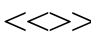
DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL



We envision an educated community where the needs of all persons living with and/or affected by HIV 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 living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.

AGENDA

12 noon, December 14, 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: People First Language — Angela F. Hawkins and Allen Murray, POZ Strike Force

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 status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Committees

A. Comprehensive HIV Planning Committee — Isis Torrente and Steven Vargas, Co-Chairs
Item: Special Study: Out of Care Interviews
Recommended Action: FYI: Brief verbal update from Amber Harbolt.

B. Quality Improvement Committee — Robert Noble and Gloria Sierra, Co-Chairs
Item: Reports from the Administrative Agency – Part A/MAI*
Recommended Action: FYI: See the attached reports:
- FY17 Procurement, dated 11/15/17
- FY16 Service Utilization, dated 11/15/17

** MAI = Minority AIDS Initiative*

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

- FY17/18 Procurement – Part B, dated 10/10/17
- FY16/17 Procurement – State Services, dated 10/10/17
- Health Insurance Assistance Service Utilization, dated 10/09/17 and 09/12/17

Item: FY 2018 Standards of Care and Performance Measures – Part A/MAI
Recommended Action: **Motion:** To approve the attached *Recommendations from the Ryan White Planning Council* which includes comments from the following:

- 2017 Comprehensive Plan Activities
- Affected Community Committee
- Consumer Feedback
- Community Workgroup
- No recommended changes to the Performance Measures

Item: FY 2018-2019 Standards of Care and Outcome Measures – Part B/SS
Recommended Action: FYI: The FY 2018-2019 Standards of Care for Part B and State Services will be reviewed by the Quality Improvement Committee in February 2018.

Item: FY 2018-2019 DSHS*** Standards of Care for Health Insurance
Recommended Action: FYI: No input recommended.

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

Item: 2017 World AIDS Day
Recommended Action: FYI: Committee members signed up to participate in a number of community World AIDS Day observances. See the attached calendar of events.

Item: Road 2 Success
Recommended Action: FYI: Members of the Affected Community Committee hosted Road 2 Success on Saturday, November 4, 2017 and Camino hacia tu Salud on Saturday, November 11, 2017. See the attached list of 2017 with details regarding these two events and others.

Item: Road 2 Success – January 13, 2018
Recommended Action: FYI: Please note that the Affected Community Committee is hosting the final Road 2 Success in the series on Saturday morning, January 13, 2017. Please see the attached flyer, in English and in Spanish, and please take additional flyers from the sign-in table to distribute to friends who might benefit from participating in the event.

*** SS = State Services funding*
****DSHS = Texas Department of State Health Services*

Item: Quarterly Committee Report
Recommended Action: FYI: See the attached 2017 Quarterly Committee Report.

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

Item: Project LEAP 2017
Recommended Action: FYI: See the attached Project LEAP 2017 Final Evaluation Report.

Item: Project LEAP 2018
Recommended Action: **Motion:** Approve the attached service definition with recommended changes for Project LEAP 2018.

Item: Project LEAP 2018
Recommended Action: **Motion:** Approve the attached Student Selection Guidelines with no recommended changes for Project LEAP 2018.

Item: Updated/Revised Council Policies
Recommended Action: **Motion:** Approve the attached Ryan White Planning Council bylaws (recommended changes are underlined and in bold text). **NOTE:** Amendments to the bylaws require two-thirds (2/3) of the entire membership of the Council and must be submitted to full Council at least 15 days prior to voting.

Item: Important Dates in 2018
Recommended Action: FYI: Please note the following important meeting Dates in 2018:

- Mentor Luncheon – Thursday, January 18, 2018
- All-day Council Orientation – Thursday, January 25, 2018

Item: Quarterly Committee Report
Recommended Action: FYI: Please see the attached Quarterly Committee Report.

Item: Election of Officers for the 2018 Planning Council
Recommended Action: **Election:** See the attached list of nominees.

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

No report

F. Positive Connections Ad Hoc Committee — David Benson and Steven Vargas, Co-Chairs

Item: Analysis of Smartphone-Based App Project
Recommendations: FYI: See two attached articles regarding evaluations of the Positive Links app.

Item: Evaluation of the Houston Positive Links App Project
Recommendations: **Motion:** Approve the attached evaluation measures for the Houston Positive Links App Project.

Item: Committee Meeting Updates
Recommendations: FYI: Verbal update on the outcome of the Monday, December 4, 2017 Committee meeting.

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)

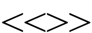
A. HOPWA — Krystal Shultz
B. Community Prevention Group (CPG) — Denis Kelly
C. Update from Task Forces:
- Sexually Transmitted Infections (STI) — Herman Finley
- African American — S. Johnson-Fairley
- Latino — Gloria Sierra
- MSM — Ted Artiaga
- Transgender — Viviana Santibanez
- Hepatitis C — Steven Vargas
- Urban AIDS Ministry — Ella Collins-Nelson
- Youth

D. HIV and Aging
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. Texas HIV Medication Advisory Committee — Nancy Miertschin
I. Texas HIV Syndicate — Amber Harbolt
J. Legislative Updates — Denis Kelly
K. Texans Living with HIV Network — Venita Ray

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL



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

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

MINUTES

12 noon, Thursday, November 9, 2017
Meeting Location: Ryan White Offices, 2223 W. Loop South, Rm 416; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Cecilia Ross, Chair	Ted Artiaga, excused	Rosalind Belcher
Carol Suazo, Secretary	David Benson, excused	Ma'Janae Chambers
Connie Barnes	Ella Collins-Nelson	Bobby Cruz
Curtis Bellard	Evelio Salinas Escamilla, excused	Ronnie G. Galley
Skeet Boyle	Herman Finley, excused	Shamra Hodge
Bianca Burley	Tracy Gorden, excused	Alex Moses
Amber David	Arlene Johnson	Crystal Starr
Johnny Deal	J. Hoxi Jones, excused	Amana Turner
Paul Grunenwald	Osaro Mgbere, excused	C. Bruce Turner
Angela F. Hawkins	Nancy Miertschin, excused	Leslie Ellis, HCPHS
Denis Kelly	Teresa Pruitt	Sean Greene, CHCP
Peta-gay Ledbetter	Venita Ray, excused	Stephen Johnson
Tom Lindstrom		
Rodney Mills		**STAFF PRESENT**
Allen Murray		*Ryan White Grant Administration*
Robert Noble		Heather Keizman
Shital Patel		Tasha Traylor
Krystal Perez		
John Poole		*The Resource Group*
Tana Pradia		Sha'Terra Johnson-Fairley
Viviana Santibanez		
Gloria Sierra		*Office of Support*
Isis Torrente		Tori Williams
Steven Vargas		Amber Harbolt
Larry Woods		Diane Beck

Call to Order: Cecilia Ross, Chair, called the meeting to order at 12:04 p.m.

During the opening remarks, Ross extended thanks to Nancy, Evelio and Ted for volunteering to proof read the Part A grant application. She asked members to take flyers from the information table and give them to friends who speak Spanish and might be interested in participating in Camino hacia tu Salud. The event is this Saturday at the Leonel Castillo Community Center. Although we have been advertising the event, it always helps to hand a flyer to a friend. She noted that there is a revised agenda at your place on light pink paper which includes the Steering Committee's motion to approve the slate of nominees for officers for the 2018 Ryan White Planning Council. According to Council policy, the slate closed at the end of the November Steering Committee meeting, but those interested in adding a candidate can do so the day of the election on December 14th.

We Appreciate Our External Committee Members: Ross presented a certificate of appreciation to each of the following 2017 external committee members: Rosalind Belcher, Ma'Janae Chambers, Bobby Cruz, Ronnie G. Galley, Shamra Hodge, Alex Moses, Crystal Starr, Amana Turner, and C. Bruce Turner.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Pradia, Torrente) to approve the October 12, 2017 minutes.* **Motion carried.** Abstentions: Barnes, Bellard, Boyle, Noble, Sierra, Woods.

Training: Intimate Partner Violence and HIV: Heather Keizman, Project Coordinator, Ryan White Grant Administration, presented the attached information.

Training: Election Policy: Curtis Bellard, Co-Chair, Operations Committee, reviewed the Planning Council's election policy, see the attached.

Public Comment and Announcements: None.

Reports from Committees:
Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following:
2017 Comprehensive Plan: Implementation Progress Report: See the attached 2017 Q2 Implementation Progress Report. By the end of June, 88% of activities slated for implementation in 2017 were completed or had progress made.

Special Study – Out of Care Interviews: The Committee reviewed the updated prospectus for the Out of Care Special Study. Staff and 3 interns will seek to interview approximately 25 PLWH, each with 2 or more periods of being out to care since their diagnosis. The Committee also developed questions for the interview guide, including reasons for falling out of care, life priorities at that time, knowledge of services available at that time, accessing medical services outside of the HIV care system, what could have been done differently to prevent them from falling out of care, and what supports helped them get back in to care. See the attached updated prospectus.

Committee Quarterly Report: See the attached Comprehensive HIV Planning Committee Quarterly Report.

Quality Improvement Committee: No report.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
FY 2018 Standards of Care: On October 23, 2017, the Committee hosted a consumer-only workgroup to provide input into standards of care for FY 2018 Ryan White Part A/MAI*, Part B and State Services

funded services. See the attached memo which summarizes committee recommendations and was sent to the Quality Improvement Committee to be included in the final recommendations.

Road 2 Success: Members of the Affected Community Committee will host Road 2 Success on Saturday, November 4, 2017 and Camino hacia tu Salud on Saturday, November 11, 2017. See the attached list of community events for details regarding these two and other events in 2017.

Operations Committee: Curtis Bellard, Co-Chair, reported on the following:
2017 Council Training Topics: See the revised list of 2017 Council Training Topics.

Updated/Revised Council Policies: **Motion #3:** *approve the attached, updated/revised Ryan White Planning Council policies (no changes recommended, only updates to document names and dates):*

- *400.03 Process for Approving the Council Support Budget*
- *800.01 Conflict of Interest*
- *1000.01 Grievance*

Motion Carried. Abstention: Noble.

2017 Cross Committee Training Evaluation: See the attached evaluation of the 2017 Cross Committee training.

Memorandum of Understanding with Part A Stakeholders: ***Motion #4:*** *make no changes to the Memorandum of Understanding with Part A Stakeholders.* **Motion Carried.** Abstention: Noble.

2018 Council Applicants: The committee interviewed four 2018 Council applicants in October and will be interviewing 2-3 additional candidates in November.

Election of 2018 Officers: See attached Slate of Nominees and Members Eligible to Run for Chair of the 2018 Ryan White Planning Council. ***Motion #5:*** *approve the attached slate of nominees who are running for officers for the 2018 Ryan White Planning Council. The nominees are: Cecilia Ross for Chair, Skeet Boyle for Vice Chair and Carol Suazo for Secretary.* **Motion Carried.**

Priority and Allocations Committee: Paul Grunenwald, Co-Chair, reported on the following:
Reports from RW Administrative Agent – Part A/MAI: See the attached:

- FY17 Procurement Report – Part A/MAI, dated 08/10/17

Martin said that the expected year-to-date figures need to be updated.

Reports from RW Administrative Agent – Part B/SS: See the attached reports:

- Response re: June 2017 allocation of State Services-Rebate funds
- FY17/18 Procurement – Part B, dated 10/10/17
- FY16/17 Procurement – DSHS State Services, dated 10/10/17 (see updated report in The Resource Group's monthly report)
- FY16/17 Health Insurance Assistance Program, dated 10/09/17
- FY16/17 Health Insurance Assistance Program, dated 09/12/17
- FY16/17 Health Insurance Assistance Program, dated 07/06/17

FY 2017 Ryan White Part A Service Category Reallocation: ***Motion #6:*** *Allocate $80,000 in unspent RW Part A funding to the Health Insurance Assistance Program.* **Motion carried.** Abstentions: Kelly, Lindstrom, Patel, Woods.

FY 2017 Ryan White Part A Carryover Funds: ***Motion #7:*** *If there are FY 2017 Ryan White Part A carryover funds, it is the intent of the committee to recommend allocating the full amount to Outpatient/Ambulatory Primary Medical Care.* **Motion carried**. Abstentions: David, Kelly, Lindstrom, Noble, Patel, Perez, Sierra, Woods.

FY 2017 Unspent Funds: ***Motion #8:*** *In the final quarter of the FY 2017 Ryan White Part A, Part B and State Services grant years, after implementing the year end Council-approved reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, Ryan White Grant Administration (RWGA) may reallocate any remaining unspent funds as necessary to ensure the Houston EMA has less than 5% unspent Formula funds and no unspent Supplemental funds. The Resource Group (TRG) may reallocate any remaining unspent funds as necessary to ensure no funds are returned to the Texas Department of State Health Services. RWGA and TRG must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting.* **Motion carried**. Abstention: Sierra.

Quarterly Committee Report: See the attached 2017 Quarterly Committee Report.

Positive Connections Ad Hoc Committee: Steven Vargas, Co-Chair, reported on the following:
2017 Positive Links Composition of Study Group: Committee members agreed by consensus That the number of people that will be enrolled in the 2017 Positive Links study group will be 50. Between November 1, 2017 and February 28, 2018, enrollees will be limited to black or Hispanic HIV-positive individuals since the project will be funded with Minority AIDS Initiative dollars during that timeframe. The goal of the project will be to improve retention in care among minority populations and that those considered for enrollment in the study will come from provider referrals.

Motion #9: *Eligibility for the 2017 Positive Links study group will be as simple as possible, as long as it meets the funding criteria. Regarding the enrollment process, the implementation site is encouraged to give priority to the special populations designated in the 2017 Comprehensive Plan, which are: youth aged 13-24, homeless, incarcerated/recently released, people who inject drugs, men who have sex with men, transgender and gender non-conforming, women of color and aged 50 years and older.* **Motion carried**. Abstention: Sierra.

Committee Meeting Dates: The next Committee meeting will be at 12 noon on Monday, November 13, 2017.

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

Report from Ryan White Grant Administration: Heather Keizman, Project Manager, summarized the attached report.

Report from The Resource Group: Sha'Terra Johnson-Fairly, Health Planner, summarized the attached report.

Medical Updates: Patel submitted the attached article about HIV and Smoking. Johnson-Fairly said that the state has a tool to help with smoking cessation for PLWH.

Community Prevention Group (CPG): Kelly said they have two new members and are still taking applications. The next meeting will be at 3 pm on November 16, 2017 at the West End Multi-Service Center located at 170 Heights Boulevard.

Updates from Task Forces
African American: Johnson-Fairley said they met this morning because tomorrow is Veteran's Day. They are having a Beat the Street outreach event for World AIDS Day. Elections will be held at the next meeting on December 8th.

Latino: Sierra said they are having a health fair in Denver Harbor on December 11 from 10am to 2pm.

MSM: Vargas said they will be doing their monthly outreach at the usual spot.

Transgender: Santibanez said they are still not being recognized as a population so no data is collected.

Hepatitis C: Vargas submitted the attached report.

HIV and Aging Coalition: Bruce Turner said that at the last meeting they had a great presentation on *Nostalgia and the Brain* from a health care provider at St. Joseph Hospital. The next meeting will be the annual Christmas party which will take place on December 2, 2017.

Positive Women's Network (PWN): See attached flyer.

END HIV Houston: Vargas said that the workgroup meetings have started up again. The End HIV plan was presented to the Mayor's Hispanic Advisory Council..

Texas HIV Medication Advisory Committee: Vargas said that the meeting in December has been cancelled. They will be meeting in January about the HCV program.

Texas HIV Syndicate: Harbolt said they met in October and a large part of it was about creating the End HIV plan for the state.

Legislative Updates: Kelly said that the open enrollment period has been moved back to mid-December so it is a much shorter timeframe this year and the advertising budget was cut drastically so please spread the word.

Texans Living with HIV Network: Murray said there will be a conference call tonight to work on the membership process.

Texas Black Women's Initiative: Johnson-Fairley said they tested over 60 students at Prairie View A&M and did condom, female condom and dental dam demonstrations.

Announcements: Vargas said that the Positive Women's Network is inclusive of Trans women. Kelly said a lot of PLWH have been removed from social security and need help with resumes and finding employment. Boyle said that St. Johns' is still distributing supplies for Harvey relief. Ross said that the Houston Housing and Community Development Department invited the Council to serve on their 2017-2019 Community Development Advisory Council (CDAC). She has appointed Johnny Deal to be our representative.

Adjournment: The meeting was adjourned at 1:31 p.m.

Respectfully submitted,

_________________________________ _____________________

Victoria Williams, Director Date

Draft Certified by
Council Chair: ___________________________ Date ________________

Final Approval by
Council Chair: ___________________________ Date ________________

Council Voting Records for November 9, 2017

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Policies 400.03, 280.01, 1000.01 **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Cecilia Ross, Chair				C				C				C
Carol Suazo, Secretary		X				X				X		
Connie Barnes		X						X		X		
Curtis Bellard		X						X		X		
Skeet Boyle		X						X		X		
Bianca Burley ja 12:09 pm	X				X					X		
Amber David		X				X				X		
Johnny Deal		X				X				X		
Paul Grunenwald ja 12:11 pm	X				X					X		
Angela F. Hawkins ja 12:12 pm	X				X					X		
Denis Kelly		X				X				X		
Peta-gay Ledbetter		X				X				X		
Tom Lindstrom		X						X		X		
Rodney Mills		X				X				X		
Allen Murray		X				X				X		
Robert Noble		X						X				X
Shital Patel ja 12:09 pm	X				X					X		
Krystal Perez		X				X				X		
John Poole ja 12:13 pm	X				X					X		
Tana Pradia		X				X				X		

	Motion #1 Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Policies 400.03, 280.01, 1000.01 **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Viviana Santibanez		X				X				X		
Gloria Sierra		X						X		X		
Isis Torrente		X				X				X		
Steven Vargas		X				X				X		
Larry Woods		X						X		X		
MEMBERS ABSENT												
Ted Artiaga												
David Benson												
Ella Collins-Nelson												
Evelio Salinas Escamilla												
Herman Finley												
Tracy Gorden												
Arlene Johnson												
J. Hoxi Jones												
Osaro Mgbere												
Nancy Miertschin												
Teresa Pruitt												
Venita Ray												

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MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Cecilia Ross, Chair				C				C				C
Carol Suazo, Secretary		X				X				X		
Connie Barnes		X				X				X		
Curtis Bellard		X				X				X		
Skeet Boyle		X				X				X		
Bianca Burley		X				X				X		
Amber David		X				X				X		
Johnny Deal		X				X				X		
Paul Grunenwald		X				X				X		
Angela F. Hawkins		X				X				X		
Denis Kelly		X				X						X
Peta-gay Ledbetter		X				X				X		
Tom Lindstrom		X				X						X
Rodney Mills		X				X				X		
Allen Murray		X				X				X		
Robert Noble				X		X				X		
Shital Patel		X				X						X
Krystal Perez		X				X				X		
John Poole		X				X				X		
Tana Pradia		X				X				X		

	Motion #4 Part A MOU **Carried**				**Motion #5** Slate of Nominees **Carried**				**Motion #6** FY17 Part A Reallocation **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Viviana Santibanez		X				X				X		
Gloria Sierra		X				X				X		
Isis Torrente		X				X				X		
Steven Vargas		X				X				X		
Larry Woods		X				X						X
MEMBERS ABSENT												
Ted Artiaga												
David Benson												
Ella Collins-Nelson												
Evelio Salinas Escamilla												
Herman Finley												
Tracy Gorden												
Arlene Johnson												
J. Hoxi Jones												
Osaro Mgbere												
Nancy Miertschin												
Teresa Pruitt												
Venita Ray												

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MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Cecilia Ross, Chair				C				C				C
Carol Suazo, Secretary		X				X				X		
Connie Barnes		X				X				X		
Curtis Bellard		X				X				X		
Skeet Boyle		X				X				X		
Bianca Burley		X				X				X		
Amber David		X						X		X		
Johnny Deal		X				X				X		
Paul Grunenwald		X				X				X		
Angela F. Hawkins		X				X				X		
Denis Kelly		X						X		X		
Peta-gay Ledbetter		X				X				X		
Tom Lindstrom		X						X		X		
Rodney Mills		X				X				X		
Allen Murray		X				X				X		
Robert Noble		X						X		X		
Shital Patel		X						X		X		
Krystal Perez		X						X		X		
John Poole		X				X				X		
Tana Pradia		X				X				X		

	Motion #7 FY17 Part A Carryover Funds **Carried**				**Motion #8** FY17 Part A Unspent Funds **Carried**				**Motion #9** 2017 Positive Links study group **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Viviana Santibanez		X				X				X		
Gloria Sierra				X				X				X
Isis Torrente		X				X				X		
Steven Vargas		X				X				X		
Larry Woods				X		X				X		
MEMBERS ABSENT												
Ted Artiaga												
David Benson												
Ella Collins-Nelson												
Evelio Salinas Escamilla												
Herman Finley												
Tracy Gorden												
Arlene Johnson												
J. Hoxi Jones												
Osaro Mgbere												
Nancy Miertschin												
Teresa Pruitt												
Venita Ray												

Comprehensive HIV Planning Committee Report

Participate in the Houston Area Out of Care Special Study

If you are living with HIV, and have had at least two periods of 12 months or longer when you did not get HIV medical care, we want to hear about your experience!

Your answers are 100% anonymous. Participation in the study consists of a friendly 30-35 minute interview about your experiences leaving and getting back in to HIV care; we will provide a gift card and a meal for your time.

Our hope is that this study will generate several recommendations to enhance the Houston HIV system to help keep people healthy and in care.

To see if you qualify to participate in this study, call or email our office:

Phone: (713) 572-3724

Fax: (713) 572-3740

Email: Amber.Harbolt@cjo.hctx.net

(Put "Special Study" in the subject line)

*This study ends **January 31, 2018** and gift cards are limited, so act soon!*

If you have any questions about the study, the Ryan White Planning Council, or how you can be involved in planning HIV services in the Houston Area, please give us a call or send us an email. We would love to hear from you!

Houston Area Ryan White Planning Council Office of Support
2223 West Loop South, Suite 240
Houston, Texas 77027
Phone: (713) 572-3724 Fax: (713) 572-3740
www.rwpcHouston.org

Participe en el Estudio especial fuera de atención del Área de Houston

Si vive con VIH, y ha tenido por lo menos dos periodos de 12 meses o más en los que no obtuvo cuidado médico para VIH, ¡queremos escuchar sobre su experiencia!

Sus respuestas son 100% anónimas. La participación en el estudio consiste en una entrevista amistosa de 30 a 35 minutos sobre sus experiencias al dejar y regresar a los cuidado de VIH; le proporcionaremos una tarjeta de regalo y una comida por su tiempo

Nuestra esperanza es que nuestro estudio genere varias recomendaciones para mejorar el sistema de VIH de Houston para ayudar a las personas a mantenerse saludables y bajo atención.

Para saber si califica para participar en este estudio, llame o envíe un email a nuestra oficina:

Teléfono: (713) 572-3724
Fax: (713) 572-3740
Email: Amber.Harbolt@cjo.hctx.net
(Escriba "*Special Study*" en la línea de asunto)

*Este estudio finaliza el **31 de enero de 2018** y las tarjetas de regalo son limitadas, ¡actúe pronto!*

Si tiene cualquier pregunta sobre el estudio, sobre Ryan White Planning Council, o sobre cómo se puede involucrar en la planeación de servicios de VIH en el Área de Houston, por favor llámenos o envíenos un email. ¡Nos encantar escucharlo!

Oficina de Soporte de Ryan White Planning Council del Área de Houston
2223 West Loop South, Suite 240
Houston, Texas 77027
Teléfono: (713) 572-3724 Fax: (713) 572-3740
www.rwpcHouston.org

Quality Improvement Committee Report

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

FY 2017 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
1	Outpatient/Ambulatory Primary Care	9,795,737	50,000	53,425	0	0	9,899,162	47.92%	9,899,162	0		3,249,625	33%	58%
1.a	Primary Care - Public Clinic (a)	3,643,839	0	0	0		3,643,839	17.64%	3,643,839	0	3/1/2017	$543,297	15%	25%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	17,809	0		958,256	4.64%	958,256	0	3/1/2017	$734,807	77%	58%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	17,808	0		804,232	3.89%	804,232	0	3/1/2017	$547,381	68%	58%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,038,843	0	17,808	0		1,056,651	5.12%	1,056,651	0	3/1/2017	$350,174	33%	58%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,166,658	0	0	0		1,166,658	5.65%	1,166,658	0	3/1/2017	$584,571	50%	58%
1.f	Primary Care - Women at Public Clinic (a)	1,902,089	0	0			1,902,089	9.21%	1,902,089	0	3/1/2017	$247,740	13%	25%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2017	$8,100	52%	58%
1.h	Vision	302,000	50,000	0	0		352,000	1.70%	352,000	0	3/1/2017	$233,555	66%	58%
2	Medical Case Management	2,215,702	0	227,500	0	0	2,443,202	11.83%	2,443,202	0		1,079,909	44%	58%
2.a	Clinical Case Management	488,656	0	115,000	0		603,656	2.92%	603,656	0	3/1/2017	$306,125	51%	58%
2.b	Med CM - Public Clinic (a)	162,622	0	0	0		162,622	0.79%	162,622	0	3/1/2017	$32,784	20%	25%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	37,500	0		358,570	1.74%	358,570	0	3/1/2017	$273,789	76%	58%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	37,500	0		358,572	1.74%	358,572	0	3/1/2017	$144,029	40%	58%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	37,500	0		144,747	0.70%	144,747	0	3/1/2017	$64,713	45%	58%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.69%	348,760	0	3/1/2017	$110,356	32%	58%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.87%	180,311	0	3/1/2017	$18,314	10%	25%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.77%	160,051	0	3/1/2017	$73,529	46%	58%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.39%	80,025	0	3/1/2017	$50,026	63%	58%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.22%	45,888	0	3/1/2017	$6,245	14%	25%
3	Local Pharmacy Assistance Program (a) (e)	2,384,796	0	30,000	0	0	2,414,796	11.69%	2,414,796	0	3/1/2017	$1,848,312	77%	58%
4	Oral Health	166,404	0	29,717	0	0	196,121	0.95%	196,121	0	3/1/2017	110,300	56%	58%
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	29,717			196,121	0.95%	196,121	0	3/1/2017	$110,300	56%	58%
5	Mental Health Services (c)	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
6	Health Insurance (c)	1,294,551	0	0	0	0	1,294,551	6.27%	1,294,551	0	3/1/2017	$837,423	65%	58%
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	0.22%	45,677	0	3/1/2017	$30,413	67%	58%
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	10,000	0	0	351,395	1.70%	351,395	0	3/1/2017	$203,448	58%	58%
11	Hospice Services	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
12	Outreach Services	490,000	-70,000				420,000	2.03%	420,000	0	7/1/2017	$0	0%	58%
13	Non-Medical Case Management	1,231,002	0	14,000	0	0	1,245,002	6.03%	1,245,002	0		668,853	54%	58%
13.a	Service Linkage targeted to Youth	110,793		0			110,793	0.54%	110,793	0	3/1/2017	$168,306	152%	58%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			0		100,000	0.48%	100,000	0	3/1/2017	$40,514	41%	58%
13.c	Service Linkage at Public Clinic (a)	427,000		0	0		427,000	2.07%	427,000	0	3/1/2017	$0	0%	25%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		14,000	0		607,209	2.94%	607,209	0	3/1/2017	$460,033	76%	58%
14	Medical Transportation	527,362	-45,275	30,000	0	0	512,087	2.48%	379,865	132,222		208,820	55%	58%
14.a	Medical Transportation services targeted to Urban	252,680	0	15,000	0		267,680	1.30%	267,680	0	3/1/2017	$168,306	63%	58%
14.b	Medical Transportation services targeted to Rural	97,185	0	15,000	0		112,185	0.54%	112,185	0	3/1/2017	$40,514	36%	58%
14.c	Transportation vouchering (bus passes & gas cards)	177,497	-45,275	0	0		132,222	0.64%	0	132,222	3/1/2017	$0	#DIV/0!	0%
15	Linguistic Services (c)	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
16	Other Professional Services	125,000	-125,000	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
17	Emergency Financial Assistance	0		50,000			50,000	0.24%	0	50,000	NA		0%	0%
18	Referral for Health Care and Support Services	0					0	0.00%	0	0	NA		0%	0%
	Total Service Dollars	18,617,626	-190,275	444,642	0	0	18,871,993	89.09%	18,689,771	182,222		8,237,102	44%	58%
	Grant Administration	1,658,827	16,220	0	0	0	1,675,047	8.11%	1,675,047	0	N/A	1,324,318	79%	58%

