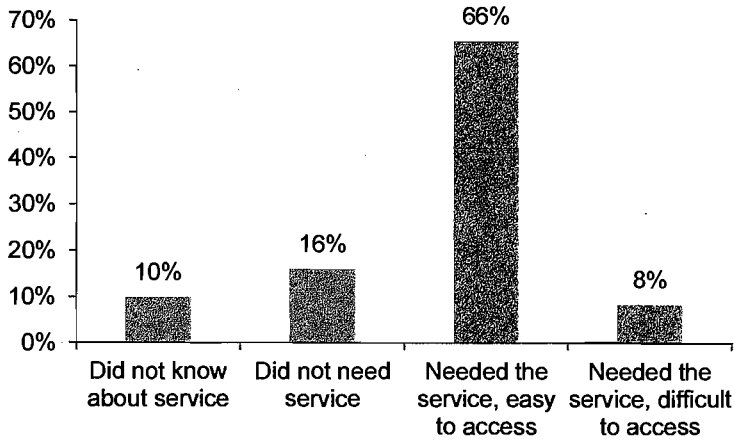


TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2016

		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

	Sex		Race/ethnicity				Age		
Experience with the Service	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[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
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%

[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

Priority and Allocations
FY 2017 Guiding Principles and Decision Making Criteria

(Priority and Allocations Committee approved 02-25-16)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort.** Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV/AIDS. Decisions will address at least one or more of the following principles **and** criteria.

Principles are the standards **guiding the discussion** *of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

Principles

A. Ensuring ongoing client access to a comprehensive system of core services as defined by HRSA
B. Eliminating barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
C. Meeting the needs of diverse populations as addressed by the epidemiology of HIV
D. Identify individuals unaware of their status and link them to care and address the needs of those that are aware of their status and not in care.
E. Expressing the needs of the communities with HIV for whom the services are intended

Allocations only

F. Documented or demonstrated cost-effectiveness of services and minimization of duplication
G. Availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies

Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.

(Continued)

DECISION MAKING CRITERIA STEP 1:

A. Documented service need with consumer perspectives as a primary consideration
B. Documented effectiveness of services with a high level of benefit to people and families living with HIV infection, including quality, cost, and outcome measures when applicable
C. Documented response to the epidemiology of HIV/AIDS in the EMA and HSDA
D. Documented response to emerging needs reflecting the changing local epidemiology of HIV/AIDS while maintaining services to those who have relied upon Ryan White funded services.
E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan and the Continuum of Care and their underlying principles to the extent allowable under the Ryan White Program: to build public support for HIV services; to inform people of their serostatus and, if they test positive, get them into care; to help people maintain their negative status; to help people with HIV improve their health status and quality of life and prevent the progression to AIDS; to help reduce the risk of transmission; and to help people with AIDS improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

DECISION MAKING CRITERIA STEP 2:

A. Services are effective with a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
B. Services are accessible to all populations infected, affected, or at risk, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).
D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
F. Services are available to meet the needs of all people and families living with or at risk for HIV infection as applicable under Part A and B guidelines
G. Services meet or exceed standards of care
H. Services reflect latest medical advances, when appropriate
I. Services meet a documented need that is not fully supported through other funding streams

PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS.
All decisions are expected to address needs of the overall community affected by the epidemic.

DRAFT

2016 Proposed Idea

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

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

#2 Control Number Date Received 02/13/17

Proposal will be reviewed by the: Quality Assurance Committee on: 02/16/17 (date)
Priority & Allocation Committee on: 02/23/17 (date)

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

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

This will provide **unknown will need staff assist** clients with _____ units of service.

2. ADDRESS THE FOLLOWING:

A. **DESCRIPTION OF SERVICE:** Cab Vouchers to access transportation for PLWHA with safety issues such as Trans-gender, Homeless, people experiencing domestic violence and others,as determined by case manager or Dr.

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

C. **SERVICES TO BE PROVIDED (including goals and objectives):** To eliminate barriers to accessing HIV core Medical Service providers in the EMA/HSDA. This services can only be used to travel to/from HIV medical services.

D. **ANTICIPATED HEALTH OUTCOMES (Related to Knowledge, Attitudes, Practices, Health Data, Quality of Life, and Cost Effectiveness):** Lack of transportation is the 5th most commonly-cited barrier among PLWHA Rank #2 w/in the 5 support services, most commonly-cited was lack of transportation (trans. study 2013) Transportation eliminates barriers to care, thereby supporting PLWHA in continuous care Transportation supports linkage to care, Maintenance/retention in care, and viral suppression.

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

x	Current Needs Assessment (Year: 2016)	Page(s): 22-23 Paragraph: 1/Tab1
x	Current HIV Comprehensive Plan (Year: 2017)	Page(s): 81 Paragraph: 1/Tab2
x	Health Outcome Results: Date: FY 2017 Serv. Cat. Info.	Page(s): 1 Paragraph: *
x	Other Ryan White Planning Document:	
	Name & Date of Document: Transgender Study 2013	Page(s): 6 Paragraph: 1&2/tab3

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

REASON FOR RECOMMENDATION:

(Continue on Page 2 of this application form)

DRAFT

Proposed Idea

THIS PAGE IS FOR THE PRIORITY AND ALLOCATIONS COMMITTEE
(See Criteria and Principles to Guide Decision Making)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY AND INCLUDE A BRIEF HISTORY OF RELATED SERVICE CATEGORY, IF AVAILABLE.

CURRENTLY APPROVED RELATED SERVICE CATEGORY ALLOCATION/UTILIZATION:

Allocation: $ 527,362

Expenditure: $ 183,376 Year-to-Date as of 10/27/16

Utilization: 3,374 Unduplicated Clients Served Year-to-Date as of 06/08/16

N/A Units of Service Provided Year-to-Date

AMOUNT OF FUNDING REQUESTED:

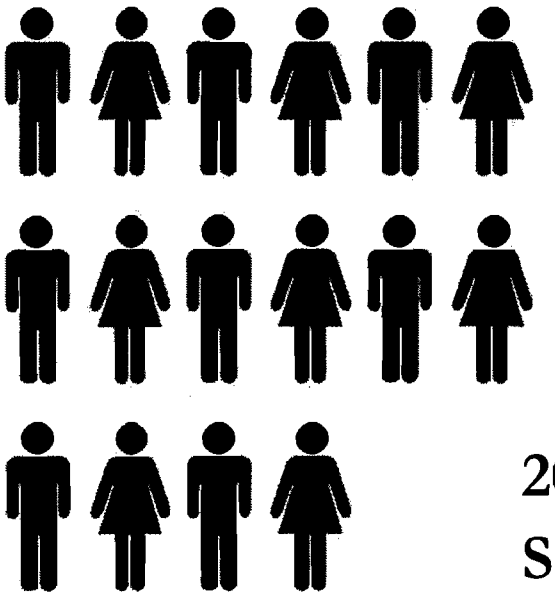
$ Unsure This will provide funding for the following purposes which will further the objectives in this service category: (describe how):

PLEASE STATE HOW THIS IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS: Principles: A,C,D,
Criteria STEP 1: A,F
Criteria Step 2: D,E,F

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

___ Recommended for Funding in the Amount of: $_____
___ Not Recommended for Funding
___ Other:

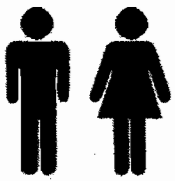
REASON FOR RECOMMENDATION:



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: December 8, 2016



Chapter 2:
Service Needs and Barriers

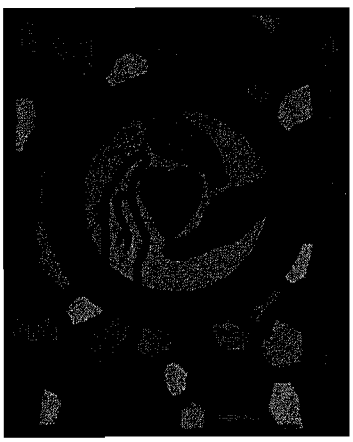
Descriptions of Barriers Encountered

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



Houston Area Comprehensive HIV Prevention and Care Services Plan

2017 - 2021

Capturing the community's vision for an ideal system of HIV prevention and care for the Houston Area

monthly household income of at least $6,000 or greater (n=349, 43.8%), and even more participants reported living in a house or apartment paid for by self (n=635, 79.7%).

Transportation has consistently been a known limitation to fluid mobility within the Houston Area given its significant geographic spread and limited public transportation system, often creating a barrier to accessing HIV care because of the difficulties in navigating this distance. For the sample population, the majority reported owning a vehicle (n=487, 61.1%) while 236 respondents reported relying on public transportation (29.6%). However, 12 participants in the sample reported having no transportation available to them (1.5%) (**Table 2**).

Table 2: **Demographics of Needs Assessment Participants (N=797)**

Description	No. (%)	Description	No. (%)
Birth sex		**Employment status**	
Male	498 (62.5%)	Full-time employment	302 (37.9%)
Female	245 (30.7%)	Part-time employment	192 (24.1%)
Intersex	13 (1.6%)	Temporary, contractual, or other work	162 (20.3%)
No response	41 (5.1%)	Student	26 (3.3%)
Race/Ethnicity		Retired	18 (2.3%)
Black or African American	396 (49.7%)	Disabled	48 (6.0%)
Hispanic	267 (33.5%)	Unemployed	16 (2.0%)
White	57 (7.2%)	No response	33 (4.1%)
Other/Multiracial	77 (9.7%)	**Household monthly income**	
Age Group		< $1000	34 (4.3%)
<18	8 (1.0%)	$1000-$1999	15 (1.9%)
18-24	188 (23.6%)	$2000-$2999	72 (9.0%)
25-34	175 (22.0%)	$3000-$3999	89 (11.2%)
35-44	240 (30.1%)	$4000-$4999	45 (5.6%)
45-54	110 (13.8%)	$5000-$5999	135 (16.9%)
55+	76 (9.5%)	$6000+	349 (43.8%)
Education		No response	58 (7.3%)
Post-secondary degree	437 (54.8%)	**Housing status**	
Technical/vocational degree	44 (5.5%)	House/apartment paid by self	635 (79.7%)
High school diploma	188 (23.6%)	House/apartment paid by other	87 (10.9%)
GED	63 (7.9%)	Subsidized housing	38 (4.8%)
Less than high school	59 (7.4%)	Stay with others	12 (1.5%)
No response	6 (0.8%)	No response	25 (3.1%)
Health Insurance		**Transportation**	
Private insurance	199 (25.0%)	Own vehicle	487 (61.1%)
Medicaid/Medicare	112 (14.1%)	Public transportation	236 (29.6%)
Harris Health System	60 (7.5%)	No transportation	12 (1.5%)
COBRA	67 (8.4%)	No response	62 (7.8%)
VA	11 (1.4%)		
Ryan White only	38 (4.8%)		
Self-pay	178 (22.3%)		
No response	340 (42.7%)		

Source: 2016 Houston HIV Prevention Services Needs Assessment

Of the total sample population, 493 identified as a man in their current gender identity or expression, with about 253 reporting woman and 5 reporting part-time as man and part-time as woman. Forty-six participants provided no response, total, for current gender identities or expression. About 473 participants reported a birth sex of male and a current gender identity of man (59.3%). Of those with a current gender identity or expression of man, 350 persons reported a sexual orientation of gay (43.9%), with the next highest percentage identifying as straight/heterosexual (n=121, 15.2%) followed by bisexual (n=20, 2.5%) and pansexual (n=1,

FY2017 Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 2/13/17

Service

Transportation
(Untargeted & Rural)
(Van & Bus Pass)

Allocation

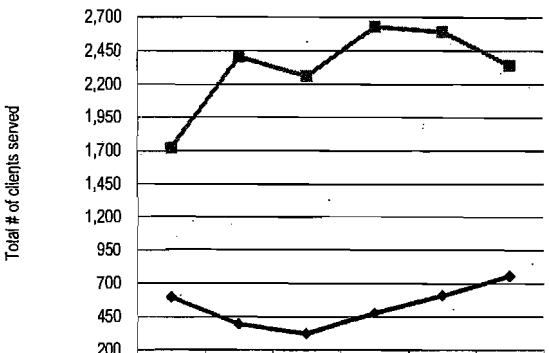
Part A:
FY98: $488,405
FY99: $580,909
FY00: $838,460
FY01: $912,947
FY02: $1,015,666
FY03: $945,743
FY04: $598,816
FY05: $570,000
FY06: $570,000
FY07: $512,000
FY08: $654,539

Part A/B:
FY09: $654,539
FY10: $595,366

Part A:
FY11: $625,366
FY12: $543,459
FY13: $543,459
FY14: $527,361
FY15: $527,362
FY16: $527,362

Source:
PROPOSED FY 2016 Allocations - Level Funding Scenario Based upon FY15 Actual Awards - as of 06/24/15

Client Utilization



	CY10	CY11	CY12	CY13	CY14	CY15
Van Based	598	394	322	478	611	754
Bus Pass	1,725	2,406	2,263	2,628	2,592	2,342

Source:
RWGA and The Resource Group, 4/25/16

Outcomes *

Van Based:
- Following van based transportation services:
  - 69% of clients accessed HIV primary care at least once:
  - 72% accessed LPAP at least once; and
  - 74% accessed oral health services at least once.

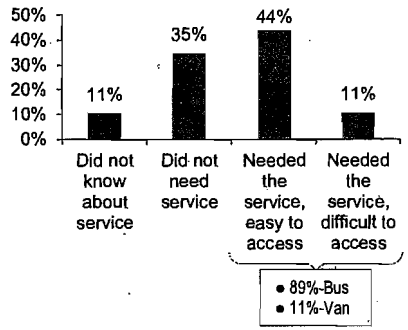
Bus Pass:
- Following bus pass transportation services:
  - 77% of clients accessed a RW service of some kind at least once;
  - 36% accessed HIV primary care at least once;
  - 20% accessed LPAP at least once; and
  - 25% accessed oral health services at least once.

Source:
RWGA FY 2013 Final Year Outcomes Reports

Needs Assessment Data

Needs Assessment Rankings:[a]

Transportation was defined as *"Transportation to/from your HIV medical appointments on a van or with a Metro bus card"* in the 2014 Needs Assessment. Results as defined are below:



- 55% of respondents reported a need for Transportation services, tying this service with Housing as the 5th highest ranked need.
- The most common barrier reported for Transportation Services was lack of transportation (18% of all reported barriers to this service).*
- Males, African American PLWHA, and PLWHA age 45+ reported the least difficulty accessing Transportation services
- Homeless PLWHA, out-of-care, and recently released had the most difficulty accessing Transportation services.

*Anecdotally, the initial transportation gap in accessing Transportation services, and the ongoing gap of refilling bus cards was noticed during data collection for the 2011 and 2014 Needs Assessments, and the IRR and Transgender special studies. However, this particular issue has not been formally measured.

Source:
2014 Houston Area HIV/AIDS Needs Assessment. Located at: http://www.rwpchouston.org/Publications/2014%20Needs%20Assessment%20-%20FINAL%203-13-14.pdf

National, State, and Local Priorities

This service aligns with the following goals:

National HIV/AIDS Strategy (NHAS) Updated for 2020 (2015)
- Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.
- Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

The Continuum of Care
- Increase the percentage of those aware of their HIV+ status retained in HIV care
- Increase the percentage of those aware of their HIV+ status with a suppressed viral load

The Texas HIV Plan Update for 2014-2015 (2013)
- Ensure continuous participation in systems of care and treatment
- Increase viral suppression

Comprehensive HIV Plan (2012-2014):
- Increase the percent of RW clients in continuous HIV care to 80%
- Reduce the proportion of diagnosed individuals who are not in HIV care by 0.8% each year
- Increase the proportion of RW clients with UVL by 10%

Recommendations from the SIRR Study:
- Distribute bus passes through EIS at discharge for use as transportation to a community-based HIV care provider.

Recommendations from the Transgender Special Study:
- Lack of transportation was cited most often (44%) by transgender consumers as a barrier to HIV care. It is recommended that the workgroup explore ways to reduce transportation barriers for this Special Population.

Access to HIV Care among Transgender and Gender Non-Conforming People in Houston

A Special Study of the Houston Area Ryan White Planning Council
Approved March 14, 2013

BACKGROUND

The Houston Area Ryan White Planning Council is responsible for designing HIV care, treatment, and support services for people living with HIV/AIDS in the Houston Eligible Metropolitan Area (EMA). The Planning Council uses several sources of information in order to meet this mandate, including epidemiological profiles, service-utilization reports, and a community-wide needs assessment of HIV-positive individuals conducted every three years. When specific populations are underrepresented in current data sources, the Planning Council may also commission a special data collection effort, or *Special Study*, to fill data gaps.

In 2012, the Planning Council released its comprehensive HIV prevention and care services plan for the Houston Area. In it are the specific HIV-infected populations in the Houston EMA with insufficient data for assessing their current level of access to HIV services. In response, the Planning Council commissioned a series of Special Studies to gather data on each underrepresented group. This article presents the results of the Planning Council's first Special Study in the series, focused on transgender and gender non-conforming people living with HIV/AIDS in the Houston EMA.

INTRODUCTION

Transgender individuals are among the highest risk for HIV infection in the U.S. today. [1] Moreover, the challenges often faced by transgender individuals in regards to discrimination, stigma, lack of resources, and other social determinants can make it difficult for them to access HIV services.[1] One study of transgender people living with HIV/AIDS showed a statistically lower rate of HIV treatment when compared to nontransgender people.[2] For these reasons and others, transgender communities are a high priority for HIV prevention, linkage, and retention in care efforts both nationally and in the Houston EMA.[3]

However, relatively little is known about the specific needs, gaps, and barriers to HIV care among transgender people in the Houston EMA. Transgender individuals are less than 1% of all Ryan White HIV/AIDS Program clients in the EMA,[4] and only 22 transgender-identified individuals participated in the EMA's most recent community-wide needs assessment of people living with HIV/AIDS.[5] This Special Study sought to describe the HIV service utilization patterns of transgender people living with HIV/AIDS in the Houston EMA, including socio-economic or behavioral factors that may be influencing their use of services, and to establish baselines for core HIV prevention and care indicators, including linkage to care and unmet need.

METHODS

Participants were self-selected, self-identified transgender HIV-positive adult residents of the Houston EMA. Because many individuals may not identify with the term "transgender," inclusion screening questions used the broader terminology of "transgender or gender non-conforming" and offered both a definition of the term and examples along a broad continuum of gender expression. The text for the transgender inclusion screening question for the study was: [6]

> **"Do you consider yourself to be transgender or gender non-conforming in any way?**
> Transgender/gender non-conforming refers to people whose gender identity or expression is different, at least part of the time, from the sex assigned to them at birth

RESULTS

HIV Testing, Diagnosis, and Linkage to Care

The first topic we wanted to address through this study was what motivates transgender people in the Houston EMA to test for HIV and where they test. In our sample, the most commonly-cited reason for testing was feeling sick (25%), followed by receiving an HIV test as part of a routine health check-up (21%). Three percent (3%) of the time the reason for testing was the recommendation of a medical provider, and another 3% was in response to community advertising, The most common location for HIV testing was a dedicated HIV clinic (34%), followed by an ER or hospital (17%). Thirteen percent (13%) said they were tested at a health department, and 9% were tested in jail or prison.