FY 2017 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
BER27517	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.55%	1,146,388	0	N/A	$1,080,632	94%	58%
PC	RWPC Support*	512,439	16,220		0	0	528,659	2.56%	528,659	0	N/A	243,686	46%	58%
BER27521	**Quality Management**	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.40%**	**495,000**	**0**	**N/A**	**$478**	**0%**	**58%**
		20,771,453	**-174,055**	**444,642**	**0**	**0**	**21,042,040**	**99.59%**	**20,859,818**	**182,222**		**9,561,898**	**45%**	**58%**
								Unallocated	Unobligated					
	Part A Grant Award:	**20,656,176**	***Carry Over:***	**0**		***Total Part A:***	**20,656,176**	**444,642**	**182,222**					

	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)	**16,244,262**	**50,000**	**350,642**	**0**	**0**	**16,644,904**	**90.45%**	**16,644,904**	**90.45%**
Non-Core (may not exceed 25% of total service dollars)	**1,883,364**	**-170,275**	**44,000**	**0**	**0**	**1,757,089**	**9.55%**	**1,757,089**	**9.55%**
Total Service Dollars (does not include Admin and QM)	**18,127,626**	**-120,275**	**394,642**	**0**	**0**	**18,401,993**		**18,401,993**	
Total Admin (must be ≤ 10% of total Part A + MAI)	**1,658,827**	**16,220**	**0**	**0**	**0**	**1,675,047**	**8.11%**		
Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.40%**		

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**	**2,057,949**	**59,936**	**233,750**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**		1,197,350	58%	25%
1.b (MAI)	Primary Care - CBO Targeted to African American	1,040,245	29,968	116,875	0	0	1,187,088	50.48%	1,040,245	146,843	3/1/2017	$679,800	65%	25%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	1,017,704	29,968	116,875	0	0	1,164,547	49.52%	1,017,704	146,843	3/1/2017	$517,550	51%	25%
17	**Emergency Financial Assistance**	0	0	50,000			50,000	2.13%	0	50,000			#DIV/0!	0%
18	**Referral for Health Care and Support Services**	0	0	347,746			347,746	14.79%	0	347,746			#DIV/0!	0%
	Total MAI Service Funds	**2,057,949**	**59,936**	**631,496**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**		**1,197,350**	**58%**	**25%**
	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%**
BED 27816	**Total MAI Funds**	**2,057,949**	**59,936**	**631,496**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**		**1,197,350**	**58%**	**25%**
	MAI Grant Award	**2,117,885**	***Carry Over:***	**0**		***Total MAI:***	**2,117,885**							
	Combined Part A and MAI Orginial Allocation Total	**22,829,402**												

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

FY 2016 Ryan White Part A and MAI Service Utilization Report

SUR - 2nd Quarter Cumulative (3/1-8/31)																		
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**4,964**	**74%**	**26%**	**100%**	**48%**	**15%**	**2%**	**35%**	**0%**	**1%**	**5%**	**25%**	**27%**	**14%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,360	69%	31%	100%	51%	10%	2%	37%	0%	0%	3%	18%	27%	15%	35%	3%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,051	70%	30%	100%	98%	0%	1%	0%	0%	1%	10%	39%	26%	10%	15%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	778	85%	15%	100%	0%	0%	0%	100%	0%	1%	6%	29%	32%	14%	18%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	459	90%	10%	100%	0%	88%	11%	1%	0%	0%	3%	26%	23%	17%	28%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	419	70%	30%	100%	42%	27%	3%	29%	0%	0%	7%	28%	27%	15%	22%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	739	0%	100%	100%	62%	8%	1%	29%	0%	0%	2%	14%	32%	17%	32%	4%
1.g	Primary Care - Pediatric (a)	7	8	75%	25%	100%	75%	13%	0%	13%	38%	50%	13%	0%	0%	0%	0%	0%
1.h	Vision	1,600	944	74%	26%	100%	48%	13%	2%	37%	0%	0%	4%	24%	24%	15%	30%	3%
2	**Medical Case Management (f)**	**3,075**	**2,814**															
2.a	Clinical Case Management	600	637	74%	26%	100%	61%	22%	2%	15%	0%	1%	6%	29%	20%	12%	28%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	337	96%	4%	100%	55%	12%	3%	30%	0%	3%	18%	20%	20%	11%	27%	2%
2.c	Med CM - Targeted to AA (a)	550	1,002	69%	31%	100%	99%	0%	1%	0%	0%	1%	8%	34%	26%	12%	18%	1%
2.d	Med CM - Targeted to H/L(a)	550	497	88%	12%	100%	0%	0%	0%	100%	0%	1%	7%	33%	31%	12%	15%	1%
2.e	Med CM - Targeted to White and/or MSM (a)	260	200	87%	14%	100%	0%	88%	12%	1%	0%	0%	4%	22%	22%	20%	29%	4%
2.f	Med CM - Targeted to Rural (a)	150	387	69%	31%	100%	46%	25%	3%	26%	0%	1%	6%	23%	25%	14%	29%	3%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	142	0%	100%	100%	57%	10%	3%	30%	0%	2%	10%	14%	32%	11%	25%	5%
2.h	Med CM - Targeted to Pedi (a)	125	67	49%	51%	100%	78%	7%	0%	15%	52%	42%	6%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	114	96%	4%	100%	72%	20%	0%	8%	0%	0%	0%	2%	4%	4%	71%	20%
2.j	Med CM - Targeted to Youth	120	68	99%	1%	100%	60%	6%	1%	32%	0%	13%	87%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**2,858**	**78%**	**22%**	**100%**	**47%**	**16%**	**2%**	**35%**	**0%**	**0%**	**5%**	**29%**	**29%**	**14%**	**21%**	**1%**
4	**Oral Health**	**200**	**170**	**65%**	**35%**	**100%**	**35%**	**36%**	**2%**	**26%**	**0%**	**1%**	**4%**	**22%**	**28%**	**10%**	**33%**	**2%**
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
4.b	Oral Health - Rural Target	200	170	65%	35%	100%	35%	36%	2%	26%	0%	1%	4%	22%	28%	10%	33%	2%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**711**	**81%**	**19%**	**100%**	**40%**	**32%**	**3%**	**25%**	**0%**	**0%**	**2%**	**13%**	**20%**	**16%**	**42%**	**6%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**11**	**100%**	**0%**	**100%**	**27%**	**45%**	**0%**	**27%**	**0%**	**0%**	**0%**	**18%**	**45%**	**9%**	**27%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**348**	**77%**	**23%**	**100%**	**41%**	**21%**	**4%**	**34%**	**0%**	**0%**	**0%**	**9%**	**16%**	**21%**	**45%**	**8%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**NA**	**5**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
13	**Non-Medical Case Management**	**7,045**	**3,658**															
13.a	Service Linkage Targeted to Youth	320	93	81%	19%	100%	58%	10%	3%	29%	0%	14%	86%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	86	66%	34%	100%	57%	6%	1%	36%	0%	0%	0%	42%	19%	12%	24%	3%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	1,638	68%	32%	100%	63%	11%	1%	25%	0%	0%	0%	18%	24%	14%	40%	4%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	1,841	78%	22%	100%	50%	15%	2%	33%	2%	1%	7%	31%	23%	13%	22%	2%
14	**Transportation**	**2,850**	**1,270**															
14.a	Transportation Services - Urban	170	173	67%	33%	100%	55%	11%	2%	31%	0%	1%	9%	28%	18%	10%	29%	5%
14.b	Transportation Services - Rural	130	39	77%	23%	100%	38%	33%	0%	28%	0%	0%	8%	26%	23%	8%	31%	5%
14.c	Transportation vouchering	2,550	1,058															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Other Professional Services (e)**	**NA**	**NA**															
17	**Emergency Financial Assistance (e)**	**NA**	**NA**															
18	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**11,657**	**9,142**	**74%**	**26%**	**100%**	**52%**	**16%**	**2%**	**31%**	**1%**	**1%**	**5%**	**23%**	**24%**	**13%**	**30%**	**3%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 17 App) (b)		**NA**	**22,830**	**74%**	**26%**	**100%**	**49%**	**23%**	**3%**	**25%**	**0%**	**6%**		**18%**	**27%**	**30%**	**18%**	
***11,657** clients to be served is based on the number of unduplicated clients served in FY 2016 (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	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	954	73%	27%	100%	99%	0%	1%	0%	0%	1%	10%	38%	26%	10%	14%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	671	86%	14%	100%	0%	0%	0%	100%	0%	1%	6%	33%	30%	13%	16%	1%

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	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**581**	**77%**	**23%**	**100%**	**55%**	**13%**	**2%**	**29%**	**0%**	**2%**	**8%**	**35%**	**27%**	**11%**	**16%**	**2%**
2	**LPAP**	**1,200**	**250**	**81%**	**19%**	**100%**	**53%**	**18%**	**1%**	**28%**	**0%**	**2%**	**6%**	**38%**	**29%**	**12%**	**13%**	**0%**
3.a	Clinical Case Management	400	64	91%	9%	100%	48%	25%	2%	25%	0%	3%	8%	41%	16%	14%	19%	0%
3.b-3.h	Medical Case Management	1,600	344	77%	23%	100%	54%	13%	3%	30%	0%	3%	10%	31%	27%	10%	16%	2%
3.i	Medical Case Manangement - Targeted to Veterans	60	31	97%	3%	100%	65%	23%	0%	13%	0%	0%	0%	3%	3%	3%	65%	26%
4	**Oral Health**	**40**	**10**	**40%**	**60%**	**100%**	**20%**	**40%**	**0%**	**40%**	**0%**	**0%**	**20%**	**10%**	**30%**	**10%**	**30%**	**0%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**842**	**75%**	**25%**	**100%**	**56%**	**14%**	**2%**	**28%**	**1%**	**1%**	**7%**	**31%**	**25%**	**12%**	**21%**	**2%**
12.b	**Service Linkage at Testing Sites**	**260**	**25**	**72%**	**28%**	**100%**	**44%**	**8%**	**0%**	**48%**	**0%**	**0%**	**4%**	**68%**	**16%**	**4%**	**8%**	**0%**

Footnotes:

(a) Bundled Category
(b) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(d) Funded by Part B and/or State Services
(e) Not funded in FY 2017

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1718 Ryan White Part B
Procurement Report
April 1, 2017 - March 31, 2018

Reflects spending through August 2017

Spending Target: 42%

Revised 10/10/2017

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 ***	$2,370,346	71%	($34,781)	$2,335,565	71%	4/1/2017	$642,401	27%
7	Health Insurance Premiums and Cost Sharing*,*	$726,885	22%	($16,122)	$710,763	22%	4/1/2017	$536,637	74%
9	Home and Community Based Health Services**	$232,000	7%	($3,840)	$228,160	7%	4/1/2017	$47,024	20%
	Total Houston HSDA	3,329,231	100%	($54,743)	$3,274,488	100%		1,226,062	37%

* The difference in the allocation is made up in SS-R funds

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: Part A 02/29/17, Part B 03/31/17, State Services 8/31/17

*** One agency was short a dentist, but has hired a replacement and spending should increase

**** Attendance has been low over the summer, but an increase of need has began and believe it will continue.

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 August 2017

Spending Target: 100%

Revised 10/10/2017

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	$222,165	74%
7	Health Insurance Premiums and Cost Sharing**	$1,043,312	53%		$1,043,312	53%	9/1/2016	$1,064,453	102%
9	Hospice **	$414,832	21%		$414,832	21%	9/1/2016	$343,640	83%
11	EIS - Incarcerated	$166,211	8%		$166,211	8%	9/1/2016	$153,632	92%
16	Linguistic Services	$48,000	2%		$48,000	2%	9/1/2016	$56,175	117%
	Total Houston HSDA	1,972,355	100%	$0	$1,972,355	100%		1,840,065	93%

* Service utilization is lagging

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: Part A 02/29/17, Part B 03/31/17, State Services 8/31/17

** The agency has seen a drop in clients and is currently performing outreach to increase spending

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-08/31/2017

Revised: 10/9/2017

Request by Type	Assisted			NOT Assisted		
	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	1732	$152,169.45	664			*0*
Medical Deductible	326	$75,531.03	209			*0*
Medical Premium	7108	$2,439,693.44	961			*0*
Pharmacy Co-Payment	5232	$496,687.66	1423			*0*
APTC Tax Liability	1	$213.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	15	$11,886.21	9	*NA*	*NA*	*NA*
Totals:	14414	$3,152,408.37	3267	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-07/31/2017

Revised: 9/12/2017

	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	1442	$126,012.45	602			*0*
Medical Deductible	326	$75,531.03	209			*0*
Medical Premium	6573	$2,240,165.83	952			*0*
Pharmacy Co-Payment	4791	$464,054.73	1385			*0*
APTC Tax Liability	1	$213.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	15	$11,375.21	9	*NA*	*NA*	*NA*
Totals:	13148	$2,894,601.83	3158	0	$0.00	

Comments: This report represents services provided under all grants.

Recommendations from the
Ryan White Planning Council

FY 2017-2018 Houston EMA Ryan White Part A/B
Standards of care for HIV Services

See the attached:

2017 Comprehensive Plan Activities
Affected Community Committee
Consumer Feedback
Community Workgroup

No recommended changes for the 2017-2018
Performance Measures

2017 Comprehensive Plan Activities Regarding Standards of Care

(Approved by the Quality Improvement Committee on 11/16/17)

1. Revise case management, service linkage, and outreach services standards of care (SOC) and policies to incorporate warm handoff protocols
    a. Recommendation: Refer to the US Health and Human Services Agency for Healthcare Research and Quality Implementation Guide for Warm Handoff protocols, and incorporate the warm handoff steps and tools listed in the guide into case management, service linkage, and outreach services SOC and/or policies as applicable. Those steps are:
        i. Obtain leadership buy-in, and identify invested champions at the provider level to help guide implementation of warm handoffs.
        ii. Design workflows that accommodate warm handoffs.
        iii. Provide clinician, staff and volunteer training in warm handoffs and these adjustments to workflows within and between providers.
        iv. Make consumers and families aware of warm handoffs and their role through a handout or posted fact sheet.
        v. Assess incorporation of warm handoff procedures and workflows to address any barriers.

2. Design SOC ensuring follow-up contact with newly diagnosed consumers throughout the first year of diagnosis.
    a. Recommendation: Incorporate SOC for service linkage, case management, and/or outreach services (whichever is most relevant to the role) that staff will make a documented attempt to contact newly diagnosed Ryan White consumers at least once every 3 months during their first year of diagnosis to assist the consumer with becoming established in care.

3. Assess and adjust SOC and other relevant policies to ensure access to facilities and services for all people regardless of sexual orientation or gender identity.
    a. Recommendation: Revise all general and service-specific SOC regarding facilities used by consumers to ensure consumer-used facilities are accessible to all people, and explicitly accessible to people of all sexual orientations and gender identities.

Request that the Ryan White Administrative Agency provide an update on the status of the above recommendations before June 2017.

RECOMMENDATIONS

TO: Members, Quality Improvement Committee

FROM: Members, Affected Community Committee

DATE: Monday, October 23, 2017

RE: FY 2018 Standards of Care Recommendations

On Monday, October 23, 2017, the Ryan White Affected Community Committee hosted a consumer-only workgroup meeting to make recommendations regarding the proposed FY 2018 Standards of Care and Performance Measures. The following are recommendations that were made:

Motion: it was moved and seconded (Boyle/Moses) that the Affected Community Committee recommends that Ryan White funded service linkage workers receive training to: 1.) handle first things first (example: if a client does not have an ID, it will be difficult for them to access services); 2.) understand that service linkage workers are expected and required to help clients get ID's; and 3.) know how to help clients get ID's. **Motion was approved unanimously.**

Motion: it was moved and seconded (Kelly/Mills) that in lieu of one year paid experience working in HIV, nursing staff receive on the job training. **Motion was approved unanimously.**

Ryan White Grant Administration

Consumer Feedback for FY 2017 Standard of Care and Outcome Measures

General Standards

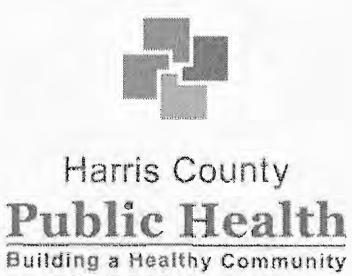
- **A question was raised about General Standard 1.4 and how the training was monitored.**

  Specifically cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers

  - **Participants were informed that RWGA Quality Analysts review and monitor employees' files regularly via annual site visits.**

- **A participant raised the question regarding General Standard 4.7 and proof of identification.**
  - **The question was centered specifically around proof of identification and the impact it may have on a cisgender person, recently released from incarceration or an undocumented individual who had not or could not due to resources obtain a valid ID.**
  - **Additional feedback included ensuring SLWs help and receive training in areas where they are lacking in services provided. (Ensure SLW and MCMs know about Project ID, Library cards, Positive 713).**
  - **Other areas should include being conscientious of clients' needs such as:**
    - **Informing the patient if the doctor has left**
    - **Calling the patient if the doctor needs to reschedule**
    - **SLW require additional training around services provided; ongoing training/cross-functional.**

- **Consumers raised the same training questions with Case Management standard 1.2 along with Medical Case Management along with the general standards above. Specifically, training for populations of homelessness and sensitivity to transgender issues as well.**



COMMUNITY WORKGROUP

SUMMARY OF CHANGES INCLUDE:
OUTREACH WORKER CATEGORY ADDED – PAGE 37
LPAP 2.2 PAGE 44

See following pages

Note: All stigmatizing language will be removed

2017-2018 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A/B
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

Outreach Worker

Outreach Worker (OW) as defined by RWGA and described/designed by the RWPC is more of a hybrid role of 85% of a MCM and 15% of a SLW. The biggest difference between the case management categories is that OW are not required to remain at their desks and yet are expected to enter into the field in search of clients who are on the cusp of falling out of care.

1.0	**Staff Training**	
1.1	Qualifications/Training Minimum Qualifications – High School Diploma or GED; unlicensed community-based outreach worker. Six months of working with, caring for or exposure to PLWH A file will be maintained securely on each outreach worker. Supportive documentation of outreach worker credentials is maintained by the agency and in each outreach worker's secure file.	• Documentation of credentials and job description in outreach worker's file
1.2	Scope of Services The outreach worker services will include at a minimum reviewing and/or generating reports of up and coming appointments to determine if a client is missing or has missed 2 consecutive appointments, such as a lab and a follow up primary care appointment. Outreach worker will maintain the reports and highlight the dates of generation and bring a copy to monthly outreach worker meetings with RWGA. Maintenance of report should create and support the working process and support progress notes of calls made, emails sent and home visits made to clients.	• Review of reporting records indicates compliance
1.3	Ongoing Education/Training for Outreach Workers After the first year of employment in the case management system outreach worker will obtain the minimum number eleven meetings to ensure compliance with RWGA's standards and guidelines.	• Attendance sign-in sheets and/or certificates of completion are maintained by the agency
2.0	**Timeliness of Service/Documentation** Outreach workers are expected to provide a precursory assessment of the client's needs. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a medical case manager for a more intensive assessment of the client's needs as necessary. If the client's needs are merely that of transportation, the outreach worker will help the client obtain suitable transportation assistance. If the client is in need of additional medication, the outreach worker will assist with linking the client to an ADAP enrollment specialist in a clinic of the client's choice. The outreach worker	• Documentation of client's needs and progress notes will be maintained in client's files

	will document the needs of the client whether acute or minor and place in the client's file.	
2.1	Outreach Worker Assessment Reassessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager.	• Documentation in client record on the brief assessment form, signed and dated A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
3.0	**Supervision and Caseload**	•

3.1	Outreach Worker Supervision A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record

Local Pharmacy Assistance Program

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

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

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

Harris County
Public Health
Building a Healthy Community

2017-2018 Houston Eligible Metropolitan Area: Ryan White CARE Act Part A/B
Standards of Care For HIV Services
Ryan White Grant Administration Section
Harris County Public Health (HCPH)

TABLE OF CONTENTS

Introduction 2

General Standards 4

Service Specific Standards

Case Management (All Case Management Service Categories) 19

Clinical Case Management 23

Non-Medical Case Management (Service Linkage) 28

Medical Case Management 32

Health Insurance Assistance 37

Local Pharmacy Assistance Program 40

Medical Nutritional Supplements 43

Oral Health 45

Primary Medical Care 48

Substance Abuse Treatment 58

Transportation 62

Vision 69

Introduction

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

Purpose

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

Scope

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

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

Part A funded services

Combination of Parts A, B, and/or Services funding

Standards Development

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

Organization of the SOCs

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

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

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

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

GENERAL STANDARDS

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

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

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

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

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

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

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

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

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

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

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

<table>
<tr><td></td><td>The Agency will notify The Resource Group (TRG) or RWGA of the following information when a wait list must be created:
An explanation for the cessation of service; and
A plan for resumption of service. The Agency's plan must address:
• Action steps to be taken Agency to resolve the service shortfall; and
• Projected date that services will resume.

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

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

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

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

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

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

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

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 101 2013 Update, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. For cultural competency training only, Agency may request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.	• Certificates of completion for applicable trainings in the case manager's file • Sign-in sheets for agency based trainings maintained by Agency • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, case managers will successfully complete CAC training and maintain CAC certification by their Certificated Application Counselor Designated Organization employer. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance
1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	• Documentation of staff training
2.0	**Timeliness of Services**	

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

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

Clinical Case Management Services

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

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

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

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

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

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

Non-Medical Case Management Services (Service Linkage Worker)

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

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

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

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

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

Medical Case Management

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

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

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

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

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

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

Health Insurance Assistance

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

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

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

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

3.0	**Client Access.**	
3.1	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
3.2	Prioritization of Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and	• Review of agency's Policies & Procedures Manual indicates compliance.

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

Outreach Worker

Outreach Worker (OW) as defined by RWGA and described/designed by the RWPC is more of a hybrid role of 85% of a MCM and 15% of a SLW. The biggest difference between the case management categories is that OW are not required to remain at their desks and yet are expected to enter into the field in search of clients who are on the cusp of falling out of care.

1.0	**Staff Training**	
1.1	Qualifications/Training Minimum Qualifications – High School Diploma or GED; unlicensed community-based outreach worker. Six months of working with, caring for or exposure to PLWH A file will be maintained securely on each outreach worker. Supportive documentation of outreach worker credentials is maintained by the agency and in each outreach worker's secure file.	• Documentation of credentials and job description in outreach worker's file
1.2	Scope of Services The outreach worker services will include at a minimum reviewing and/or generating reports of up and coming appointments to determine if a client is missing or has missed 2 consecutive appointments, such as a lab and a follow up primary care appointment. Outreach worker will maintain the reports and highlight the dates of generation and bring a copy to monthly outreach worker meetings with RWGA. Maintenance of report should create and support the working process and support progress notes of calls made, emails sent and home visits made to clients.	• Review of reporting records indicates compliance
1.3	Ongoing Education/Training for Outreach Workers After the first year of employment in the case management system outreach worker will obtain the minimum number eleven meetings to ensure compliance with RWGA's standards and guidelines.	• Attendance sign-in sheets and/or certificates of completion are maintained by the agency
2.0	**Timeliness of Service/Documentation** Outreach workers are expected to provide a precursory assessment of the client's needs. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a medical case manager for a more intensive assessment of the client's needs as necessary. If the client's needs are merely that of transportation, the outreach worker will help the client obtain suitable transportation assistance. If the client is in need of additional medication, the outreach worker will assist with linking the client to an ADAP enrollment specialist in a clinic of the client's choice. The outreach worker	• Documentation of client's needs and progress notes will be maintained in client's files

	will document the needs of the client whether acute or minor and place in the client's file.	
2.1	<u>Outreach Worker Assessment</u> Reassessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager.	• Documentation in client record on the brief assessment form, signed and dated A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
3.0	**Supervision and Caseload**	•

3.1	<u>Outreach Worker Supervision</u> A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record

Local Pharmacy Assistance Program

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

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

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

Medical Nutritional Therapy/Supplements

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

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

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

Oral Health

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

1.0	**Staff HIV/AIDS knowledge is based on documented training.**	
1.1	Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV/AIDS is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
1.2	Experience – HIV/AIDS A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
2.2	Consultation for Treatment	• Documentation of communication in the client record

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

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

Primary Medical Care

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

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

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

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

	examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include: • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results • Resistance testing and co receptor tropism assays as clinically indicated • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care • Sexual history • Substance abuse history • Review of Systems	
1.7	Medical Records Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered • The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies)	• Documentation in client's record

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

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

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

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

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

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

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

Substance Abuse Services

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

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

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

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

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

Transportation Services

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

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

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

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

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

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

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

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

Vision Services

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

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

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

Appendix B

HIV Performance Measures

The following performance indicators are measured system wide to assess the impact of HIV services on the health status of the people living with HIV/AIDS in the Houston EMA. These indicators are based on current HHS Guidelines for HIV/AIDS health care and community input, and will be revised annually to reflect new directives.

Clinical Case Management

- A minimum of 75% of clients will utilize Part A/B/C/D primary care at least two or more times three months apart after accessing clinical case management
- Percent of clinical case management clients who utilized mental health services.
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- Percentage of clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year.
- Percent of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment
- Percent of clients who are homeless or unstably housed

Legal Services

- Change in the number of permanency planning cases completed over time
- 65% of completed SSI disability, insurance, public benefits and income-related cases will result in access to or continued access to benefits

Local Pharmacy Assistance

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Medical Case Management

- A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management
- Percent of medical case management clients who utilized mental health services.
- Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management.
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a

minimum of 60 days between medical visits

- Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- 60% of medical case management clients will have a medical case management care plan developed and/or updated two or more times in the measurement year.
- Percent of clients who are homeless or unstably housed

Medical Nutritional Supplements

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- 90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year

Oral Health

- 75% of oral health clients will have a dental and medical health history (initial or updated) at least once in the measurement year.
- 90% of oral health clients will have a dental treatment plan developed and/or updated at least once in the measurement year.
- 85% of oral health clients will receive oral health education at least once in the measurement year.
- 90% of oral health clients will have a periodontal screen or examination at least once in the measurement year.
- 60% of oral health clients will have a Phase 1 treatment plan that is completed within 12 months.
- 75% of diagnosed HIV/AIDS-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up.

Primary Medical Care

- 100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible client to receive an initial appointment to enroll in outpatient/ambulatory medical care
- Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible client to receive an appointment to receive outpatient/ambulatory medical care
- 90% of clients with HIV infection will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year
- Less than 20% of clients who have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care

- 80% of clients aged six months and older with a diagnosis of HIV/AIDS, will have at least two CD4 cell counts or percentages performed during the measurement year at least 3 months apart
- 100% of clients with a diagnosis of HIV/AIDS, will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis
- 100% of pregnant women with HIV infection will be prescribed antiretroviral therapy
- 75% percent of female clients with a diagnosis of HIV will receive cervical cancer screening in the last three years
- 55% of clients with HIV infection will complete the vaccination series for Hepatitis B
- 95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection
- 85% of clients with HIV infection will receive HIV risk counseling within the measurement year
- 95% of clients with a diagnosis of HIV will have been screened for substance abuse (alcohol and drugs) in the measurement year
- 90% of clients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and will have a fasting lipid panel during the measurement year
- Percent of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year
- 65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year.
- 85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year
- 75% of clients with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
- 95% of clients with HIV infection will have been screened for Hepatitis B virus infection status (ever)
- 65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR who reported previous receipt of an influenza immunization
- 95% of clients will be screened for clinical depression using a standardized tool and follow up plan documented.
- 90% of clients with HIV infection will have ever received pneumococcal vaccine
- 100% of clients will be screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
- 90% of clients with a diagnosis of HIV/AIDS will have a viral load test performed at least every six months during the measurement year
- 80% of clients for whom there is lab data in the CPCDMS will be virally suppressed

(<200)

- Percentage of clients 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
- 95% of clients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year
- Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- 85% of clients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year

Non-Medical Case Management/Service Linkage

- A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)
- Percent of clients who accessed primary medical care for the first time after accessing service linkage for the first time
- Number of days between first ever service linkage visit and first ever primary medical care visit (Mean, Median, &/or Mode)
- 60% of newly enrolled clients will have a medical visit in each of the 4-month periods of the measurement year

Substance Abuse

- A minimum of 70% of clients will utilize Part A/B/C/D primary medical care after accessing Part A funded substance abuse treatment services
- Change in the rate of program completion over time
- 55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Transportation

- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing Van Transportation services.
- 35% of clients will utilize Part A/B LPAP services after accessing Van Transportation services.
- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing Bus Pass services.
- A minimum of 20% of clients will utilize Part A/B LPAP services after accessing Bus Pass services.

- A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services.

Vision

- 75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve, or stay the same over time
- 100% of vision clients will have a vision and medical health history (initial or updated) at least once in the measurement year.
- 100% of vision clients will have a comprehensive eye examination at least once in the measurement year

Appendix C

Performance Improvement Goals for FY 2017

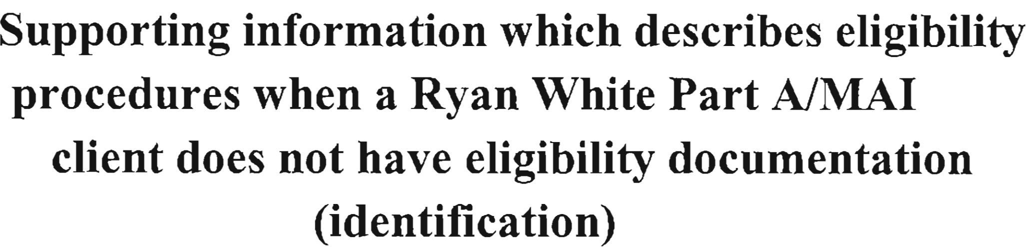
The following performance goals consist of process and outcome indicators and are based on US Department of Health and Human Services guidelines and areas identified for improvement from review of the Houston EMA FY 2015 chart review reports, outcomes and needs assessment data. National goals and Benchmarks being utilized for comparisons include Institute of Health Care Improvement (IHI) goals for HIV/AIDS care and the 2011 HIVQUAL Performance Data Report. Ryan White Part A funded providers are required to implement improvement projects that will facilitate the attainment of these system-wide goals.

Primary Medical Care

- 90% of clients with HIV infection will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year
- Fewer than 20% of clients will have more than a 6 month gap in medical care in the measurement year
- 95% of clients will be prescribed Antiretroviral Therapy (ART)
- 80% of all clients will be virally suppressed (<200)
- 80% of African-American clients who are retained in care will be virally suppressed (<200)
- 75% of eligible female clients will receive cervical cancer screening in the last three years

Non-Medical Case Management/Service Linkage

- 60% of newly enrolled clients will have a medical visit in each of the 4-month periods of the measurement year
- 60% of African-American clients, and youth aged 18-24, will have a medical visit in each of the 4-month periods of the measurement year



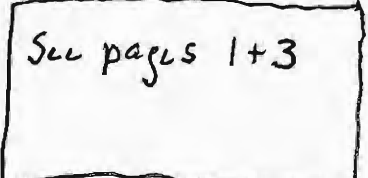
Supporting information which describes eligibility procedures when a Ryan White Part A/MAI client does not have eligibility documentation (identification)

See * on pages 1 and 3

Dated: 11/20/17

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

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080



HARRIS COUNTY PUBLIC HEALTH
RYAN WHITE GRANT ADMINISTRATION
POLICY AND PROCEDURE

ELIGIBILITY VERIFICATION –
RYAN WHITE PART A AND MEDICAID/MEDICARE OR THIRD PARTY

REVISED DATE: 02/17 Site Visit Guidelines 7.2, 7.3, 7.4, 7.5, 7.7

POLICY:

All persons seeking services must provide the following documentation in order to be eligible for services:

1. HIV+ diagnosis[1]
2. Verification of identity
3. Verification of current residency within Houston EMA
4. Verification of current household income
5. Verification of Health Insurance Coverage

PROCEDURES:

Duration of Eligibility: All documentation accepted during eligibility verification must be current. Per current HRSA/HAB National Monitoring Standards policy, a client's eligibility for services must be reassessed at least every six (6) months from the date the client's eligibility was established. Clients must update their eligibility at least once a year (i.e. every 12 months). The CPCDMS Client Verification form will display the eligibility expiration date. Proof of HIV+ diagnosis does not have an expiration date and does not need to be updated.

Agency may not deny services to Ryan White clients who are missing eligibility documentation other than proof of HIV+ status. Agency should allow client a reasonable amount of time to provide the missing eligibility documentation. Agencies may enter client encounters into the CPCDMS for billing up to 30 days beyond the client's eligibility expiration date for the record owning agency, and up to 60 days for the non-record owning agency. The record owning agency should update client's eligibility in CPCDMS within 30 days of expiration. For record owning agencies, if a client's eligibility is more than 30 days overdue (i.e. expired more than 30 days prior to the service date) encounters cannot be entered into the CPCDMS and must be tracked manually. Once eligibility is updated in the CPCDMS, the encounters may be entered into

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

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

CPCDMS and billed during the designated billing period. Eligibility documentation must be valid during service dates.

Once an agency's final Contractor Expense Report of the respective contract year has been submitted and processed for payment, no further encounters may be submitted for payment.

[1] For services available to non-HIV+ persons, documentation of the client's relationship to an HIV+ person and the HIV+ person's diagnosis must be provided.

In addition, as Ryan White is the payer of last resort for those services that are reimbursable by Medicaid/Medicare or third party, the files of clients receiving Medicaid/Medicare or third party eligible services must contain documentation of the agency's efforts to verify Medicaid/Medicare or third party eligibility at every visit or on a monthly basis. (In lieu of maintaining the information in individual client records, the agency may employ a mechanism that assures Medicaid/Medicare or third party verification at least monthly).

A. **HIV+ DIAGNOSIS (REQUIRED BY ALL AGENCIES)**

Acceptable documentation:

1. A computer-generated HIV+ lab test with the individual's name pre-printed. Examples are:
    - Antibody screening test {e.g. Reactive Enzyme Immunoassay (EIA) with confirmatory western blot or Indirect Immunofluorescence Assay test (IFA)} or
    - HIV Nucleic Acid (DNA or RNA) detection test {e.g. Polymerase Chain reaction (PCR), HIV p24 Antigen test, HIV Isolation (viral culture)} or
    - HIV Testing Medical Report on HDHHS letterhead
2. A statement or letter signed by a medical professional (acceptable signatories listed below) indicating that the individual is HIV+, including the individual's name and the phone number of the medical professional.
3. A medical progress note, hospital discharge paperwork, or other document signed by a medical professional (acceptable signatories listed below) indicating that the individual is HIV+, including the individual's name and the phone number of the medical professional.
4. An anonymous HIV test result containing identifying information sufficient to ensure a reasonable certainty as to the identity of the test subject, e.g. gender and date of birth (valid for only 60 days from the start of services at the agency).

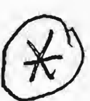
5. A Texas Department of Criminal Justice (TDJC) physician-completed Medical Certification Form (MCF)

Acceptable signatories:

- A licensed physician
- A licensed physician assistant
- A licensed nurse practitioner
- A registered nurse working under the supervision of a physician
- A licensed Master's level social worker (LMSW) working under the supervision of a physician
- An Advanced Practice Nurse

NOTE: Proof of HIV+ Diagnosis does not have an expiration date and does not need to be updated annually.

B. **VERIFICATION OF IDENTITY: (REQUIRED BY ALL AGENCIES)**



Acceptable documentation:

1. Texas Driver's License
2. Texas Identification Card
3. Texas Department of Corrections identification card
4. Employment badge with picture
5. Student ID with picture
6. U.S. immigration documents with picture
7. Credit card with picture
8. Metro picture ID
9. U.S. naturalization, citizenship, passport or other Federal documents with picture
10. Driver's license or identification card issued by another US state
11. A government-issued ID from a country other than the U.S.
12. Birth certificate (cannot be used by married women)
13. Social Security card
14. Medicaid/Medicare card
15. VA ID Card

The following documentation is acceptable only for undocumented and/or homeless clients and clients recently released from or referred by the Harris County jail:

- Letter on company letterhead from a case manager, social worker, counselor or other professional from another agency who has personally provided services to the client
- Letter on company letterhead from the Harris County jail.

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

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

C. **VERIFICATION OF CURRENT RESIDENCY WITHIN HOUSTON EMA:** *(Documentation required by record owning agency. CPCDMS client verification form accepted for non- record owning agency)*

Residency documentation for minors is required for a parent or guardian with whom the minor resides.

Acceptable residency documentation: (must be current)

- Client self-attestation (acceptable at every 6 month reassessment) of no change or self-attestation of change with acceptable documentation
- Residency and Income Affidavit (see sample forms)
- Valid copy of "CPCDMS Client Verification" form (Agencies Online who are NOT Record Owners)
- Current lease in the name of the client or listing the client as an occupant
- Current Property tax documents
- Current utility/phone/cable bill in the name of the client
- Current credit card bill in the name of the client
- Current letter on company letterhead signed by the director of a recognized group home, care home or transitional living facility
- Any type of current business correspondence with the client's name and address pre- printed, (e.g. auto registration, insurance, bank/brokerage statement, food stamp letter, Social Security letter, Medicaid letter/card)
- Current pay stub with address
- Supporter statement with address and valid signature by client supporter
- P.O. Box, along with another means to verify the address such as current utility bill or case manager's verification letter

The following documentation is acceptable only for undocumented and/or homeless clients:

- Agency temporary affidavit signed and dated by the client (valid for only *60 days* from the start of services at the agency)
- Letter on company letterhead from a case manager, social worker, counselor or other professional from another agency who has personally provided services to the client

An approved Request for Waiver is required for clients outside the Houston EMA.

D. **VERIFICATION OF CURRENT HOUSEHOLD INCOME:** *(Documentation required by record owning agency. CPCDMS client verification accepted for non-record owning agency)*

All clients must be screened for financial eligibility for Ryan White Part A funded services. Services should not be provided to clients whose gross household income

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

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

exceeds the cap established by the Ryan White Planning Council for each service category.[2]

Documentation of income must be provided for all members of the client's household.[3] Income documentation for minors is required for the parent(s) or guardian(s) with whom the minor resides.

Acceptable income documentation (must be current):

- Client self-attestation (acceptable at every 6 month reassessment) of no change or self-attestation of change with acceptable documentation
- Valid copy of "CPCDMS Client Verification" form (Agencies Online who are NOT Record Owners)
- Payroll stub/copy of payroll check/bank statement showing direct payroll deposit
- Letter from employer on company letterhead indicating weekly or monthly wages
- Unemployment benefits letter/copy of check
- IRS 1040 form (tax return)/W2 form/1099 form (Preferred)
- Social Security award letter
- VA benefits letter
- Private disability/pension letter on company letterhead
- Medicaid letter/Card
- Child or spousal support order with judge's signature and date
- Food Stamp and/or Temporary Assistance for Needy Families (TANF) award letter

The following documentation is acceptable only for clients claiming no income:

- Agency temporary affidavit signed and dated by the client (valid for only 60 days from initial service date)
- Residency and Income Affidavit (see sample forms)
- Proof of application for Social Security (valid for 6 months only)
- Client living off savings: bank/investment account statements from 3 consecutive months showing withdrawals for living expenses
- Client being supported by someone else: statement signed and dated by the supporter, which includes the amount and type of support (room only, room and board, cash assistance, etc.) and the supporter's phone number for verification[4]
- Homeless client: letter on company letterhead from a case manager, social worker, counselor or other professional from another agency who has personally provided services to the client

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

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

E. Verification of Health Insurance Coverage: Medicaid/Medicare or Third Party Eligibility Verification

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[2] See the US Dept. of Health and Human Services Poverty Guidelines for the current year and the "Ryan White Federal Poverty Guidelines" table.
[3] Refer to P&P for Determining Household Income
[4] Ryan White Grant Administration recommends using the supporter statement provided in this manual

The following service categories must provide verification of client ineligibility for Medicaid/ Medicare or third party coverage (to assure that Ryan White Part A is payer of last resort) at every visit or monthly (whichever is less frequent).

Medicaid/Medicare or Third Party Reimbursable Service Categories

- Primary Medical Care (including pediatric and women's services)
- Psychiatry
- Local Pharmacy Assistance Program (LPAP)
- Dental
- Substance Abuse Treatment
- Vision Services
- Transportation (Medicaid only)
- Case Management (Children up to 20 years old and

Acceptable documentation to verify Medicaid/Medicare or third party eligibility status:

- Client self-attestation (acceptable at every 6 month reassessment) of no change or self-attestation of change with acceptable documentation
- The preferred method for documenting insurance verification is printing the results and filing in client record or electronically in an organized and identifiable manner
- Verification of employment, i.e. payroll stub, copy of payroll check, bank statement showing direct payroll deposit, letter from employer on company letterhead indicating weekly or monthly wages no greater than 6 months old (to demonstrate Medicaid/Medicare or third party eligibility status)
- Medicaid/Medicare or third party rejection/denial letter covering the dates of service
- Medifax slips or other automated system (must be done at least monthly)

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

2223 West Loop South
Houston, Texas 77027
Tel: (713) 439-6000
Fax: (713) 439-6080

The following documentation is acceptable only for undocumented and/or homeless clients:

- Letter on company letterhead from a case manager, social worker, counselor or other professional (certifying Medicaid/Medicare or third party eligibility status) from another agency who has personally provided services to the client, stating that the client is undocumented and/or homeless.

The Ryan White Grant Administration Quality Analyst Team will, during site visits to agencies providing Medicaid/Medicare or third party reimbursable services, record the social security numbers of "reviewed" client records only. This measure is intended for the sole purpose of assuring that Ryan White Part A is the payer of last resort, as directed/dictated by The Health Resources & Services Administration (HRSA).

After the Medicaid/Medicare or third party eligibility status has been verified/established, all records of the Social Security Number are shredded. All references to a client will be made by the use of the established 11-character code.

Services rendered under Ryan White Part A for days on which a client was eligible for Medicaid/Medicare, or another third party payer will be recouped by Harris County.

The agency however, will not be cited for failing to use Ryan White as the payer of last resort if the above documentation showing the client is ineligible for Medicaid/Medicare or third party is in the client record at the time of the site visit.

Approved by Manager
DATE
HCPH – Ryan White Grant Administration

Standards of Care Report from Tasha Traylor

November 9, 2017

Health Insurance

Health Insurance Premium and Cost Sharing Assistance (HIA) for Low-Income Individuals Service Standard

HRSA Definition: Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services;
- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

Limitations:

HIA cannot be in the form of direct cash payments to clients.

HIA excludes plans that do not cover HIV-treatment drugs; specifically, the plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services.

Any cost associated with liability risk pools cannot be funded by Ryan White HIV/AIDS Program (RWHAP).

RWHAP funds cannot be used to cover costs associated with Social Security.

HIA funds may not be used to pay fines or tax obligations incurred by clients for not maintaining health insurance coverage required by the Affordable Care Act (ACA).

HIA funds may not be used to make out-of-pocket payments for inpatient hospitalization and emergency department care.

HIA funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.

HIA must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.

Services: The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes out-of-pocket costs such as premium payments, co-payments, coinsurance, and deductibles. Please refer to DSHS Policy #260.002 (Health Insurance Assistance) for further clarification and guidance.

The cost of insurance plans must be lower than the cost of providing health services through grant-supported direct delivery, including costs for participation in the ADAP (be "cost-effective").

HIA may be extended for job or employer-related health insurance coverage and plans on the individual and group market, including plans available through the federal Health Insurance Marketplace (Marketplace). HIA funds may also be used towards premiums and out-of-pocket payments on Medicare plans and supplemental insurance policies, as long as the primary purpose of the supplemental policy is to assist with HIV-related outpatient care.

Funds may be used for:

- Purchasing health insurance (both job or employer-related plans and plans on the individual and group market) that provides comprehensive primary care and pharmacy benefits for clients that provide a full range of HIV medications;
- Standalone dental insurance premiums and/or cost sharing assistance and oral health care services when provided in compliance with requirements described in PCN 16-02 including the FAQ;
- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection), deductibles, and co-insurance for medical and dental plans on behalf of the client;
- Providing funds to contribute to a client's Medicare Part D true out-of-pocked (TrOOP) costs; and/or
- Certain tax liabilities.

Program Guidance: Traditionally, RWHAP Parts funding support health insurance premiums and cost sharing assistance. The following TDSHS policies/standards and RWHAP Policy Change Notices (PCN) provide additional clarification for allowable uses of this service category:

- ***TDSHS Policy 260.002*** (Revised 11/2/2015): Health Insurance Assistance
- ***TDSHS HIV/STD Ryan White Part B Program Universal Standards:*** Health Insurance Premium and Cost Sharing Assistance
- ***PCN 07-05***: Program Part B ADAP Funds to Purchase Health Insurance;
- ***PCN 13-05***: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance;

- ***PCN 13-06***: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid;
- ***PCN 14-01*** (Revised 4/3/2015): Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act;
- ***PCN 16-02:*** Eligible Individuals & Allowable Uses of Funds and ***FAQ for Standalone Dental Insurance***.

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.

Part A

Health Insurance Assistance

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

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

Standard	Performance Measure	Part A	Part A Performance Measures are separate	
Health Insurance Plans: The agency must ensure that 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. This must be documented in the client's primary record.	Percentage of clients with documented evidence of health care coverage that includes at least one drug in each class of core ART from HHS treatment guidelines along with appropriate HIV OAHS as indicated in the client's primary record. Percentage of clients with documented evidence of insurance payments made to the vendor within five	**Staff/Training** Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required.	Client eligibility is assessed at initial intake from provider.	QA Team measures information in files. (Primary source of documentation.

Agencies will ensure payments are made directly to the health insurance vendor within five (5) business days of approved request.	(5) business days of the approved request.			
Co-payments, Premiums, Deductibles, and Co-insurance: Otherwise eligible clients with job or employer-based insurance coverage, Qualified Health Plans (QHP), or Medicaid plans, can be provided assistance to offset any cost-sharing programs may impose. Clients must be educated on the cost and their responsibilities to maintaining medical adherence. Education must be provided to clients specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP	Percentage of clients with documented evidence of education provided regarding reasonable expectations of assistance available through RWHAP Health Insurance to assist with healthcare coverage as indicated in the client's primary record.		• Materials for staff training and continuing education are on file • Staff interviews indicate compliance	•

can assist with to ensure healthcare coverage is maintained.				
Cost Sharing Education: Education is provided to clients, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. It must be evidenced in the client's primary record that the individual must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace. Clients who are not eligible for cost-sharing reductions (those under 100% FPL in Texas; those with incomes above 400% FPL; clients who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those	Percentage of clients with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record.	<u>Staff Experience</u> A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file	

who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the client's health care needs.				
Premium Tax Credits Education: Agencies have documented evidence in the client's primary record of the enrollment in a QHP in the Marketplace, as applicable to the individual (clients that are between 100-400% FPL without access to minimum essential coverage). Education provided to the client regarding tax credits and the requirement to file income tax returns must be documented in the client's primary record. Clients must be provided education on the importance of	Percentage of clients with documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.	**Client Eligibility** <u>Advance Premium Tax Credit Reconciliation</u> Agency will ensure all clients receiving assistance for Marketplace QHP premiums: • Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment • Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods • Submit prior year tax information no later than May 31st. Tax		

reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.		information must include: Federal Marketplace Form 1095-A IRS Form 8962 IRS Form 1040 (excludes 1040EZ) Reconciliation of APTC credits or liabilities		
Prescription Eyewear: Agency must keep documentation from physician stating that the eye condition is related to the client's HIV infection when HIA funds are used to cover co-pays for prescription eyewear.	Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV infection as indicated in the client's primary record.		• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance	QA team monitors files DSHS goes in to greater detail regarding vision criteria.
Medical Visits: Clients accessing health insurance premium and cost sharing assistance services are adherent with their HIV medical care and have documented evidence of attendance of HIV medical appointments in	For clients with applicable data in ARIES or other data system used at the provider location,[1] percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month	<u>Comprehensive Intake/Assessment</u> Agency performs a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to	• Review of client record	QA team monitors files

[1] For clients who use HIA for OAHS at RW-funded providers and therefore have visit and lab data in ARIES or other data system.

the client's primary record. Note: For clients who use HIA to enable their use of medical care outside of the RW system: HIA providers are required to maintain documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months.	measurement period with a minimum of 60 days between medical visits.. ***(HRSA HAB Measure)*** OR For clients who use HIA to enable their use of medical care outside of the RW system: Percentage of clients with documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months.	purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health insurance marketplace.		
Viral Suppression: Clients receiving Health Insurance Premium and Cost-Sharing Assistance services have evidence of viral suppression as documented in viral load testing.	For clients with applicable data in ARIES or other data system used at the provider location, percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. ***(HRSA HAB Measure)***	**Client Access.**		QA team monitors files
		<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of	• Documentation of referrals received	QA team monitors files

<table>
<tr><td></td><td></td><td>HIV/AIDS service providers and makes appropriate referrals out when necessary.</td><td>• Documentation of referrals out
• Staff reports indicate compliance</td><td></td></tr>
<tr><td></td><td></td><td><u>Prioritization of Service</u>
Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology.

Priority Ranking of Cost Sharing Assistance (in descending order):
1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary)
2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications)
3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments)
Medicare Part D (Rx) premiums</td><td>• Review of agency's Policies & Procedures Manual indicates compliance. Review of agency's monthly reimbursement indicates compliance</td><td></td></tr>
<tr><td></td><td></td><td><u>Decreasing Barriers to Service</u>
Agency establishes formal</td><td>• Review of agency's Policies</td><td>•</td></tr>
</table>

		written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.)	& Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance	

References

TDSHS HIV/STD Ryan White Part B Program Universal Standards (pg. 30-31) http://www.dshs.texas.gov/hivstd/taxonomy/universal.shtm

TDSHS HIV/STD Prevention and Care Branch, Policy 260.002. Health Insurance Assistance http://www.dshs.texas.gov/hivstd/policy/policies/260-002.shtm

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 31-35.

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 07-05, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-05, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-06, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 14-01, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

TDSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001. Located at: http://www.dshs.texas.gov/hivstd/policy/policies.shtm

HRSA/HAB, Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance. Located at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/HAB_FAQs_on_Dental_Insurance.pdf

Standard	HRSA: HAB Performance Measure

Affected Community Committee Report

2017 World AIDS Day Events

Compiled by the Office of Support for the Ryan White Planning Council - www.rwpcHouston.org

Updated November 29, 2017

For questions concerning any of the events listed, *please contact the event host*.

Access Care of Coastal Texas

December 1, 2017 World AIDS Day Observance
5:30 p.m. *707 23rd Street; Galveston, TX 77550*

Join us as we increase awareness, celebrate the great strides made in prevention, support people living with AIDS, and honor those whom we have lost. There will be a World AIDS Day Proclamation presented by a Galveston public official and a guest speaker, and we will end the evening at the Wall of Remembrance. Light refreshments. HIV testing is available all day. ACCT will host a quilt panel from the Names Project November 27 thru December 1. For more information contact Mark Hinson at (409) 763-2437.

AIDS Foundation Houston

December 1, 2017 World AIDS Day Luncheon
11:30 a.m. *Hilton Houston Post Oak 2001 Post Oak Boulevard; Houston, TX 77056*

Luncheon co-chairs Caroline Starry and Jeff Gremillion invite you to the 2017 World AIDS Day Luncheon: Mission Undetectable, jointly hosted by and benefitting AIDS Foundation Houston and Avenue 360 Health & Wellness. This year's luncheon is generously presented by Chevron and features a keynote address by Olympic diver and HIV advocate Greg Louganis. The Houston Health Department Bureau of HIV/STD and Viral Hepatitis Prevention is the 2017 Shelby Hodge Vision Award Honoree for innovative prevention programs, including Molecular HIV Surveillance. www.aidshelp.org

Catholic Charities

December 1, 2017 World AIDS Day Health Fair
10:00 a.m.-2:00 p.m. *333 S. Jensen Drive, Houston, TX 77003*

We invite you to join us for free HIV testing, free diabetes and blood pressure testing, food, open mic for testimonials/poetry/reading/etc, education, support, moment of silence, and red balloon release for female veterans. For more info call Heather at 713 227-2989

Change Happens

December 1, 2017 2017 World AIDS Day Block Party
3:00 p.m. *Cuney Homes Apartments 3260 Truxillo, Houston, TX 77004*

The Change Happens HIV Prevention Program in collaboration with Cuney Homes Apartments will host the First Annual World AIDS Day Block Party from 3pm-7pm. Food, games, vendors, resources, free health screenings, and more. Free and open to the public.

Fundación Latinoamericana de Acción Social, Inc.

December 1, 2017 Consulado General de México en Houston
10 a.m.-1:00 p.m. *4507 San Jacinto Street; Houston, TX 77004*

FLAS, Inc. and the Consulate General of Mexico invite you a World AIDS Day health fair *"Empowering People's Lives"*. For more information please contact Kimmy Palacios: (832) 459-8694.

Harris Health System

December 1, 2017 Thomas Street Health Center
10:00-11:00 a.m. *2015 Thomas Street; Houston, TX 77009*

The 18th Annual World AIDS Day Observance *Living Beyond HIV/AIDS* will take place at 10:00 a.m. followed by the Tree of Remembrance Ceremony at 11:00 a.m. -- a Christmas tree is placed outside the clinic for clients, clinic staff and the public to place a Christmas ornament in honor of loved ones or friends who have passed away due to AIDS-related illnesses. The tree will remain up throughout the month of December.

🎗 Legacy Community Health - Beaumont

December 1, 2017 World AIDS Day Event
4:00 p.m. *450 N. 11th Street; Beaumont, TX 77702*

Join us for live music, guest speakers, refreshments and the unveiling of a new art piece in memory of those we've lost due to HIV/AIDS related complications and to honor those fighting to end the epidemic.

🎗 Legacy Community Health - Montrose

December 1, 2017 World AIDS Day Vigil
6:00 p.m. *1415 California Street; Houston, TX 77006*

Join us for the beginning of the end of HIV at a World AIDS Day Vigil at our Montrose location. There will be a brief program with guest speakers, followed by a reading of names and a walking candlelight vigil.

🎗 Montrose Center

December 1, 2017 World AIDS Day Screening: United in Anger
7:00 p.m. *401 Branard St, Houston, TX 77006*

Join the Montrose Center in observance of World AIDS Day (December 1) for a community viewing of Jim Hubbard's inspiring documentary, United in Anger: A History of ACT UP

about the birth and life of the AIDS activist movement from the perspective of the people in the trenches fighting the epidemic. Utilizing oral histories of members of ACT UP, as well as rare archival footage, the film depicts the efforts of ACT UP as it battles corporate greed, social indifference, and government negligence. The film highlights the importance of community spaces and the courage and struggles of those personally battling with a positive status during the height of the crisis.

🎗 Qfest

December 1, 2017 BPM (Beats Per Minute): An Observance of World AIDS Day
7:00 p.m. *Rice Cinema - Rice Media Center*
2030 University Boulevard; Houston, TX 77005

QFest proudly presents BPM (Beats Per Minute), winner of the Grand Prix at the 2017 Cannes Film Festival. Set during the early 90's after a decade of loss of life to AIDS, a group of young ACT UP-Paris members aggressively mobilize to bring attention to France's AIDS crisis, combatting politically motivated resistance from the French government, greedy pharmaceutical companies, and a very homophobic public.