Because treatment for HIV can extend life expectancy and quality of life for those infected, length of time for linkage to care post-diagnosis and current care status are used as indicators of community health related to HIV both nationally and locally.[3,9] At the time of this study, baselines were missing for both of these measures for the transgender population in the Houston EMA. Therefore, the next topics we sought to address in the study were linkage to care and patterns of care. We asked respondents when they first saw a doctor for HIV following their diagnosis (either within three months or more than three months, per the federal benchmark[9]) and if they were currently meeting the national definition of being in care, which is defined as completing at least one of the following in the last 12 months: (1) seen a doctor for HIV, (2) taken HIV medications, (3) had an HIV viral load test, or (4) had a CD4 count test.[10]

(See Table 2) The majority of the transgender people in this study was linked to care within three months of their HIV diagnosis (76%). This percentage is comparable to current estimates for the Houston EMA as a whole (77%), [11] though lower than both local and national goals.[3,9] For those in the sample who did report delayed care, the most commonly-cited reason was denial about being HIV-positive (80%). However, 16% of the time the reasons were lack of knowledge about where to go for HIV services, fear about how the medical staff would react to their gender variance, and fear about how other clients would react. Twelve percent (12%) of the time the reason for delayed care was having to disclose their gender variant status to providers and staff.

TABLE 2-Linkage to Care among Participating Transgender People Who Are HIV Positive (n=133) Compared to the General HIV-Positive Population in the Houston Area and Local and National Goals

	Transgender Participants	General HIV+ Population[a]	Goal[b]
Linked to HIV Care within 3 Months of Diagnosis	75.9%	77.4%	85.0%

[a]Texas Department of State Health Services, 8/20/12
[b]National HIV/AIDS Strategy for the United States (July 2010); Houston Area Comprehensive HIV Prevention and Care Services Plan (2012 – 2014)

The majority of the people in this study was also currently in care (97%). This percentage far exceeds estimates for the general HIV-positive population in the Houston EMA (75%).[12] This is most likely a bias in our sample, rather than a true unmet need result, due to study recruitment taking place at HIV clinics and HIV group homes. Therefore, no additional analysis was performed on this data point.

HIV Care Service Utilization, Barriers to Care, and Service Needs

(See Table 3) Another topic we wanted to explore in this study was the use of specific HIV care, treatment, and support services by transgender people in the Houston EMA. To do this, we

TABLE 3-HIV Care Services Used and Barriers Reported by Participating Transgender People Who Are HIV Positive (n=132) in the Houston Area

Service Category (in order)	Reporting Use of Service # (%)	Service Category (in order)	Reporting Barrier to Use # (%)
Primary HIV care	113 (85.6)	Oral health care	28 (21.2)
Transportation	76 (57.6)	Primary HIV care	23 (17.4)
Case management	64 (48.5)	Case management	23 (17.4)
Oral health care	60 (45.5)	Transportation	18 (13.6)
Mental health counseling	59 (44.7)	Medical nutritional therapy	15 (11.4)
Medical nutritional therapy	51 (38.6)	Mental health counseling	13 (9.8)
HIV medication assistance	46 (34.8)	Legal services	8 (6.1)
Substance abuse treatment	28 (21.2)	Health insurance assistance	7 (5.3)
Health insurance assistance	25 (18.9)	Hospice care	7 (5.3)
Legal services	21 (15.9)	HIV medication assistance	6 (4.5)
Day treatment	19 (14.4)	Day treatment	6 (4.5)
Language services	14 (10.6)	Substance abuse treatment	4 (3.0)
Hospice care	9 (6.8)	Language services	4 (3.0)

asked each respondent if, in the past 12 months, they had used each of the services that the Planning Council had prioritized for funding through the Ryan White HIV/AIDS Program and if they had experienced any difficulties accessing each of the services, regardless of recent use. Primary HIV care (86%), transportation (58%), and clinic-based case management (49%) were the most used services in past 12 months. The services cited most often as having difficulties to access were oral health care (21%), primary HIV care (17%), and clinic-based case management (17%). These findings are consistent with the general population of HIV-positive people in the Houston EMA.[13]

(See Table 4) Specific barriers faced by this population when seeking HIV services were also explored. When asked what barriers, if any, respondents had faced at any time since their diagnosis, the most commonly-cited was lack of transportation (44%). Also high on the list was being treated poorly by staff due to gender variance (29%), lack of funds to pay for services (28%), and denial about being HIV-positive (24%). In addition, 19% of respondents reported lack of provider familiarity with transgender needs as a barrier to care. Twenty-two percent (22%) reported no barriers. When compared to

TABLE 4-Most Commonly-Cited Specific Barriers to HIV Care Reported by Participating Transgender People Who Are HIV Positive (n=105) Compared to the General HIV-Positive Population in the Houston Area

Specific Barrier Experienced (in order)	# (%) Reporting	Rank among General HIV+ Population[a]
No transportation	46 (43.8)	6
Treated poorly by staff due to being transgender	30 (28.6)	--
No money, the services cost too much	29 (27.6)	11
Fear or denial about being HIV-positive	25 (23.8)	14
Wait times for services were too long	20 (19.0)	3
Hard to get an appointment for HIV services	20 (19.0)	5
Providers are not familiar with transgender needs	20 (19.0)	--
A problem with drugs or alcohol	18 (17.1)	--
Lack of housing	18 (17.1)	--
Felt fine, not sick, "didn't think I needed HIV care"	16 (15.2)	--
HIV care a low priority	16 (15.2)	--
No Barriers Experienced	30 (22.2)	--

[a]2011 Houston Area HIV/AIDS Needs Assessment, April 2011 (n=924). Ranking is for core and support services combined; no distinction between type of service was made in our study.

Priority and Allocations
FY 2017 Guiding Principles and Decision Making Criteria

(Priority and Allocations Committee approved 02-25-16)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort.** Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV/AIDS. Decisions will address at least one or more of the following principles **and** criteria.

Principles are the standards **guiding the discussion** *of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

Principles

A. Ensuring ongoing client access to a comprehensive system of core services as defined by HRSA
B. Eliminating barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
C. Meeting the needs of diverse populations as addressed by the epidemiology of HIV
D. Identify individuals unaware of their status and link them to care and address the needs of those that are aware of their status and not in care.
E. Expressing the needs of the communities with HIV for whom the services are intended

Allocations only

F. Documented or demonstrated cost-effectiveness of services and minimization of duplication
G. Availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies

Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.

(Continued)

DECISION MAKING CRITERIA STEP 1:

A. Documented service need with consumer perspectives as a primary consideration
B. Documented effectiveness of services with a high level of benefit to people and families living with HIV infection, including quality, cost, and outcome measures when applicable
C. Documented response to the epidemiology of HIV/AIDS in the EMA and HSDA
D. Documented response to emerging needs reflecting the changing local epidemiology of HIV/AIDS while maintaining services to those who have relied upon Ryan White funded services.
E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan and the Continuum of Care and their underlying principles to the extent allowable under the Ryan White Program: to build public support for HIV services; to inform people of their serostatus and, if they test positive, get them into care; to help people maintain their negative status; to help people with HIV improve their health status and quality of life and prevent the progression to AIDS; to help reduce the risk of transmission; and to help people with AIDS improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

DECISION MAKING CRITERIA STEP 2:

A. Services are effective with a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
B. Services are accessible to all populations infected, affected, or at risk, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).
D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
F. Services are available to meet the needs of all people and families living with or at risk for HIV infection as applicable under Part A and B guidelines
G. Services meet or exceed standards of care
H. Services reflect latest medical advances, when appropriate
I. Services meet a documented need that is not fully supported through other funding streams

PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS.
All decisions are expected to address needs of the overall community affected by the epidemic.

Must meet in July

Williams, Victoria (County Judge's Office)

From: Carter,Jesse (DSHS) <Jesse.Carter@dshs.state.tx.us>
Sent: Tuesday, December 20, 2016 1:51 PM
To: Harbolt, Amber (County Judge's Office); Williams, Victoria (County Judge's Office)
Cc: Vazquez,Janina (DSHS)
Subject: 2017 Part B SOC Revision schedule

Hi Amber and Tori,

This has been a challenge but I think the solution is to try to have the council review what they can when they can. Each standard will be posted and the council will have roughly 60-75 days to provide comment. This includes the 30 days that we are providing stakeholders (AA, providers, councils) to comment and the following 30 days that the standard will be out for general public comment.

Below is a draft schedule with the due dates for both comment periods. If the council cannot submit comment during the stakeholder time period, they can submit during the public comment period.

	SOC	Q1 PC	SOC Released		
January	Universal Standard OAHC	Feb March	1/4/2017	Stakeholder Comment due Public Comment due	1/31/2017 3/15/2017
February	MCM	Feb March	2/1/2017	Stakeholder Comment due Public Comment due	2/28/2017 4/15/2017
March	Non MCM	Feb March	2/1/2017	Stakeholder Comment due Public Comment due	3/31/2017 5/15/2017
April	Mental Health Psychosocial Support Professional Services	May June	4/1/2017	Stakeholder Comment due Public Comment due	4/30/2017 6/15/2017
May	Sub Abuse - Out Sub Abuse - Res Housing	May June	5/1/2017	Stakeholder Comment due Public Comment due	5/31/2017 7/15/2017
June	LPAP Linguistic Services	July Aug	6/1/2017	Stakeholder Comment due Public Comment due	6/30/2017 8/15/2017
July	Home/Community Health Services HERR Rehabilitation Services EFA	July Aug	7/1/2017	Stakeholder Comment due Public Comment due	7/31/2017 9/15/2017
August	Hospice Outreach Respite Care	Aug Sept	8/1/2017	Stakeholder Comment due Public Comment due	8/31/2017 10/15/2017
September	~~Med Nutritional Therapy~~ ~~Food Bank~~ Pt A only ~~Child Care~~	Nov Dec	9/1/2017	Stakeholder Comment due Public Comment due	9/30/2017 11/15/2017
October	Health Insurance	Nov Dec.	10/1/2017	Stakeholder Comment due Public Comment due	10/31/2017 12/15/2017

UNIVERSAL STANDARDS

The Universal Standards listed below are applicable to all service categories funded under the Ryan White Part B Program. These Universal Standards are taken directly from the minimum requirements listed in the HIV/AIDS Bureau National Monitoring Standards. Recipients are required by HRSA/HAB to adhere to these monitoring standards and as such, sub-recipients funded for Ryan White Part B services will be held to these standards.

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBLITY	LIMITATIONS	SOURCE CITATION
***Section A*: ACCESS TO CARE**				
1. Structured and ongoing efforts to obtain input from clients in the design and delivery of services	1. Documentation of Consumer Advisory Board and public meetings – minutes, and/or 2. Documentation of existence and appropriateness of a suggestion box or other client input mechanism, and/or 3. Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted at least annually	1. Maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes 2. Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented 3. Maintain visible suggestion box or other client input mechanism	MUST have confidentiality clause	Universal Monitoring Standards[1] Public Health Service Act, 42 U.S.C. sections 2602(b)(6), 2605 (a)(7)(B), 2616(c)(4), 2617(b)(7)(A) DSHS POPS 13.2
2. Provision of services regardless of an individual's ability to pay for the service	Sub-recipients billing and collection policies and procedures do ***not***: ▪ Deny services for non-payment ▪ Deny payment for inability to produce income documentation ▪ Require full payment prior to service ▪ Include any other procedure that denies services for non-payment	1. Have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay 2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of compliant review and decision reached		Universal Monitoring Standards PHS Act sections 2605(a)(7)(A)(i), and 2617(b)(7)(B)(i) DSHS Policy AA-5018 Section F.
3. Provision of services regardless of the current or past health condition of the individual to be served	Documentation of eligibility and clinical policies to ensure that they do ***not***: ▪ Permit denial of services due to pre-existing conditions ▪ Permit denial of services due to non-HIV-related conditions (primary care) ▪ Provide any other barrier to care due to a person's past or present health condition	1. Maintain files of eligibility and clinical policies 2. Maintain file of individuals refused services		Universal Monitoring Standards PHS Act sections 2605(a)(7)(A) and 2617(b)(7((B)(i) DSHS Policy AA-5018

[1] HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs & Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements). Accessed December 2016 on http://hab.hrsa.gov/program-grants-management/ryan-white-hivaids-program-recipient-resources. *Universal Monitoring Standards will be utilized throughout Source Citation in this document and reflects this footnoted resource.*

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section A*: ACCESS TO CARE (continued)**				
4. Provision of services in a setting accessible to low-income individuals with HIV disease	1. A facility that is handicapped accessible, accessible by public transportation 2. Policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation 3. No policies that may act as a barrier to care for low-income individuals	1. Comply with Americans with Disabilities Act (ADA) requirements 2. Ensure that the facility is accessible by public transportation or provide for transportation assistance	***NO direct cash payments to clients*** can be made for transportation needs.	Universal Monitoring Standards PHS Act sections 2605(a)(7)(B), 2617(b)(7)(B)(ii), 2616(c)(4)
5. Efforts to inform low-income individuals of the availability of HIV-related services and how to access them	Availability of informational materials about sub-recipients services and eligibility requirements such as: ▪ Newsletters ▪ Brochures ▪ Posters ▪ Community Bulletins ▪ Any other types of promotional materials	Maintain file documenting sub-recipients activities for the promotion of HIV services to low-income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements		Universal Monitoring Standards PHS Act sections 2605(a)(7)(C), 2617(b)(7)(B)(iii), 2616(c)(5)
***Section B*: Eligibility Determination**				
1. Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction (in this case State) or ADAP: ▪ Eligibility determination of clients to determine eligibility for Ryan White services within a predetermined timeframe ▪ Reassessments of clients every 6 months to determine continued eligibility	1. Documentation of eligibility required in client records, with copies of documents (e.g., proof of HIV status, proof of residence, proof of income eligibility based on the income limit established by the State, ADAP, or local area, proof of insurance, uninsured or underinsured), using approved documentation as required by the State 2. Eligibility and Determination Enrollment forms for other third party payers such as Medicaid and Medicare 3. Eligibility policy and procedures on file 4. Documentation that all staff involved in eligibility determination has participated in required training	1. Initial Eligibility Determination & Once a year/12 month period recertification documentation requirements: ▪ HIV/AIDS diagnosis (at initial determination) ▪ Proof of residence ▪ Low income (Not more than 500% of FPL) ▪ Uninsured or underinsured status (insurance verification as proof) ▪ Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare		Universal Monitoring Standards PHS Act sections 2616(b)(102), 2617(b)(7)(B) Funding Opportunity Announcement PCN #13-02 DSHS Policy HIV/STD 220.001

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section B*: Eligibility Determination (continued)**				
	5. Sub-recipient client data reports are consistent with eligibility requirements specified by funder 6. Documentation of reassessment of client's eligibility status every six months 7. Training provided by the sub-recipient/ contractor to ensure understanding of the policy and procedures	▪ For underinsured, proof this service is **not** covered by other third party insurance programs including Medicaid and Medicare ▪ Proof of compliance with eligibility determination as defined by the State or ADAP 2. Recertification (minimum of every six months) documentation requirements: • Proof of residence • Low income documentation (not more than 500% FPL) • Uninsured or underinsured status (insurance verification as proof) • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare **Note**: At six-month recertification one of the following is acceptable: *full application and documentation, self-attestation of no change or self attestation of change with documentation.* 3. Proof of compliance with eligibility determination as defined by the State or ADAP 4. Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum of every six months 5. Document that all staff involved in eligibility determination have participated in required training 6. Sub-recipient client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services		

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section B*: Eligibility Determination (continued)**				
2. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services	Documentation that eligibility determination policies and procedures do not consider VA health benefits as the veteran's primary insurance and deny access to Ryan White services citing "payer of last resort"	Ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement		Universal Monitoring Standards HAB Policy Notice 04-01 Dr. Parham-Hopson Letter 8/04 HAB Policy Notice 07-07 DSHS HIV/STD Policy 220.001
***Section C*: Anti-Kickback Statute**				
1. Demonstrated structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program	1. Employee Code of Ethics including: ▪ Conflict of Interest ▪ Prohibition on use of property, information or position without approval or to advance personal interest ▪ Fair dealing – engaged in fair and open competition ▪ Confidentiality ▪ Protection and use of company assets ▪ Compliance with laws, rules, and regulations ▪ Timely and truthful disclosure of significant accounting deficiencies ▪ Timely and truthful disclosure of non-compliance	1. Maintain and review file documentation of: ▪ Corporate Compliance Plan (required by CMS if providing Medicare-or Medicaid-reimbursable services) ▪ Personnel Policies ▪ Code of Ethics or Standards of Conduct ▪ Bylaws and Board policies ▪ File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct ▪ Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution 2. For not-for-profit contractors/sub-recipient organizations, ensure documentation of sub-recipient Bylaws, Board Code of Ethics, and business conduct practices		Universal Monitoring Standards 42 USC 1320a7b(b) AA Core Competencies

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section C*: Anti-Kickback Statute**				
2. Prohibition of employees (as individuals or entities), from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Any documentation required by the Compliance Plan or employee conduct standards that prohibits employees from receiving payments in kind or cash from suppliers and contractors of goods or services	1. Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: ▪ Awarding contracts ▪ Referring clients ▪ Purchasing goods or services, and/or ▪ Submitting fraudulent billings 2. Have employee policies that discourage: ▪ The hiring of persons who have a criminal record relating to or are currently being investigated for Medicaid/Medicare fraud ▪ Large signing bonuses		42 USC 1320 7b(b) AA Core Competencies
***Section D*: Grantee Accountability**				
1. Proper stewardship of all grant funds including compliance with programmatic requirements	Policies, procedures, and contracts that require: • Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category • Timely submission of programmatic reports • Documentation of method used to track unobligated balances and carryover funds • A documented reallocation process • Report of total number of funded sub-recipients/contractors • A-133 or single audit • Auditor management letter	Meet contracted programmatic and fiscal requirements, including: • Provide financial reports that specify expenditures by service category and use of Ryan White funds as specified by Recipient (Grantee) • Develop financial and sub-recipient Policies and Procedures Manual that meet federal and Ryan White program requirements • Closely monitor any sub-recipients/contractors • Commission an independent audit; for those meeting thresholds, an audit that meet A-133 requirements • Respond to audit requests initiated by Recipient (Grantee)		Universal Monitoring Standards 45 CFR 74.21, 45 CFR 92.20, 2 CRF215.200 Funding Opportunity Announcement Part B Manual Steven Young & Heather Hauck Letter 9/20/2012 http://hab.hrsa.gov/manageyourgrant/files/subgrant exemption.pdf AA Core Competencies

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section D*: Grantee Accountability (continued)**				
2. Grantee accountability for the expenditure of funds it shares with lead agencies (usually health departments), sub-recipients	1. A copy of each contract 2. Fiscal, program site visit reports and action plans 3. Audit reports 4. Documented reports that track funds by formula, supplemental, service categories 5. Documented reports that track unobligated balance and carryover funds 6. Documented reallocation process 7. Report of total number of funded sub-recipients/contractors 8. Sub-recipient A-133 or single audit conducted annually and made available to the State every one year. (Note: State requires submission to the System Agency and Office of Inspector General within 30 calendar days of receipt of the audit reports every year an audit is completed)* 9. Auditor management letter	Establish and implement: 1. Fiscal and general policies and procedures that include compliance with federal and Ryan White programmatic requirements 2. Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources 3. Timely submission of independent audits (A-133 audits if required) to the State		Universal Monitoring Standards Part B Manual *Submission of audit to State: HHSC Uniform Terms and Conditions Section 4.03
3. Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the Grantee (Recipient) assurances and the Notice of Grant Award	1. Review of sub-recipient contracts 2. Fiscal and program site visit reports and action plans 3. Policies and Procedures that outline compliance with federal and Ryan White programmatic requirements 4. Independent audits 5. Auditor management letter	Ensure that the following are in place: 1. Documented policies and procedures and fiscal /programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements		Universal Monitoring Standards 2 CFR 215.17(b)3; 45 CFR 92.3 OMB Circular A-102
4. Responsibility for activities that are supported under the Ryan White Program as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement Program Assurances, and Notice of Grant Award (NOA)	Desk audits of budgets, applications, yearly expenses, programmatic reports; audit reports or on-site review when assessing compliance with fiscal and programmatic requirements	Ensure fiscal and programmatic policies and procedures are in place that comply with federal and Ryan White program requirements		Universal Monitoring Standards & DSHS Statement of Work 2 CFR 215.17(b)3; 45 CFR 92.3; 45 CFR 74.2 OMB Circular A-102

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section E*: Reporting**				
1. Submission of standard reports as required in circulars as well as program-specific reports as outlined in the Notice of Grant Award	Records that contain and adequately identify the source of information pertaining to: ▪ Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income, interest ▪ Client level data ▪ Aggregate data on services provided; clients served, client demographics and selected financial information	Ensure: 1. Submission of timely sub-recipient reports 2. File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with existing financial or programmatic data. Example: Test program income final FFR with calendar year RDR. 3. Submission of periodic financial reports that document the expenditure of Ryan White funds, positive and negative spending variances, and how funds have been reallocated to other line-items or service categories		Universal Monitoring Standards & Part B Manual 45 CFR 74.50-51 45 CFR 92.40-41
***Section F*: Monitoring**				
1. Any grantee or sub-recipient or individual receiving federal funding is required to monitor for compliance with federal requirements and programmatic expectations	Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of awards	1. Participate in and provide all material necessary to carry out monitoring activities 2. Monitor any service contractors for compliance with federal and programmatic requirements		Universal Monitoring Standards & Part B Manual & FOA 45 CRF 74.51; 45 CFR 92.40; 2 CRF 215.51 DSHS Statement of Work
2. Monitoring activities expected to include annual site visits of all Provider/Sub-recipients. Note: Code of Federal Regulations (45 CFR 74.51; 92.40 and 215.51) states that the HHS awarding agency will prescribe the frequency of monitoring activities	Review of the following program monitoring documents and actions: a. Policies and procedures b. Tools, protocols, or methodologies c. Reports d. Corrective action plans e. Progress on meeting goals of corrective action plans	1. Establish policies and procedures to ensure compliance with federal and programmatic requirements 2. Submit auditable reports 3. Provide the grantee access to financial documentation		Universal Monitoring Standards 45 CFR 74.51; 45 CFR 92.40; 2 CFR 215.51 Steven Young & Heather Hauck Letter 10/4/2012

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section F*: Monitoring (continued)**				
3. Performance of fiscal monitoring activities to ensure that Ryan White funding is being used for approved purposes	Review of the following fiscal monitoring documents and actions: ▪ Fiscal monitoring policy and procedures ▪ Fiscal monitoring tool or protocol ▪ Fiscal monitoring reports ▪ Fiscal monitoring corrective action plans ▪ Compliance with goals of corrective action plans	Have documented evidence that federal funds have been used for allowable services and comply with Federal and Ryan White requirements		Universal Monitoring Standards & Part B Manual Funding Opportunity Announcement Inspector General 2004 OEI-02-01-00641 DSHS Statement of Work I. M.
4. Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of the most current HRSA Executive Salary Level II. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts for substantive work under a HRSA grant or cooperative agreement.	1. Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Executive Salary Limit. 2. Determine whether individual staff receive additional HRSA income through other sub-awards or subcontracts.	1. Monitor staff salaries to determine whether the salary limit is being exceeded. 2. Monitor prorated salaries to ensure that the salary, when calculated at 100%, does not exceed the HRSA Executive Salary Limit 3. Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other federal sources including all parts of Ryan White do not exceed the limitation. 4. Review payroll reports, payroll allocation journals, and employee contracts.		Universal Monitoring Standards Consolidated Appropriations Act, 2012, Division F, title II, Sec. 203, P.L. 112-74.
5. Salary Limit Fringe Benefits: If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.	Identification of individual employee fringe benefit allocation.	Monitor to ensure that when an employee salary exceeds the salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary.		Universal Monitoring Standards Consolidated Appropriations Act, 2012, Division F, title II, Sec. 203, P.L. 112-74

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section F*: Monitoring (continued)**				
6. Corrective actions taken when sub-recipient outcomes do not meet program objectives and grantee expectations, which may include: ▪ Improved oversight ▪ Redistribution of funds ▪ A "corrective action" letter ▪ Sponsored technical assistance	1. Review corrective action plans 2. Review resolution of issues identified in corrective action plan 3. Policies that describe actions to be taken when issues are not resolved in a timely manner	Prepare and submit: ▪ Timely and detailed response to monitoring findings ▪ Timely progress reports on implementation of corrective action plan		Universal Monitoring Standards Part B Manual DSHS Program Policy 540.001
***Section G:* Quality Management**				
1. Implementation of a Clinical Quality Management (CQM) Program to: • Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent HHS guidelines for the treatment of HIV/AIDS and related opportunistic infections • Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services CQM program to include: • A Quality Management Plan • Quality expectations for providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved Service Standards • *The State will provide periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under the Part B Program*	1. Documentation that the Part B Program has in place a Clinical Quality Management Program that includes, at a minimum: • A Quality Management Plan • Quality expectations for providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved service category definition for each funded service 2. Review of CQM program to ensure that both the grantee and providers are carrying out necessary CQM activities and reporting CQM performance data 3. Develop and monitor own Service Standards as part of CQM Program	Participate in quality management activities as contractually required; at a minimum: • Compliance with relevant service category definitions • Collection and reporting of data for use in measuring performance		Ryan White Part B National Monitoring Standards PHS Act 2618(b)(3)(C&E) DSHS Statement of Work AA Core Competencies

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section H*: Other Service Requirements**				
1. WICY – Women, Infants, Children, and Youth: Amounts set aside for women, infants, children, and youth to be determined based on each of these population's relative percentage of the total number of persons living with AIDS in the State ***Note**: Waiver* available if grantee can document that funds sufficient to meet the needs of these population groups are being provided through other federal or state programs	1. Documentation that the amount of Part B funding spent on services for women, infants, children, and youth is at least equal to the proportion each of these populations represents of the entire population of persons living with AIDS in the State 2. If a waiver is requested, documentation that the service needs of one or more of these populations are already met through funding from another federal or state program	**Not Applicable:** DSHS will conduct all necessary documentation requirements to fulfill the State WICY report.		RW Part B National Monitoring Standards Dr. Joseph F. O'Neill Letter 8/10/2000 Doug Morgan Letter 6/17/03 Funding Opportunity Announcement
2. Referral relationships with key points of entry: Requirement that Part B service providers maintain appropriate referral relationships with entities that constitute key points of entry Key points of entry defined in legislation: • Emergency rooms • Substance abuse and mental health treatment programs • Detoxification centers, • Detention facilities • Clinics regarding sexually transmitted disease • Homeless shelters • HIV disease counseling and testing sites • Health care points of entry specified by eligible areas • Federally Qualified Health Centers • Entities such as Ryan White Part A, C and D and F grantees	1. Documentation that written referral relationships exist between Part B service providers and key points of entry	1. Establish written referral relationships with specified points of entry 2. Document referrals from these points of entry		RW Part B National Monitoring Standards PHS Act 2617(b)(7)(G)

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities**				
1. Drug Use and Sexual Activity: Ryan White funds cannot be used to support AIDS programs or materials designed to promote or directly encourage intravenous drug use or sexual activity, whether homosexual or heterosexual	1. Signed contracts, grantee and sub-recipient assurances, and/or certifications that define and specifically forbid the use of Ryan White funds for unallowable activities 2. Grantee review of sub-recipient budget and expenditures to ensure that they do not include any unallowable costs or activities	1. Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities 2. Ensure that budgets and expenditures do not include unallowable activities 3. Ensure that expenditures do not include unallowable activities 4. Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs or activities		RW Part B National Monitoring Standards Notice of Award PHS Act 2684
2. Purchase of Vehicles without Approval: No use of Ryan White funds by grantees or sub-recipients for the purchase of vehicles without written approval of HRSA Grants Management Officer (GMO)	1. Implementation of measure/ method, grantee responsibility and provider/sub-recipient responsibility actions specified in I.1 above 2. Where vehicles were purchased, review of files for written permission from GMO	1. Carry out sub-recipient actions specified in I.1 above 2. If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file		RW Part B National Monitoring Standards Notice of Award HAB Policy Notice 10-02
3. Broad Scope Awareness Activities: No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public	1. Implementation of actions specified in I.1 above 2. Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	1. Carry out sub-recipient actions specified in I.1 above 2. Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities		RW Part B National Monitoring Standards Notice of Award HAB Policy Notice 07-06

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-REICIPENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities (continued)**				
4. Lobbying Activities: Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel	1. Implementation of actions specified in I.1 above 2. Review of lobbying certification and disclosure forms for both the grantee and sub-recipients	1. Carry out sub-recipient actions specified in I.1 above 2. Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds		RW Part B National Monitoring Standards 45 CFR 93 Conditions of Grant Award Dr. Parham-Hopson Letter 2/3/2009
5. Direct Cash Payments: No use of Ryan White program funds to make direct payments of cash to service recipients	1. Implementation of actions specified in I.1 above 2. Review of Service Standards and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co- pays and deductibles, food and nutrition) 3. Review of expenditures by sub-recipients to ensure that no cash payments were made to individuals	1. Carry out sub-recipients actions specified in I.1 above 2. Maintain documentation of policies that forbid use of Ryan White funds for cash payments to service recipients	NO direct cash payments to service recipients (clients/ consumers)	RW Part B National Monitoring Standards PHS Act 2618(b)(6) HAB Policy Notice 10-02 TDSHS AA Contract SOW II. F.
6. Employment and Employment-Readiness Services: Prohibition on the use of Ryan White program funds to support employment, vocational, or employment- readiness services	Implementation of actions specified in I.1 above	Carry out sub-recipient actions specified in I.1 above		RW Part B National Monitoring Standards HAB Policy Notice 10-02

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities (continued)**				
7. Maintenance of Privately Owned Vehicle: No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees **Note:** This restriction does not apply to vehicles operated by organizations for program purposes	1. Implementation of actions specified in I.1 above 2. Documentation that Ryan White funds are not being used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees – except for vehicles operated by organizations for program purposes	Carry out sub-recipient actions specified in I.1 above		RW Part B National Monitoring Standards HAB Policy Notice 10-02
8. Syringe Services: No use of Ryan White funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs.	1. Implementation of actions specified in I.1 above 2. Documentation that Ryan White funds are not being used for programs related to sterile needles or syringe exchange for injection drug use.	Carry out sub-recipient actions specified in I.1 above		RW Part B National Monitoring Standards Consolidated Appropriations Act 2012, Division F, Title V, Sec. 523 Ronald Valdiserri Letter 3/29/2012 Dr. Parham-Hopson Letter 1/6/2012

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESONBILITY	LIMITATIONS	SOURCE CITATION
***Section I*: Prohibition on Certain Activities (continued)**				
9. Additional Prohibitions: No use of Ryan White Funds for the following activities or to purchase these items: • Clothing • Funeral, burial, cremation or related expenses • Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) • Household appliances • Pet foods or other non- essential products • Off-premise social/recreational activities or payments for a client's gym membership • Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility • Pre-exposure prophylaxis	1. Implementation of actions specified in I.1 above 2. Review and monitoring of grantee and sub-recipient activities and expenditures to ensure that Ryan White funds are not being used for any of the prohibited activities	Carry out sub-recipient actions specified in I.1 above		RW Part B National Monitoring Standards HAB Policy Notice 10-02 PHS Act 2618(b)(6) Dr. Parham-Hopson Letter 12/2/2010
***Section J*: Minority AIDS Initiative**				
1. Reporting Submission of an Annual Plan 60 days after the budget start date or as specified on the Notice of Award that details: • The actual award amount • Anticipated number of unduplicated clients who will receive each service • Anticipated units of service • Planned client-level outcomes for each minority population served under the Minority AIDS Initiative (MAI)	Documentation that the grantee has submitted a MAI Annual Plan 60 days after the budget start date that contains required elements and meets HRSA/HAB reporting requirements	• **Not Applicable**: DSHS will maintain tracking and reporting for MAI services and expenditures.		RW Part B National Monitoring Standards Part B Minority AIDS Initiative (MAI) Reporting Instructions

HRSA/DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
***Section J*: Minority AIDS Initiative (continued)**				
2. Submission of an Annual Report following completion of the MAI fiscal year	Documentation that the grantee has submitted an Annual Report on MAI services that includes: • Expenditures • Number and demographics of clients served • Outcomes achieved	**Not Applicable**: DSHS will maintain tracking and reporting for MAI services and expenditures.		RW Part B National Monitoring Standards Part B Minority AIDS Initiative (MAI) Reporting Instructions
***Section K*: Data Reporting Requirements**				
1. Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR).	Documentation that all service providers have submitted their sections of the online service providers report	1. Report all the Ryan White Services the provider offers to clients during the funding year 2. Submit both interim and final reports by the specified deadlines		RW Part B National Monitoring Standards Ryan White HIV/AIDS Program Services Report Instruction Manual DSHS Statement of Work
2. Submission of the online client report	Documentation that all service providers have submitted their sections of the online client report	1. Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client Identifier 2. Submit this report online as an electronic file upload using the standard format 3. Submit both interim and final reports by the specified deadlines		RW Part B National Monitoring Standards Ryan White HIV/AIDS Program Services Report Instruction Manual DSHS Statement of Work

STATEWIDE PROGRAMMATIC STANDARDS

The following programmatic standards are identified for ease in determining program compliance specific to services provided in the Ryan White Part B Program for the State of Texas.

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section L: General HIV Policies & Procedures				
Grievance Policies: All contractors are required to have a written client complaint procedure in place to meet the minimum requirements for client complaints.	Agencies have a policy and/or procedure for handling client grievances.	AAs will ensure all subcontractors and vendors will have a policy and/or procedure for handling client grievances.		DSHS Policy 530.002 section 5.5
Delivery of Client Services: Maintain client relations of the highest possible quality.	Agencies **must** have written procedures to deal with clients who may be disruptive or uncooperative. Agencies **must have** written procedures to deal with clients who are violent or exhibit threatening behavior.	AAs will ensure all subcontractors and vendors have written procedures to deal with clients who may be disruptive or uncooperative. AAs will ensure all subcontractors and vendors have written procedures to deal with clients who are violent or exhibit threatening behavior.		DSHS Policy 530.002 section 6.0 DSHS Policy 530.003
Non-Discrimination Policy: Written non-discrimination policies and procedures are in place that addresses protected classes and persons with disabilities, including prohibiting discrimination against sexual orientation and gender identity.	Agencies shall have comprehensive non-discrimination policies, which prohibits discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, age, or disability, gender identity, and any other non-discrimination provision in specific statures under which application for federal or state assistance is being made.	AAs will ensure all subcontractors have comprehensive non-discrimination policies and procedures in place.		DSHS Policy AA-5018
Payer of Last Resort: Ensure that RWHAP Part B and State Services funds distributed by DSHS are used as PoLR for eligible services and eligible clients.	Agencies have written policies and/or protocols for ensuring RWHAP Part B and State Services funds are used as PoLR for eligible services and eligible clients.	AAs will develop and assure compliance with local policies required by DSHS policies, and monitor provider billing of third party payers to determine compliance with PoLR requirements.		Part B Monitoring Standards DSHS Policy 590.001 & 220.001

DSHS STANDARD	PERFORMANCE MEASAURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section L: General HIV Policies and Procedures (continued)				
Confidentiality regarding Patient Information: It is the policy of the DSHS THSVH Unit that information collected to prevent, treat, and control the spread of TB, HIV, STDs and Viral Hepatitis will be protected and maintained to ensure patient confidentiality.	All staff, management, and volunteers must complete a signed confidentiality agreement affirming the individuals' responsibility for keeping client information and data confidential. All staff, management, and volunteers must successfully complete confidentiality and security training.	AAs are to ensure that all vendors, subcontractors, and subrecipient staff, management and volunteers have completed signed confidentiality agreements annually. AAs are to ensure that all vendors, subcontractors, and subrecipient staff, management and volunteers have completed confidentiality and security training.		DSHS Policy 2011.01
Breach of Confidentiality: All subcontractors and subrecipient agencies must have policies that outline how to address negligent or purposeful release of confidential client information.	Agencies will have detailed policies outlining how to address negligent or purposeful release of confidential client information in accordance with the Texas Health and Safety Code.	AAs are to ensure that all subcontractors, vendors, and subrecipient agencies have detailed policies outlining how to address negligent or purposeful release of confidential information in accordance with the Texas Health and Safety Code.		DSHS Policy 2011.04
Child Abuse Reporting: HIV and STD contractors who provide clinical and/or case management services or are required to review these services if provided by subcontractors are required to monitor for compliance with Texas child abuse reporting laws and for compliance with DSHS policy referenced relating to the reporting of child abuse and the use of the DSHS "Checklist for DSHS Monitoring".	Any person who has cause to believe that a child's physical or mental health or welfare has or may be adversely affected by abuse or neglect is required to report the situation. In addition, professionals are required by law to report the situation no later than the 48th hour after becoming aware of the suspected abuse or neglect. No other person may be delegated or relied upon to make the report. All agencies are required to report suspected cases of child abuse, etc. as defined by Texas law.	All contracting agencies are required to ensure their staff is trained on Texas child abuse reporting laws and that suspected cases of child abuse are being reported as prescribed by Texas law. Note: The Child Abuse Reporting Form can be accessed on the Texas DSHS website at the following web address: http://www.dshs.texas.gov/childabusereporting/checklist.shtm		DSHS Policy 530.001

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONISIBLITY	LIMITATIONS	SOURCE CITATION
Section L: General HIV Policies and Procedures (continued)				
Incarcerated Persons in Community Facilities: Ryan White and State Services funds may not be used to pay for medical care or medications for any person incarcerated in a state or federal prison, or a local jail.	Agencies will have policies ensuring RWHAP and State Services funds are not utilizing in paying for medical care or medications when incarcerated persons in community facilities are receiving services in local service provider locations.	All contracting agencies have policies in place ensuring RWHAP and State Services funding is not utilized in paying for medical care or medications when incarcerated persons in community facilities are receiving services in local service provider locations.	RWHAP and State Services funds are NOT utilized to pay for services rendered to incarcerated individuals	DSHS Policy 591.000
Conflict of Interest: Services will be provided without interference by any conflict of interest.	Agencies will have policies ensuring services will be provided without interference by any conflict of interest.	All contracting agencies have written conflict of interest policies and procedures. All employees and board members of any agency are required to complete and sign a Conflict of Interest Disclosure Form, which contains, at a minimum, the content in the sample provided by DSHS.		DSHS Policy 241.005 DSHS Conflict of Interest Statement Form AA Core Competencies
Personnel Policies and Procedures: Personnel and human resources policies are available that address new staff orientation, ongoing training plan and development, employee performance evaluations, and employee/staff grievances.	Agencies have personnel policies and procedures in place that address all items as indicated.	Agencies have personnel policies and procedures that are in compliance with local, state, and federal program requirements.		DSHS POPS 13.2 Ryan White Service Delivery Statement of Work
Required Training: Personnel and human resource departments required trainings, conferences, and meetings are documented and attended as indicated in the staff development plan, and/or in accordance with licensure requirements for direct care service providers.	Staff will attend required trainings, conferences, and meetings as indicated in the staff development plan and/or as directed by DSHS Program Staff.	Agencies will maintain documented evidence of staff trainings, conferences, and meetings to ensure program compliance.		Ryan White Service Delivery Statement of Work