Afterward, Guava Lamp and QFest collaborate with Steven Evans, artist, writer, curator, and Executive Director of FotoFest to commemorate World AIDS Day. Inspired by his conceptual book, The Number One Song in Heaven, Steven has curated a collection of songs that capture the spirit and resilience of our community during the devastation wrought upon us by the AIDS crisis. DJ ESTEFF will bring her extensive collection of vinyl to capture the era from which so many of these songs were first heard and danced to in gay clubs of the time. Guava Lamp is located at 570 Waugh Drive, Houston, TX 77019.

Please join us for this very special day to celebrate those who fought with their lives to bring our entire community to a time and place in which treatments such as PrEP, PEP and even Treatment as Prevention point us to a foreseeable future in which AIDS can and will be eventually eradicated.

🎗 Resurrection Metropolitan Community Church

December 1, 2017 World AIDS Day Vigil
11 a.m. - 1 p.m. *2025 W. 11th Street; Houston, TX 77008*

World AIDS Day is an opportunity to raise awareness, commemorate those who have died, and celebrate victories such as increased access to treatment and prevention. **www.resurrectionmcc.org**, 713 861-9149

For questions concerning any of the events listed, *please contact the event host*.

🎗 Rothko Chapel

December 1, 2017 Twilight Moments: World AIDS Day Observation
8:00 a.m. *3900 Yupon Street; Houston, TX 77006*

Join as we unite in support of those living with the disease and to remember the many individuals who have lost their lives to the virus. There will be a light breakfast and coffee on the plaza from 8-8:30am, followed by meditation from 8:30-9:30am. For more information, please visit http://rothkochapel.org/experience/events/register/1277.

🎗 The T.R.U.T.H. Project

December 1, 2017 A Story Told: A World AIDS Day Experience
6:00 p.m. *MATCH | Midtown Arts & Theater Center Houston*
3400 Main Street; Houston, TX 77002

The T.R.U.T.H. Project, Inc., with support from AIDS Foundation Houston and the Houston Health Department Bureau of HIV/STD and Viral Hepatitis Prevention, presents "A Story Told: A World AIDS Day Experience". This multidisciplinary performance uses spoken word, movement, song and theater to explore issues of HIV stigma, prevention and education. The event is free. The performance begins at 7:30 p.m. and will be preceded by a reception and mixer at 6 p.m.

🎗 University of Houston - Downtown

November 27 - World AIDS Week
December 1, 2017 World AIDS Week is held each year at UH in conjunction with World AIDS Day.

Monday, November 27
11am – 12:30pm - Cupcakes and Condoms; Student Center South
Join the Women & Gender Resource Center for an informative trivia game on myths and misconceptions of HIV.

Tuesday, November 28
12pm – 2pm - "Normal Heart"; Student Center North Room 201
The LGBTQ Resource Center will have a screening of The Normal Heart.

Wednesday, November 29
11:30am – 1pm - PrEP Workshop; Student Center South Heights Room 224
Learn about PrEP, how it works, and why you should consider taking it. Brought to you by Legacy Community Health and sponsored by the LGBTQ Resource Center.

1pm – 3pm - Our Red Ribbon Responsibility; Student Center South B12
A cultural conversation about ways to provide an inclusive environment that allows individuals to have open discussions about HIV, reducing stigma, and how to show support and solidarity.

4pm – 5pm - The State of HIV in the Greater Houston Area; Student Center South Heights Room
The UH Wellness Center invites you to an engaging discussion. Panelists will answer questions as well as share resources and other helpful information.

Thursday, November 30th
11am – 1pm - World AIDS Display & Resource Fair; Butler Plaza
Learn about resources available in the community pertaining to HIV; organizations include the Montrose Center, Change Happens!, Legacy Community Health and many more!

Friday, December 1
10am – 4pm - HIV Testing; Campus Recreation and Wellness Center
SMART Cougars will provide free HIV Testing to students that are interested in knowing their status. Testing will take place in a judgement free, confidential area.

11am – 1pm - Ribbon Handout; Student Center South & Student Center Satellite
UH Wellness will pass out red ribbons to show support for World AIDS Day and help eliminate stigma.

For questions concerning any of the events listed, *please contact the event host*.

UTMB - Galveston

December 1, 2017 World AIDS Day

10am – 2:00pm - Red Ribbon Pins; UHC (1005 Harborside Dr) and Jennie Sealy Hospital (712 Texas Ave)
The Infectious Disease Department will be providing free red ribbon pins.

10am – 6:00pm - World Aids Day Health Fair; Mid County Annex Bldg. (9850 Emmett F Lowry, Texas City 77591)
Free HIV, Syphilis, and TB testing, and information on area programs will be provided by Coastal Health and Wellness, the Gulf Coast Center, Houston Area Black Nurses Association, and Access Care of Coastal Texas, in cooperation with the Galveston County Health District. This event is open to the public. For information call 409-765-2528 or go to **www.gchd.org/std**.

2017 World AIDS Day Events

Compiled by the Office of Support for the Ryan White Planning Council - www.rwpcHouston.org

Updated November 16, 2017

For questions concerning any of the events listed, *please contact the event host*.

Access Care of Coastal Texas

December 1, 2017 World AIDS Day Observance
5:30 p.m. *707 23rd Street; Galveston, TX 77550*

Join us as we increase awareness, celebrate the great strides made in prevention, support people living with AIDS, and honor those whom we have lost. There will be a World AIDS Day Proclamation presented by a Galveston public official and a guest speaker, and we will end the evening at the Wall of Remembrance. Light refreshments. HIV testing is available all day. ACCT will host a quilt panel from the Names Project from November 27 thru December 1.

For more information contact Mark Hinson at (409) 763-2437.

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December 1, 2017 World AIDS Day Luncheon
11:30 a.m. *Hilton Houston Post Oak*
2001 Post Oak Boulevard; Houston, TX 77056

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Change Happens

December 1, 2017 2017 World AIDS Day Block Party
3:00 p.m. *Cuney Homes* Apartments
3260 Truxillo, Houston, TX 77004

The Change Happens HIV Prevention Program in collaboration with Cuney Homes Apartments will host the 1st Annual World AIDS Day Block Party from 3pm-7pm. The Event is free and open to the public. Food, games, vendors, resources, free health screenings, and more!

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10:00 a.m.-11:00 a.m. *2015 Thomas Street; Houston, TX 77009*

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Legacy Community Health

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4:00 p.m. *Legacy Community Health – **Beaumont***
450 N. 11th Street; Beaumont, TX 77702

Join us for a World AIDS Day event featuring live music, guest speakers, refreshments and the unveiling of a new art piece in memory of those we've lost due to HIV/AIDS related complications and to honor those fighting to end the epidemic.

6:00 p.m. World AIDS Day Vigil
*Legacy Community Health – **Montrose***
1415 California Street; Houston, TX 77006

Join us for the beginning of the end of HIV at a World AIDS Day Vigil at our Montrose location. There will be a brief program with guest speakers, followed by a reading of names and a walking candlelight vigil.

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Immediately following the screening, Guava Lamp and QFest are proud to be collaborating with Steven Evans, artist, writer, curator, and Executive Director of FotoFest to commemorate World AIDS Day. Inspired by his conceptual book, The Number One Song in Heaven, Steven has curated a collection of songs that capture the spirit and resilience of our community during the devastation wrought upon us by the AIDS crisis. Bringing the music alive will be DJ ESTEFF, who will bring her extensive collection of vinyl to capture the era from which so many of these songs were first heard and danced to in gay clubs of the time. Guava Lamp is located at 570 Waugh Dr., Houston, TX 77019.

Please join us for this very special day to celebrate those who fought with their lives to bring our entire community to a time and place in which treatments such as PrEP, PEP and even Treatment as Prevention point us to a foreseeable future in which AIDS can and will be eventually eradicated.

For questions concerning any of the events listed, *please contact the event host*.

Rothko Chapel

December 1, 2017 Twilight Moments: World AIDS Day Observation
8:00 a.m. *3900 Yupon Street; Houston, TX 77006*

In commemoration of World AIDS Day, the Rothko Chapel will hold a morning meditation. Join as we unite in support of those living with the disease and to remember the many individuals who have lost their lives to the virus. There will be a light breakfast and coffee on the plaza from 8-8:30am, followed by meditation from 8:30-9:30am. For more information, please visit www.rothkochapel.org.

The T.R.U.T.H. Project

December 1, 2017 A Story Told: A World AIDS Day Experience
6:00 p.m. *MATCH | Midtown Arts & Theater Center Houston*
3400 Main Street; Houston, TX 77002

The T.R.U.T.H. Project, Inc., with support from AIDS Foundation Houston and the Houston Health Department Bureau of HIV/STD and Viral Hepatitis Prevention, presents "A Story Told: A World AIDS Day Experience". Directed by Kevin Anderson and choreographed by Nick Muckleroy, this multidisciplinary performance uses spoken word, movement, song and theater to explore issues of HIV stigma, prevention and education. The event is free to attend. The performance begins at 7:30 p.m. and will be preceded by a reception and mixer at 6 p.m.

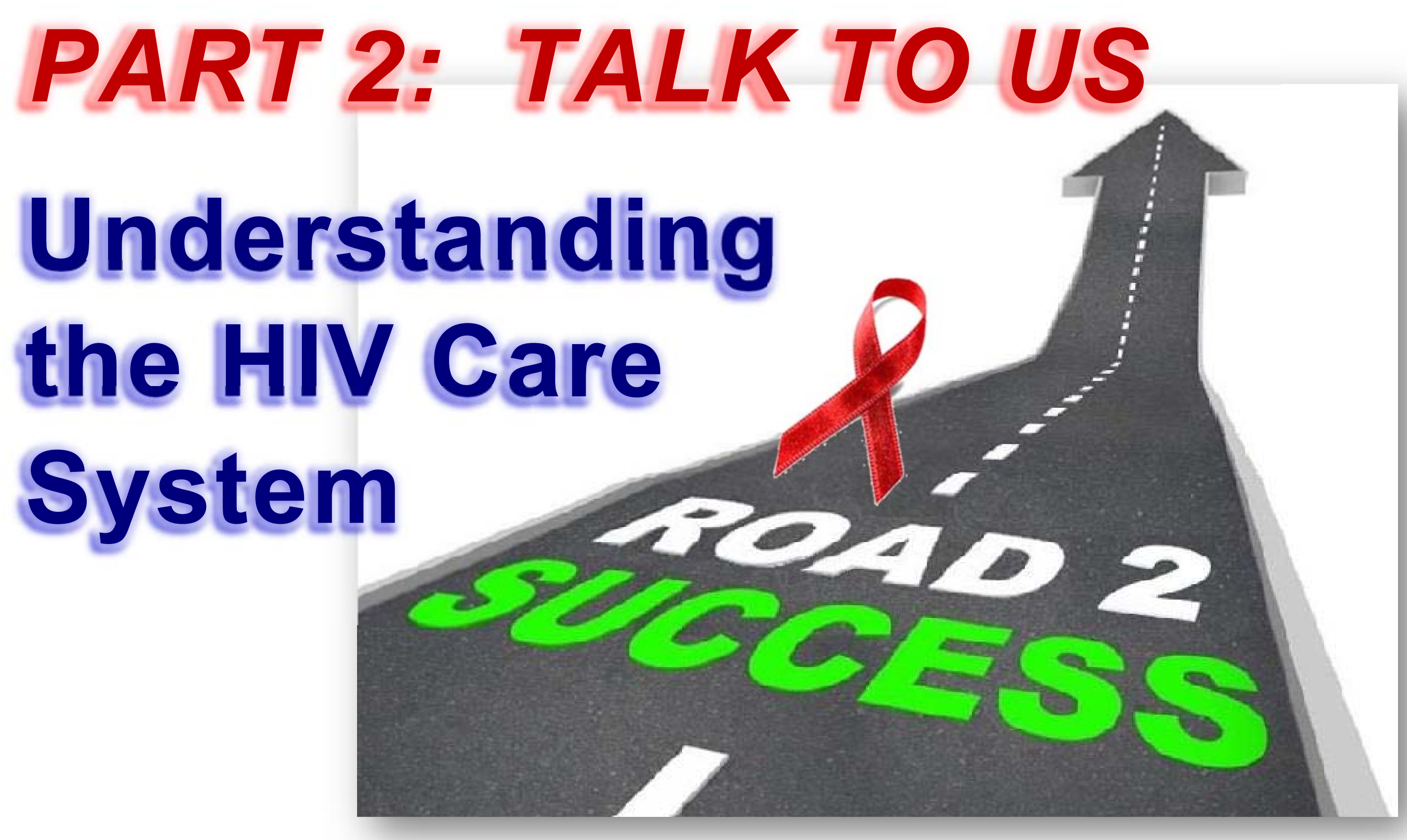
Affected Community Committee
2017 Community Events (as of 11/21/17)

Point Person (PP): Committee member who picks up display materials and returns them to the Office of Support.

Day, date, times	Event	Location	Participants
Sunday, March 5 1pm-Walk	AIDS Foundation Houston (AFH) AIDS Walk	Houston Park Downtown 1100 Bagby Street, 77002	Allen Murray will distribute Project LEAP flyers.
Saturday, June 24 Noon – 7:00 pm	Pride Festival	Downtown near City Hall	Shift 1 (11:30 am-2 pm) : **PP Tracy G,** Tana, Steven V. Shift 2 (2-4:30 pm) Alex, Allen, Isis Shift 3 (4:30-7 pm): **PP: John P.,** Rodney, Alex
Thursday, June 29 11:30 am – 2 pm	Road 2 Success	Thomas Street Health Center 2015 Thomas Street, 77009	**Need 5 Volunteers:** Curtis, Cecilia, Teresa, Denis, Isis and Alex.
Monday, September 25 5 pm – 8 pm	Camino hacia tu Salud	Positive713 Leonel Castillo Community Center 2101 South Street, 77009	**Need 7 Volunteers:** Isis, Tana, Skeet, Curtis, Alex, Steven and Evelio
Sunday, October 22	MISS UTOPIA	Crowne Plaza Northwest-Brookhollow 12801 Northwest Freeway Houston, TX 77040	**Volunteers: PP: Skeet**, Curtis, Alex, Isis, Cecilia, Tana DISTRIBUTE LEAP FLYERS
Friday, October 27, 2017	Santa Maria Hostel – health fair		**Volunteer:** Tana
Saturday, November 4	Road 2 Success	Montrose Center 401 Branard Street, 2nd Floor, 77006	**Volunteers:** Tana, Rodney, Steven, Allen, Teresa, John P, and Crystal
Saturday, November 11	Camino hacia tu Salud	Leonel Castillo Community Ctr. 2101 South Street, 77009	**Volunteers:** Tana, John P, Carol S, Steven
Tuesday, December 1	World AIDS Day Events		Most committee members attend events DISTRIBUTE LEAP FLYERS
Saturday, December 11	Latino HIV Task Force Health Fair	Denver Harbor	**Contact Person:** Gloria Sierra **Volunteers**: Cecilia, Rodney, Teresa, Tana
Saturday, January 13 **2018**	Road 2 Success	Montrose Center 401 Branard Street, 2nd Floor, 77006	**Need 7 Volunteers (incl. Spanish speaking):** Denis, Allen, Rodney, Tana, Veria, John P., Johnny D. DISTRIBUTE LEAP FLYERS

PART 2: TALK TO US

Understanding the HIV Care System



FREE classes to help you get the most from HIV services in the Houston area!

Join us for Registration and Breakfast at 9:30 a.m. After breakfast we want to hear from you -- tell us about your experience with HIV services and how we can improve your medical care. Find out what to do when you have a problem or complaint and learn how you can be involved in planning HIV services. We will wrap up with a networking lunch.

Saturday, January 13, 2018

Montrose Center
401 Branard Street
1st Floor, Room 107
Houston, TX 77006

Please RSVP!

FOR MORE INFORMATION:

Ryan White Planning Council
Office of Support
713 572-3724
www.rwpcHouston.org

ASL interpreters will be available; for more information please call: 713 572-2813 (TTY)
Intérpretes Español estarán presentes; por favor llame para más información: 713 572-3724

PARTE 2: HABLE CON NOSOTROS

Comprendiendo el Sistema de Cuidado Médico del VIH

¡Clases GRATUITAS para ayudarle a obtener lo mejor de los servicios del VIH disponibles en Houston!

Lo invitamos a reunirse con nosotros para la Registración y un Desayuno empezando a las 9:30 am. Después del desayuno queremos escucharlo- díganos de sus experiencias con los sistemas de cuidado médico del VIH y cómo podríamos mejorar su cuidado médico. Entérese de que hacer cuando tiene problemas o necesita hacer una queja, y también aprenda como participar en los planes de los servicios del VIH. Concluiremos con un almuerzo social.

Sábado, 13 de Enero de 2018

Montrose Center
401 Branard Street
1st Floor, Room 107
Houston, TX 77006

Favor haga reservación

PARA MAYOR INFORMACION, LLAME A:

Ryan White Planning Council
Office of Support
713 572-3724
www.rwpcHouston.org

Intérpretes de Lenguaje de Señas Americano y de Español estarán presentes

2017 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE
(November 2017)

Status of Committee Goals and Responsibilities (* indicates a HRSA mandate):

1. Educate consumers so they understand how to access HIV/AIDS treatment and medication. Provide information that can be understood by consumers of diverse educational backgrounds on client-centered issues.
   Status: Road to Success

2. In 2017, get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more.
   Didn't get invited. Miss Utopia

3. Assure participation by people living with HIV/AIDS in all Council work products.
   Status: We do have someone

4. *Work with other committees to coordinate Public Hearings regarding the FY 2018 How to Best Meet the Need Results & Priorities and Allocations for Ryan White Parts A and B and State Services.
   Status: Great Job.

5. Recruit Council applicants throughout the year.
   Status: Out reach come involved in Council Membership.

6. Annually, review the status of committee activities identified in the current Comprehensive Plan.
   Status: Feb and March.

[signature] 11-20-2017

Committee Chairperson Date

Operations Committee Report

DRAFT

Houston Area HIV Services Ryan White Planning Council
Office of Support

2017 Project LEAP Final Report

Approved: Pending

Prepared by:
Amber Harbolt
Office of Support
(713) 572-3724 telephone
www.rwpchouston.org

Houston Area HIV Services Ryan White Planning Council
Office of Support
2017 Project LEAP Final Report

Table of Contents

Introduction...3

Service Definition Objective 1... 4

- Contact Hours Requirements... 4
- Curriculum Requirements...5

Service Definition Objective 2... 6

- Class Composition vs. Current HIV Prevalence... 6
- Course Completion... 7
- Pre/Post-Training Evaluation Results...8
- Process Evaluation and Lessons Learned...9

"Project LEAP Means I Can Be a Confident Knowledgeable Voice for the PLWH Community": The Life-Changing Impact of Project LEAP... 11

Budget Information and Comparison...13

Acknowledgments... 14

Attachments...15

- FY17 Project LEAP Service Definition (approved 12-08-16)
- 2017 Project LEAP Course Overview
- 2017 Pre/Post-Training Evaluation Forms

Introduction

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

Project LEAP is currently designed as a weekly class spanning 16 weeks including classroom training, out-of-class time observation, and experiential community-based learning. On the 17th week, students are recognized through a graduation ceremony and encouraged to apply to RWP and CPG. Annually, the RWPC reviews and makes recommendations for the Project LEAP Service Definition based on program results and student needs. An External Advisory Panel consisting of representatives from the RWPC, CPG, and Project LEAP alumni also advises Project LEAP.

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

This report summarizes results from the 2017 Project LEAP cohort, including the ways in which the 2017 syllabus met the objectives outlined in the RWPC-approved Service Definition, the extent of the program's achievement in increasing the knowledge and skills of PLWH and affected individuals, and lessons learned for future program implementation.

Obj. 1: Contact Hours Requirements

From the FY17 Project LEAP Service Definition:

Since 2013, Project LEAP has been designed to include multiple experiential community-based learning opportunities, including direct observations of Planning Body activities. To ensure each Project LEAP student has the same opportunity for community-based learning activities, the FY17 Project LEAP Service Definition requires contact hours for out-of-class time and service learning. The approved contact hours for Project LEAP are as follows:

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

From the 2017 Project LEAP Syllabus:

- Two classes were held each week from April 5 – July 19, 2017 (**Figure 1**), including:
    1. 48 hours of classroom training;
    2. 12 hours of participation in RWPC or CPG meetings or activities; and participation in HIV-related community activities;
- For a total of 60 hours of instruction. This is 3 hours *more per class* than the Service Definition requirement.
- A graduation dinner and ceremony was held on July 26, 2017.

Figure 1: Project LEAP Contact Hours, 2017

	FY17 Service Definition (approved 12-08-16)	**2016 Project LEAP Syllabus** (conducted 4-5-17 through 7-19-17)	
Requirement	Number of Hours	Number of Hours	Method
Graduation	n/a	n/a	Graduation ceremony held 7-26-17
Classroom training	44	52	12 weekly classroom sessions conducted at 4 hours/session; 4 hours of classroom sessions before RWPC, and P&A Committee mtgs
PC/Community participation	12	10*	Student attendance at 1 RWPC mtg (2 hrs), 1 P&A Committee mtg (2 hrs), 1 community mtg (2 hrs), and participation in 1 volunteer shift at an HIV testing event (4 hrs)
Total per class	56	62	
Number of classes	≤2	2	
Total contact hours	56-112	124	

*Due to changes in scheduling, students were unable to attend a CPG meeting on 5-24-17, as originally stated in the course curriculum.

Obj. 1: Curriculum Requirements

FY17 Project LEAP Service Definition curriculum requirements met through curriculum:

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

- ☑ Week #2 (4/12/17): Panel – Barriers to Reaching, Linking, & Retention in Care (Epidemiology Overview & Special Populations (Meyer, Stoker, Sierra, Koroma, & Johnson)
- ☑ Week #3 (4/19/17): Overview of HIV Care Funds & RW Program: HRSA to Council and Designing HIV Care Services: HTBMN (Williams)
- ☑ Week #7 (5/17/17): HIV Prevention Program: CDC to CPG Panel (Wiley, Blue, & Townsend)
- ☑ Week #9 (5/31/17): Overview of Housing Opportunities for People with HIV/AIDS (Schultz)
- ☑ Week #12 (6/21/17): Attendance at Priorities & Allocations (P&A) Committee meeting (Williams)

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

- ☑ Week #1 (4/6/16): History of HIV in the Houston Area Interactive Exercise (Vargas & Williams)
- ☑ Week #3 (4/19/17): Overview of HIV Care Funds & RW Program: HRSA to Council and Designing HIV Care Services: HTBMN (Williams)
- ☑ Week #3 (4/19/17): PB & Jelly Exercise (Function of Policies & Procedures) (Harbolt)
- ☑ Week #10 (6/8/17): Attendance at Ryan White Planning Council (RWPC) meeting
- ☑ Week #11 (6/14/17): Training and Exercise on the P&A Process (Williams)
- ☑ Week #11 (6/14/17): Organizing Graduation/Robert's Rules of Order Practice (Williams)
- ☑ Week #15 (7/12/17): Project LEAP to Planning Body (Ross, Gorden, Escamilla, Blue, & Kelly)
- ☑ Week #15 (7/12/17): RWPC and CPG Application Process (Williams)
- Week #16 (7/19/17): RWPC & COI Refresher and Mock Interviews (Williams & Harbolt)

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

- ☑ Week #2 (4/12/17): Introduction to Robert's Rules of Order (Williams)
- ☑ Week #2 (4/12/17): LEAP Special Study Project Survey Development (Harbolt)
- ☑ Week #3 (4/19/17): LEAP Special Study Project – Survey Skills Training (Harbolt)
- ☑ Week #4 (4/26/17): Robert's Rules of Order Exercise (Williams)
- ☑ Week #4 (4/26/17): Community Needs Assessment (Harbolt)
- ☑ Week #5 (5/3/17): Leadership Skills and Team Building (Alexander)
- ☑ Week #6 (5/10/17): Speakers Related to Survey Topics (Keizman & Vargas)
- ☑ Week #7 (5/17/17): LEAP Special Study Project – Analyze Survey Data (Harbolt)
- ☑ Week #9 (5/31/17): LEAP Special Study Project –Presentation Practice (Harbolt)
- ☑ Week #10 (6/8/17): Presentation of LEAP Special Study Project to RWPC
- ☑ Week #13 (7/28/17): Advocacy 101 (Ray)
- ☑ Week #13 (7/28/17): Training on HIV Resources/Blue Book Treasure Hunt (Beck & Williams)
- ☑ Week #16 (7/19/17): Community Meeting Report-Backs (Williams)
- ☑ Week #16 (7/19/17): Leadership and Self-Deception (Goodie) – evening class only

Ongoing: Weekly designation of meeting chairs, weekly practice with Robert's Rules and following meeting agendas, regular in-class small/large-group activities requiring student presentations

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

- ☑ Week #3 (4/19/17): Overview of HIV Care Funds & RW Program: HRSA to Council and Designing HIV Care Services: HTBMN (Williams)
- ☑ Week #4 (4/26/17): Comprehensive HIV Planning (Harbolt)
- ☑ Week #4 (4/26/17):): HIV Continuum of Care (Harbolt)
- ☑ Week #15 (7/12/17): Training on Standards of Care and Performance Measures (Harbolt)

Obj. 2: Class Composition vs. Current HIV Prevalence

From the FY17 Project LEAP Service Definition:

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

From the 2017 Project LEAP Cohort (**Figure 2**):

- 21 PLWH and 11 affected others were enrolled at the beginning of the 2017 Project LEAP program.
- Of graduating students, 11 were PLWH, and 11 were affected (50% each).
- Compared to HIV prevalence proportions for the Houston EMA, a greater proportion of black, non-Hispanic (53%) and Hispanic (31%) students enrolled in the program, and a greater proportion of black non-Hispanic students graduated from the program (59%).
- No youth enrolled in the program in 2017.
- One transgender student enrolled in the program and graduated.

Figure 2: Project LEAP Class Composition, 2017

	EMA HIV Prevalence (as of 12/31/15)		**2017 Project LEAP Enrollees** (as of 4/6/17)		**2017 Project LEAP PLWH Enrollees** (as of 4/6/17)		**2017 Project LEAP Graduates** (as of 7/26/17)	
Race/Ethnicity	#	%	#	%	#	%	#	%
White, not Hispanic	5,228	20	4	13	3	14	2	9
Black, not Hispanic	13,226	49	17	53	13	62	13	59
Hispanic	7,445	28	10	31	5	24	6	27
Other/Unknown	1,064	4	1	3	0	0	1	5
Total	27,023	100	32	100	21	100	22	100
Sex	#	%	#	%	#	%	#	%
Male	20,255	75	13	41	10	50	8	36
Female	6,768	25	18	56	10	50	13	59
Transgender	n/a	n/a	1	3	*	*	1	5
Total	27,023	100	32	100	20	100	22	100
Age	#	%	#	%	#	%	#	%
13 – 24 years	1,302	5	0	0	0	0	0	0
Total	1,302	5	0	0	0	0	0	0

*Data suppressed to maintain confidentiality

Obj. 2: Course Completion

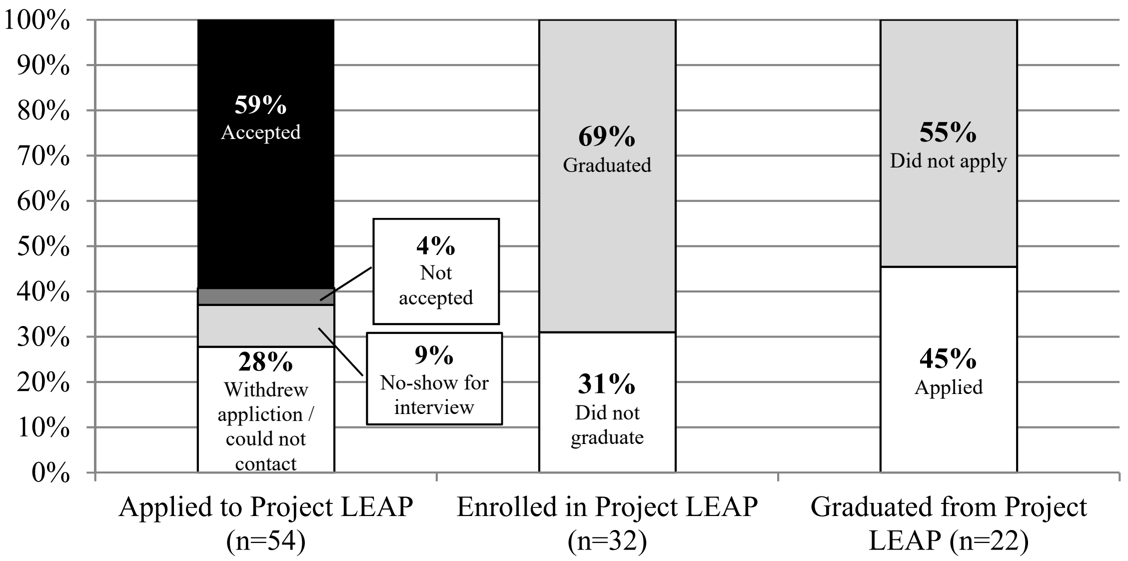
From the FY17 Project LEAP Service Definition:

- Enroll a minimum of 12 (20 if evening class) PLWH individuals, and no more than six (6) (10 if evening class) affected others in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA.
- Establish realistic training schedules that accommodate varying health situations of participants.