DSHS STANDARD	PERFORMANCE MEASURE/METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section M: ARIES				
ARIES Security Policy: Policies are in place to ensure that ARIES and the information collected in ARIES is protected and maintained to ensure patient confidentiality.	Policies are in place at all agency locations that are funded in the state of Texas with RWHAP Part B and State Services funds that ensure ARIES information is protected and maintained to ensure patient confidentiality.	Agencies will maintain policies and procedures to ensure ARIES information is protected and maintained to ensure patient confidentiality.		DSHS Policy 231.001
ARIES Data Managers Core Competencies: Data managers are required to perform certain activities and possess certain knowledge, skills, and abilities, which includes but is not limited to managing and overseeing data collecting, reporting, and the Uniform Reporting System ARIES.	Data managers develop and implement local policy and procedures relating to ARIES and the data collected through ARIES.	Agencies have local policies and procedures in place relating to ARIES and the data collected through ARIES.		DSHS Policy 231.002
Section N: Core Services Additional Policies and Procedures				
Outpatient/Ambulatory Health Services: OAHS are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting.	Documentation of the following: • Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting • Only allowable services are provided • Services are provided as part of the treatment of HIV infection • Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects • Services are consistent with HHS guidelines • Peer Review is completed annually to determine that quality care is being provided with results from peer review evaluated for possible improvements in health care	1. Ensure that client medical records document services provided, the dates and frequency of services provided, that services are for the treatment of HIV infection. 2. Include clinician notes in patient records that are signed by the licensed provider of services. 3. Maintain professional certifications and licensure documents and make them available to the Grantee on request. 4. Peer Review is completed annually 5. Standing Delegation Orders are available to staff and are reviewed annually, dated and signed	Service is NOT being provided in an emergency room, urgent care, hospital or any other type of inpatient treatment center	RWHAP Part B National Monitoring Standards PCN 16-02 22 Texas Administrative Code § 193.2

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Local AIDS Pharmaceutical Assistance Program (LPAP): RWHAP Part B recipients using the LPAP service category must establish the following: • Uniform benefits for all enrolled clients throughout the service area; • A recordkeeping system for distributed medications; • An LPAP advisory board; • A drug formulary approved by the local advisory committee/board; • A drug distribution system; • A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at a minimum of every six months; • Coordination with the state's RWHAP Part B ADAP (Statement of Need) • Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program	Documentation that the LPAP program's drug distribution system has: • A client enrollment and eligibility determination process that includes ADAP and LPAP eligibility with rescreening every six months • An LPAP advisory board • Uniform benefits for all enrolled clients through the region(s) • Compliance with RWHAP requirement of payer of last resort • A recordkeeping system for distributed medications • A drug distribution system that includes a drug formulary approved by the local advisory committee/ board • Medications are secured and locked/stored appropriately • System for drug therapy management • Policy for timeliness of services • MOUs with local pharmacies to ensure cost efficiency with established dispensing fees.	1. Provide to the Grantee upon request, documentation that the LPAP program meets HRSA/HAB requirements. 2. Maintain documentation, and make available to the Grantee upon request, proof of client LPAP eligibility. 3. Only authorized personnel dispense/ provide prescription medication. 4. Medications and supplies are secured in a locked area and stored appropriately. 5. Agency has a system for drug therapy management. 6. Policy for timeliness of services. 7. MOUs ensuring cost efficient methods are in place 8. MOUs ensure dispensing fees are established and implemented.	Only Part B Base award funds may be used to support an LPAP. LPAP are not to be used for EFA. Medications are NOT dispensed with LPAP funds as: 1. A result or component of a primary medical visit 2. A single occurrence of short duration (an emergency) without arrangements for longer term access to medications 3. Vouchers to clients on a single occurrence without arrangements for longer-term access to medications	RWHAP Part B National Monitoring Standards PCN 16-02 LPAP Policy Clarification Memo

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Oral Health Care: Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.	Documentation that: 1. Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines. 2. Oral health professionals providing the services have appropriate and valid licensure and certification, based on State and local laws. 3. Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations on the procedures, or a combination of any of the above, as determined by the State and/or local communities.	1. Maintain dental files for all clients. 2. Maintain, and provide to Grantee upon request, copies of professional licensure and certification. 3. X-rays are taken by dental assistants who are registered with the State Board of Dental Examiners. 4. OH caps are documented at the regional level and are tracked for each client in the service area that receives OH services. 5. If cost of dental care exceeded regional caps set, documentation of reason is in the client record.		PHS ACT 2612(b)(3)(D) RWHAP Part B National Monitoring Standards 22 Texas Administrative Code § 108.11 22 Texas Administrative Code § 114.2
Early Intervention Services: includes identification of individuals at points of entry and access to services and provisions of: • HIV Testing and Targeted counseling to help unaware • Referral services to improve HIV care at key points of entry • Linkage to care such as OAHS, MCM, and Substance Abuse Care • Outreach and Health Education/Risk Reduction related to HIV diagnosis *NOTE: All 4 components MUST be present, but Part B funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding*	Documentation that: 1. Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and RW funds will supplement and not supplant existing funds for testing 2. Individuals who test positive are referred for and linked to health care and supportive services 3. Health education and literacy training is provided that enables clients to navigate the HIV system 4. EIS is provided at or in coordination with documented key points of entry 5. EIS services are coordinated with HIV prevention efforts and programs	1. MOUs are in place with key points of entry into care 2. All four required EIS service components are documented in the RWHAP Part B EIS program policies both at local and regional systems of care 3. Document that HIV testing activities and methods meet CDC and state requirements, including licensure to conduct phlebotomy services where applicable. 4. Establish linkage agreements with testing sites where Part B is not funding testing but is funding referral and access to care 5. Ensure agencies have capacity and training to document number of tests (if applicable), number of referrals, and results of testing.		RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Health Insurance Premium and Cost-sharing Assistance: Provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RHWAP Part recipient must implement a methodology that incorporates the following requirements: • Ensure clients are buying health coverage that, at a minimum, includes at least one drug in each class of core ART from the HHS treatment guidelines along with appropriate HIV OAHS • Must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV OAHS, and allocate funding to HIPCSA only when determined to be cost effective. • HIV insurance continuation funds will only be used for payment of insurance premiums, deductibles, co-insurance payments, copayments, and related administrative costs. HIV insurance assistance shall be provided directly to the insurance carrier, insurance administrator, or health provider, rather than to the client. Insurance premiums may be prepaid, including that part of the coverage period, which extends beyond the Contract term.	Documentation that: • Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications • Assurance that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by RW • Assurance that RW funds are not being used to cover costs associated with Social Security • Documentation of clients' low income status • Documentation that HIV insurance continuation funds will only be used for payment of insurance premiums, deductibles, co-insurance payments, copayments, and related administrative costs. HIV insurance assistance shall be provided directly to the insurance carrier, insurance administrator, or health provider, rather than to the client.	Provide upon request: • Where premiums are covered by RW funds, provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications • Maintain proof of low-income status • Provide documentation that demonstrates that funds were not used to cover costs associated with the creation, capitalization, or administration of a liability risk pool, or social security costs		RWHAP Part B National Monitoring Standards PCN 16-02 DSHS Policy 260.002

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Home Health Care: Provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include: • Administration of prescribed therapeutics • Preventive and specialty care • Wound care • Routine diagnostics testing administered in the home • Other medical therapies The provision of Home Health Care is limited to clients that are homebound.	Assurance that: • Services are limited to medical therapies in the home and exclude personal care services • Services are provided by home health care workers with appropriate licensure as required by State and local laws	1. Maintain on file and provide to the grantee upon request, copies of the licenses of home health care workers.	Home settings do NOT include nursing facilities or inpatient mental health/substance abuse treatment facilities	RWHAP Part B National Monitoring Standards PCN 16-02 40 Texas Administrative Code **§97.211**
Home and Community-based Health Services: Provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include: • Appropriate mental health, development, and rehabilitation services • Day treatment or other partial hospitalization services • Durable medical equipment • Home health aide services and personal care services in the home	1. Provide assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community based health services. 2. Documentation of appropriate licensure and certifications for individuals providing the services, as required by local and state laws.	Assurance of: 1. Services are being provided in an HIV-positive client's home, and/or a day treatment or other partial hospitalization services program as licensed by the State. 2. Maintain, and make available to grantee, copies of appropriate licenses and certifications for professionals providing services.	Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Hospice Services: End of life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are: • Mental health counseling • Nursing care • Palliative therapeutics • Physician services • Room and board. Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that is designated and staffed to provide hospice care. Physician must certify that a patient is terminally ill and has a defined life expectancy as established by recipient.	Documentation including: 1. Physician certification that the patient's illness is terminal as defined under Medicaid hospice regulations. 2. Appropriate and valid licensure of provider as required by the State in which hospice care is delivered. 3. Types of services provided, and assurance that they include only allowable services. 4. Locations where hospice services are provided, and assurance that they are limited to a home or other residential setting or a non-acute care section of a hospital designated and staffed as a hospice setting. 5. Assurance that services meet Medicaid or other applicable requirements.	1. Obtain and have available for inspection appropriate and valid licensure to provide hospice care. 2. Maintain and provide the grantee access to program files and client records.	Does NOT extend to skilled nursing facilities or nursing homes.	RWHAP Part B National Monitoring Standards PCN 16-02 40 Texas Administrative Code **§97.211**
Mental Health Services: Provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.	1. Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State, including supervision of licensed staff. 2. Documentation of the existence of a detailed treatment plan for each eligible client. 3. MOUs to provide services if specific service is not available. 4. Agency has emergency/crisis intervention plan.	1. Obtain and have on file and available for grantee review appropriate and valid licensure and certification of mental health professionals, including supervision of licensed staff. 2. Maintain client records that include detailed treatment plans and documentation of services provided. 3. MOUs are available for referral needs. 4. Policies/procedures in place.	Only for HIV-infected clients.	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Medical Nutrition Therapy: MNT includes nutrition assessment and screening, dietary/nutritional evaluation, food and/or nutritional supplements per medical provider's recommendation, and nutrition education and/or counseling. These services can be provided in individual and/or group settings and outside of HIV OAHS. All services performed must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.	Documentation of: 1. Licensure and registration of the dietitian as required by the State	1. Maintain and make available to the grantee copies of the dietitian's license and registration		RWHAP Part B National Monitoring Standards PCN 16-02
Medical Case Management: Provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. ***Please reference DSHS MCM service standard for full complement of key activities***.	1. Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team. 2. Documentation that all activities are being carried out for all clients. 3. Documentation of case management services and encounters. 4. Documentation in client records of services provided.	1. Maintain documentation showing that MCM services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team. 2. Maintain client records that include all required elements for compliance with contractual and RW programmatic requirements. 3. Policies and procedures are in place for conducting MCM services.		RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section N: Core Services Additional Policies and Procedures (continued)				
Substance Abuse Treatment Services – Outpatient: Provision of outpatient services for the treatment of drug or alcohol use disorders. Services include: • Screening • Assessment • Diagnosis, and/or • Treatment of substance use disorder	1. Documentation that services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State. 2. Documentation through program files that services provided meet the service category definition. 3. All services provided are allowable under RW 4. Assurance that RW funds are used to expand HIV-specific capacity of programs only if timely access would not otherwise be available to treatment and counseling. 5. Assurance that services provided include a treatment plan that calls for only allowable activities	Maintain and provide: 1. Provider licensure or certifications as required by the State 2. Staffing structure showing supervision by a physician or other qualified personnel 3. Evidence that all services are provided on an outpatient basis 4. Program files and client records that include treatment plans	Syringe access services are allowable, to the extent that they comport with appropriate law and applicable HHS guidance, including HRSA- or HAB-specific guidance.	RWHAP Part B National Monitoring Standards PCN 16-02
Section O: Support Services Policies and Procedures				
Non-Medical Case Management: Provides guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. ***Please reference DSHS NMCM service standard for full complement of key activities***.	1. Documentation that scope of activity includes advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. 2. Services cover all types of encounters and communications. 3. Where transitional case management for incarcerated persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correction system for a brief period.	1. Maintain client records that include the required elements as detailed by the Grantee. 2. Provide assurances that any transitional case management for incarcerated persons meets contract requirements. 3. Policies and procedures are in place for conducting NMCM services.		RWHAP Part B National Monitoring Standards PCN 16-02
Child Care Services: RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.	1. Documentation of parent's eligibility as defined by the State. 2. Appropriate and valid licensure and registration of child care providers under applicable State and local laws where services are provided in a day care setting.	1. Maintain documentation of child care services provided. 2. Maintain valid licensure and registration of child care providers. 3. Informal child care arrangements are in compliance with Grantee requirements.	No cash to clients or primary caregivers to pay for these services.	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Emergency Financial Assistance: Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and medication. Services must be for limited amounts, uses, and periods of time.	1. Documentation of services and payments to verify that EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the Grantee. 2. Documentation ensuring assistance is provided only for the following essential services: utilities, housing, food, or medications through a voucher program or short-term payments to the service entity. 3. Emergency funds are allocated, tracked, and reported by type of assistance. 4. No more than a 30-day supply of medications are purchased at a time.	1. Maintain client records that document client eligibility, types of EFA provided, dates of EFA, and method of providing EFA. 2. Maintain and provide documentation of assistance provided to clients. 3. Provide assurance to State that all EFA was for allowable types of assistance, was used where RW was payer of last resort, met State or local specified limitations on amount and frequency of assistance to an individual, and provided through allowable payment methods. 4. Policies include medication purchase limitations.	Must be a direct payment to an agency or through a voucher program. Continuous provision of an allowable service to a client should not be funded through EFA. Grocery/Food vouchers can not be used for the purchase of alcohol and/or tobacco products.	RWHAP Part B National Monitoring Standards PCN 16-02
Food Bank/Home-Delivered Meals: Provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to: • Personal hygiene products • Household cleaning supplies • Water filtration/purification systems in communities where issues of water safety exist	1. Documentation that services supported are limited to food bank, home-delivered meals, and/or food voucher programs. 2. Documentation of types of non-food times provided. If water filtration/ purification systems are provided, community has documented water purity issues. 3. Assurance of compliance with federal, state, and local regulations including any required licensure or certification for the provision of food banks and/or home-delivered meals. 4. Monitoring of providers to document actual services provided, client eligibility, number of clients served, and level of services.	Maintain documentation of: • Services provided by type • Amount and use of funds for purchase of non-food items • Compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certifications. • Assurance that RW funds were used only for allowable purposes and RW was the payer of last resort.	Unallowable costs include household appliances, pet foods, and other non-essential products.	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Health Education/Risk Reduction: Provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.	Documentation that: 1. Clients are educated about HIV transmission and how to reduce the risk of HIV transmission to others. 2. Clients receive information about available medical and psychosocial support services.	1. Maintain records of services provided. 2. Document in client files client eligibility, information provided on available services, education about HIV transmission, counseling on how to improve their health status and reduce risk of HIV transmission.	HE/RR services cannot be delivered anonymously.	RWHAP Part B National Monitoring Standards PCN 16-02
Housing Services: Provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain OAHS services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.	1. Must have mechanisms in place to allow newly identified clients access to housing services. 2. Documentation that funds are used only for allowable purposes. 3. Services are provided by case managers or other housing professionals. 4. Policies and procedures to provide individualized written housing plans, consistent with Housing Policy, covering each client receiving short term, transitional, and emergency housing services.	1. Maintain documentation of services provided. 2. Ensure staff providing housing services are case managers or other professionals who possess knowledge of local, state, and federal housing programs and how to access those programs. 3. Policies and procedures are written ensuring individualized written housing plans are consistent with Housing Policy.	Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.	RWHAP Part B National Monitoring Standards PCN 16-02
Linguistic Services: Provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic service providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.	1. Documentation that linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of RW-eligible services in both group and individual settings. 2. Services are provided by appropriately trained and qualified individuals holding appropriate State or local certification.	1. Document the provision of linguistic services. 2. Maintain documentation showing that interpreters and translators employed with RW funds have appropriate training and hold relevant State and/or local certification.	Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Other Professional Services: Provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: • Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease. • Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them. • Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.	1. Documentation that funds are used only for allowable services as indicated in Standard. 2. Assurance that program activities do not include any criminal defense or class-action suits unrelated to access to services eligible for funding under the RWHAP Part B program.	1. Document services provided, including specific types of services. 2. Provide assurance that funds are being used only for services directly necessitated by an individual's HIV status. 3. RW serves as payer of last resort. 4. Maintain client files that include: client eligibility; description of how service is necessitated by individual's HIV status; types of services provided; and hours spent in provision of such services.	Exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.	RWHAP Part B National Monitoring Standards PCN 16-02
Medical Transportation Services: Provision of nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.	1. May be provided through contracts with providers of transportation services. 2. Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or support services, but should not in any case exceed the established rates for federal programs. 3. Purchase or lease of organizational vehicles for client transportation programs, provided recipient receives prior approval for the purchase of vehicle. 4. Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed).	1. Maintain program files. 2. Maintain documentation that the provider is meeting stated contract requirements with regard to methods of providing transportation. 3. Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services. 4. Obtain HRSA and State approval prior to purchasing or leasing a vehicle(s). 5. Voucher or token systems.	No direct cash payments or reimbursements to clients. No direct maintenance expenses of a privately-owned vehicle. No costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.	RWHAP Part B National Monitoring Standards PCN 16-02 DSHS HIV Care Services Medical Transportation Services Standard

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Outreach Services: Provision of the following three activities: • Identification of people who do not know their HIV status and linkage into OAHS • Provision of additional information and education on health care coverage options • Reengagement of people who know their status into OAHS	1. Conducted at times and in places where there is a high probability that individuals with HIV infection are present and/or high-risk behaviors are being exhibited 2. Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness 3. Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort. 4. Targeted to populations known, through local epidemiological data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection	1. Document the design, implementation, target areas and populations, and outcomes of outreach activities. 2. Document and provide data showing that all RFP and contract requirements are being met with regard to program design, targeting, activities, and use of funds. 3. Provide financial and program data demonstrating that no outreach funds are being used to pay for HIV counseling and testing, to support broad-scope awareness activities, or to duplicate HIV prevention outreach efforts.	Funds may not be used to pay for HIV counseling or testing.	RWHAP Part B National Monitoring Standards PCN 16-02
Psychosocial Support Services: Provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. Services include: • Bereavement counseling • Child abuse and neglect counseling • HIV support groups • Nutrition counseling provided by a non-registered dietitian • Pastoral care/counseling services	1. Documentation that psychosocial services funds are used only to support eligible services. 2. Documentation that pastoral care/ counseling services meet the following: • Provided by an institutional pastoral care program; • Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; • Available to all individuals eligible for RW services. 3. Assurance that no funds under this service are used for the provision of nutritional supplements.	1. Document the provision of psychosocial support services. 2. Maintain documentation that demonstrates funds are used for allowable services only, no funds are used for provision of nutritional supplements, and any pastoral care/ counseling services meet all stated requirements.	Funds may not be used to provide nutritional supplements. Funds may not be used for social/recreational activities or to pay for a client's gym membership.	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Referral for Health Care/Supportive Services: Directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible.	1. Documentation that funds are used only for allowable services. 2. Documentation of method of client contact; method of providing referrals; and referrals and follow up provided.	1. Maintain program files. 2. Maintain client records that include required elements as detailed by the State. 3. Maintain documentation demonstrating that services and circumstances of referral services meet contract requirements.		RWHAP Part B National Monitoring Standards PCN 16-02
Rehabilitation Services: Provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.	Documentation that services: 1. Intended to improve or maintain a client's quality of life and optimal capacity for self-care. 2. Limited to allowable activities. 3. Provided by a licensed or authorized professional. 4. Provided in accordance with an individualized plan of care that includes components specified by the State.	1. Maintain and share all program and financial records that document types of services provided, type of facility, provider licensing, use of funds only for allowable services. 2. Maintain client records that include the required elements as detailed by the State.		RWHAP Part B National Monitoring Standards PCN 16-02
Respite Care: Provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV. Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within OAHS or satellite facilities.	1. Documentation that funds are used only for allowable services.	1. Maintain program files that include number of clients served, and settings/methods of providing care. 2. Maintain client files that include: eligibility and services provided.	Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.	RWHAP Part B National Monitoring Standards PCN 16-02

DSHS STANDARD	PERFORMANCE MEASURE/ METHOD	SUB-RECIPIENT RESPONSIBILITY	LIMITATIONS	SOURCE CITATION
Section O: Support Services Policies and Procedures (continued)				
Substance Abuse Treatment – Residential: Provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes: pretreatment/recovery readiness programs; harm reduction; behavioral health counseling associated with substance use disorder; medication assisted therapy; neuro-psychiatric pharmaceuticals; relapse prevention; and detoxification if offered in a separate licensed residential setting.	1. Documentation that services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State. 2. Documentation that services provided meet the service category definition. 3. Documentation that services are provided in accordance with a written treatment plan. 4. Assurance that services are provided only in a short-term residential setting. 5. Documentation that if provided, acupuncture services are limited through some financial cap, are provided only with a written referral from the client's primary care provider, and are offered by a provider with appropriate State license and certification, if it exists.	1. Maintain documentation of provider licensure or certifications as required by the State. This includes licensures and certifications for a provider of acupuncture services. 2. Documentation of staffing structure showing supervision by a physician or other qualified personnel. 3. Provide assurance that all services are provided in a short-term residential setting. 4. Maintain program files that document allowable services provided, and the quantity/frequency/modality of treatment services. 5. Maintain client records.	Funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.	RWHAP Part B National Monitoring Standards PCN 16-02

Outpatient/Ambulatory Health Services
Service Standard

HRSA Definition: Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight.

Limitations: Emergency room or urgent care services are NOT considered outpatient settings, therefore services cannot be reimbursed. (RWHAP Legislation, PCN 16-02)

Services: Allowable activities include:

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

Care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Early Intervention Services provided by Ryan White Part C and Part D programs should be included here under Outpatient/Ambulatory Medical Care. ***NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here.***

Diagnostic Laboratory Testing includes all indicated medical diagnostic testing including all tests considered integral to treatment of HIV and related complications (e.g. Viral Load, CD4 counts, and genotype assays). Funded tests must meet the following conditions:

- Tests must be consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations or organizations;
- Tests must be (1) approved by the FDA, when required under the FDA Medical Devices Act and/or (2) performed in an approval Clinical Laboratory Improvement Amendments of 1988 (CLIA) certified laboratory or State exempt laboratory; and
- Tests must be (1) ordered by a registered, certified or licensed medical provider and (2) necessary and appropriate based on established clinical practice standards and professional clinical judgment.

Telemedicine is an acceptable means of providing outpatient/ambulatory health services but must conform to the Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 and the 2016 Texas Medicaid Provider TELECOMMUNICATION SERVICES HANDBOOK, Volume 2

~~Personnel and Staff Training Requirements~~

~~Staff Qualification~~	~~Expected Practice~~
~~**Qualifications**~~ ~~Health Service providers shall have unconditional licensure/ certification in area of practice (i.e. MD, NP, PA, RN)~~	~~All agency staff, contractors, and consultants who provide direct care services, and who require licensure, shall be properly licensed by the State of Texas, or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act (or in the case of a nurse, the Nursing Practice Act), including satisfactory arrangements for malpractice insurance.~~
~~**Peer Review**~~ ~~Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA). .~~	~~Provider will document peer review has occurred annually.~~
~~**Staff Experience**~~ ~~Service providers shall employ clinical staff who are experienced regarding their area of clinical practice as well as knowledgeable in the area of HIV/AIDS clinical practice .~~	~~Personnel records/resumes/applications for employment will reflect requisite experience/education.~~ ~~All staff without experience with HIV/AIDS shall be supervised by an employee with at least one (1) year of experience.~~
~~**Staff Education**~~ ~~Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate CME/CEUs based on individual licensure requirements to include HIV-related courses.~~ ~~.~~	~~Provider will document training received according to professional licensure requirements.~~ ~~Providers shall complete cultural competency to include cultural awareness of the aging population through participation in formal CME activities.~~
~~**Standing Delegation Orders (SDO)**~~ ~~Standing delegation orders provide direction to RNs, LVNs, and when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).~~	~~Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider.~~ ~~Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually.~~ ~~Use of standing delegation orders will be documented in patient's primary record system.~~

This section was removed and placed in the Statewide Programmatic Requirements section of the Universal Standard.

Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving clinical care throughout the State of Texas within the Ryan White Part B and State Services Program. The most current U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Guide for HIV/AIDS Clinical Care – 2014 Edition are source cited throughout the Standards for additional reference materials for direct care service providers.

Standard	Measure
Medical Evaluation/Assessment All HIV infected clients receiving medical care shall have a completed initial comprehensive medical evaluation/assessment and physical examination that adheres to the current U.S. Department of Health and Human Services (HHS) guidelines within 3 months of HIV diagnosis or within 15 business days of initial contact with patient who has been in care. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. ***Source***: Page 61, https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of new clients (newly diagnosed, never in care) with a documented comprehensive assessment/evaluation completed by the MD, NP, CNS, or PA within 3 months of HIV diagnosis in accordance with professional and established HIV practice guidelines. ***(HRSA HAB Measure – Linkage to Care)*** Percentage of existing clients (return to care and those in current medical care for more than one year) with a documented comprehensive assessment/evaluation completed by the MD, NP, CNS, or PA within 15 business days of initial contact with patient in accordance with professional and established HIV practice guidelines.
Comprehensive HIV related history History shall include at a minimum, general medical history, a comprehensive HIV related history and psychosocial history to include: • Medical and surgical history that assesses for chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc. per HHS guidelines. • Psychosocial history to include socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and housing status. • Lifestyle including tobacco use, alcohol use, illicit substance use, exercise, travel history.	Percentage of new clients with a documented comprehensive HIV related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. Percentage of existing clients with a documented comprehensive HIV related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines.

• Sexual Health including partners, practices, past STIs, contraception use (past and present). • HIV-related health history including most recent CD4 and Viral Load results, current ART (if applicable), previous adverse ART drug reactions, history of HIV related illness and infections, HIV treatment history and staging. ***Source***: Page 61-70; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	
Physical examination Providers should perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV. Physical examination will include a complete review of systems. Examination of the oral cavity should be included in both the initial and interim physical examination of all HIV-infected patients. ***Source***: Page 73-77; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of new clients with a documented annual physical examination including complete review of systems. Percentage of new clients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year (based on self report or other documentation). ***(HRSA HAB Measure)*** Percentage of existing clients with a documented annual physical examination including complete review of systems. Percentage of existing clients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year (based on self report or other documentation). ***(HRSA HAB Measure)***

Initial laboratory tests, as clinically indicated by licensed provider: Tests will include as clinically indicated: • HIV Antibody, if not documented previously; • CD4 Count and/or CD4 Percentage • Quantitative Plasma HIV RNA (HIV Viral Load) • Drug Resistance Testing (genotype, phenotype) • Coreceptor Tropism Test • HLA-B*5701 • Complete Blood Count (CBC) with Differential and Platelets • Chemistry Profile: Electrolytes, Creatinine, eGFR (Estimated Glomerular Filtration Rate), Blood Urea Nitrogen (BUN) • Liver Transaminases, Bilirubin (Total and Direct) Urinalysis with Urine Protein and Creatinine • Lipid Profile (Total Cholesterol, LDL, HDL, Triglycerides); fasting • Glucose (preferably fasting) or hemoglobin A1C ***Source***: Page 79-89; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of new clients with documented initial laboratory tests completed according the OAHS Standard and HHS treatment guidelines. Percentage of new clients with documented CD4 count (absolute). Percentage of new clients with documented HIV-RNA viral load. ***(HRSA HAB Measure)*** Percentage of new clients with documented drug resistance testing, as applicable.
Other diagnostic testing Chest x-ray will be completed if pulmonary symptoms are present or LTBI test is positive. ***Source***: Page 85: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of new clients with documented chest x-ray completed if pulmonary symptoms were present or LBTI test was positive. Percentage of existing clients with documented chest x-ray completed if pulmonary symptoms were present or LBTI test was positive.
Initial Screenings/Assessments Patients should receive screening for opportunistic infections and assessment of psychosocial needs initially and annually according to the most current HHS guidelines. Screening should include at a minimum: • Quantitative HCV RNA viral load testing • Hepatitis A, B & C screens at initial intake.	Percentage of new clients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. Percentage of new female clients with a diagnosis of HIV who were screened for cervical cancer in the last three years. ***(HRSA HAB Measure)***

• Providers should screen all HIV-infected patients for anti-HCV antibodies at baseline. • Mental health assessment that includes screening for clinical depression • Psychosocial assessment, including domestic violence and housing status • Substance use and abuse screening • Patients on ART receive lipid screening annually • Tobacco use screening • Pediatric clients (14 years and younger) will be screened for child abuse as defined in Chapter 261 of the Texas Family Code and DSHS policy. Consider screening youth 14-17 for child abuse • Oral health assessment and screening • Ophthalmology Screening • Cervical Cancer Screen • *Toxoplasma gondii* IgG • Tuberculosis (TB) Screening • Pregnancy Test • Serum VDRL or RPR (Syphilis Screening) • Gonorrhea (GC) and Chlamydia (CT) Testing • Trichomoniasis Testing ***Source***: Page 83-89, 127, https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Consider Anal Pap tests (CIII recommendation) - examination for all HIV-infected adults, regardless of age at baseline and as part of the annual physical	Percentage of new clients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for chlamydia within the measurement year. ***(HRSA HAB Measure)*** Percentage of new clients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year. ***(HRSA HAB Measure)*** Percentage of new adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. ***(HRSA HAB Measure)*** Percentage of new clients with documented serologic test for syphilis performed. ***(HRSA HAB Measure)*** Percentage of new clients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. ***(HRSA HAB Measure)*** Percentage of new clients with documented initial psychosocial assessment to include domestic violence and housing status. ***(HRSA HAB Measure)*** Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. ***(HRSA HAB Measure)*** Percentage of new clients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Percentage of new clients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger).

	Percentage of new patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV infection. ***(HRSA HAB Measure)*** Percentage of new clients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity. ***(HRSA HAB Measure)*** Percentage of new clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV. ***(HRSA HAB Measure)***
Immunizations/Antibiotic Treatment Immunizations/vaccinations will be given according to the current HHS guidelines. Providers will initiate prophylaxis for specific opportunistic infections. Patients will be offered vaccinations for the following: • Tetanus, Diphtheria, and Pertussis (Tdap) - every 10 years; if potential exposure (wound), after 5 years • Measles, Mumps, Rubella (MMR) • Influenza (inactivated vaccine)- annually during flu season October 1st - March 31st • Pneumococcal is recommended for all clients • Completion of hepatitis B (HBV) vaccines series, unless otherwise documented as immune • Completion of hepatitis A (HAV) vaccines series, unless otherwise documented as immune. • Varicella-Zoster (VZV) • Zoster vaccine • Human Papillomavirus (HPV) • Meningococcal	Percentage of patients with Tetanus, Diphtheria, and Pertussis current within 10 years or documentation of refusal. Percentage of patients with documentation that MMR was administered or referral given, seropositive for antibody, or refusal. (***HRSA HAB Measure for Pediatrics)*** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis B. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis A.

Antibiotic treatment for opportunistic infection will be initiated if active infection has been ruled out and seropositive for: - Mycobacterium avium complex (MAC) if CD4<50 cells/µL - Toxoplasmosis if CD4<100 cells/µL ***Source***: Page 157-160; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of patients with diagnosis of HIV who received, or documented patient refusal, HPV.
Antiretroviral Therapy and Pneumocystis jiroveci pneumonia (PCP) Prophylaxis Antiretroviral therapy will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART. PCP Prophylaxis will be completed adhering to the current HHS Guidelines. ***Source***: (PCP and MAC Prophylaxis) Page 173-179; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. ***Source***: (ARV) Page 207-220; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	Percentage of patients, regardless of age, with a diagnosis of HIV are prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year. ***(HRSA HAB Measure)*** Patients aged 6 weeks or older with a diagnosed of HIV/AIDS, with CD4 counts of less than 200 cells/µL or a CD percentage below 15% will be prescribed PCP prophylaxis. ***(HRSA HAB Measure)***
Drug Resistance Testing Drug resistance testing must follow most recent, established resistance testing guidelines, including genotypic testing on all naïve patients. Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, registered nurse and/or other	Percentage of patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year. ***(HRSA HAB Measure)***

appropriate licensed healthcare provider (if designated by the practitioner). ***Source*:** Page 81; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	
Health Education/Risk Reduction Health education will adhere to the most current HHS guidelines. Providers will provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients. Since patients' behaviors change over time as the course of their disease changes and their social situations vary, health education providers will tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the particular point in time in the patient's life. The following will be conducted initially and as needed: • Providers should discuss safer sexual practices so to decrease risk of transmitting HIV during HIV infection. • Providers should counsel HIV-infected patients about the risk of acquiring syphilis and other STIs from unprotected sexual contact, including all sites of possible transmission, such as anus, cervix, vagina, urethra, and oropharynx. • Providers should discuss family planning with patients • Contraception counseling/hormonal contraception • Drug interaction counseling • Providers should counsel patients on tobacco cessation annually (or document decline of tobacco use) • When current alcohol or other substance use is identified, providers should discuss the possible effects of such use on the patient's general health and HIV medications, as well as options for treatment if indicated. • Providers should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options	Percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year. ***(HRSA HAB Measure)*** Percentage of clients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Percentage of patients with documented counseling about family planning method appropriate to patient's status, as applicable. Percentage of patients with documented preconception counseling as appropriate. Percentage of patients with documented instruction regarding new medications, treatments, tests as appropriate. Percentage of patients with documented counseling regarding the importance of disclosure to partners.

for voluntary partner notification.
• Preconception care for HIV infected females of child-bearing age.
• When HIV-infected patients are diagnosed with early syphilis (primary, secondary, or early latent), providers should intensify risk-reduction counseling, including discussions about the importance of condom use.
• Nutritional Counseling regarding:
  • Quality and quantity of daily food and liquid intake
  • Exercise
 	
Source: (Smoking Cessation) page 189-196; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.
 	
Source: (Patient Education) Page 57-59, 89, 102, 107, 111, 126, 143-154; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.
 	
Source: (Nutrition) page 197-202; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

Treatment Adherence Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines. Patients are assessed for treatment adherence and counseling at a minimum of twice a year. Those who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. If adherence issue is identified, referral to an appropriate health care professional for counseling and follow-up action is documented. ***Source***: Page 273; https://hab.hrsa.gov/sites/default/files/hab/clinical-	Percentage of patients with documented assessment for treatment adherence two or more times within the measurement year if patient is on ARV. Percentage of patients with documented adherence issue, received counseling for treatment adherence two or more times within the measurement year.

quality-management/2014guide.pdf.	
Referrals Providers will refer to specialty care in accordance with current USPHS guidelines. At a minimum, patients should receive referrals to specialized health care/providers/services as needed to augment medical care: • If CD4 count below 50, should be referred for ophthalmic examination by a trained retinal specialist. • AIDS Drug Assistance Program (ADAP) • Medication Assistance Programs • Medical care coordination • Medical specialties • Mental health and substance use services -Treatment education services • Partner counseling and referral • Annual hygiene and intraoral examinations, including dental caries and soft-tissue examinations. • Medical Nutrition Therapy (MNT) • Health maintenance, as medically indicated, such as: o Cervical Cancer Screening o Family Planning o Colorectal Screening o Mammogram • Specialty medical care for any preexisting chronic diseases • Case Management Services or a Disease Investigation Specialist (DIS) for follow-up if missing appointments. Providers/staff are expected to follow-up on each referral to assess attendance and outcomes. Source: Page 73; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of patients, as medically indicated, who had documentation of referrals for: • Health maintenance • Adherence counseling • Mental Health and/or Substance Use • Oral Health • Ophthalmic services • Treatment Suitability (HCV treatment) • Child abuse if suspected abuse • Disease intervention specialist • Other specialty services. Percentage of patients with a documented referral in the measurement year, has a progress note in the patients chart regarding attendance and outcomes of the referral.

Follow-up Visits Outpatient Medical Care will adhere to the current HHS guidelines for on-going health care. Reassessment/reevaluation of health history, comprehensive physical examination, and annual laboratory testing should be documented in patient medical record. Ongoing lab tests for patients should include: • **Annual:** CBC, liver function tests, BUN, cholesterol, triglycerides (preferably fasting) • **Every 3-6 months:** CD4 counts and HIV-RNA viral loads monitored every 3-6 months based on compliance and medication adherence. Patients receiving ARV therapy should have follow- up visits scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence. -Patients on ART receive lipid screening annually -In accordance with HHS guidelines follow-up and ongoing lab tests for patients on ARV should include: • CBC, liver function tests, BUN, creatinine, glucose, cholesterol, triglycerides (preferably fasting), CD4, HIV-RNA and Syphilis serology. • Urine and extra-genital GC/Chlamydia (vaginal swabs recommended for females) should be offered for sexually active patients at increased risk. Providers will continually evaluate patients for adverse outcomes and documents actions taken, outcomes, and follow-up. ***Source***: (Follow Up/Interim Exams and Labs) Page 79 and 91; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Source: (Adverse Outcomes) Page 527; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of existing clients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. Percentage of patients, 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. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. ***(HRSA HAB Measure)*** Percentage of existing female clients with a diagnosis of HIV who were screened for cervical cancer in the last three years. ***(HRSA HAB Measure)*** Percentage of existing clients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for chlamydia within the measurement year. ***(HRSA HAB Measure)*** Percentage of existing clients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year. ***(HRSA HAB Measure)*** Percentage of existing adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. ***(HRSA HAB Measure)*** Percentage of existing clients with documented serologic test for syphilis performed. ***(HRSA HAB Measure)***

	Percentage of existing clients aged 12 years and older screened for clinical depression (annually) on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. ***(HRSA HAB Measure)*** Percentage of existing clients with documented annual psychosocial assessment to include domestic violence and housing status. ***(HRSA HAB Measure)*** Percentage of existing patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. ***(HRSA HAB Measure)*** Percentage of existing clients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Percentage of existing clients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger). Percentage of existing patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV infection. ***(HRSA HAB Measure)*** Percentage of existing clients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity. ***(HRSA HAB Measure)*** Percentage of existing clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV. ***(HRSA HAB Measure)***

	Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and who had a fasting lipid panel during the measurement year. ***(HRSA HAB Measure)***
Documentation in Patients Chart Clinicians will develop/update plan of care at each visit. At a minimum, clinician will document/update the following at each visit: • Chief complaint • Vital signs • Assessment/diagnosis • Proposed treatment • Problem list • Medical plan of care in accordance with the current USPHS treatment guidelines. • Current medications • Vaccinations • Referrals and recommendations • Any decline in services offered/referrals • Outreach efforts to bring patient who has missed appointments back into care. If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's chart. The provider developing the plan will sign each entry. ***Source***: Page77; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of patient records with signed clinician entries. Percentage of flow sheets present and updated in the patient records. Percentage of problem lists present and updated in the patient records. Percentage of medication lists present and updated in the patient records.
Documentation of missed patient appointments and efforts to bring the patient into care. Provider and/or staff will conduct the following: • Contact patients who have missed appointments using at least 3	Percentage of patient records with documentation of a minimum of 3 different contacts (email, phone, mail, emergency contact, home visit by DIS) when patient has missed 3 scheduled appointments in a 3-month period.

different forms of contact (email, phone, mail, emergency contact, phone call, referral to DIS for home visit) • Address any specific barriers to accessing services • Documentation includes number of missed clients appointments and efforts to bring the client into care ***Source***: Page 1; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	Percentage of patient records with documentation of any specific barriers and efforts made to address missed appointments.