From the 2017 Project LEAP Cohort (**Figures 3**):

- 54 individuals applied for 2017 Project LEAP; 15 applicants withdrew from the interview process or could not be contacted after they applied. The remaining 39 applicants had interviews scheduled. Five applicants did not show up for their interviews, two applicants were interviewed but not accepted into the program, and 32 applicants were enrolled.
- Out of the 32 students enrolled, 22 graduated from the program, for a graduation rate of 69%. Reasons for attrition were conflicts with other priorities and medical concerns that prevented attendance. Five students enrolled, but never attended class. An additional five students attended classes, but did not complete the course.
- Average weekly class size was 12 students for the morning class, and 10 students for the evening class. Weeks involving off-site locations, alternate days/times, or with inclement weather correlated with higher absences. Two students had perfect attendance.
- When asked about next steps after Project LEAP, 74% of graduates planned to apply to RWPC or an External Committee; 47% planned to apply to CPG, 37% planned to join a Community Advisory Board (**CAB**), 58% planned to join a Task Force, and 32% planned to sign up for the Positive Organizing Project.
- Ten students (or 45% of the graduating class) submitted applications to RWPC for PC (8) and/or External Committee (9) membership. As of October 2017, nine graduates and one 2014 Project LEAP graduate have been appointed as External Committee members.

Figure 3: Project LEAP Application, Enrollment, and Course Completion, 2017



Obj. 2: Pre/Post-Training Evaluation

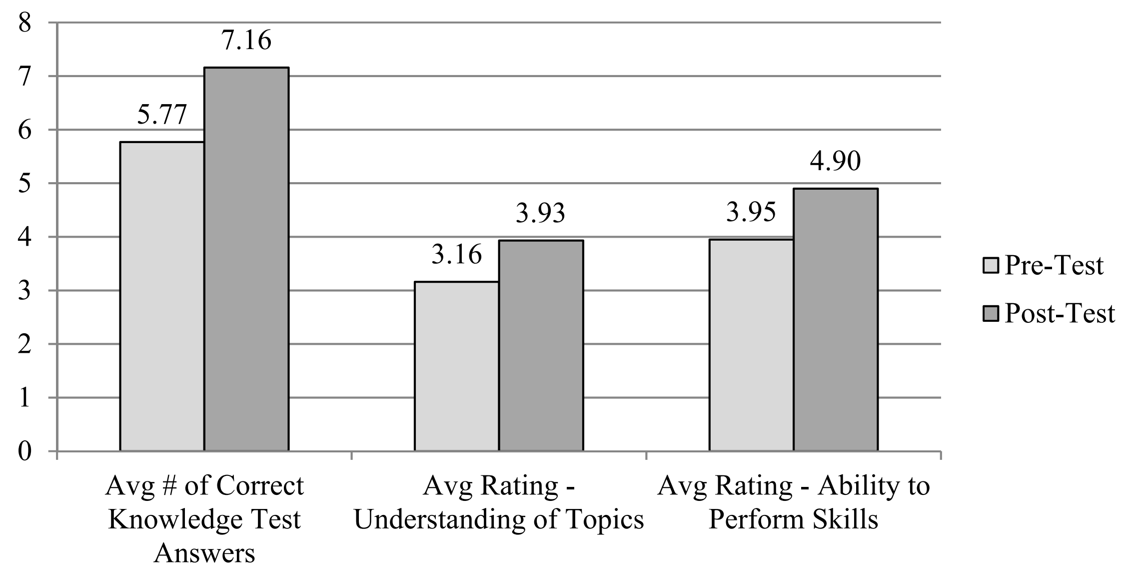
From the FY17 Project LEAP Service Definition:

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

From the 2017 Project LEAP Cohort:

- A matched pre-training and post-training evaluation was conducted at Weeks 1 and 16. The evaluation tool (**See Attachment**) included the following:
  1. A 10-item fact-based multiple choice quiz specific to Service Definition topics measuring change in knowledge;
  2. A self-assessment of understanding of Service Definition topics (1 = "not well"; 5 = "very well") measuring self-assessed change in understanding; and
  3. A self-assessment of ability to perform the skills or activities required by the Service Definition (1 = "not well"; 5= "very well") measuring self-assessed change in skills.
- 97% of the graduating class was evaluated at both pre and post with the following results (**Figure 4**):
  1. The average number of correct answers to the fact-based multiple choice questions increased from 5.77 to 7.16, or a 24% increase in average knowledge test scores.
  2. The average self-assessment rating of understanding increased from 2.30 to 4.40 (out of 5), or a 91% increase in self-assessed understanding.
  3. The average self-assessment rating of ability to perform skills or activities increased from 3.16 to 3.93 (out of 5), or a 24% increase in self-assessed skills.
  4. As in previous years, the greatest improvements occurred in: knowledge of the purpose of the RW program and RWPC activities; understanding of the structure and function of the RWPC; and ability to effectively use Robert's Rules of Order.

Figure 4: Project LEAP Pre/Post-Training Evaluation Results, 2017



Obj. 2: Process Evaluation and Lessons Learned

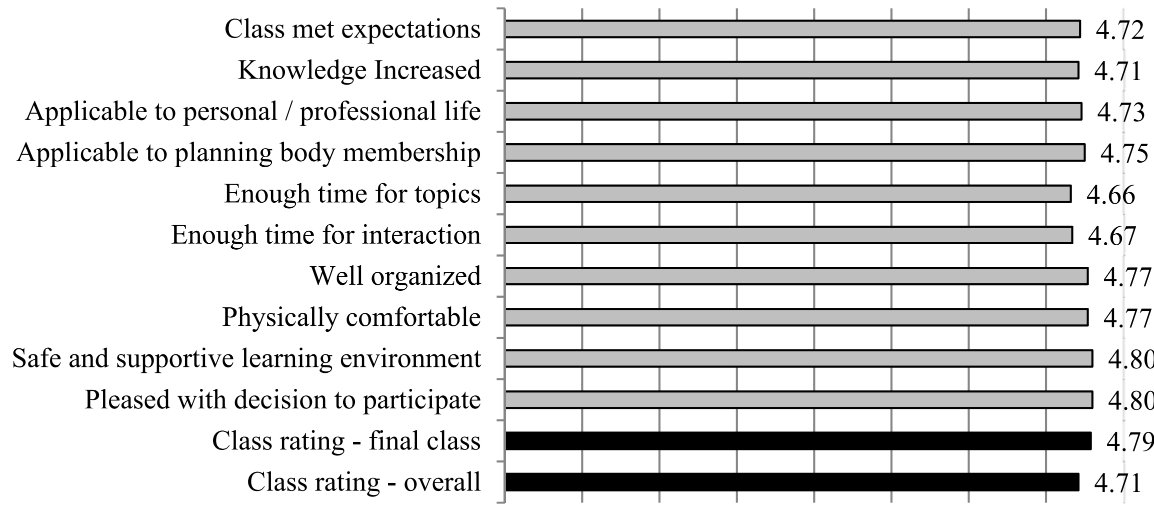
From the FY17 Project LEAP Service Definition:

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

From the 2017 Project LEAP Syllabus and Cohort:

- A variety of teaching methods was employed to meet the Service Definition:
  1. *Lectures*: included 27 guest speakers (in addition to three Office of Support staff/facilitators)
  2. *Hands-on activities*: 100% of classroom sessions included an interactive activity (e.g., Robert's Rules practice, team-building activities, group discussion, and report-back)
  3. *Experiential activities*: Graduation requirements included a special study project, attendance at a community meeting, and a volunteer shift at an HIV testing event. Two weeks of class occurred at a RWPC or Committee related function.
- Staff assessed course instruction quality was weekly. (**Figure 5**)
  1. In general, average ratings were highly favorable, with an average rating heavily skewed toward "Strongly Agree" in all quality measures assessed.
  2. The highest ratings indicate that, generally, students felt the Project LEAP class was a safe and supportive learning environment (4.80/5), were pleased with their decision to participate in Project LEAP (4.80/5), and found the class to be well organized and physically comfortable (each 4.77/5).
  3. Though still very high, lower ratings indicate students thought there was not always enough time to fully address topics (4.66/5) or interact with classmates (4.67/5).
  4. Overall, classes received an average rating of 4.71/5. The final class received an average rating of 4.79/5.

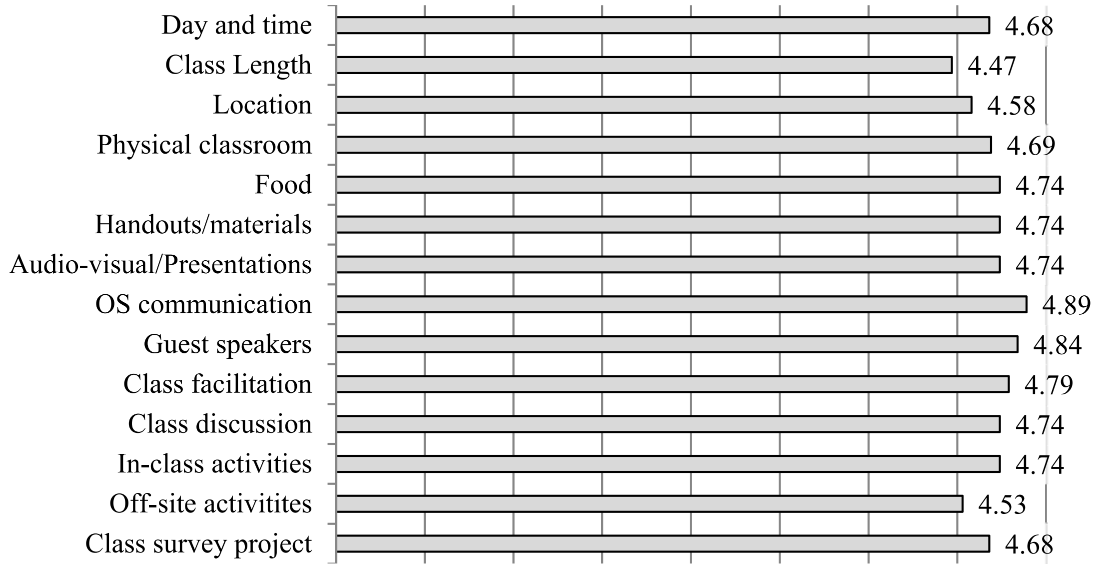
Figure 5: Project LEAP Weekly Evaluation Results, Average Ratings (1=Strongly Disagree, 5=Strongly Agree; Class Rating, 1=Poor, 5=Excellent), 2017



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

- Staff assessed course logistics quality at the mid-point and end of the course. (**Figure 6**)
  1. Most logistics elements showed no significant changes between the mid-point (not shown) and end-point evaluations, except a slight improvement in the food/drinks provided.
  2. Average ratings were highly favorable, with all course logistics elements rated "Very Good" (7%) or "Excellent" (93%).

Figure 6: Project LEAP Logistics, Evaluation Ratings (1=Very Poor, 5=Excellent), 2017



- General impressions of course quality were measured at the mid-point and end-point. As of the final Project LEAP 2017 class:
  1. 100% of students felt better able to be productive planning body members following Project LEAP.
  2. 100% of students were pleased with their decision to participate in Project LEAP and would recommend Project LEAP to someone else.
  3. 100% of students agreed or strongly agreed that Project LEAP made them more knowledgeable about HIV prevention and care services planning.

- Staff collected qualitative data at the mid-point and end-point with an open-ended question inviting students to suggest ways of making Project LEAP even better in the future:
  1. Give speakers more time for their presentations and questions
  2. Offer longer classes / weekend classes / classes in Spanish
  3. Continue engaging students in current events, update presentations, and avoid stigmatizing language
  4. Provide "refreshers" on previous classes the following week, and briefly review the course (all weeks) on the last day of class.
  5. Shorten evaluations

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

"Project LEAP Means I Can Be a Confident Knowledgeable Voice for the PLWH Community": The Life-Changing Impact of Project LEAP

Near the end of the course, the 2017 Project LEAP students were asked to share the impact of the program had on their lives. The quotes were displayed in a presentation that played during the graduation ceremony. The following quotes convey sentiments shared by many of the students:

- "I have learned a lot. New challenges, new feelings and big hope for the future. Project LEAP will help me help others."
- "Being a Project LEAP student has meant the world to me. Participating in this program has definitely expanded my knowledge in various spectrums of HIV in our community. Project LEAP has encouraged me to be more involved in the prevention of HIV. Because of Project LEAP I now have the knowledge and skills to become an advocate for the Deaf and Hard of Hearing community."
- "This has been a thoroughly enjoyable experience for me! Today I graduate with more knowledge and understanding. Thank you Project LEAP!!!"
- "Project LEAP has furthered my understanding of the HIV epidemic in 2017, as well as the need for Ryan White funding. I have also learned how important the Ryan White Planning Council is to our community."
- "To me, Project LEAP has meant the opportunity to learn about the current/present state of HIV on a national and local level. Project LEAP has also allowed me the opportunity to gain a better understanding and appreciation for the history and sacrifices made regarding the epidemic. Project LEAP has provided me with the knowledge and tools needed to better serve my patients and community and for that I'm so fortunate to have been a student. Thank you ☺"
- "Project LEAP is the best way to learn about all of the resources available for people living with HIV and it helps me understand the process used to award money to organizations. This class will help me become a better advocate!"
- "Project LEAP has meant the ability to gain valuable information, form unbreakable bonds and obtain great contacts to help in my advocacy work for the transgender and homeless communities."
- "To me, Project LEAP has meant empowerment, knowledge, gaining understanding of PLWH, the RWGA system, grants available, perceptions, survey, needs assessment."
- "Project LEAP has meant being able to learn and understand more about the HIV world. Project LEAP has also given me the knowledge and skills I need to be successful in my work field as a risk reduction supervisor."
- "Project LEAP has empowered me to become a stronger HIV prevention and care advocate. I feel more knowledgeable and better equipped to actively participate in HIV prevention and care planning services as a result of being a Project LEAP student. I am very grateful for Project LEAP."

"Project LEAP Means I Can Be a Confident Knowledgeable Voice for the PLWH Community": The Life-Changing Impact of Project LEAP (Con't)

- "Project LEAP has meant education and preparation for people with needs, when they don't know what to do a way to know what to do. People that care, the education is thorough. Basically how to advocate, advocacy."
- "Project Leap means… HOPE: Having the Opportunity to Provide Empowerment to my clients, friends & family."
- "We are the ones we've been waiting for. Nothing about us without us!"
- "Project LEAP has meant having a supportive space to share our personal experiences and aspirations to uplift individuals and families affected by HIV, while gaining knowledge of resources available to make a difference in the community."
- "Project LEAP means one more step towards making a difference in people's lives by providing services from a more informed perspective."
- "Project LEAP is a wonderful learning experience and an opportunity to be part of a great group of people who made a choice to make a positive impact in the life of fellow Houstonians."
- "Project LEAP has given me the opportunity to see and view more closely how homeless medication is needed for them, and medical attention."
- "Project LEAP has provided me with accurate knowledge which I can pass on to others to help them make better informed decisions about their health and safety when it involves treatment and prevention of HIV, and how I can be a more effective advocate of people living with HIV."
- "Project LEAP has given me tools to understand HIV, and now I no longer feel it has any power over me. I am stronger than this disease."
- "I am glad I took the Project LEAP class, I learned a lot in the class."
- "Project LEAP has given me a lifelong guide to help me give back the knowledge I have learned."
- "Project LEAP means I can be a confident knowledgeable voice for the PLWH community, having the ability to link the community with resources and other available tools to make a positive impact."

Budget Information and Comparison

Original Cost of the Program: $ 52,000

2017 Cost of the Program: $ 13,824

Total Savings: $ 38,176

2017 Expenses:

Supplies	$ 466
Facilities Rental	724
Speaker Fees	100
Student Reimbursement (mileage only – no dependent care needed in 2017)	4,525*
Meals and Snacks	6,989
Staff Mileage	0
Miscellaneous (graduation shirts)	1,020
TOTAL	**$13,824**

* Of the $4,525 spent on transportation, $3,040 was for group transportation to and from AFH housing facilities

Project LEAP Budget Comparison, 2012 – 2017

Item	2012 Expenses	2013 Expenses	2014 Expenses	2015 Expenses	2016 Expenses	2017 Expenses
Personnel & Fringe	$ 0	$ 0	$ 0	$0	$ 0	$ 0
Supplies	1,182	1,159	523	638	493	466
Facilities Rental	268	875	318	274	1158	724
Speaker Fees	0	0	0	0	100	100
Student Reimbursement						
Transportation	3,294	3,178	4,878	1,031	1,242	4,525*
Dependent Care	560	705	0	0	0	0
Food	7,844	5,897	7,553	4,091	3,734	6,989
Staff Mileage	200	25	20	20	20	0
Miscellaneous	630	858	809	301	494	1,020
TOTAL	**$13,978**	**$12,697**	**$14,100**	**$6,355****	**$7,241****	**$13,824**

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

Acknowledgments

Project LEAP 2017 was a collaboration of the:

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

Project LEAP 2017 was made possible by the following individuals:

Project LEAP Advisory Committee

Tracey Gorden, Co-Chair
Teresa Pruitt, Co-Chair

Curtis Bellard
Johnny Deal
Herman Finley
Angela F. Hawkins
Denis Kelly
Rodney Mills
Allen Murray
Alex Moses
Robert Noble
John Poole
Venita Ray
Isis Torrente
Steven Vargas

Guest Speakers

Mike Alexander
MLA Consulting

Lydia Avila
Harris County Sherriff's Office

Melody Barr
Houston Department of Housing & Community Development

Nike Blue
AIDS Foundation Houston

Evelio Salinas Escamilla
Avenue 360 Health and Wellness.

Rodney Goodie
Saint Hope Foundation

Tracy Gorden
Vice Chair, Ryan White Planning Council

Annette Johnson
Baylor College of Medicine, Teen Health Clinic

Heather Keizman
Ryan White Grant Administration

Denis Kelly
Member, Community Planning Group,;
Committee Member, Ryan White Planning Council

Juma Koroma
Legacy Community Health

Januari Leo
Legacy Community Health

Judy Levison, MD, MPH
Baylor College of Medicine, Northwest Health Center

Sandra Longoria
Legacy Community Health

Jeffrey Meyer, MD, MPH
Houston Health Department

Scot More
Coalition for the Homeless of Houston/Harris County

John Nechman
Katine & Nechman L.L.P.

Venita Ray
Legacy Community Health

Cecilia Ross
Chair, Ryan White Planning Council

Gloria Sierra
Latino HIV Task Force;
Member, Ryan White Planning Council

Paul Simmons, MSN, NP-C
Legacy Community Health

Charleston Stoker
AIDS Foundation Houston

Crystal Townsend
Co-Chair, Community Planning Group

Steven Vargas
Member, Ryan White Planning Council
Association for the Advancement of Mexican Americans

Lou Weaver
Equality Texas

Cathy Wiley
Houston Health Department

Office of Support Staff

Tori Williams, Director
Amber Harbolt, Health Planner
Diane Beck, Council Coordinator
Rodriga Avila, Assistant Coordinator

HHD Bureau Staff

Marlene McNeese, Bureau Chief
Cathy Wiley, Training Administrator

Attachments

- FY17 Project LEAP Service Definition (approved 12-08-16)
- 2017 Project LEAP Course Overview
- 2017 Pre/Post-Training Evaluation Forms

Revised: 12-20-16
Council approved 12-15-17

Service Category Title: Grant Administration - Project LEAP

Unit of Service Definition:
1 unit of service = 1 class hour of training to Project L.E.A.P. participants. No other costs may be billed to the contract issued for Project LEAP.

GOAL: Agency will increase the number and effectiveness of People Living With HIV (PLWH) and the affected community who can participate in organizations, councils and committees dealing with the allocation of public funds for HIV-related prevention and care services, through an effort known as "Project LEAP" (Learning, Empowerment, Advocacy and Participation). Enrollment should include 20 to 30 persons who are living with HIV. No more than 10 individuals are to be enrolled in the training program who are affected by HIV. The race, ethnicity and gender composition of the classes must reflect current local HIV prevalence data to the extent feasible. Agency will prioritize to enroll individuals from groups that are disproportionally affected by HIV disease, including youth and transgender persons living with HIV, in Project LEAP.

Project LEAP will increase the knowledge, participation and efficacy of PLWH and affected participants through a training program specifically developed to provide PLWH and affected persons with the knowledge and skills necessary to become active, informed, and empowered members of HIV planning bodies and other groups responsible for the assessment of HIV-related prevention and service needs in the Houston EMA/HSDA. The primary focus of training is to prepare participants to be productive members of local HIV planning bodies, with an emphasis on planning activities conducted under the auspices of the Houston Ryan White Planning Council (RWPC).

Each class provided during the term of this agreement will include graduation and at least:

A. 44 contact hours of classroom training;

B. 6 hours of participation in Ryan White Planning Council and/or Committee related activities; and

C. 6 hours of participation in HIV-related community activities;

no more than 2 classes at 56 hours per class. The Council-approved minimum outline for the training curriculum includes: HIV funding sources, general and specific operational procedures of HIV-related planning bodies, information regarding assessment of the needs of PLWH in the Houston EMA/HSDA, evaluation skills needed to review proposals submitted by vendors for Request for Proposals (RFP) issued by local funding sources, organizational case studies and mentoring, presentation skills, knowledge related to accessing services, overview of HIV-related quality assurance (QA) processes and parliamentary procedure/meeting management skills.

Agency will provide reimbursement of eligible expenses to participants during the period of enrollment to reimburse these participants for out of pocket costs related to their participation, limited to transportation, childcare, and meals. Agency agrees to provide Harris County Public Health (HCPH)/Ryan White Grant Administration (RWGA) and the Houston RWPC with written reports and project summaries as requested by Harris County and in a form acceptable to Harris County, regarding the progress and outcome of the project.

Agency will provide Harris County with a written report summarizing the activities accomplished during the term of the contract within thirty calendar days after the completion of this contract.

Objective 1: Agency will identify and provide training to at least 20 persons who are living with HIV and no more than 10 affected individuals in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA. The following training curriculum shall be provided:

1. Information on PrEP and the sources and purposes of HIV service funds in the Houston EMA/HSDA;
2. The structure, functions, policies and procedures of the Houston HIV Health Services Planning Council (Ryan White Planning Council/RWPC) and the Houston HIV Prevention Community Planning Group (CPG);
3. Specific training and skills building in needs assessments, parliamentary procedures and meeting management procedures, presentation skills, reviewing and evaluating proposals for HIV-related funding such as serving on an external review panel, accessing and utilizing support resources and role models, and competence in organizational participation and conduct; and
4. Specific training on HIV-related Standards of Care, quality assurance methods and HRSA service category definitions.

Objective 2: Agency will enhance the participation of the people living with HIV and affected persons in the decision-making process by the following documented activities:

1. Establishing realistic training schedule(s) which accommodate varying health situations of those selected participants;
2. Conducting a pre-training evaluation of participants to determine their knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area. Agency must incorporate responses from this pre-training evaluation in the final design of the course curriculum to ensure that, to the extent reasonably possible, the specific training needs of the selected participants are addressed in the curriculum;
3. Conducting a post-training evaluation to measure the change in participants knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area;

4. Providing reimbursement of allowable expenses to help defray costs of the individual's participation, limited to transportation, child care, and meals; and
5. Providing both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning.

Objective 3: Agency will encourage cooperation and coordination among entities responsible for admin-istering public funds for HIV-related services by:

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

Agency will provide RWGA with the attached matrix and chart 21 and 14 days before the first class and again the day after the first class demonstrating that the criteria established by the Project LEAP External Advisory Panel was met. The matrix must be approved by RWGA 14 days before the first class.

Revised: 12-20-16
Council approved 12-15-17

EXAMPLE

Recommended Project LEAP Class of 2017

Candidate	M	F	T	HIV+	Non-Aligned HIV+	W	B	H	Youth Age 18 - 19	Youth Age 20 - 24
1	X			X	X	X				
2		X		X			X		X	
3		X					X			X
4		X		X	X			X		X
5	X					X				
6	X			X	X		X			
7	X			X	X	X				
Totals	4	3		5	4	3	3	1	1	2

	EMA HIV/AIDS prevalence as of 12/31/10*		PC Members as of 09/01/11		Non-Aligned Consumers on PC	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
Black, not Hispanic	10,225	48.98%	19	52.78%	8	50.00%
Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**
Gender	**Number**	**Percentage**	**No.**	**%**	**No.**	**%**
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**

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

Houston Area HIV Services Ryan White Planning Council
Office of Support

Project L.E.A.P. 2017 Course Overview

**Class will take place at an alternate location, day, and/or time*

Course Key: Classroom Guest Speaker In-Class Activity Off-Site Class
Group Project Deadline Graduation

Week	Date	Topics	Key
1	April 5 Room 416	• Overview of Project LEAP • Housekeeping, Logistics, and Ground Rules • Student Introductions and Expectations • HIV and Hepatitis • Suggest topics for LEAP Special Study Project • The History of HIV in the Houston Area	
2	April 12 Room 416	• Epidemiology Overview • Panel: Barriers to Reaching, Linking & Retention in Care, focusing on African Americans, Hispanics, MSM and Youth • LEAP Special Study Project - Survey Development • Introduction to Robert's Rules of Order	
3	April 19 Room 416	• Overview of HIV/AIDS Care Funds • From HRSA to Council: Overview of the Ryan White HIV/AIDS Program • LEAP Special Study Project –Survey skills training • Policies and Procedures: the PB&J Exercise	
4	April 26 Room 416	• Community Needs Assessments • Comprehensive HIV Planning • The HIV Continuum of Care • Designing HIV Care Services: How to Best Meet the Need • Robert's Rules of Order Exercise	
5	May 3 Room 416	• Leadership and Presentation Skills Building	
6	May 10 Room 416 **Dismiss class at 12 noon and 7:30 pm so students can attend a Community Meeting on date of choice**	• **IMPORTANT**: Submit completed survey forms • Speaker related to survey topic – 60 min. • Student choice speaker – 60 min.	

Course Key: Classroom Guest Speaker In-Class Activity Off-Site Class Group Project Deadline Graduation

Week	Date	Topics	Key
7	May 17 Room 416	• HIV Prevention Programs: CDC to CPG • LEAP Special Study Project – analyze data, prepare class presentation • Prepare for CPG Meeting	
8	May 24 Room 416	Attend the HIV Prevention Community Planning Group (CPG) Meeting	
9	May 31 Room 416	• Homelessness and HIV • Housing Opportunities for Persons with AIDS (HOPWA) • Prepare for the Planning Council meeting • LEAP Special Study Project – practice presentation	
10	**THURSDAY** June 8 Room 416	Attend the RWPC Meeting and Present the Class Special Study Project	
11	June 14 Room 416	• Plan for LEAP Graduation – Student photos • Priority and Allocations Exercise • Prepare for Priority & Allocations Committee Meeting	
12	June 21 Room 416	• Attend the Priority & Allocations Committee Meeting • Disclosure: To Do or Not to Do • Plan for LEAP Graduation	
13	June 28 Room 416	• Blue Book Treasure Hunt • Intimate Partner Violence & HIV • The Criminalization of HIV • Advocacy 101	
14	July 5 Room 416	Participate in an HIV Testing Event	
15	July 12 Room 240	• Ryan White Standards of Care & Performance Measures • Introduction to Transgender Topics • From Project LEAP to Planning Body: Panel of Planning Body and C.A.B. Members • Council and CPG Application Process/Forms	
16	July 19 Room 240	• The 5 Languages of Love • Community Meeting Report-Backs • Council and COI Refresher & Mock Interviews • Course Wrap-Up	
17	July 26 Room 416	Graduation Dinner and Ceremony	

Houston Area HIV Services Ryan White Planning Council
Office of Support
Project L.E.A.P. 2017 *Knowledge Assessment*

The purpose of this questionnaire is to measure your understanding of core Project L.E.A.P. topics and skills *before* the course begins. You will complete the same questionnaire at the end of the course. We will then compare both questionnaires. This comparison helps us know how well we did in reaching our goal to help your Project L.E.A.P. class improve its HIV Community Planning knowledge, skills, and abilities.