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Medical Case Management
Service Standard

HRSA Definition: Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that include other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

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

Limitations: Medical Case Management is a service based on need, and is not appropriate or necessary for every client accessing services. Medical Case Management is designed to serve individuals who have complex needs related to their ability to access and maintain HIV medical care. **Medical Case Management should not be used as the only access point for medical care and other agency services.** Clients who do not need Medical Case Management services to access and maintain their medical care should not be enrolled in MCM services, and if they are enrolled in MCM services, they should be graduated from Medical Case Management services.

Medical Case Management services have as their objective ***improving health care outcomes*** whereas Non-Medical Case Management Services have as their objective providing ***guidance and assistance in improving access to needed services***. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

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

Services: Medical Case Managers act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan and assisting in the coordination and follow-up of the client's medical care between multiple providers. The goals of this service are 1) the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the staff providing Medical Case Management services and 2) to address needs for concrete services such as health care, public benefits and assistance, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system.
Core components of Medical Case Management services are:

1) Coordination of Medical Care – scheduling appointments for various treatments and referrals including labs, screenings, medical specialist appointments, mental health, oral health care and substance abuse treatment
2) Follow-up of Medical Treatments – includes either accompanying client to medical appointments, calling, emailing, texting or writing letters to clients with respect to various treatments to ensure appointments were kept or rescheduled as needed. Additionally, follow-up also includes ensuring clients have appropriate documentation, transportation, and understanding of procedures. MCM staff must also encourage and enable open dialogue with medical healthcare professionals.
3) Treatment Adherence – the provision of counseling or special programs to ensure readiness for, and adherence to, HIV/AIDS treatments.

Key activities include:

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

Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Performance Measure
Initial Comprehensive Assessment Initial Comprehensive Assessment must be completed within 30 calendar days of the first appointment to access MCM services and includes at a minimum: a) Client health history, health status and health-related needs, including but not limited to: • HIV disease progression • Tuberculosis • Hepatitis • STI history and/or history of screening • Other medical conditions • OB/GYN as appropriate, including pregnancy status • Routine health maintenance (ex. Well women exams, pap smears) • Medications and adherence • Allergies to medications • Complementary therapy • Current health care providers; engagement in and barriers to care • Oral health care • Vision care • Home health care and community-based services • Substance Use (validated and reliable substance use disorder screening tool must be used. See website for SAMISS) • Mental Health (validated and reliable substance use disorder screening tool must be used. See website for SAMISS) • Medical Nutritional Therapy • Clinical trials • Family Violence • Sexual health assessment and risk reduction counseling b) Additional information • Client strengths and resources • Other agencies that serve client and household • Brief narrative summary of assessment session(s) • Supervisor signature and date, signifying review and approval, for case management staff during their probationary period	Percentage of clients who access MCM services that have a completed comprehensive assessment within 30 calendar days of the first appointment to access MCM services and includes all required documentation. Percentage of clients that received at least one face-to-face meeting with the MCM staff that conducted the initial comprehensive assessment. Percentage of those clients who are missing information who were contacted to follow-up on completion of the assessment. Percentage of clients discharged due to non-responsiveness. (See case closure) Percentage of clients who have documented Initial Comprehensive Assessment in the primary client record system.

Case Management Acuity Level and Client Contact MCM clients have a documented acuity level using an approved acuity scoring tool with the comprehensive assessment. Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in a client's acuity should be documented appropriately. Acuity and frequency of contact is documented in the primary client record system.	Percentage of clients who have a completed acuity level documented using an approved acuity scale with the comprehensive assessment. Percentage of clients with acuity that have documented evidence of review of acuity minimum every three (3) months to ensure acuity is still appropriate level for the client's needs. Percentage of clients whose acuity score is based on the results of the initial assessment and is documented in the client primary care record. Percentage of clients with documented decreased acuity during the measurement year. Percentage of clients with documented evidence of acuity and frequency of contact by MCM matches acuity level in the primary client record.

Care Planning
The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum:
• Problem Statement (Need)
• Goal(s) – no more than three goals
• Intervention
  o Task(s)
  o Referral(s)
  o Service Deliveries
• Individuals responsible for the activity (case management staff, client, other team member, family)
• Anticipated time for each task
• Client signature and date, signifying agreement
 	
The care plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals, at a minimum, every 3 months. Tasks, referrals and services should be updated as they are identified or completed – not at set intervals.
	Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year. ***(HRSA HAB Measure)***
	
	Percentage of client records with issues noted in the care plans that have ongoing case notes that match the stated need and the progress towards meeting the goal identified.
	
	Percentage of Care Plans documented in the primary client record system.

Viral Suppression/Treatment Adherence An assessment of treatment adherence support needs and client education should begin as soon as clients enter MCM services and should continue as long as a client remains in MCM	Percentage of MCM patients assessed for medication/treatment adherence and, in coordination with the client, develop specific treatment adherence care plans.

services. Medical Case Management services should involve an individually tailored adherence intervention program, and **staff providing medical case management should reinforce treatment adherence at every contact whether it is during face-to-face contact or telephone contact.** The following criteria can help medical case management staff and clients examine the client's current and historical adherence to both medical care and treatment regimens: **-Medication Adherence:** Relates to current level of adherence to ARV medication regimen and client ability to take medications as prescribed. MCM staff will use any available treatment adherence tool to promote adherence. **-Appointments:** Relates to current level of completion of appointments for core medical services and understanding of the importance of regular attendance at medical and non-medical appointments in order to achieve positive health outcomes. **-ARV Medication Side Effects:** Relates to adverse side effects associated with ARV treatment and the impact on functioning and adherence. MCM staff will discuss side effects of medications as challenges and barriers to treatment adherence, including diarrhea, nausea, rash, headache, vomiting, swallowing and problems due to thrush. **-Knowledge of HIV Medications:** Relates to client understanding of prescribed ARV regimen, the role of medications in achieving positive health outcomes and techniques to manage side effects. **-Treatment Support:** Relates to client relationship with family, friends, and/or community support systems, which may either promote or hinder client adherence to treatment protocols.	Percentage of MCM patients with documented education about the goals of therapy. Percentage of MCM patients with documented discussion on the importance of medication adherence and consequence of missing doses (leading to viral resistance and mutations) at every contact with client. Percentage of MCM patients with treatment adherence discussions and interventions as indicated in the standard documented in the primary client record system. Percentage of MCM patients with documented education on basic HIV information as needed (newly diagnosed, return to care), including explanation of viral load and viral suppression. Percentage of MCM patients with documented evidence of sexual health literacy and education provided on harm reduction. Percentage of MCM patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year (that is documented in the medical case management record). ***(HRSA HAB measure)*** Percentage of MCM patients, 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. ***(HRSA HAB Measure)***
Referral and Follow-Up Case management staff will work with the client to determine barriers to referrals and facilitate access to referrals. Case management staff will ensure that clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their Care Plan When clients are referred for services elsewhere, case notes include not only documentation	Percentage of MCM patients with documented referrals initiated immediately with client agreed participation upon identification of client needs. Referrals declined by the client must be documented in the primary client record system Percentage of MCM patients with referrals that have documentation of follow up to the referral including

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

Non-Medical Case Management
Service Standard

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

Limitations: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.

Non-Medical Case Management is a service based on need, and is not appropriate or necessary for every client accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). Non-Medical Case Management should not be used as the only access point for agency services. Clients who do not need Non-Medical Case Management services to access and maintain in systems of care should not be enrolled in N-MCM services, and if they are enrolled in N-MCM services, they should be graduated from Non-Medical Case Management services.

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

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

Services: Non-Medical Case Management services provide guidance and assistance to clients to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

Key activities include:

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

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

Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Performance Measure
Initial Assessment The Initial Assessment is required for clients who are enrolled in Non-Medical Case Management services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer-standing access and/or barriers to medical and/or psychosocial needs. The 30 day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: a) Client's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner Services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (i.e. food, shelter, education, medical, safety (CPS/APS referral as indicated) • Family Violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, SSDI applications) • Linguistic Services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education b) Additional information • Client strengths and resources • Other agencies that serve client and household • Brief narrative summary of assessment session(s)	Percentage of clients who access N-MCM services that have a completed assessment within 30 calendar days of the first appointment to access N-MCM services and includes all required documentation. Percentage of clients that received at least one face-to-face meeting with the N-MCM staff that conducted the initial assessment. ~~Percentage of clients whose relevant information was not received by the end of the 30 calendar days of the initiated comprehensive assessment.~~ ~~Percentage of those clients who are missing information who were contacted to follow-up on completion of the assessment.~~ Percentage of clients have documented Initial Assessment in the primary client record system.
~~**Case Management Acuity Level and Client Contact**~~ ~~NMCM clients have a documented acuity level using an approved acuity scoring tool with~~	~~Percentage of clients who have a completed acuity level within 30 days of the comprehensive assessment.~~

~~the comprehensive assessment.~~ ~~Acuity and frequency of contact is documented in the primary client record system. *See policy number 231.004 "Documenting CM Actions in ARIES" for further details*~~	~~Percentage of clients whose acuity score is based on the results of the initial assessment and is documented in the client primary care record.~~ ~~Percentage of clients with documented evidence of acuity and frequency of contact by N-MCM in the primary client record.~~

Care Planning
The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum:
• Problem Statement (Need)
• Goal(s) – no more than three goals
• Intervention
  o Task(s)
  o Referral(s)
  o Service Deliveries
• Individuals responsible for the activity (case management staff, client, other team member, family)
• Anticipated time for each task
• ~~Client signature and date, signifying agreement~~ Client acknowledgment
 	
The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every 3 months. Tasks, referrals and services should be updated as they are identified or completed – not at set intervals.
	Percentage of non-medical case management patients, regardless of age, with a diagnosis of HIV who had a non-medical case management care plan developed and/or updated two or more times in the measurement year. ***(DSHS Performance Measure)***
	
	~~Percentage of client records with issues noted in the care plans that have ongoing case notes that match the stated need and the progress towards meeting the goal identified~~. Percentage of client records with documented follow up for issues presented in the care plan.
	
	Percentage of Care Plans documented in the primary client record system.

Referral and Follow-Up Case management staff will work with the client to determine barriers to referrals and facilitate access to referrals. Case management staff will ensure that clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their Care Plan When clients are referred for services elsewhere, case notes include ~~not only~~ documentation of follow-up. ~~but also level of client satisfaction with referral~~.	Percentage of N-MCM patients with documented referrals initiated ~~immediately~~ upon identification of client needs and with the agreement of the client. Referrals denied by the client should also be documented in the primary client record system Percentage of N-MCM patients with referrals have documentation of follow up to the referral. ~~including appointment attended and the result of the referral~~. ~~Percentage of N-MCM patients with documented evidence of a referral tracking mechanism to monitor completion of all case management referrals~~.
Case Closure/Graduation Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below.	Percentage of N-MCM patients with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge

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

Affected Community Committee Report

Affected Community Committee Training

Purpose of the Planning Council
Participation in Health Fairs
Purpose of Public Hearings

February 20, 2017

Purpose of the Planning Council

- What does the Planning Council do?
  - Decide which services are provided for persons living with HIV/AIDS in the Houston HSDA
  - Make a list of the most important services
  - Decide how much money goes to those services
  - Conduct a Needs Assessment
  - Review data about HIV services
  - Create a plan to improve HIV services in Houston

Purpose of the Planning Council

- What does the Planning Council NOT do?
  - Review grant applications from agencies
  - Decide which agencies in Houston get money
  - Hire and fire staff at agencies
  - Respond to complaints from consumers about specific agencies
  - Write letters to politicians in Washington
  - March at protests
  - Conduct HIV prevention
- HRSA sets the rules Planning Councils
  - HRSA says Planning Councils can only focus on services, not specific agencies.
  - The Administrative Agency (Carins office) monitors grants and agencies.

Participation in Health Fairs

- Tell the public about what the Ryan White Planning Council does
- Tell the public about services by giving out the Blue Book
- Tell the public how to volunteer with the Planning Council

- Give out condoms or HIV prevention materials
- Do HIV prevention
- Tell the public about specific agencies

Purpose of Public Hearings

- Twice a year Inform the community about recommended changes that the Planning Council will decide upon.
- Get feedback from consumers of Ryan White services as to how the recommended changes will affect their ability to receive care and support services.
- Community input is vital to all of the Planning Councils processes and is encouraged at every level.
  - Public Hearings are televised to help all PLWHAs participate in the planning process – especially PLWHAs who cannot travel to Planning Council meetings

PROPOSED

2017 Road 2 Success/Camino hacia tu Salud

Proposed change: Move Road 2 Success/Camino hacia tu Salud under the auspices of the Affected Community Committee.

Goal: Increase participation in Road 2 Success by:

- Hosting 2 two- hour Road 2 Success meetings in partnership with other consumer groups between February and October 2017. These meetings will be held at the location where the partner typically hosts meetings with consumers. Example: a large support group, community advisory group (like Thomas Street Advisory Council), HIV housing complex, etc.
- In November 2017 and January 2018 the Committee will host 3 four-hour Road 2 Success events. Advertise to those who attended the shorter classes, as well as the general HIV community, to increase participation and build momentum for the half day classes. The location for the four-hour classes could continue to be the Montrose Center and the Leonel Castillo Community Center.

Format for the two-hour Road 2 Success meetings:

Hour 1: A speaker and a consumer will team up to present information that is relevant to the partner group.

Hour 2: A focus group in which consumers can talk about barriers to their care and ways to improve services. The Health Planner for the Office of Support and the Project Coordinator for Ryan White Grant Administration will facilitate the focus group portion of the class. The findings from the focus groups and the *We Are Listening* class will be reported to the Affected Community Committee in February of each year so that the findings can be used in the How To Best Meet the Need process and to develop content for future Road 2 Success/Camino classes.

Affected Community Committee Meeting Schedule:

See page 2.

(OVER)

PROPOSED

2017 Affected Community Committee Meeting Schedule

January - 2 four-hour Road 2 Success Classes (*Camino* and *We Are Listening*)

February – Committee orientation and training.

March - Training for the How To Best Meet the Need process (HTBMN).

April - No meeting so members can participate in HTBMN training & workgroups.

May – Organizational meeting for 2 two-hour Road 2 Success Classes

June – FIRST 2-HOUR ROAD 2 SUCCESS CLASS @ Thomas St. Health Center?

July – SECOND 2-HOUR ROAD 2 SUCCESS CLASS in Spanish @ Chris Escalante's support group?

August - Standards of Care Training

September - Consumer-Only Workgroup on Standards of Care

October - Organizational meetings for December and January Classes

November – One 4-hour Road 2 Success/Camino Classes

December – One 4-hour Road 2 Success/Camino Classes - in Spanish?

January - One 4-hour Road 2 Success Class (*We Are Listening* format)

Comprehensive HIV Planning Committee Report

DRAFT

Houston Area HIV Services Ryan White Planning Council
Comprehensive HIV Planning Committee
2017 Committee Timetable
January – December 2017

Updated: 02-08-2017

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	NOTES
Epi Profile				2017 Comp Plan Epi Overview data used in HTBMN					Epi Profile developed	Epi WG and Committee approve Epi Profile	Council approves Epi Profile		
Needs Assessment / Special Studies		Recently Released Profile available	Determine and plan Special Studies for 2017 Transgender and Gender Non-conforming Profile available	2016 NA results used in HTBMN Youth & Aging Profiles available	Rural Profile available	Women of Color Profile available	MSM Profile available	Unstably Housed / Homeless Profile available		Committee approves Special Study report(s)	Council approves Special Study report(s)		Priority Special Study topics: - OOC - Soc. Determ. of Health Profiles based on 2017-21 Comp Plan Special pops.
Comprehensive HIV Plan*	2017 Comp Plan Kickoff		Committee approves Y4 (2015) Evaluation Report	2017 Q1 Activities Update Council approves Y4 (2015) Evaluation Report			2017 Q2 Activities Update			2017 Q3 Activities Update Eval WG conducts 2012-2016 Comp Plan closeout report	Committee approves closeout report	Council approves closeout report	Joint feedback from HRSA/CDC anticipated late February / early March
EIIHA			EIIHA WG reviews FY17 EIIHA criteria; requests additional data types if needed				EIIHA WG ***tentatively*** meets to develop FY18 EIIHA Plan	EIIHA WG ***tentatively*** meets to develop FY18 EIIHA Plan					FY18 EIIHA plan subject to changes pending HRSA guidance

Special Study Data Collection

*Speakers Bureau Workgroup will meet in April, August, and December.

= Committee approval

= Council approval

2016 Houston HIV Care Services Needs Assessment: Profile of the Recently Released

PROFILE OF THE RECENTLY RELEASED

The Texas Department of Criminal Justice (**TDCJ**) estimates that 386 people living with HIV (**PLWH**) with legal residence in Harris County were released from incarceration in 2015 (TDCJ, 2016). This represents 31% of estimated PLWH released from TDCJ in 2015, a greater proportion than any other county in Texas. Data about PLWH re-entering Harris County and the greater Houston area after incarceration of particular importance to local HIV planning as this information equips communities to provide timely and appropriate linkage to HIV medical care and needed support services.

Proactive efforts were made to gather a representative sample of all PLWH in the 2016 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This Profile highlights results *only* for participants who were recently released from incarceration at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: "Recently released from incarceration" and "recently released" are defined in this analysis as PLWH who indicated at survey that they were released from jail or prison within the past 12 months at time of survey. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 41 participants in the 2016 Houston HIV Care Services Needs Assessment were released from jail or prison within the 12 months prior to survey, comprising just over 8% of the total sample.

Ninety-seven percent (97%) of recently released participants were residing in Houston/Harris County at the time of data collection. Like all needs assessment participants, the majority of recently released participants was male (68%), African American/Black (80%), between the ages of 25 and 49 (46%) and identified as heterosexual (63%). No recently released participants reported being out of care. However, several differences were observed in comparison to the total sample. The proportion of recently released participants who identified as African American/Black was 22% higher than that the total sample. Compared to all needs assessment participants, greater proportions of recently released participants identified as bisexual (15% v. 8%) rather than gay or lesbian (17% v. 34%). Though representing a relatively small overall number, the proportion of transgender participants was 47% higher among recently released participants than the total sample.

Several socio-economic characteristics of recently released participants were also different from all participants. A lower proportion of recently released participants reported having private health insurance (7% v. 9%) or public health insurance in the form of Medicaid and/or Medicare (29% v. 50%). The average annual income among recently released participants who reported income was almost half the total sample ($4,800 v. $9,380). A greater proportion of recently released participants reported experiencing current housing instability compared to the total sample (50% v. 28%; *not shown*).

Characteristics of recently released participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Adults between the ages of 25 and 49
- Heterosexual
- With higher occurrences of no health insurance coverage, lower average annual income, and a greater proportion unstably housed.