Today's Date: 04/05/2017

First Name: ____________________ **Last Name:** ____________________

***Please know that the only reason we need your name on this form is to match it to the questionnaire you will complete at the end of the course. Your name will not be used for any other reason.*

Please rate how well you currently understand each of the following topics:

I understand...	Very Well	Quite Well	Fairly Well	A Little	Not at All
The sources and purposes of HIV care, treatment, and support services funding	☐	☐	☐	☐	☐
The structure and function of the Houston Ryan White Planning Council (RWPC)	☐	☐	☐	☐	☐
The structure and function of the Houston HIV Prevention Community Planning Group (CPG)	☐	☐	☐	☐	☐
HRSA service category definitions for HIV care, treatment, and support	☐	☐	☐	☐	☐
HIV-related Standards of Care and quality assurance methods	☐	☐	☐	☐	☐

Please rate how well you can currently perform each of the following skills or activities:

I can...	Very Well	Quite Well	Fairly Well	A Little	Not at All
Read and understand needs assessments	☐	☐	☐	☐	☐
Use Robert's Rules of Order	☐	☐	☐	☐	☐
Engage in public speaking and give presentations	☐	☐	☐	☐	☐
Access community resources	☐	☐	☐	☐	☐
Serve as a role model	☐	☐	☐	☐	☐
Work in a group setting	☐	☐	☐	☐	☐

1. **What is the purpose of the Ryan White HIV/AIDS Program?** *Select* *one:*
   - Ⓐ To provide routine HIV testing in all health care settings
   - Ⓑ To provide emergency and/or transitional housing for People Living with HIV/AIDS
   - Ⓒ To provide HIV-related care, treatment, and support services for those who may not have sufficient resources to manage their HIV
   - Ⓓ To lobby for new state and local legislation regarding HIV

2. **What federal agency funds the Ryan White HIV/AIDS Program?** *Select* *one:*
   - Ⓐ The Centers for Disease Control and Prevention (CDC)
   - Ⓑ The Health Resources and Services Administration (HRSA)
   - Ⓒ The U.S. Department of Housing and Urban Development (HUD)
   - Ⓓ Office of National HIV/AIDS Policy (ONAP)

3. **What federal agency funds HIV prevention activities in states and cities?** *Select* *one:*
   - Ⓐ The Centers for Disease Control and Prevention (CDC)
   - Ⓑ The Health Resources and Services Administration (HRSA)
   - Ⓒ The U.S. Department of Housing and Urban Development (HUD)
   - Ⓓ Office of National HIV/AIDS Policy (ONAP)

4. **Which Houston Ryan White Planning Council (RWPC) document contains data on consumer-reported HIV care needs?** *Select* *one:*
   - Ⓐ The Assessment of the Administrative Mechanism
   - Ⓑ Epidemiologic Profile
   - Ⓒ The "Blue Book" Resource Guide
   - Ⓓ Community Needs Assessment

5. **Which of the following lists only Core Medical Services for HIV, as defined by HRSA?** *Select* *one*:
   - Ⓐ Food bank, medical case management, and legal services
   - Ⓑ Oral health, transportation, and primary care
   - Ⓒ Primary medical care, HIV medications, and medical case management
   - Ⓓ Linguistic services, mental health, and HIV medications

6. **Which of these lists only Support Services for HIV, as defined by HRSA?** *Select* *one:*
   - Ⓐ Transportation, legal services, and food bank
   - Ⓑ HIV medications, hospice care, and primary care
   - Ⓒ Medical case management, substance abuse treatment, and transportation
   - Ⓓ Food bank, oral health, and linguistic services

7. **In the Houston Area, what do the Administrative Agents do?** *Select* *one:*
   - Ⓐ Provide direct services to Ryan White consumers
   - Ⓑ Distribute HIV care funds by contracting with agencies that provide direct services to Ryan White consumers
   - Ⓒ Bring tasty snacks to all the meetings
   - Ⓓ Provide support to the Planning Council

8. **Which of the following is an activity of the Houston Ryan White Planning Council (RWPC)?** *Select* *one:*
   - Ⓐ Assessing the needs of People Living with HIV/AIDS
   - Ⓑ Allocating Ryan White HIV/AIDS Program dollars
   - Ⓒ Maintaining a comprehensive plan for HIV care services
   - Ⓓ All of the above

9. **Which organization administers HIV prevention education, provides HIV/STD testing, and gives administrative support to the Houston Area HIV Prevention Community Planning Group (CPG)?** *Select* *one:*
   - Ⓐ Ryan White Grants Administration (RWGA)
   - Ⓑ Houston Department of Health and Human Services (HDHHS)
   - Ⓒ Houston Regional HIV/AIDS Resource Group (TRG)
   - Ⓓ Texas Department of Health and Human Services (DSHS)

10. **What is the purpose of a Standard of Care, as it relates to HIV services?** *Select* *one:*
    - Ⓐ To determine whether an agency gets funding from Ryan White
    - Ⓑ To set the minimum level of quality for HIV services
    - Ⓒ To measure client satisfaction with HIV services
    - Ⓓ To evaluate agencies funded through Ryan White

11. **Take a deep breath, and give yourself a pat on the back! You did marvelously.** ☺

Service Category Title: Grant Administration - Project LEAP

<u>Unit of Service Definition:</u>
1 unit of service = 1 class hour of training to Project L.E.A.P. participants. No other costs may be billed to the contract issued for Project LEAP.

<u>GOAL</u>: Agency will increase the number and effectiveness of People Living With HIV (PLWH) and the affected community who can participate in organizations, councils and committees dealing with the allocation of public funds for HIV-related prevention and care services, through an effort known as "Project LEAP" (Learning, Empowerment, Advocacy and Participation). Enrollment should include 20 to 30 persons who are living with HIV. No more than 10 individuals are to be enrolled in the training program who are affected by HIV. The race, ethnicity and gender composition of the classes must reflect current local HIV prevalence data to the extent feasible. Agency will prioritize to enroll individuals from groups that are disproportionally affected by HIV disease, including youth and transgender persons living with HIV, in Project LEAP.

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Each class provided during the term of this agreement will include graduation and at least:

A. 44 contact hours of classroom training;

B. 6 hours of participation in Ryan White Planning Council and/or Committee related activities; and

C. 6 hours of participation in HIV-related community activities;

no more than 2 classes at 56 hours per class. The Council-approved minimum outline for the training curriculum includes: HIV funding sources, general and specific operational procedures of HIV-related planning bodies, information regarding assessment of the needs of PLWH in the Houston EMA/HSDA, **<u>a general understanding of an RFP process,</u>** organizational case studies and mentoring, presentation skills, knowledge related to accessing services, overview of HIV-related quality assurance (QA) processes and parliamentary procedure/meeting management skills.

Agency will provide reimbursement of eligible expenses to participants during the period of enrollment to reimburse these participants for out of pocket costs related to

their participation, limited to transportation, childcare, and meals. Agency agrees to provide Harris County Public Health (HCPH)/Ryan White Grant Administration (RWGA) and the Houston RWPC with written reports and project summaries as requested by Harris County and in a form acceptable to Harris County, regarding the progress and outcome of the project.

Agency will provide Harris County with a written report summarizing the activities accomplished during the term of the contract within thirty calendar days after the completion of the project. If completed with a noncontract agreement, written report must be submitted no later than 30 days prior to the end of the project calendar year.

Objective 1: Agency will identify and provide training to at least 20 persons who are living with HIV and no more than 10 affected individuals in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA. The following training curriculum shall be provided:

1. Information on PrEP and the sources and purposes of HIV service funds in the Houston EMA/HSDA;
2. The structure, functions, policies and procedures of the Houston HIV Health Services Planning Council (Ryan White Planning Council/RWPC) and the Houston HIV Prevention Community Planning Group (CPG);
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4. Specific training on HIV-related Standards of Care, quality assurance methods and HRSA service category definitions.

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3. Conducting a post-training evaluation to measure the change in participants knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area;

4. Providing reimbursement of allowable expenses to help defray costs of the individual's participation, limited to transportation, child care, and meals; and
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1. Involving HCPH/RWGA, The Houston Regional HIV/AIDS Resource Group (TRG) and other administrative agencies for public HIV care and prevention funds in curriculum development and training activities;
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   - Assist in curriculum development;
   - Provide input into criteria for selecting Project LEAP participants;
   - Assist with the development of a recruitment strategy;
   - If the agency finds it difficult to find individuals that meet the criteria for participation in the Project, assist with student recruitment; and
   - Review the final report for the Project in order to highlight the successes and brainstorm/problem solve around issues identified in the report. The results of the review will be sent to the Ryan White Operations Committee and the next Advisory Panel.
3. Collaborating with the Project LEAP External Advisory Panel during the initial 60 days of the Contract term. The criteria developed and utilized will, to the maximum extent possible, ensure participants selected represent the groups most affected by HIV disease, consistent with current HIV epidemiological data in the Houston EMA/HSDA, including youth (ages 18-24) and transgender persons living with HIV.

Agency will provide RWGA with the attached matrix and chart 21 and 14 days before the first class and again the day after the first class demonstrating that the criteria established by the Project LEAP External Advisory Panel was met. The matrix must be approved by RWGA 14 days before the first class.

DRAFT
Revised: 11-15-17

EXAMPLE

Recommended Project LEAP Class of 2018

Candidate	M	F	T	HIV+	Non-Aligned HIV+	W	B	H	Youth Age 18 - 19	Youth Age 20 - 24
1	X			X	X	X				
2		X		X			X		X	
3		X					X			X
4		X		X	X			X		X
5	X					X				
6	X			X	X		X			
7	X			X	X	X				
Totals	4	3		5	4	3	3	1	1	2

	EMA HIV/AIDS prevalence as of 12/31/10*		PC Members as of 09/01/11		Non-Aligned Consumers on PC	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
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Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**
Gender	**Number**	**Percentage**	**No.**	**%**	**No.**	**%**
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**

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

DRAFT

2018 Project LEAP Student Selection Guidelines

The following guidelines will be used by the Office of Support to select students for the 2017 Project LEAP cohort. They are presented in order of priority:

1. As outlined in the 2018 Service Definition for Project LEAP:

   a. The Office of Support shall enroll 20 to 30 persons who are living with HIV prior to the commencement of the training program. No more than 10 affected individuals are to be included in the training program. Preference will be given to non-aligned (non-conflicted) consumers of Ryan White HIV Program services in the Houston EMA and high risk applicants.

   b. Selected students shall be representative of the demographics of current HIV prevalence in the Houston EMA, with particular attention to sex/gender, race/ethnicity, and the special populations of youth (age 18 - 24) and transgender.

2. Not be a prior Project LEAP graduate.

   a. If the applicant is a prior LEAP graduate, they may be selected for the 2018 cohort if they have not been appointed to the Planning Council following LEAP participation and if space in the class is available.

3. Be available for the 2018 Project LEAP class schedule.

4. Have the ability to commit to Project LEAP expectations in regards to class participation, activities, and homework assignments.

5. Demonstrate an interest in planning HIV services in the Houston EMA. Students should have an understanding of the expected roles of Project LEAP graduates in local HIV prevention and care services planning.

6. Demonstrate an interest in volunteerism, advocacy, and other types of community involvement. If possible, have a history of past volunteerism, advocacy, and/or community involvement.

7. Demonstrated interpersonal skills consistent with successful participation in Project LEAP, such as ability/willingness to work in a team, effective communication skills, etc.

BYLAWS of the
HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

Revised December 13, 2007

SEE GREY TEXT FOR RECOMMENDED CHANGES

ARTICLE I

Establishment, Definitions and Purposes

Section 1.01. Establishment. The Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 USC §300ff et. seq. (West 1991 & Supp. 1997),), later revised as the Ryan White HIV/AIDS Treatment **Extension** ~~Modernization~~ Act of **2009**, requires the establishment of an HIV health services planning council by the chief elected official of the eligible area involved, as defined in §300ff 12(a)(1) of the Act. The County Judge (as hereinafter defined) has established the Ryan White Comprehensive AIDS Resources Emergency Act HIV Health Services Planning Council in conformity to Section §300ff 12(a)(1) of the Act. The Council, as established by the County Judge, is not incorporated under the Laws of the State of Texas or any other jurisdiction.

Section 1.02. Definitions. The following definitions shall have the ascribed meaning when used herein, except to the extent the context hereof clearly requires and indicates otherwise:

"Acquired Immune Deficiency Syndrome" (AIDS) is defined by the current criteria established by the Centers for Disease Control (CDC).

"Act" is defined as the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 USC §300ff et.seq.(West 1991 & Supp. 1997), later revised as the Ryan White HIV/AIDS Treatment **Extension** ~~Modernization~~ Act of **2009**.

"AIDS" is defined as Acquired Immune Deficiency Syndrome.

"~~Harris County HIV Services~~ Ryan White Grant Administration" is defined as the section of Harris County Public Health ~~and Environmental Services~~ that administers grant funds allocated to the "Eligible Metropolitan Area" under the Act.

"Council" is defined as the Ryan White HIV Health Services Planning Council established by the County Judge.

"County Judge" is defined as the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals living with HIV ~~with AIDS~~, as defined in §300ff 12(a)(1) of the Act and herein refers to the duly elected County Judge of Harris County, Texas.

"Eligible Metropolitan Area" is defined as the Houston/Harris County Area which area has been determined by the Centers for Disease Control to consist of Harris County, Waller County, Fort Bend County, Montgomery County, Chambers County and Liberty County.
"Emergency" is defined as an unforeseen combination of circumstances or the resulting state that

calls for immediate action.

"HIV" is defined as the Human Immunodeficiency Virus.

"HIV Infection" is defined as the presence of HIV in the bloodstream as confirmed by the diagnostic tests prescribed by the Centers for Disease Control.

"HRSA" is defined as the Health Resources Services Administration of the Public Health Service of the United States Department of Health and Human Services.

"HSDA" is defined as the Texas Department of Health Services Delivery Area.

"RFPs" is defined as Request for Proposals.

Section 1.03. Purposes. The purposes for which the Council is established are:

(1) To conduct needs assessment activities;

(2) To develop a comprehensive plan for the organization and delivery of health services described in §300ff 14 of the Act that is compatible with any existing State of Texas or local plan regarding the provision of health services to individuals living with HIV ~~with HIV Infection~~ or AIDS;

(3) To establish priorities for the allocation of funds within the Eligible Metropolitan Area;

(4) To allocate funds within the Eligible Metropolitan Area;

(5) To assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the Eligible Metropolitan Area.

ARTICLE II

Appointment of Council, Composition of Council, Term and Compensation

Section 2.01. Appointment of Council. All members of the Council shall be appointed by the County Judge. Vacancies occurring on the Council shall be filled by appointment of the County Judge and serve at the pleasure of the County Judge. All candidates are subject to the established Nominations Screening process, with the exception of persons representing HRSA required governmental bodies, including the State Medicaid Agency, HOPWA and others.

Section 2.02. Composition of Council. The Planning Council will be made up of individuals as specified in Sec.2602(2) PLANNING COUNCIL REPRESENTATION as stated in the most current Ryan White Program, and will be reflective of the local HIV/AIDS epidemic. The Planning Council may also request other positions/representation in order to maintain diversity within the EMA reflecting the pandemic and/or needed expertise within the EMA subject to the approval of the County Judge. These positions are subject to the Nominations Screening Process.

Section 2.03. Term. Each Council position is for a term of two (2) years. The terms of one-half the Council positions shall terminate in even-numbered years and the other half of the positions shall terminate in odd-numbered years. A term shall begin on January 1 and shall terminate on December 31 of the second year following. Council members appointed to vacancies shall complete the unexpired term of office.

Section 2.04. Term Limits. The County Judge shall appoint Council members to no more than three two-year terms. All members serve at the pleasure of the County Judge through an open nominations process.

Section 2.05. Compensation/Reimbursement. Persons serving as members of the Council shall not receive any salary or other compensation for their services as a member of the Council. All Council members may be reimbursed allowable expenses as approved by Harris County Public Health ~~and Environmental Services~~, the Ryan White Planning Council, and the CEO.

ARTICLE III

Duties of the Council

Section 3.01. Duties. The duties of the Council are to see to the establishment and implementation of the purposes of the Council as set out in Section 1.03 of these Bylaws and those duties which are prescribed by the provisions of the Act as within the purview of the Council.

Section 3.02. Orientation. All new members shall be required to attend mandatory orientation within 6 months.

ARTICLE IV

Committees

Section 4.01. Steering Committee. The Steering Committee shall be composed of the following persons: Chair of the Council, Vice Chair of the Council, Secretary of the Council, and the Chair, or Co-Chairs, of each Standing Committee. Actions of the Steering Committee are subject to ratification by the Council. The Steering Committee is responsible for the following:

(1) setting agendas for the Ryan White Planning Council;

(2) making recommendations to the Ryan White Planning Council;

(3) providing leadership;

(4) previewing reports from the Standing Committees;

(5) and functioning in "emergency" situations as they arise.

Section 4.02. Standing Committees. There shall be six Standing Committees. Each member of the Council except the Planning Council Chair is required to serve on at least one of the following standing committees.

1) Affected Community
2) Operations

3) Comprehensive HIV Planning
4) Priority and Allocations
5) Quality ~~Assurance~~ Improvement
6) Steering

Section 4.03. Ad hoc groups, work groups, subcommittees. The Chair of the Council or the Council may, from time to time, establish such other ad hoc groups as may be expedient or necessary to carry out the duties and responsibilities of the Council. The scope and responsibilities of such ad hoc groups shall be delineated at the time such groups may be established.

ARTICLE V

Officers, Election of Officers, Election of Committee Chairs
Duties of Officers and Duties of Service Committee Chairs

Section 5.01. Officers. The officers of the Council shall be a Chair, a Vice Chair and a Secretary. Officers cannot serve as Standing Committee Chairs. Ryan White Part A or B or State Services funded providers/employees/subcontractors/Board Members and or employees/ subcontractors of the Grantee shall not be eligible to run for office of Chair of the Ryan White Planning Council. A parliamentarian may be appointed at the pleasure of the Chair. Subsequent to election, if the Chair becomes a contractor, he/she shall be removed and a new election held to elect a new Chair.

Section 5.02. Election of Officers. The officers shall be elected by the majority vote of the members of the Council at the December meeting, which shall be termed the Organizational Meeting. (Per letter from Judge Eckels dated 12-13-00: "As in any political election, the number of candidates is not regulated. Following the first vote in the race, if one candidate has not received the majority, a run-off election is held between the two candidates receiving the most votes. The Council may accept nominations for the slate of officers that exceeds two candidates and may receive nominations from the floor regardless of the number of candidates already nominated.") One of the three officers must be a self-identified HIV positive person. Officers elected at the Organizational Meeting of the Council shall serve from the date of election to the next annual Organizational Meeting. If a vacancy occurs in any office, the Council shall elect a replacement to serve the remainder of the term.

Section 5.03. Appointment of Committee Chairs. Committee Chairs will be appointed by the Planning Council Chair. Committee Chairs must be members of the Planning Council for at least one year. If committee leadership is not available from among Planning Council members with at least one year's service, the Chair may seek leadership among remaining Planning Council members.

Section 5.04. Duties of Officers. The officers of the duly appointed Council shall have the responsibility for the performance of the following duties:

Chair: The Chair of the Council shall serve as the Chief Executive Officer of the Council and shall preside at all meetings of the Council and the Steering Committee. The Chair is the only official spokesperson for the Council and will be responsible for interfacing with the public and with the media. As the only authorized spokesperson, the Chair will have a business card that includes his/her name. He/she will also be responsible for correspondence to members regarding attendance and participation issues. The Chair shall perform such other duties as are normally performed by a chair of an organization or such other duties as the Council may prescribe from time to time. The Chair of the Council is an ex-offico member of all committees (standing, subcommittee, and work groups). Ex-offico means that he/she is welcome to attend and is allowed to be a part of committee discussion. They are not allowed to vote. In the absence of the Chair of the Council, the next officer will assume the ex-offico role with committees.

Vice Chair: The Vice Chair of the Council shall preside at meetings of the Council and Steering Committee in the absence of the Chair. The Vice Chair shall perform such other duties as the Chair may designate or the Council shall prescribe from time to time.

Secretary: Per Texas law, the Secretary may not chair a meeting. The position of Secretary shall include the following duties:

1) The Secretary will ensure that minutes are taken, approved, and filed as mandated by the Ryan White Program.
2) The Secretary will be responsible for keeping an up-to-date roll of Planning Council members.
3) When a roll call vote is taken, the Secretary will call the roll call vote, note the vote and announce the results of the roll call vote. The Secretary will monitor voting for possible conflicts of interest, the Secretary will process inquiries into votes made in conflict of interest.
4) The Secretary will keep a copy of the Planning Council Bylaws and other relevant Policies and Procedures at the Planning Council meetings, and will provide the Council with clarification from the Bylaws and Policies & Procedures, as requested.
5) The Secretary will keep a record of all committees of the Planning Council. When (if) new committees are established, the Secretary will assure or cause to be assured the actual formation and implementation of the new committees.
6) The Secretary will be responsible for notification of specially called Planning Council meetings, corresponding to the members as required by the Bylaws.

Standing Committee Chairs/**Co-Chairs**: The Standing Committee Chairs (ADD:, or one of the Standing Committee Co-Chairs,) shall preside at all meetings of their respective committees. The Committee Vice Chair shall preside at all committee meetings in the absence of the Chair (ADD: or both of the Co-chairs). If ~~neither~~ none are present, committee members shall use consensus to select another committee member to chair that particular meeting. The Committee Chairs (/Co-chairs) are responsible for the execution of the duties prescribed herein for the Committees and for such other duties as may be prescribed by the Chair of the Council or the Council from time to time. The Committee Chairs (/Co-chairs) are responsible for the recording of or cause to be

recorded all deliberations undertaken by each respective Committee. Copies of all approved minutes are available in the Office of Support for the Ryan White Planning Council.

ARTICLE VI

Quorum, Voting, Proxies and Attendance

Section 6.01. Quorum. A majority of the members of the Council are required to constitute a quorum at Council meetings. In computing a quorum, vacant seats on the Council or Committee shall not be counted. A minimum of one (1) self-identified HIV positive member must be present to constitute a quorum.

At least two (2) committee members and a Chair must be present; one of these must be a self-identified HIV positive member, to constitute a Standing Committee quorum.

Section 6.02. Voting. Each member of the Council shall be entitled to one vote on any regular business matter coming before the Council. A simple majority of members present and voting is required to pass any matter coming before the Council except for that of proposed Bylaw changes, which shall be submitted (in written form) for review to the full Council at least fifteen (15) days prior to voting and will require a two-thirds (2/3) majority for passage. The Chair of the Council shall not vote except in the event of a tie. The Chairs of the Standing Committees shall not vote at Committee meetings except in the event of a tie.

Section 6.03. Proxies. There shall be no proxy voting.

Section 6.04. Council Attendance.
Council members are required to attend meetings of the Houston Area HIV Health Services (Ryan White) Planning Council. Any Council member with four (4) absences from Council meetings within a calendar year or who fails to perform the duties of a Council member described herein without just cause, is subject to removal by the CEO. The Secretary shall cause attendance records to be maintained and shall regularly provide such records to the Chair.

Standing Committee Attendance:
Committee members are required to attend regularly scheduled committee meetings. Four (4) absences from committee meetings in a calendar year may be grounds for reassignment or termination of committee membership. The Council Chair will be responsible for determining reassignment or termination of committee membership. Reasons for absences that would be used for determining reassignment or termination include: 1) sickness; 2) work related conflicts (in or out of town and vacations); and 3) unforeseeable circumstances. The Chair of the Operations Committee will notify the Planning Council Chair if a member is absent for four (4) committee meetings and, if warranted, the Planning Council Chair will formally notify the member in writing of removal from committee membership. The member will be given an opportunity to request assignment to another committee. If the member continues to fail to meet committee requirements, (ADD: it is the sole responsibility of the County Judge to determine if) the member will ~~not~~ be (ADD: discharged) ~~permitted to continue as a member of~~ (ADD: from membership on the) Planning Council.

Any Planning Council member who is unable to attend a Planning Council meeting or standing committee meeting of the committee must notify the Office of Support prior to such meeting. The

Office of Support staff will document why a member is absent. The Operations Committee will review attendance records quarterly.

ARTICLE VII

Administration of Funds, Information Regarding Funding
and Council Oversight of Funding

Section 7.01. Administration of Funds. The County Judge shall designate the lead agency which will be charged with the administration and distribution of any funds granted to the Eligible Area under the Act. The Council shall report to the County Judge its findings and recommendations regarding the prioritization and allocation of funds granted under the Act, together with its recommendations as to the use of any such funds in accordance with the provisions of the Act.

Section 7.02. Information Regarding Funding. ~~Harris County HIV Services~~ **Ryan White Grant Administration** will be responsible for the collection and dissemination of monthly reports to the Council on the administration of the funds granted to the Eligible Metropolitan Area under the Act.

Section 7.03. Council Oversight of Funding. The Council is responsible for an annual assessment of the administrative mechanism and distribution of the funds granted to the Eligible Metropolitan Area under the Act by the lead agency designated by the County Judge. The Council shall perform such other oversight duties as may be required by the Act or any regulation promulgated there under.

ARTICLE VIII

Conflicts of Interest

Section 8.01. Conflict of Interests. A conflict of interest (COI) occurs: 1) when an appointed or voting member of the planning council has a direct or indirect fiduciary or other personal or professional interest in a council decision or the outcome of a vote, 2) when a member uses his/her positions for purposes that are motivated by pursuit of private gain for themselves or their families, friends, or business associates. COI is defined to include interests that existed within 12 months preceding the date when the conflict ended. The mere perception of COI is a significant concern.

The Council, acknowledging that perception is as important as reality, has elected to voluntarily adopt the following code of conduct regarding conflict of interest to be followed during all deliberations and decisions.

1) In order to make members aware of any potential positive bias, Council members agree to disclose their associations with any organization seeking to do business with the Ryan White Part A or B Administrative Agencies for which they or their spouse or domestic partner, during the past twelve months:
    a) own, have ownership interest, or have been employed;
    b) are or have been a Board member;
    c) are or have been a consultant; or

d) are or have been involved in a contractual relationship.

3) In order to make other members aware of any potential negative bias, Council members agree to disclose their associations with any organization seeking to do business with the Ryan White Part A or B Administrative Agencies with which they or their spouse or domestic partner, during the past twelve months are or were involved in mediation, arbitration or litigation over any employment, contract, service delivery or other matter.

4) Council members agree to abstain from voting on any decision related to any organization for which they or their spouses or domestic partner have association as specified in number 1, above.

4) Council members will not serve on Grantee proposal review panels.

Section 8.02. Disclosure of Conflicts of Interests. Council members who have COI must declare that conflict before the discussion of a motion. This will be recorded in the official minutes. All council members must submit signed affidavits disclosing any COI when joining the Council, and at least annually, and/or more often as needed, thereafter. Members who are closely affiliated with an applicant are excluded from the prioritization process.

ARTICLE IX

Regular Meetings, Special Meetings, Notice and Business to be Considered

Section 9.01. Regular Meetings. Regular Meetings of the Council shall be held no less than quarterly at such times and places as shall be designated by the Council. Written Notice of Regular Meetings shall be given (ADD: by email) no less than five (5) calendar days prior to such Regular Meeting.