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

	No.	Released %	Total %
County of residence			
Harris	38	97.44%	93.40%
Fort Bend	1	2.56%	4.20%
Liberty	0	-	0.20%
Montgomery	0	-	1.20%
Other	0	-	1.00%
Primary race/ethnicity			
White	2	4.88%	11.80%
African American/Black	33	80.49%	62.70%
Hispanic/Latino	5	12.20%	23.90%
Asian American	0		1.00%
Other/Multiracial	1	2.44%	0.60%
Immigration status			
Born in the U.S.	37	92.50%	84.60%
Citizen > 5 years	2	5.00%	6.50%
Citizen < 5 years	0	-	0.80%
Undocumented	0	-	2.00%
Prefer not to answer	1	2.50%	4.40%
Other	0	-	1.80%

	No.	Released %	Total %
Age range (median: 50-54)			
13 to 17	0	-	0.20%
18 to 24	1	2.44%	3.40%
25 to 49	19	46.34%	43.20%
50 to 54	13	31.71%	24.30%
55 to 64	8	19.51%	26.20%
≥65	0	-	2.80%
Seniors (≥50)	21	51.22%	53.30%
Sexual orientation			
Heterosexual	26	63.41%	54.00%
Gay/Lesbian	7	17.07%	33.70%
Bisexual	6	14.63%	7.70%
Other	2	4.88%	4.50%
MSM	14	34.15%	42.60%
Yearly income (average: $4,800)			
Federal Poverty Level (FPL)			
Below 100%	21	80.77%	78.80%
100%	4	15.38%	12.70%
150%	0	-	3.70%
200%	1	3.85%	2.80%
250%	0	-	0.60%
≥300%	0	-	1.40%

	No.	Released %	Total %
Sex at birth			
Male	28	68.3%	67.30%
Female	13	31.7%	37.70%
Intersex	0	-	-
Transgender	3	7.32%	3.90%
Currently pregnant	0		0.20%
Health insurance (multiple response)			
Private insurance	3	6.67%	8.60%
Medicaid/Medicare	13	28.89%	49.80%
Harris Health System	20	44.44%	23.70%
Ryan White Only	9	20.00%	17.00%
None	0	-	1.00%

BARRIERS TO RETENTION IN CARE

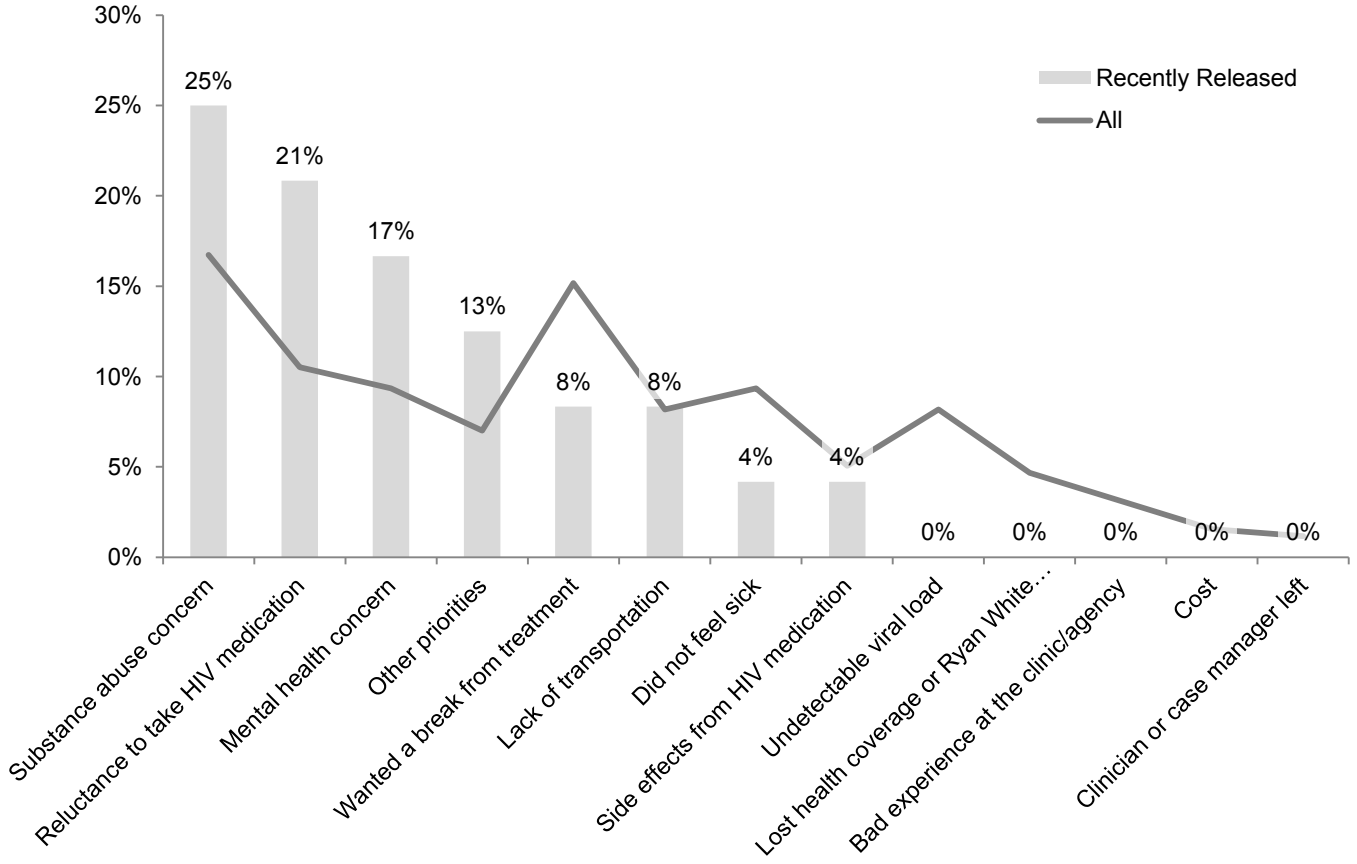
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2014) in order to produce proportional results (See: *Methodology*, full document).

While 71% of all needs assessment participants needs assessment participants reported no interruption in their HIV care for 12 months or more since their diagnosis, only 34% of recently released participants reported no interruption in care. 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 their reasons.

(**Graph 1**) Among recently released participants, experiencing substance abuse concerns was cited most often as the reason for interruption in HIV medical care at 25% of reported reasons, followed by reluctance to take HIV medication (21%), experiencing mental health concerns (17%), and having competing priorities other than HIV (13%). The greatest differences between recently released participants and the total sample were in the proportions reporting reluctance to take HIV medication (21% v. 11%), substance abuse concerns (25% v. 17%), having an undetectable viral load (0% v. 8%), and wanting a break from treatment (8% v. 15%) as reasons for falling out of care. The only write-in reason for recently release participants falling out of care was experiencing homelessness.

GRAPH 1-Reasons for Falling Out of HIV Care among Recently Released PLWH in the Houston Area, 2016

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



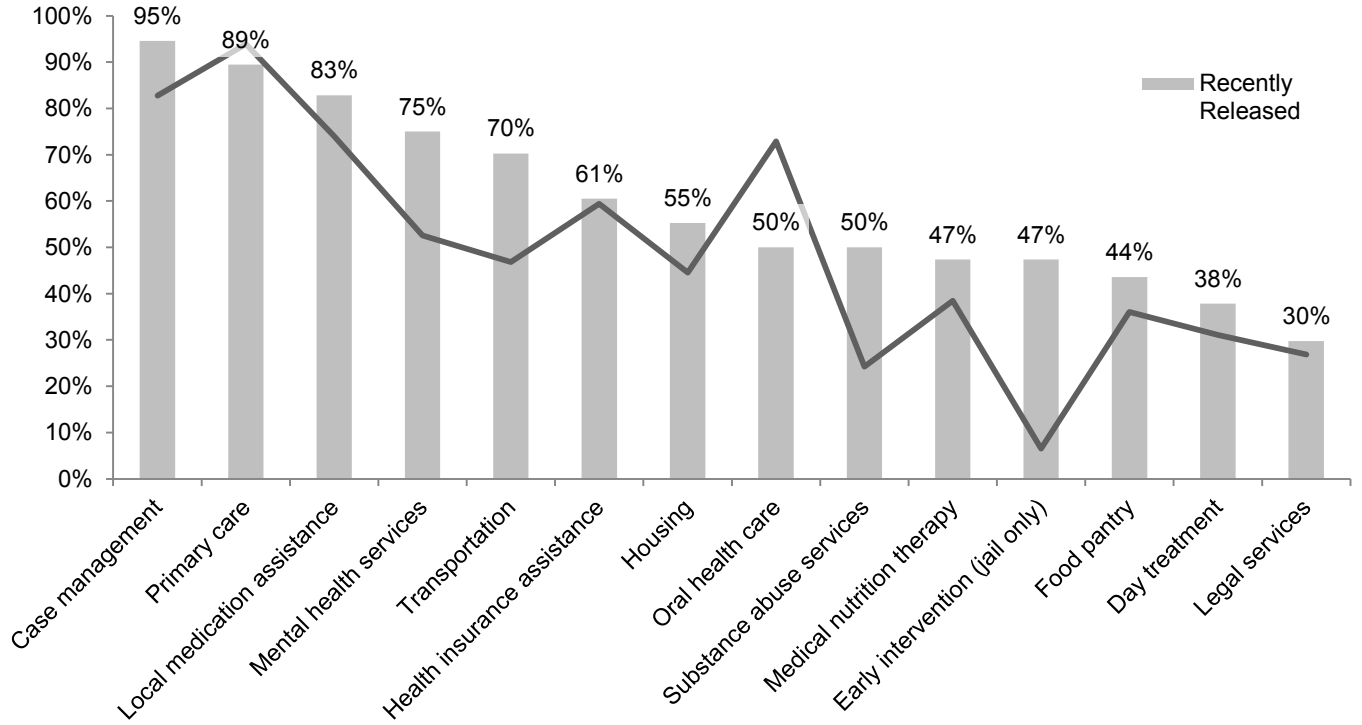
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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 2**) Among recently released participants, case managements was the most needed funded service at 95% of recently release participants, followed by primary care (89%), local medication assistance (83%) mental health services (75%) and transportation assistance (70%). The greatest differences between recently released participants and the total sample were in the proportions reporting need for early intervention services (47% v. 7%), substance abuse services (50% v. 24%), and oral health care (50% v. 73%).

GRAPH 2-Ranking of HIV Services among Recently Released in the Houston Area, By Need, 2016

Definition: Percent of recently released needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

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.

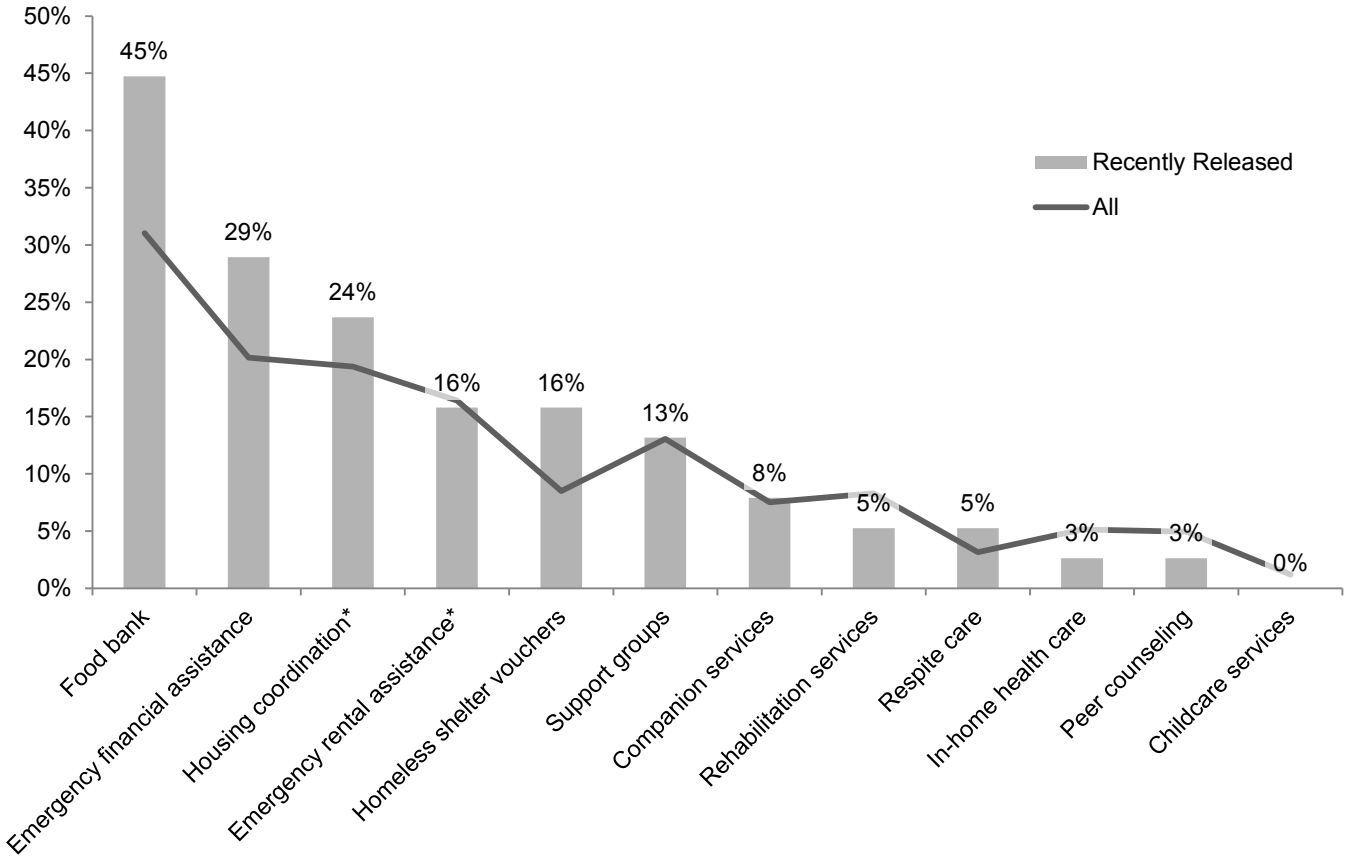
(**Graph 3**) From the 12 services options provided, the greatest proportion of recently released participants reported also needing food bank services (45%), followed by emergency financial assistance (29%), housing coordination (24%), emergency rental assistance (16%) and homeless shelter vouchers (16%). Compared to the total sample, greater proportions of recently released participants reported needing food bank (45% v. 31%), emergency financial assistance (29% v. 20%), homeless shelter vouchers (16% v. 8%), housing coordination (24% v. 19%), and respite care (3% v. 2%).

Recently released participants provided no write-in services.

GRAPH 3-Other Needs for HIV Services among Recently Released PLWH in the Houston Area, 2016

Definition: Percent of recently released 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.



OVERALL BARRIERS TO HIV CARE

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.

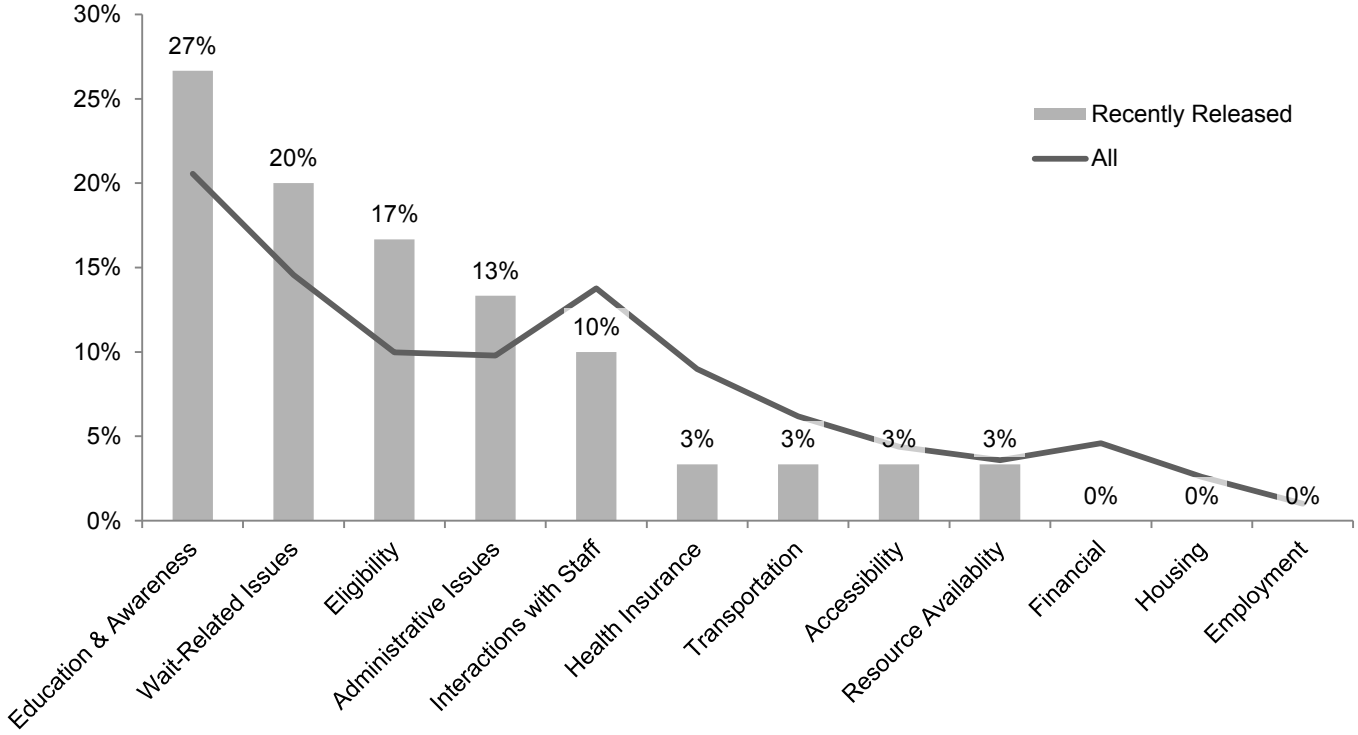
(**Graph 4**) Overall, the barrier types reported most often among recently released participants related to service education and awareness issues (27% of all reported barriers); wait-related issues (15%); eligibility issues (17%); administrative issues (13%); and interactions with staff (10%).

Compared to the total sample, recently released participants reported greater proportions of eligibility-related barriers (17% v. 10%) such as not meeting eligibility requirements for needed services; education and awareness barriers (27% v. 21%) like not knowing not knowing that a service exists or is available; and wait-related barriers (20% v. 15%) such as being placed on a waitlist for services.

Among all accessibility barriers reported in the survey, 32% of stemmed from for former incarceration status, i.e. being restricted from services due to probation, parole, or felon status. This was observed most often for housing services.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Recently Released PLWH 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.



For more information or a copy of the full 2016 Houston HIV Care Services Needs Assessment contact:

Houston Area Ryan White Planning Council
2223 West Loop South #240
Houston, TX 77027
Tel: (713) 572-3724
Fax: (713) 572-3740
Web: www.rwpchouston.org

Operations Committee Report

LIST OF COUNCIL MEMBERS WHO HAVE NOT SUBMITTED THEIR
OPEN MEETINGS ACT TRAINING CERTIFICATE
(as of 02-17-17)

NAME	Certificate in Chart	Missing Certificate
Cecilia Ross, Chair	**X**	
John Lazo, Vice Chair	**X**	
Carol Suazo, Secretary	**X**	
Ted Artiaga	**X**	
Connie L. Barnes	**X**	
Curtis W. Bellard	**X**	
David Benson	**X**	
Ardry "Skeet" Boyle, Jr.	**X**	
Bianca Burley	**X**	
Ella Collins-Nelson	**X**	
Amber David	**X**	
Johnny Deal	**Submitted 02/03/17**	
Denny Delgado		**X**
Evelio Salinas Escamilla	**X**	
Herman L. Finley III	**X**	
Tracy Gorden	**X**	
Paul E. Grunenwald	**X**	
Angela F. Hawkins	**X**	
Arlene Johnson	**X**	
J. Hoxi Jones	**X**	
Denis Kelly	**X**	
Peta-gay Ledbetter	**X**	
Tom Lindstrom	**Submitted 02/16/17**	
Osaro Mgbere	**X**	
Nancy Miertschin	**X**	
Rodney Mills	**X**	
Allen Murray	**X**	
Robert Noble	**X**	
Shital Patel		**X**
John Poole	**X**	
Tana Pradia	**X**	
Teresa Pruitt	**X**	
Venita Ray	**X**	
Viviana Santibanez	**Submitted 02/15/17**	
Gloria Sierra	**X**	
Krystal Shultz		**X**
Isis Torrente	**X**	
Steven Vargas	**X**	
Larry Woods	**X**	

2017 Council Orientation Evaluation Results

Introduction

The 2017 Houston Area Ryan White Planning Council Orientation was held on January 26, 2017 at Third Coast [formerly Trevisio] Restaurant and Conference Center. The Planning Council Operations Committee serves the official Orientation host. Members attending Orientation were asked to complete evaluation forms at the end of the event. Twenty-six attendees completed an evaluation form, **31%** of whom were new members.

Members were asked to:

- Describe their favorite part of Orientation
- Rate the quality of logistic features of the event
- Rate the helpfulness of each session for preparing the members to serve on Council
- Rate their confidence in their ability to successfully participate in Council following Orientation
- Suggest any topics they thought would be useful to include in the 2018 Council Orientation

Successes

1. In descending order, the favorite parts of Orientation:
    a. Ann Robbins' presentation on the State of the State
    b. The "Guess Who Loves Me" lunch activity
    c. Meeting Committee mentors
2. All meeting logistic features had mean quality ratings of **4.23** or higher. This means that, on average, the location, meeting space, food and drink provided, materials, overall agenda, facilitators, and staff communication were rated as "**Very Good**" or "**Excellent**".
3. All Orientation sessions had a mean helpfulness rating of **4.04** or higher. This means that, on average, all sessions were rated as "**Very Helpful**", or "**Extremely Helpful**". Ann Robbin's State of the State Presentation received the highest mean helpfulness rating (**4.79**), followed by Bob Hergenroeder's Confidentiality training (**4.67**) and the Timeline of Critical Council Activities (**4.56**).
4. All new member sessions received helpfulness ratings of **4.67** or higher, meaning that, on average, all new member sessions were rated as "**Very Helpful**", or "**Extremely Helpful**". The Overview of HIV Funding received the highest mean helpfulness rating (**4.89**).
5. The mean confidence rating was **4.64**. This means, on average, members reported being "**Very Confident**" to "**Completely Confident**" following the 2017 Orientation, with skewing toward "**Completely Confident**".

Challenges

1. Though Food/Drink and Location received "**Very Good**" average ratings (**4.23** and **4.31**, respectively), these two logistic features had the lowest mean quality ratings compared to the other logistic features. Both received at least one "**Poor**" rating, and, though not solicited, comments on parking difficulty were written into the margins of the evaluation form.
2. The "Guess Who Loves Me" lunch activity (**4.04**) received the lowest mean helpfulness rating. However, this activity was also listed as the second most favorite part of Orientation. If this activity is included in future Orientations, the perception of helpfulness may be improved briefly discussing the benefits of connecting member names and faces with their shared photo and story and getting to know one's fellow Council members.

Opportunities

The following are direct quotes from members who attended Orientation on what topics they would like to see included in the 2018 Council Orientation:

- "Details about what the role of each department did. Actually confused about how my committee affects everything."
- "Houston information added instead of just hearing Texas data/stats."
- "Overview of local and national political environment re: HIV"
- "Overview of Task Forces, and information for new people about how important it is to participate on Task Forces."
- "Showing the area's of progress via Treatment Cascade"

Training Topics for 2017 Ryan White Planning Council Meetings **(updated: 02-08-17)**

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Shading = may be room on agenda for a second speaker

Month	Topic	Speaker
January 26 2017	Council Orientation	N/A
February 9	END HIV Houston Crosswalk: END HIV Houston and 2017 Houston Area HIV Prevention and Care Comp. Plan	Venita Ray, Coordinator, END HIV Houston, Legacy Amber Harbolt, Health Planner, Office of Support
March 9	2017 HIV Comprehensive Plan: Council Activities How To Best Meet the Need Process & Training	Amber Harbolt, Health Planner, Office of Support Robert Noble & Gloria Sierra, Quality Improvement
April 13	Tentative: How to Read Council Reports Southern Cities Initiative	Ryan White Staff Nancy Miertschin working on a speaker
May 11	DSHS Legislative Update (include ADAP update)	Shelly Lucas, Texas Dept. of State Health Services
June 8	Project LEAP Presentation	Project LEAP 2017 Students
July 13	Priority Setting and Allocations Processes	Ella Collins-Nelson & Paul Grunenwald, Co-Chairs, Priority & Allocations
August 10	DSHS Budget & Program Update	Shelly Lucas, Texas Dept. of State Health Services
September 14	Prevention Of Domestic & Sexual Violence	RW Grant Administration staff
October 12	TENTATIVE: Update on ACA EIIHA Update	Carin Martin, RWGA Amber Harbolt, Health Planner
November 9	We Appreciate Our External Members Election Policy	Chair, Ryan White Planning Council Operations Committee
December 14	Elections for the 2018 Officers	Co-Chairs, Operations Committee

Requests: DSHS Updates (2/year) Training in reading Council reports

Revisions to the FY 2017 Council Support Budget

(as of 01/31/17)

Budget Item	Original Amount	Revised Amount	Difference
Health Insurance Changed from $11,116/employee/year to $13,000/employee/year	$47,200	$52,000	+ $ 4,800
Retirement Changed from 10.75%/employee/year to 14%/employee/year	$27,735	$36,120	+ $8,385
Equipment Replaced all staff computers in FY 2016	$ 3,000	$ 500	- $ 2,500
Travel No national meetings in FY 2017	$ 5,800	$ 2,000	- $ 3,800
Supplies	$ 6,000	$ 5,000	- $ 1,000
Needs Assess Activities Incentives usually provided by The Resource Group	$ 3,000	$ 2,115	- 885
Postage	$ 10,000	$ 5,000	- $ 5,000
TOTALS			0

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Houston Ryan White Planning Council
FY 2017 Council Support Budget

(Prepared 01-27-17)

		Subtotal	Total
PERSONNEL			
RWPC Manager (V. Williams) ($6621/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$79,446	**$258,002**	
RWPC Health Planner (A. Harbolt) ($6068/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$72,820		
RWPC Coordinator (D. Beck) ($4,718/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$56,611		
Assistant Coordinator (R. Avila) ($4094/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$49,125		
FRINGE		**$115,386**	
Social Security @ 7.65%	$19,737		
Health Insurance (4 x $13,000/FTE)	$52,000		
Retirement @ 14%	$36,120		
Workers Compensation @ 0.83%	$2,141		
Supplemental Death Insurance @ 0.50	$1,290		
Unemployment Insurance @ 0.60%	$1,548		
Incentives/allowances	$2,550		

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Houston Ryan White Planning Council
FY 2017 Council Support Budget
Includes FY 2016 3% Cost of Living Increase
(Prepared 01-27-17)

		Subtotal	Total
EQUIPMENT Replacement computers to replace obsolete units	$500	**$500**	
TRAVEL		**$2,000**	
Local travel @ $0.575/mile for Planning Council Support Staff	$500		
Out of EMA travel: One out of state trip for Office of Support staff for HIV planning meeting and five in State trips for staff and/or volunteer Council members for statewide HIV Planning meetings	$1,500		
SUPPLIES General consumable office supplies including materials for Council Members and Public Meetings	$5,000	**$5,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$131,551**	
Resource Guide	$60,000		
Needs Assessment Activities	$2,115		
Reimbursement for PC member expenses: Reimbursement for travel, childcare, meals and other eligible expenses resulting from participation in Council approved/ HRSA grant required activities.	$23,686		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (phone, pagers): For local and long distance phone expenses and internet charges.	$3,500		
Web Page Technical Assitance Costs: For additional training/consultation to staff in order to update/improve web site.	$500		

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Houston Ryan White Planning Council
FY 2017 Council Support Budget
Includes FY 2016 3% Cost of Living Increase
(Prepared 01-27-17)

		Subtotal	Total
Council Education: For speakers & training costs primarily for Council member orientation, room rentals & the cost of speakers for ongoing training to insure that key decision-makers receive necessary and relevant information. This includes the Sept. & Nov. 2015 Council meetings & the Jan. 2016 training/orientation meeting, all to be held off-site at locations within Harris County, Texas.	$3,500		
Project LEAP Student Reimbursement: 30 participants for 17 week course including travel, childcare and other eligible expenses resulting from participation in Council approved training activities related to the HRSA grant.	$5,500		
Project LEAP Education: Training costs for 17 weeks including speaker fees, room rental for off-site meetings & educational materials.	$9,500		
Interpreter Services For Spanish-speaking and sign-language interpretation services during public meetings, focus groups, etc.	$1,500		
Fees and Dues Registration costs for attending meetings, trainings and conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council materials into Spanish.	$1,000		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$5,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used for Council and Office of Support.	$9,250		
TOTAL			**$512,439**

Priority and Allocations Committee Report

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Priority and Allocations
FY 2018 Guiding Principles and Decision Making Criteria

(Priority and Allocations Committee approved 02-23-17)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort.** Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV/AIDS. Decisions will address at least one or more of the following principles **and** criteria.

Principles are the standards **guiding the discussion** *of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

Principles

A. Ensuring ongoing client access to a comprehensive system of core services as defined by HRSA
B. Eliminating barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
C. Meeting the needs of diverse populations as addressed by the epidemiology of HIV
D. Identify individuals unaware of their status and link them to care and address the needs of those that are aware of their status and not in care.
E. Expressing the needs of the communities with HIV for whom the services are intended

Allocations only

F. Documented or demonstrated cost-effectiveness of services and minimization of duplication
G. Availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies
H. Reduction of time period between diagnosis and entry into HIV medical care to facilitate timely linkage.

Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.

(Continued)

DECISION MAKING CRITERIA STEP 1:

A. Documented service need with consumer perspectives as a primary consideration
B. Documented effectiveness of services with a high level of benefit to people and families living with HIV infection, including quality, cost, and outcome measures when applicable
C. Documented response to the epidemiology of HIV/AIDS in the EMA and HSDA
D. Documented response to emerging needs reflecting the changing local epidemiology of HIV/AIDS while maintaining services to those who have relied upon Ryan White funded services.
E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan and the Continuum of Care and their underlying principles to the extent allowable under the Ryan White Program: to build public support for HIV services; to inform people of their serostatus and, if they test positive, get them into care; to help people maintain their negative status; to help people with HIV improve their health status and quality of life and prevent the progression to AIDS; to help reduce the risk of transmission; and to help people with AIDS improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

DECISION MAKING CRITERIA STEP 2:

A. Services ~~are effective with~~ have a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
B. Services are accessible to all populations infected, affected, or at risk, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).
D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
F. Services are available to meet the needs of all people and families living with or at risk for HIV infection as applicable under Part A and B guidelines
G. Services meet or exceed standards of care
H. Services reflect latest medical advances, when appropriate
I. Services meet a documented need that is not fully supported through other funding streams

PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS. All decisions are expected to address needs of the overall community affected by the epidemic.

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FY 2018 Priority Setting Process

(Priority and Allocations Committee approved 02-23-17)

1. Agree on the principles to be used in the decision making process.
2. Agree on the criteria to be used in the decision making process.
3. Agree on the priority-setting process.
4. Agree on the process to be used to determine service categories that will be considered for allocations. (This is done at a joint meeting of members of the Quality Improvement, Priority and Allocations and Affected Community Committees and others, or in other manner agreed upon by the Planning Council).
5. Staff creates an information binder containing documents to be used in the Priority and Allocations Committee decision-making processes. The binder will be available at all committee meetings and copies will be made available upon request.
6. Committee members attend a training session to review the documents contained in the information binder and hear presentations from representatives of other funding sources such as HOPWA, Prevention, Medicaid and others.
7. Staff prepares a table that lists services that received an allocation from Part A or B or State Service funding in the current fiscal year. The table lists each service category by HRSA-defined core/non-core category, need, use and accessibility and includes a score for each of these five items. The utilization data is obtained from calendar year CPCDMS data. The medians of the scores are used as guides to create midpoints for the need of HRSA-defined core and non-core services. Then, each service is compared against the midpoint and ranked as equal or higher (H) or lower (L) than the midpoint.
8. The committee meets to do the following. This step occurs at a single meeting:
   - Review documentation not included in the binder described above.
   - Review and adjust the midpoint scores.
   - After the midpoint scores have been agreed upon by the committee, **public comment** is received.
   - During this same meeting, the midpoint scores are again reviewed and agreed upon, taking public comment into consideration.
   - Ties are broken by using the first non-tied ranking. If all rankings are tied, use independent data that confirms usage from CPCDMS or ARIES.
   - By matching the rankings to the template, a numerical listing of services is established.
   - Justification for ranking categories is denoted by listing principles and criteria.
   - Categories that are not justified are removed from ranking.
   - If a committee member suggests moving a priority more than five places from the previous year's ranking, this automatically prompts discussion and is challenged; any other category that has changed by three places may be challenged; any category that moves less than three places cannot be challenged unless documentation can be shown (not cited) why it should change.
   - The Committee votes upon all challenged categorical rankings.
   - At the end of challenges the entire ranking is approved or rejected by the committee.

(Continued on next page)

9. At a subsequent meeting, the Priority and Allocations Committee goes through the allocations process.
10. Staff removes services from the priority list that are not included on the list of services recommended to receive an allocation from Part A or B or State Service funding. The priority numbers are adjusted upward to fill in the gaps left by services removed from the list.
11. The single list of recommended priorities is presented at a Public Hearing.
12. The committee meets to review public comment and possibly revise the recommended priorities.
13. Once the committee has made its final decision, the recommended single list of priorities is forwarded as the priority list of services for the following year.

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2017 Policy for Addressing Unobligated and Carryover Funds

(Priority and Allocations Committee approved 02-24-17)

Background

The Ryan White Planning Council must address two different types of money: Unobligated and Carryover.

Unobligated funds are funds allocated by the Council but, for a variety of reasons, are not put into contracts. Or, the funds are put into a contract but the money is not spent. For example, the Council allocates $700,000 for a particular service category. Three agencies bid for a total of $400,000. The remaining $300,000 becomes unobligated. Or, an agency is awarded a contract for a certain amount of money. Halfway through the grant year, the building where the agency is housed must undergo extensive remodeling prohibiting the agency from providing services for several months. As the agency is unable to deliver services for a portion of the year, it is unable to fully expend all of the funds in the contract. Therefore, these unspent funds become unobligated. The Council is informed of unobligated funds via Procurement Reports provided to the Quality Assurance (QA) and Priority and Allocations (P&A) Committees by the respective Administrative Agencies (AA), HCPHS/ Ryan White Grant Administration and The Resource Group.

Carryover funds are the RW Part A Formula and MAI funds that were unspent in the previous year. Annually, in October, the Part A Administrative Agency will provide the Committee with the estimated total allowable Part A and MAI carryover funds that could be carried over under the Unobligated Balances (UOB) provisions of the Ryan White Treatment Extension Act. The Committee will allocate the estimated amount of possible unspent prior year Part A and MAI funds so the Part A AA can submit a carryover waiver request to HRSA in December.

The Texas Department of State Health Services (DSHS) does not allow carryover requests for unspent Ryan White Part B and State Services funds.

It is also important to understand the following applicable rules when discussing funds:

1.) The Administrative Agencies are allowed to move up to 10% of unobligated funds from one service category to another. But, the 10% rule applies to the amount being moved from one category and the amount being moved into the other category. For example, 10% of an $800,000 service category is $80,000. But, if a $500,000 category needs the money, the Administrative Agent is only allowed to move 10%, or $50,000 into the needy category, leaving $30,000 unobligated.

2.) Due to procurement rules, it is difficult to RFP funds after the mid-point of any given fiscal year.

In the final quarter of the applicable grant year, after implementing the Council-approved October reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, the AA may reallocate any remaining unspent funds as necessary to ensure the Houston EMA/HSDA has less than 5% unspent Formula funds and no unspent Supplemental funds. The AA for Part B and *State Services* funding may do the same to ensure no funds are returned to the Texas Department of State Health Services (TDSHS). The applicable AA must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting.

Recommendations for Addressing Unobligated and Carryover Funds:

1.) Requests from Currently Funded Agencies Requesting an Increase in Funds in Service Categories where The Agency Currently Has a Contract: These requests come at designated times during the year. Usually, requests of this nature are addressed using unobligated funds.

A.) In response, the AA will provide funded agencies a standard form to document the request (see attached). The AA will state the amount currently allocated to the service category, state the amount being requested, and state if there are eligible entities in the service category. This form is known as a *Request for Service Category Increase*. The AA will also provide a Summary Sheet listing all requests that are eligible for an increase (e.g. agency is in good standing).

The AA must submit this information to the Office of Support in an appropriate time for document distribution for the April, July and October P&A Committee meetings. The form must be submitted for all requests regardless of the completeness of the request. The AA for Part B and State Services Funding will do the same, but the calendar for the Part B AA to submit the Requests for Service Category Increases to the Office of Support is based upon the current Letter of Agreement. The P&A Committee has the authority to recommend increasing the service category funding allocation, or not. If not, the request "dies" in committee.

2.) Requests for New Ideas: These requests can come from any individual or agency at any time of the year. Usually, they are also addressed using unobligated funds. The individual or agency submits the idea and supporting documentation to the Office of Support. The Office of Support will submit the form(s) as an agenda item at the next QA Committee meeting for informational purposes only, the Office of Support will inform the Committee of the number of incomplete or late requests submitted and the service categories referenced in these requests. The Office of Support will also notify the person submitting the New Idea form of the date and time of the first committee meeting where the request will be reviewed. All committees will follow the RWPC bylaws, policies, and procedures in responding to an "emergency" request.

Response to Requests: Although requests will be accepted at any time of the year, the Priority and Allocations Committee will Review requests at least three times a year (in April, July, and October). The AA will notify all Part A or B agencies when the P&A Committee is preparing to allocate funds.

3.) Committee Process: The Committee will prioritize recommended requests so that the AA can distribute funds according to this prioritized list up until May 31, August 31 and the end of the grant year. After these dates, all requests (recommended or not) become null and void and must be resubmitted to the AA or the Office of Support to be considered in the next funding cycle.

After reviewing requests and studying new trends and needs the committee will review the allocations for the next fiscal year and, after filling identified gaps in the current year, and if appropriate and possible, attempt to make any increase in funding less dramatic by using an incremental allocation in the current fiscal year.

4.) Projected Unspent Formula Funds: Annually in October, the Committee will allocate the projected, current year, unspent, Formula funds so that the Administrative Agent for Part A can report this to HRSA in December.