Section 9.02. Special Meetings. Special Meetings of the Council shall be held at such times and places as shall be designated by the Chair of the Council or upon the written request of one-half (1/2) of the members of the Council. Notice of Special Meetings shall be given (ADD: by telephone or email) no less than three **(3) working** days prior to such Special Meeting.

Section 9.03. Notice. It shall be the duty of the Secretary to give or cause to be given such notice to each member of the Council. Notice of Regular Meetings shall be given in writing. Notice of Special Meetings may be given telephonically, by email or by telecopier. Notice of Council meetings shall be posted in accordance with the Open Meeting Act, TEX. GOV'T CODE ANN. §§ 551.001-551.146, as amended.

Section 9.04. Business to be Considered. Any business coming before the Council shall be considered at a duly constituted and noticed Regular Meeting or Special Meeting. Only items approved by the Steering Committee for presentation to the Council and posted on the agenda may be voted on.

Section 9.05. Public Comment. There is an opportunity for public comment at all meetings. Persons wishing to speak must follow the Policies and Procedures for Public Comment.

ARTICLE X

Grievance

Section 10.01. Grievance. There is a Ryan White Planning Council grievance process and the Grievance Policies & Procedures must be followed.

ARTICLE XI

Amendments, Governing Procedure, Compliance and Invalidity of Provisions

Section 11.01. Amendments. These Bylaws may be amended from time to time by a vote of two-thirds (2/3) of the entire membership of the Council. Proposed amendments shall be submitted (in written form) for review to the full Council at least fifteen (15) days prior to voting.

Section 11.02. Governing Procedure. The meetings of the Council shall be conducted in accordance with Roberts Rules of Order; revised except to the extent the provisions of Roberts Rules of Order conflict with the Bylaws of the Ryan White Planning Council in which event the Bylaws shall prevail.

Section 11.03 Compliance. The Council shall at all times comply with the duties and responsibilities set out in the Act and shall perform all of its deliberations in accordance therewith.

Section 11.04. Invalidity of Provisions. In the event any provision hereof conflicts with the provisions of the Act or other applicable law, such provision shall be deemed stricken and the remainder of these Bylaws shall be in full force and effect without regard to such invalid provision.

2017 QUARTERLY REPORT
OPERATIONS COMMITTEE

(submit November 2017)

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

1. Design and implement Orientation for Council members and new external committee members in January and February 2017.
   Status: done 11/14/17

2. When necessary, address member needs for additional orientation and training, including through the Committee Mentoring Program. (Example: create more training for mentors and a "Frequently Asked Questions" form. The information for this document can be gathered from Project LEAP and others.)
   Status: implemented committee cross training

3. *When necessary, review and revise the bylaws, policies, and procedures of the Ryan White Planning Council.
   Status: did throughout 2017

4. When necessary, review and revise policies and procedures for the Council support staff.
   Status: done

5. *Investigate and make recommendations regarding complaints and grievances brought before the committee in order to assure member/staff compliance with bylaws, policies, and procedures.
   Status: none

6. *Resolve any grievances brought forward.
   Status: NA

7. *Make nominations to the CEO, which ensure the reflectiveness and representativeness of the Council.
   Status: almost done 11/14/17

8. Evaluate the performance of the Manager in conjunction with the Planning Council Chair and CEO.
   Status: not yet - due in Dec.

9. Ensure that the Council is complying with HRSA, County and other open meeting requirements.
   Status: ongoing

10. Annually, review the status of Committee activities identified in the Comprehensive Plan.
    ongoing

Status of Tasks on the Timeline:

Nancy Mietschin
Committee Chairperson

Nov. 14, 2017
Date

SLATE OF NOMINEES

As of Thursday, November 2, 2017, the following people have been nominated as officers for the 2018 Ryan White Planning Council:

Chair:

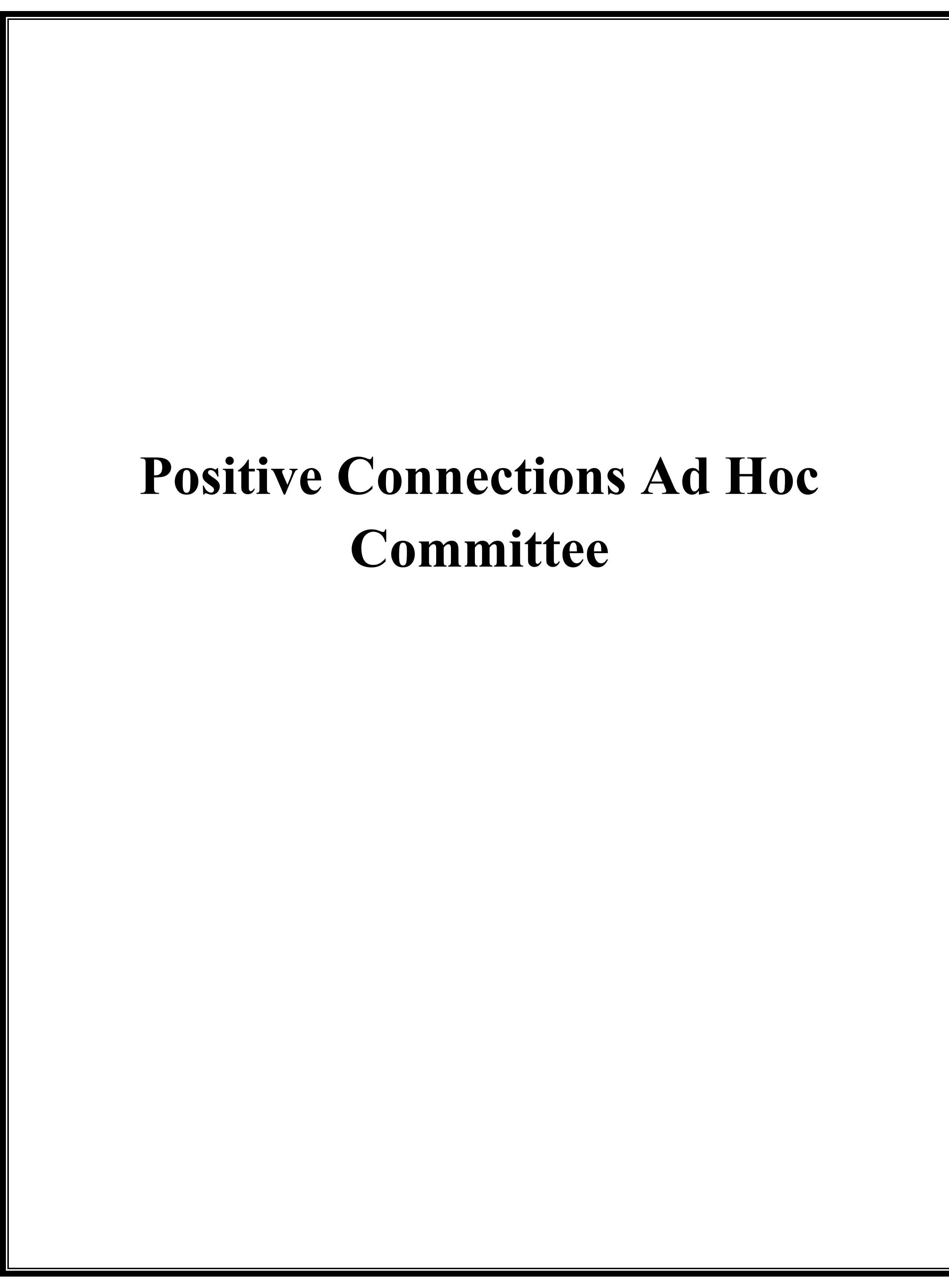
Cecilia Ross

Vice Chair:

Skeet Boyle

Secretary:

Carol Suazo



Positive Connections Ad Hoc Committee

Content Analysis and User Characteristics of a Smartphone-Based Online Support Group for People Living with HIV

Tabor E. Flickinger, MD, MPH,[1] Claire DeBolt, BA,[1] Erin Wispelwey, MSc,[1] Colleen Laurence, MPH,[2] Erin Plews-Ogan, BA,[1] Ava Lena Waldman, MHS, CHES,[1] George Reynolds,[3] Wendy F. Cohn, MEd, PhD,[1] Mary Catherine Beach, PhD,[4] Karen Ingersoll, PhD,[1] and Rebecca Dillingham, MPH, MD[1]

[1]Department of Medicine, University of Virginia School of Medicine, Charlottesville, Virginia.
[2]Department of Medicine, Wake Forest School of Medicine, Winston Salem, North Carolina.
[3]Health Decision Technologies, Oakland, California.
[4]Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Abstract

Background: Although there is growing interest in mobile applications and online support groups to enhance chronic disease self-management, little is known about their potential impact for people living with HIV (PLWH). Introduction: We developed an innovative online support group delivered through a community message board (CMB) within a clinic-affiliated smartphone application Positive Links (PL). We analyzed characteristics of posters and nonposters to the CMB and evaluated content posted to the CMB. Materials and Methods: For this study, 38 HIV-infected patients received cell phones with the PL application that included the opportunity to interact with other users on a CMB. Logistic regressions investigated associations between participant characteristics and posting. CMB messages were downloaded and analyzed qualitatively. Results: 24 participants posted to the CMB; 14 did not. Participants had lower odds of posting if they were white (p = 0.028) and had private insurance (p = 0.003). Participants had higher odds of posting if they had unsuppressed viral loads (p = 0.034). Of the 840 CMB messages over 8 months, 62% had psychosocial content, followed by community chat (29%), and biomedical content (10%). Discussion: Psychosocial content was most prevalent on this CMB, in contrast to other online forums dominated by informational content. Participants who posted expressed support for each other, appreciation for the community, and a perception that the app played a positive role in their HIV self-management. Conclusions: This CMB on a clinic-affiliated mobile application may reach vulnerable populations, including racial/ethnic minorities and those of lower socioeconomic status, and provide psychosocial support to PLWH.

Keywords: *HIV/AIDS, qualitative analysis, online support groups, mobile app, m-health, behavioral medicine*

Introduction

People living with HIV (PLWH) face many challenges, including unmet needs for support and information from peers. Online support groups have the potential to overcome barriers to meeting these needs. Prior studies of online support groups for a variety of chronic diseases have shown that the online support group content generally focuses on informational support and illness experience.[1–5] Online support groups can promote patient empowerment,[6–8] but may also present risks.[8–11] Lack of nonverbal cues can lead to misunderstandings, while lack of quality control may allow misinformation to disseminate. Negative postings or inappropriate interactions may undermine users' sense of support. PLWH may be particularly vulnerable to the risks of online support groups, due to the stigma surrounding this illness and the sensitivity of disclosure. At the same time, stigma may make online support groups particularly valuable for PLWH, as a means of accessing support while maintaining anonymity.

Our study examines an online support group delivered through a community message board (CMB) within an innovative smartphone application (Positive Links [PL]) designed to promote linkage and retention in HIV care. The app was developed in-house by the study team and is available only to participants referred by project partners. In addition to the CMB, the PL app includes daily queries of stress and medication adherence, appointment reminders, tailored educational resources, and access to the study team for individualized counseling and assistance. The CMB within the PL app provides a unique data set for content analysis of an online support group for PLWH. In addition to users' posts, our app study includes demographic and clinical data on our participants not available in prior studies in HIV, which used online recruitment

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of anonymous support group users or publicly accessible postings.[2,10,12] Furthermore, the app targets a population not previously studied. Prior work on online support groups in HIV and other chronic diseases has focused on Caucasian highly educated groups.[10,12–15] Our group may be more representative of the HIV-positive population in the United States, which disproportionately affects disadvantaged persons, including racial/ethnic and sexual minorities and those of lower socioeconomic status.

To our knowledge, there are no HIV medical apps that offer an anonymous online CMB. To address this gap, we developed the PL app and are conducting a pilot study on its impact. In the current analysis of the CMB, our objectives were to (1) compare characteristics of posters and nonposters to the CMB and (2) evaluate content posted to the CMB. We hypothesized that posters would be more likely to be female, younger, and with a longer time period since diagnosis, based on the literature about posting behaviors in other chronic diseases.[13–15] In the content analysis, we anticipated a predominance of biomedical content, similar to the patterns found in other online support groups. Ultimately, an online CMB (provided within an app) may be an opportunity to reach vulnerable PLWH, connect them with information and support from peers, and help them link to and remain in medical care, fostering better health outcomes.

Materials and Methods

COMMUNITY MESSAGE BOARD

The PL app was developed using an iterative formative phase, in which we gathered input from our patient population to identify features that would be relevant, useful, and appealing.[16] Formative phase participants welcomed the idea of a CMB and emphasized the importance of anonymity and access to support.

For the current phase of the study, enrollment began in September 2013. Eligibility criteria were as follows: a score of 40 on the Wide Range Achievement Test (WRAT-4) or passing a subsequent reading test *and* HIV diagnosis since January 2012 OR at risk of falling out of care, as determined by their care provider. Participants were adults, age 18 years and older. There were no additional explicit exclusion criteria. We recruited participants through provider referrals at our local university-based Ryan White Clinic and from area AIDS service organizations and HIV testing sites. During enrollment, individuals consented to participate in the study, completed the WRAT-4 literacy test, answered baseline questions, and learned how to use the phone and PL app. Samsung Galaxy 2 or Galaxy 3 phones were provided and included a voice/data plan with unlimited minutes, texting, and data for the study duration. Phones were encrypted and password protected and had a remote locate and wipe functionality. The app was also password secured. After enrollment, each participant will be included in the study for 18 months. Due to staggered enrollment, the total duration of the study is projected to require 2 years for all participants to complete study procedures and follow-up. The current analysis has been performed after 8 months of study duration, to evaluate preliminary findings in app usage to inform further iterative development of the app and, in particular, the CMB.

Participants had the opportunity to interact on the CMB through user names that they selected for themselves, to protect anonymity. Participants could start new conversations on the board or respond to older conversations. The PL team also introduced new conversation topics on HIV or general well-being and posted weekly funny videos, as had been suggested by formative phase participants. The team monitored the board for incorrect information or inflammatory comments and could also communicate with participants privately, as needed. This study was approved by the Institutional Review Board.

QUANTITATIVE ANALYSIS

Participants' characteristics were collected at enrollment by self-report. Demographic characteristics included age, gender, race, transmission risk behavior, time since diagnosis, and religious belief. Participants were categorized as "newly diagnosed" if they were enrolled in the study less than 3 months after their HIV diagnosis. Socioeconomic variables included education, insurance status, food security, employment status, and self-reported income. Participants also completed the WRAT-4 to assess literacy,[17] the Perceived Stress Scale,[18] and the Berger Stigma Scale.[19] Clinical data were extracted from the electronic medical record. Characteristics were compared between posters and nonposters to the CMB with Fisher's exact tests for categorical variables and *T*-tests for continuous variables. We performed logistic regressions to investigate associations between participant characteristics and posting on the CMB. All analyses were done using STATA 11 (StataCorp, College Station, TX).

QUALITATIVE ANALYSIS

After the PL study had been ongoing for 8 months, the CMB messages were downloaded and imported into NVivo qualitative data analysis software (QSR International Pty Ltd. Version 10, 2012). Using a Grounded Theory approach,[20] two independent coders assigned codes to every post to categorize themes expressed by participants. Individual codes were grouped into

three broad types of content: biomedical, psychosocial, and community chat. The codebook was refined until intercoder agreement reached a kappa statistic of 0.93. After thematic saturation was achieved with no additional topics identified by either coder, the codebook was applied to the entire data set of posts, so that the frequency of each topic category could be evaluated.

Results

CHARACTERISTICS OF POSTERS AND NONPOSTERS

Among the 38 participants in this analysis, mean age was 34.1 years (SD 11.5). Twenty-eight participants were male (74%), 9 were female (24%), and 1 transgender male to female (3%). Seventeen participants identified as black, non-Hispanie (45%), 13 as white, non-Hispanic (34%), 3 as Hispanic (8%), 3 as multiple races (8%), 1 as African American/Caucasian (3%), and 1 refused to answer (3%). *Table 1* shows differences in participant characteristics between the 24 who posted to the CMB (posters) and 14 who never posted (nonposters). Posters were more likely to be nonwhite, with 76% of nonwhite participants posting and only 38% of white participants ($p=0.035$). The majority of nonwhite participants (68%) self-identified as "Black, non-Hispanic". Participants with public insurance or uninsured were more likely to post than those with private insurance (79% vs. 20%, $p=0.002$). Participants with unsuppressed viral loads were also more likely to post than those who were suppressed (82% vs. 48%, $p=0.043$). Several other trends were suggested by the data, such as posters being younger and more likely to be newly diagnosed with HIV than nonposters, but these findings were not statistically significant. There were no differences in gender, literacy scores, perceived stress, or stigma scores.

Table 2 shows the results of unadjusted logistic regression analyses investigating associations between participant characteristics and posting on the CMB. Partieipants had lower odds of posting if they were white [OR 0.20 (0.05–0.84), $p=0.028$] and had private insurance [OR 0.07 (0.01–0.41), $p=0.003$]. Participants had higher odds of posting if they had unsuppressed viral loads [OR 5.13 (1.13–23.30), $p=0.034$)]. When race, insurance status, and viral load were included in one multivariable model, race was no longer significant, but insurance status and viral load remained significant ($p=0.020$ and 0.047, respectively). The association between viral suppression and posting was attenuated when adjusted for newly diagnosed status, but a trend remained [OR 4.44 (0.87–22.56), $p=0.073$]. When race, insurance status, viral load, and newly diagnosed status were all included in multivariate analysis, only insurance status remained statistically significant [OR 0.09 (0.01–0.71), $p=0.023$].

CONTENT AND THEMES POSTED ON THE CMB

In total, 840 messages from participants posting on the CMB were analyzed. Posts on the CMB were most commonly psychosocial content (62% of posts), followed by community chat (29%) and biomedical content (10%). *Table 3* shows each category from the codebook with frequency of occurrence and examples. Posts could be assigned more than one code if several different topics were expressed.

PSYCHOSOCIAL CONTENT

Of psychosocial content, posts frequently described stressors, offered support for and affirmations of other users, described users' state of mind, and discussed coping strategies. Posts describing stressors represented 9.3% of total posts ($N=840$) and 15.2% of posts with psychosocial content ($n=515$). Participants reported many sources of stress, including from relationships outside the CMB and HIV-related concerns, including disclosure, stigma, and both geographic and social isolation. Many posts expressed more than one stressor and, either explicitly or implicitly, asked the CMB community for advice. It should be noted that posters frequently used abbreviations common in text messages, such as "u" for "you," and additionally used nonstandard grammar, punctuation, and spelling, perhaps consistent with the skew toward lower educational attainment in this sample.

Among coping strategies identified, participants most frequently used the CMB for coping, in 31.6% of total posts and 51.5% of posts with psychosocial content. Participants reached out to the community for help with statements such as "Im so mad and not sure what to do … Need someone to talk to." Participants also discussed coping methods that had helped them and could help others, which included prayer, music or dance, maintaining positive thinking, and maintaining positive relationships outside the CMB. Non-CMB coping methods were shared in 9.8% of total posts and 16.0% of posts with psychosocial content.

Posts expressing the user's state of mind represented 10.6% of total posts and 17.3% of posts with psychosocial content. Positive posts endorsed optimism, contentment, perseverance, and gratitude. Negative emotions were also shared, including anger, frustration, depression, grief, embarrassment, worry, or anxiety. These negative posts were generally met with encouragement and empathy, such as "I know how u feel … but one thing I can say there is light at the end of the tunnel." However, some negative posts appeared to be disturbing or disruptive to the community. In particular, posts expressing suicidal thoughts caused tension on the CMB. The PL team reached out privately to participants expressing mental health concerns, including suicidal thoughts, to provide assistance.

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Table 1. Characteristics of All Participants, and Comparing Posters Versus Nonposters to the Community Message Board

CHARACTERISTIC	ALL PARTICIPANTS (N=38)	POSTERS (N=24)	NONPOSTERS (N=14)	p
Age in years: mean (SD)	34 (11.5)	33.5 (11.8)	35.1 (11.3)	0.680
Gender, n (%)				0.715
Male	28 (74)	17 (61)	11 (39)	
Female	10 (26)	7 (70)	3 (30)	
Race, n (%)				0.035
White, non-Hispanic	13 (34)	5 (38)	8 (62)	
Not white (all other categories)	25 (66)	19 (76)	6 (24)	
Transmission risk, n (%)				0.740
Men who have sex with men (MSM)	21 (55)	14 (67)	7 (33)	
Not MSM	17 (45)	10 (59)	7 (41)	
Religious practices, n (%)				0.611
Religious	16 (42)	9 (56)	7 (44)	
Spiritual	15 (39)	11 (73)	4 (27)	
Neither	7 (18)	9 (57)	3 (43)	
Education, n (%)				1.000
Did not complete 12th grade	7 (18)	5 (71)	2 (29)	
Completed high school	31 (82)	19 (62)	12 (39)	
Insurance, n (%)				0.002
Private	10 (26)	2 (20)	8 (80)	
Does not have private insurance	28 (74)	22 (79)	6 (21)	
Employment status, n (%)				0.168
Employed	15 (39)	7 (47)	8 (53)	
Unemployed	23 (61)	17 (74)	6 (26)	
Poverty, n (%)				1.000
Income below 100% federal poverty level	17 (45)	11 (65)	6 (35)	
Income above 100% federal poverty level	21 (55)	13 (62)	8 (38)	
Food security, n (%)				0.329
High	23 (61)	13 (57)	10 (43)	
Less than high	15 (39)	11 (73)	4 (27)	
Owns a cell phone, n (%)				0.383
Owns a cell phone	32 (84)	19 (59)	13 (41)	
Does not own a cell phone	6 (16)	5 (83)	1 (7)	
Literacy level (WRAT score): mean (SD)	55.8 (8.7)	54.6 (8.1)	57.3 (9.8)	0.462
Perceived stress score: mean (SD)	25.8 (8.9)	25.3 (8.8)	26.9 (9.4)	0.608
Stigma score: mean (SD)	100 (19.8)	99 (20.7)	101 (18.7)	0.7415

continued →

Table 1. Characteristics of All Participants, and Comparing Posters Versus Nonposters to the Community Message Board *continued*

CHARACTERISTIC	ALL PARTICIPANTS ($N=38$)	POSTERS ($N=24$)	NONPOSTERS ($N=14$)	p
Enrollment type, n (%)				0.198
Newly diagnosed	10 (26)	8 (80)	2 (20)	
Not newly diagnosed	28 (74)	16 (57)	12 (43)	
CD4 count, n(%)				0.268
Participants with CD4 < 200	10 (26)	8 (80)	2 (20)	
Participants with CD4 > 200	28 (74)	16 (57)	12 (43)	
Viral load, n (%)				0.043
Suppressed VL (VL <50)	21 (55)	10 (48)	11 (52)	
Unsuppressed VL (VL >50)	17 (45)	14 (82)	3 (18)	

SD, standard deviation; VL, viral load.

COMMUNITY CHAT CONTENT

Community chat was defined as content that was not related to psychosocial or medical information or concerns. This category was initially termed "chit-chat" because it contained seemingly superficial content such as comments on the weather and holidays. However, these interactions appeared to serve a more significant function, as a means of community building, and were renamed "community chat".

Table 2. Odds of Being a Poster (Versus Nonposter) by Participant Characteristics

CHARACTERISTIC	ODDS RATIO (95% CI)	p
Age	0.99 (0.93–1.05)	0.673
Male gender	0.66 (0.14–3.12)	0.603
White, non-Hispanic	0.20 (0.05–0.84)	0.028
Men who have sex with men (MSM)	1.40 (0.37–5.27)	0.619
Did not complete 12th grade	1.58 (0.26–9.48)	0.617
Private insurance	0.07 (0.01–0.41)	0.003
Employed	0.31 (0.08–1.22)	0.094
Income below 100% federal poverty level	1.13 (0.30–4.26)	0.859
High food security	0.47 (0.12–0.94)	0.298
Literacy level (WRAT score)	0.97 (0.89–1.05)	0.428
Perceived stress score	0.98 (0.91–1.06)	0.590
Stigma score	0.99 (0.96–1.03)	0.740
Newly diagnosed	2.63 (0.54–16.77)	0.211
CD4 Count >200	0.33 (0.06–1.86)	0.211
Unsuppressed VL (VL >50)	5.13 (1.13–23.30)	0.034

WRAT, wide range achievement test.

In this category, greetings were most common, found in 8.3% of total posts ($N=840$) and 29.1% of posts with community chat content ($n=240$). Greetings included messages welcoming new members, greetings to individual users, and greetings to the entire group. Participants discussed events in their lives unrelated to HIV in 7.8% of total posts and 27.3% of posts with community chat content. Community chat also included religious or spiritual posts not related to a particular problem or coping strategy, such as "its all good don't forget God loves YOU," in 1.8% of total posts and 6.3% of posts with community chat content. Participants appeared to regard the CMB as a community, with group-related messages in 6.8% of total posts and 23.8% of posts with community chat content. These messages included such posts as "I don't know if many of you realize it, but each and every one of us who uses this app is making a difference in someone else's life battling every day of this new journey." One participant suggested a name for the community as the Positive Links Posse (PLP). This was adopted by other members as well, with such as expressions as "PLP 4 LIFE" or "PL Family."

BIOMEDICAL CONTENT

Of biomedical content, most posts discussed medications, 4.1% of total posts ($N=840$) and 40.5% of posts with biomedical content ($n=85$). Other frequent topics were seeing a healthcare provider (2.2% of total posts, 21.7% of posts with biomedical content) and laboratory results (1.5% of total posts, 14.8% of posts with biomedical content). Posts on medications were centered on the importance of adherence and support for

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Table 3. Community Message Board Content with Categorized Themes, Examples, and Frequencies

CATEGORY AND DEFINITION	EXAMPLE	FREQUENCY (% OF TOTAL POSTS)
Biomedical Content		10.1
Alternative medicines: describes options of alternative medical treatments or experiences with them.	"... All they can do is treat me with acupuncture and injections and medication to help with the pain."	0.1
Laboratories: describes different laboratories or results; can include an individual's initial laboratory results, changes, or current values.	In response to another user's concern about their cd4 count: "(I've) been fine but when I got emitted to the hosp my cd4 was 8 and my viral was in the mill. Kinda scarey but I'm good now."	1.5
Comorbidities: describes a different health problem (outside of HIV) that a user has; it can also describe treatments or visits to a provider regarding the problem. Can include comorbidities related to HIV, such as opportunistic infections or neuralgias.	"... they said that my skull is actually smaller than my brain so they are sending my to a neurologist. I'm still in pain my neck and back still sore hopefully I will get better soon."	1.0
Drug use: discusses how drug(s) might affect user or HIV medication efficacy.	"Is it good to smoke weed on HIV meds or even at all?"	0.4
HIV symptoms: discusses how user experienced initial symptoms of HIV; does not include descriptions of how laboratory results have changed.	Describing time before diagnosis: "My last six months begain to make sence. I have lost 120 lbs in two months and found myself getting sicker more than I have ever in my life."	0.4
Medications for HIV/AIDS: includes details of and coherence to treatment plan, initiation of medications, and side effects of medications.	In response to another user asking about side effects of ATRIPLA: "I asked the doctor about the zside effects to my med and got her to print out all of the info on them. U should do so as well. One needs to know exactly what is possible so they can adjust accordingly."	4.1
Seeing a healthcare provider: discusses appointment (planned or upcoming meeting with care provider) or emergency appointment (going or possible going to emergency department or hospital).	In response to another user discussing headache: "... hate 2 hear ur not feeling well with a headache ... not good! If this headache continues, go back 2 hospital!!! This is important!!! Keep me posted!!!"	2.2
Sex and protection: discusses sex practices and concerns about transmitting HIV to partners; also includes suggestions and concerns about sex practices.	In response to another user's fear about infecting their partner: "I feel ya [X] I still have sex bc I use condoms and as long as u and ur partner are comfortable it will get better. My wife and I are very active so talk to ur partner and see how he feels."	0.5
Community chat		28.6
Group-related content: expresses appreciation for the board and community support, as well as interest in meeting other members of the group.	"I don't know if many of you realize it, but each and every one of us who uses this app is making a difference in someone else's life batting every day of this new journey ... We all are making a difference together 1 day, one app, and one click at a time!"	6.8
Greetings: participant-to-participant or participant-to-group greetings; also includes personal introductions to group and "welcome" messages to group.	"I just want to say hello n I hope everyone has a good weekend n week. I love y'all!"	8.3
Miscellaneous: chitchat that is nonspecific, such as jokes and riddles.	"Did u checkout the riddle I threw out there?"	4.0
Outside events and activities: includes posts about current events, participant hobbies, personal activities, seasons and weather, and holidays.	"Happy Halloween everyone!!!!"	7.8
Religious: has religious content that is written in a nonspecific manner or noncoping manner.	"its all good don't forget God loves YOU"	1.8

continued →

Table 3. Community Message Board Content with Categorized Themes, Examples, and Frequencies *continued*

CATEGORY AND DEFINITION	EXAMPLE	FREQUENCY (% OF TOTAL POSTS)
Psychosocial content		61.3
Coping strategies		9.8
Activity-based coping: participant describes their own coping strategy. Includes spirituality; also includes maladaptive behavior, such as violent thinking.	"I went out today and did some african drumming ... Then went on a walk and listened to nothing but some uplifting music. And not one thought crossed my mind."	
Relationships outside of the board: describes how participant uses partners, family, or friends outside of the board for coping.	"I was blessed! I have [X]. He excepted it from the beginning ... but sometimes I question why. Never-the-less, he stands by my side! I do thank God!"	
Strategies suggested by the Positive Links Team: suggestions from the Positive Links Team that receive participant endorsement.	"Just tried the auditory resource when I actually needed it ... It seemed to have an even better effect than normal. Please remember them. They do help."	
Coping by using the board		31.6
Coping by using the board: user describes a problem or stressor; can ask for help with the problem.	"Im so mad and not sure what to do ... Need someone to talk to."	
Support for another user: community or another user's suggestions on activities for coping or on using outside resources. Can also include compliments or affirmations for the original user.	"CONGRATS [X]!! :) I am happy 4 u! i have faith that you will move mountains ... u go girl!"	
Describing participant's state of mind		10.6
Negative state of mind: describes feelings such as anger, frustration, depression, grief, embarrassment, worry, or anxiety.	"Hi community its [x] ... Not really feeling in the best mood right now inside I want to cry times are not easy doing it on my own ..."	
Positive state of mind: describes feelings such as contentment, optimism, perseverance, gratefulness, or otherwise improved state of being.	"I appreciate the welcome ... I have full assurance that one day this will be eradicated and people will say I never knew you were hiv positive and my response will be I was because I know for me HIV means Heavens in View."	
Stressors		9.3
Drug use: describes relapses, wanting to come off drugs and not feeling able to, or previous drug use that user finds disappointing.	"... I told my sycho doc that I would fall deep ... and now im falling im relasping in so my diff way and I can't stop I would do things for fun now it's a habit I can't break and I don't know what to do it sucks!"	
Financial and work stress: conveys stress about working, making enough money to pay for expenses, and information about financial expenses.	"... thank U [X] trying to stay on my meds but its hard with no food to eat"	
Geographic isolation: describes living away from others or family.	"... when I think about my family in jersey city I get a lil down ... im just a lil homesick u know"	
HIV-related psychosocial stress: describes a user's appointments, how they contracted HIV, disclosure of their status to others or a partner's status to others, feelings about their health status or insurance, and social isolation and stigma.	"How can I feel good to talk about my HIV status with my roommate who is also a best friend to me ..."	
Relationship stress: includes stress resulting from family, friends and roommates, and partners.	"Why do I have a husband that don't do anything but play on his phone he don't clean cook nothing im tired of doing it by myself"	

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others who might be having difficulty: "Keep your head high, everything will b okay. Just remember your lifeline .... Your Meds!!!!!" One participant who was newly diagnosed reached out to the CMB community with concerns about starting medications. Others responded with encouragement, advice about how to find more information on treatment, and personal stories of success.

In addition to seeking biomedical information from healthcare providers, participants asked their questions to the CMB community. Many questions addressed issues of substance use (4.0% of biomedical content) and sexual behavior (4.9% of biomedical content). One participant asked: "Is it good to smoke weed on HIV meds or even at all?" Another inquired about risks of transmission and received advice, such as "I still have sex but I use condoms and as long as u and ur partner are comfortable it will get better." The PL study team also provided posts addressing biomedical questions, if an incomplete or incorrect answer was offered by the community or conflicting opinions were posted.

Discussion

This study of a CMB within a smartphone app for PLWH revealed several unexpected findings. First, we found that posting behaviors did not vary with gender or age, and posters did not have more illness experience, in contrast to studies of online support groups in other chronic diseases.[8,13,14] In fact, there was a trend toward those newly diagnosed with HIV being more likely to post on the CMB, although this did not reach statistical significance. Participants in this sample who were white, had private insurance, and had suppressed viral loads were significantly less likely to post to the CMB. Second, we found that the CMB contained more psychosocial than biomedical content. Again, this contrasts with published data on other online support groups, in which biomedical content is predominant.

The population targeted in this study has been underrepresented in prior work on online support groups, which have generally focused on well-educated Caucasian groups. This is an ongoing pilot project with a small number of participants, therefore, firm conclusions cannot be drawn. However, our findings suggest that our CMB is being used by participants from racial/ethnic minority groups and lower socioeconomic status, who tend to be disproportionately affected by HIV and are at risk for health disparities. The lower rate of viral suppression among the CMB posters (compared to nonposters) also suggests that the intervention may target those who need it most, that is, those who are at risk for poor clinical outcomes. Furthermore, the app may reach a population with relatively low literacy. Nonstandard spelling and grammar were more prominent on our CMB than other qualitative studies of online support groups. This may be a function of the mobile medium, in which autocorrect and shorthand tend to be more accepted than other settings. However, an informal style of exchange could encourage participation from those with lower literacy and this will be investigated with participant interviews.

There was much more psychosocial content and community chat than biomedical content on this CMB. Most other studies have identified informational support as the primary content on online forums for chronic illness.[1–5] Possible explanations for this difference might be that participants in our study have other sources of biomedical information (such as their healthcare providers), users are less readily able to look up or share biomedical content on their cell phones, or that an important usage of the app is social interaction with peers. Participants who posted on the CMB expressed support for each other, appreciation for the community, and a perception that the app was playing a positive role in their daily struggles with HIV. Even the community chat content, which did not relate to a specific problem or concern, appeared to serve an important function of support and community building.

Despite the generally positive nature of interactions on the CMB, there are potential dangers. Negative posts could be disruptive to other CMB users or result in the poster not seeking adequate help. Posts with personal identifiers (which were specifically prohibited during the enrollment and app training process, but did rarely occur) might pressure users who wish to remain anonymous. Last, while no misinformation was observed on this CMB, the potential for misinformation must be considered in online forums.[21,22]

This study has several limitations to consider. As there was a small sample size and potential for truncated age ranges or limited variance in other characteristics, we may have been unable to detect some true differences between posters and nonposters. Second, the value of the CMB to "lurkers" (those who read others' posts, but do not contribute their own) was not assessed, although we are conducting interviews with participants that may address this question. Third, the app functions in close coordination with the PL study team and with connections to the participants' HIV care setting. Some potential dangers, such as negative interactions or misinformation, may have been mitigated by the study team, which included licensed clinicians. Monitoring the CMB and reaching out to participants who appeared to need additional help were accomplished by the PL study team and in coordination with the participants' care providers. The functioning of the app and particularly of the CMB would likely be different if delivered through a publicly available app marketplace and without the link to a care setting.

Next steps will include further evaluation of the CMB, such as investigation of support mechanisms and community dynamics, and longitudinal assessment of users and evaluation of outcomes of the PL app and CMB participation. Investigation of barriers to CMB participation may also help adapt the CMB to reach nonposters. The app will be refined, using participant input and additional formative work, and integrated further with the users' clinical care. After this next demonstration project is complete, plans for offering the app to other users or care settings will be pursued.

To our knowledge, this is the first study to examine an online support group delivered through a CMB as part of a smartphone app for PLWH. Results indicate that the CMB may be able to reach a previously understudied vulnerable population. Exploratory analysis reveals a predominance of psychosocial content, possibly indicating that the CMB is meeting a previously unmet need for information and support from peers. Online support groups have the potential to address challenges faced by PLWH, including social isolation, while protecting anonymity. Further development of this smartphone application and its CMB will include investigation of possible benefits in improving social support, linkage and retention in HIV care, and health outcomes for PLWH.

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Address correspondence to:
Rebecca Dillingham, MD, MPH
UVA Center for Global Health
P.O. Box 801379
Charlottesville, VA 22908

E-mail: rd8v@virginia.edu

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ORIGINAL PAPER

Social Support in a Virtual Community: Analysis of a Clinic-Affiliated Online Support Group for Persons Living with HIV/AIDS

Tabor E. Flickinger[1] · Claire DeBolt[1] · Ava Lena Waldman[1] · George Reynolds[2] · Wendy F. Cohn[1] · Mary Catherine Beach[3] · Karen Ingersoll[4] · Rebecca Dillingham[1,5]

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Abstract Social support can improve outcomes for people living with HIV (PLWH) and could be provided through online support groups. The Positive Links smartphone app is a multicomponent intervention that allows users to interact in a clinic-affiliated anonymous online support group. We investigated how social support was exchanged in a group of 55 participants over 8 months, using an adaptation of the Social Support Behavior Code. Participant interviews assessed their experiences and perceptions of the app. Of 840 posts analyzed, 115 (14 %) were coded as eliciting social support and 433 (52 %) as providing social support. Messages providing support were predominantly emotional (41 %), followed by network (27 %), esteem (24 %), informational (18 %), and instrumental (2 %) support. Participants perceived connection and support as key benefits of the app. Technical issues and interpersonal barriers limited some participants in fully using the app. Mobile technology offers a useful tool to reach populations with barriers to in-person support and may improve care for PLWH.

✉ Rebecca Dillingham
rd8v@virginia.edu

1 Department of Medicine, University of Virginia School of Medicine, Charlottesville, VA, USA

2 Health Decision Technologies, Oakland, CA, USA

3 Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, MD, USA

4 Department of Psychiatry and Neurobehavioral Sciences, University of Virginia School of Medicine, Charlottesville, VA, USA

5 UVA Center for Global Health, P.O. Box 801379, Charlottesville, VA 22908, USA

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Introduction

Despite recent advances in care, many patients continue to face significant challenges in coping with HIV/AIDS. Social support can help to improve outcomes for people living with HIV/AIDS (PLWH) and has been associated with more active coping strategies, improved medication adherence, better immune function, and higher quality of life [1–4]. Perceived social support can improve both physical and mental health for PLWH, through direct and indirect mechanisms, including relief of depressive symptoms [5], which are a common barrier to adherence and retention in care [6]. PLWH are more likely to achieve suppressed viral loads if they perceive informational and emotional support to be available [7]. Informational support refers to the sharing of information or advice, while emotional support refers to the sharing of concern, encouragement, or the expression of caring for others. Social support can also take the form of esteem support (the expression of respect for others or confidence in them), network support (the concept of belonging to a group with similar concerns or experiences), or instrumental support (providing tangible assistance, such as performing a task or willingness to help others in a practical way) [8].

Online support groups may help provide social support and improve psychosocial function for patients coping with illness. Virtual connections may be particularly valuable to patients with barriers to seeking in-person groups, such as geographic or social isolation. In serious, life-threatening diseases such as cancer, patients seek both emotional and informational support online [9–13]. In many chronic

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diseases, informational support tends to dominate online forums [14–16]. However, evidence of benefit is mixed, due to lack of high quality studies and studies that include online support as part of more complex interventions [17, 18].

For PLWH, use of the internet to seek health information and social connection is becoming increasingly common [19–21]. There is growing evidence that online tools using peer-to-peer support can help patients struggling with adherence to antiretroviral therapy (ART) [22], encourage risk reduction [23], and promote patient empowerment and psychological health [24, 25]. Social support in online networks appears to increase with the frequency of contacts between participants [26]. In one prior study of social support within a publically accessible online support group for PLWH, the most frequent types of posted messages were related to information support, followed by emotional, esteem, network support, and tangible assistance [27]. More evidence is needed to guide the development of technological interventions to promote social support for PLWH [28].

The Positive Links project offers a unique opportunity to observe social support mechanisms within a private, clinic-affiliated online support group, with assessment of user and non-user perspectives. The Positive Links smartphone app was developed with the input of patients seeking HIV care at a university clinic and includes the ability for users to interact on a community message board through anonymous user names. In this exploratory analysis, our research questions were (1) How is social support exchanged in a clinic-affiliated online support group for PLWH? (2) How do users and non-users of the online support group perceive its benefits and limitations as a source of support?

Methods

Development of the Community Message Board

Positive Links is a Smartphone app developed as part of a multi-component intervention intended to improve linkage and retention in care for PLWH in southwestern Virginia. Key features of the app include tailored educational resources; daily queries of stress, mood and medication adherence; appointment reminders; access to the study team for individualized counseling and assistance; and the opportunity for participants to interact anonymously on a community message board (CMB). Participants selected user names for themselves to protect anonymity, although participant's chosen user names were known to study investigators. This allowed the investigator team to monitor the board regarding posts that reflected mental health concerns, including suicidal content, as well as for misinformation or inflammatory comments, and to communicate with participants privately, as needed. Positive Links staff members monitored the board daily by reading all posts. If a concern was identified, the staff member referred the issue to a licensed clinician to follow up with the participant and address the issue, for example, offering the participant individualized counseling or case management. The study team was able to link participants' user names to their study identification numbers, in order to facilitate analysis of users' demographic and clinical information. However, participant identities remained private on the board. Under their anonymous user names, participants could start new conversations on the board or respond to older conversations. The Positive Links team also introduced new conversation topics on HIV or general well-being. Participants could receive notifications on their app's main screen letting them know that a new post had been made.

During an iterative formative phase, patients seeking care at the university-based Ryan White HIV Clinic provided input on app design and features. During the current pilot phase of the study, participants were recruited from the clinic and from area AIDS service organizations (ASOs) and HIV testing sites. Eligibility criteria were focused on ability to use the app (either a score of 40 on the Wide Range Achievement Test (WRAT-4) or passing a subsequent reading test) and risk of falling out of HIV care (either HIV diagnosis since January 2012 OR at risk of falling out of care as determined by their care provider). The reading test corresponded to a fourth grade reading level and design of the app was tailored to accommodate low literacy. Providers assessed risk of falling out of care based on their experience with patients' missed appointments, difficulties with adherence, and psychosocial barriers to retention in care. Providers referred patients to the program by contacting the study team, who then made contact with patients to assess eligibility. Participants were given Samsung Galaxy 2 or Galaxy 3 phones with the app installed and a voice/data plan with unlimited minutes, texting, and data for the 18-month study period. Phones were encrypted and password protected and had a remote locate and wipe functionality. The app was also password-secured. The study team continued to refine the app using the feedback of participants. IRB approval was obtained for the study.

Participant Characteristics

Enrollment for the current phase of the Positive Links study began in September 2013 and was ongoing through the study period. During enrollment, individuals consented to participate in the study, completed the WRAT-4 literacy test, and answered baseline questions. Participants were

then instructed in how to use the phone and Positive Links app. Participant training in using the phone and the app took approximately 10 to 15 min. Participants were not prompted to use the board at any particular time or frequency. They were informed of how to use it at enrollment and had the option to use it if they wished to do so. Participants then completed usability interviews after 3 weeks of enrollment to address any technical difficulties and obtain feedback on use of the app. Overall, participants were followed for 18 months and completed assessments at 6, 12, and 18 months. They received $25 for completing the 12-month assessment and $25 for completing the 18-month assessment. They did not receive any compensation for using the community message board. The project budget allowed for recruitment of 75 participants, which was our ultimate enrollment target. Enrollment took place on a rolling basis, with total recruitment of 77 participants achieved over the course of September 2013 to May 2015. This paper concerns our interim analysis performed on data collected up to May 2014. At that time, enrollment included 55 participants. This interim analysis timing was chosen as approximately half-way in the study follow-up period for the earliest enrollees. This time point was far enough into the study so that participants had the opportunity for interactions to occur on the CMB but early enough that changes could be made to the CMB app feature if it did not appear to be functioning as intended. The approach used was consistent with the study principles of following an iterative, user-driven process to optimize the app for participants.

Participants' demographic characteristics included age, gender, race, transmission risk behavior, time since diagnosis, and religious belief. Socio-economic variables included education, insurance status, employment status, and self-reported income. Participants also completed the Wide Range Achievement Test (WRAT-4) to assess literacy [29], the Perceived Stress Scale [30], and the Berger Stigma Scale [31]. Social support was evaluated using the Social Support Appraisals (SS-A) Scale, which has demonstrated good reliability, convergent and divergent validity with other social support measures, and predicted associations with psychological wellbeing [32]. Religious belief was assessed by self-report as an exploratory question of the role of religious belief in coping with HIV. During the formative phase of app development, religious and spiritual themes were frequently cited by clients of the clinic as important aspects of their HIV experience. Stigma was assessed using the Berger Stigma Scale, which has been previously validated and shown to be a possible mediator of engagement in care [31]. Participants were categorized as "newly diagnosed" if they were enrolled in the study less than three months after their HIV diagnosis. Clinical data were extracted from the electronic medical record.

Analysis of the Community Message Board

After 8 months, CMB posts were downloaded and analyzed. In order to evaluate social support messages on the CMB, content analysis was performed using the Social Support Behavior Code (SSBC) developed by Cutrona and Suhr [8]. This coding framework categorizes content intended to provide five types of support: information support (information or advice), esteem support (expressing respect or confidence in others), network support (belonging to a group with similar concerns or experiences), emotional support (expressions of concern or empathy), and instrumental support (providing tangible assistance). Subcategories were adapted from coding methods used in prior analyses of social support on a publicly accessible online support group for PLWH [27] and a Facebook group for HIV-infected youth [33]. We added further subcategories during our codebook development to capture additional types of expression that were prominent on the CMB: community companionship (as a subcategory of network support) and prayer (as a subcategory of emotional support). We also adapted coding methods used to assess posts seeking social support in three categories of information, emotional, and instrumental support [34].

Validity of the coding method was enhanced by using a previously established system for categorization of social support (the Social Support Behavior Code) and by expert consensus of the study co-authors on the adaptation of this coding system to our data set. Our expert team included the perspectives of an HIV care physician (RD), a clinical psychologist (KI), and an investigator in public health sciences with expertise in evaluation methods (WC). Team members were part of the Positive Links project and had access to the data. Reliability was assessed by using 2 independent coders (TF and CD) and an iterative process for development of the codebook. Analysis of the codes was performed by a primary analyst (TF) in discussion with a secondary analyst (CD), and presented for further discussion with the expert team (RD, KI, WC) in order to assess the validity of interpretation during the analysis process. This analysis categorized the types of support expressed and examined the context in which support-related posts occurred, focused on the interactions between posts seeking support and subsequent posts providing support in response. Team meetings during the analysis phase included updates on the themes elicited, categorization of themes, and synthesis of findings, as well as resolution of any discrepancies between the primary and secondary analysts. Final results were composed by the primary analyst (TF) and reviewed by all co-authors.

Analysis of the Participant Interviews

Usability interviews for the participants (both users and non-users of the CMB) were transcribed for analysis. The focus of analysis in this study was to assess perceptions of potential benefits and barriers to the CMB as a source of social support. The interview guide included open-ended questions asking what users liked most about the app, which features they used, what problems they might have experienced, and what suggestions they might have for further improvements to the app. The interviewers explored responses further with clarification questions. The analytic method for the usability interviews used a constant comparisons approach to identify emerging themes from the qualitative data. Relevant themes to this analysis were categorized as perceived benefits of the app, negative aspects of the app, and barriers to using the app. Validity of this coding scheme was assessed by expert consensus, as described above. Reliability was assessed by using two independent coders and an iterative process for development of the codebook.

For both phases of analysis, codebooks were refined until excellent reliability was achieved (kappa 0.90 for social support message coding and kappa 0.84 for interview coding). Analyses were performed using NVivo qualitative data analysis software (QSR International Pty Ltd. Version 10, 2012).

Results

Participant Characteristics

Table 1 shows demographic and clinical characteristics of the study participants. Among the 55 participants in this analysis, mean age was 39 years (SD 11.68). Thirty-seven participants were male (67 %), seventeen were female (31 %), and 1 transgender male to female (2 %). Twenty-seven participants identified as black, non-Hispanic (49 %), 18 as white, non-Hispanic (33 %), 5 as multiple/other races (9 %), 4 as Hispanic (7 %), and 1 as Asian (2 %). Many participants were unemployed (45 %) and did not have insurance (35 %). Most participants identified themselves as religious (38 %) or spiritual (47 %). Thirty-three participants (60 %) had unsuppressed viral loads. At baseline, participants had unmet needs for social support, with mean scores of 43.51 (SD 12.38) on the Social Support Appraisal (SS-A) questionnaire [32]. This instrument measures perception of support received from family, friends, and others with a standardized scale up to a maximum score of 100. For comparison, mean scores have been reported in studies of alcohol dependence, ranging from 37.7 to 64.7 among patients categorized as having low social support [35].

Frequency of Posting on the Community Message Board

Of the 55 participants in this analysis, 24 posted on the board at least once. Due to rolling enrollment, participants were in the study for varying durations at the time of the 8-month interim analysis. Posters had been in the study for a mean of 23 weeks, ranging from 8 to 34 weeks. Posting frequency fluctuated over time, with the highest numbers of posts during the 28th week (71 posts, primarily among 3 users with 11, 19, and 21 posts each) and the lowest number of posts during the first 3 weeks of the study (0–2 posts). Total posts declined after the peak of 28 weeks, but use continued with 5–10 posts per week from week 30 onward. The number of posts per user per week was calculated, in order to account for the changing denominator of total users over time. On average, users posted 1.3 times per week, with a median of 0.5. The 3 highest utilizers posted on average 3.8, 4.8, and 5.1 times per week.

Social Support on the Community Message Board

Of the 840 messages on the CMB, 115 (14 %) were coded as eliciting social support and 433 (52 %) as providing social support. Table 2 presents each category of social support messages, with definitions, examples, and frequency of occurrence. Participants' use of abbreviations and non-standard spelling and grammar has been retained in quoted messages.

Messages seeking social support were predominantly related to emotional support (74 % of messages seeking support; 10 % of total messages). These included posts asking for encouragement, comfort, congratulations, praise, empathy, concerns, or gratitude. Posts seeking information support were less common (26 % of messages seeking support; 4 % of total messages) and included posts asking for medical or health-related advice, guidance, or news. There were no posts classified as seeking instrumental support, though a small number of posts (1 % of total messages) did offer to provide instrumental support in response to messages that were primarily emotional in nature.

Messages providing social support were predominantly focused on emotional support (41 % of messages providing support; 21 % of total messages). Of subcategories of emotional support, the most common were encouragement (51 % of messages providing emotional support), expressions of care (41 %), and prayer (38 %). The subcategory of prayer was added during codebook development to

Table 1 Characteristics of participants

Characteristic	All participants (n = 55)
Age in years: Mean (SD)	39 (11.68)
Gender (*n*[%])	
Male	37 (0.67)
Female	17 (0.31)
Transgender Male to Female	1 (0.02)
Race (*n* [%])	
Black, non-Hispanic	27 (0.49)
White, non-Hispanic	18 (0.33)
Multiple/Other	5 (0.09)
Hispanic	4 (0.07)
Asian	1 (0.02)
Education (*n*[%])	
Did not complete 12th grade	9 (0.16)
Completed high school	46 (0.84)
Sexual orientation (n[%])	
Has sex with men	39 (0.71)
Has sex with women	9 (0.16)
Has sex with both men and women	6 (0.16)
Declined to answer	1 (0.02)
Transmission risk (n[%])	
Men who have sex with men (MSM)	27 (0.49)
IV Drug User (IDU)	2 (0.04)
Not MSM (Includes heterosexual, Transgender)	26 (0.47)
Insurance (*n*[%])	
Public	24 (0.44)
Private	12 (0.22)
None	19 (0.35)
Employment status (n[%])	
Employed	30 (0.55)
Unemployed	25 (0.45)
Poverty: Mean % of federal poverty level (SD)	60.05 (78.79)
Religious practices (n[%])	
Spiritual	26 (0.47)
Religious	21 (0.38)
Neither	8 (0.15)
CD4 Count (n[%])	
Participants with CD4 < 200	13 (0.24)
Participants with CD4 > 200	42 (0.76)
Viral Load (n[%])	
Suppressed VL (VL < 50)	22 (0.40)
Unsuppressed VL (VL > 50)	33 (0.60)
Enrollment type (*n*[%])	
Newly diagnosed	13 (0.24)
Not newly diagnosed	42 (0.76)
Owns a cell phone (*n*[%])	
Owns a cell phone	43 (0.78)
Does not own a cell phone	12 (0.22)
Literacy level (Wrat Score): Mean (SD)	55 (9.25)
Perceived Stress Score: Mean (SD)	28.49 (9.16)
Social Support Score: Mean (SD)	43.51 (12.38)
Stigma Score: Mean (SD)	101.53 (17.97)

Table 2 Types of social support sought and provided on community message board, with definitions, examples, and frequencies

Support category	Definition	Example	Number of posts	% of total posts
Seeking support (n = 115)				
A. Emotional support	Post asks for encouragement, comfort, congratulations, praises, empathy, concerns, or gratitude	"How ean I feel good to talk about my HIV status with my roommate who is also a best friend to me"	85	10.12
B. Informational support	Post asks for information on a particular subject, including medical or health-related advice, guidance, news, or findings	"Me to do u ever feel like u gain wait on it and do u ever think differently on it" (About a medication)	30	3.57
C. Instrumental support	Post asks for tangible aid		0	0
Providing support (n = 433)				
A. Emotional support (communicating love, concern, empathy)			178	21.19
Encouragement	Provides the recipient with hope, optimism, and confidence	"We are all blessed and can show the ENTIRE world that even though they may consider us to be less that we are stronger and even in better health than they are..."	90	10.71
Expression of care	Conveys supporter's engagement of recipient's wellbeing	"Thank you [X] hope all is well with you and just know that you have a friend in me"	73	8.69
Prayer	Offers prayer or blessings for the recipient, reminders of faith	"I thank the lord for another day healthy... I pray that you conitnue to bless... other people who deal with the same thing I do. I pray that you continue to give us the strenght to fight and get healthy again in jesus name I pray AMEN..."	68	8.10
Empathy	Expressions of understanding the situation and/or discloses similar experience in a way that conveys understanding	"[X] I'd b untruthful if I told you that I understand bc I don't but I could only speculate what's like 2 do this without someone to hold..."	27	3.21
Virtual affection	Physical affection expressed (but virtual)	"We are here for you! *hugs*"	8	0.95
Sympathy	Conveys sorrow for the recipient's distress	"Hey [X]... it will make you feel better to talk to someone close to you. I had to do the same it was hard but once I got it out I felt better"	6	0.71
Confidentiality	Keeps the recipient's problem in confidence		0	0
B. Network support (communicating belonging to a group of persons with similar concerns or experiences)			115	13.69
Community companionship	Indicates community's unique position to share experiences, importance of community closeness, and gratitude for community support.	"I remember when I first came on to the site [X] told me some things that actually helped me tremendously. And to this day I still think her everyday"	71	8.45
Presence	Presence of listeners and reminders that others are available to offer support	"ENJOY YOUR NIGHT MY FRIEND, IM ONE CLICK AWAY..."	52	6.19
Access	Messages that appeared to broaden recipient's social network by establishing access to *new* members; "welcome" messages	"[X] here welcome to the fam"	19	2.26
C. Esteem support (gives positive feedback, communicating respect and confidence in abilities)			77	9.17
Compliment	Conveys positive assessments of the recipient and his or her abilities	"[X] that sounds like a great idea"	57	6.79
Validation	Acknowledges agreement or emphasizes similar views with recipient	"Ameen brother. We have HIV. It dosnt have us" (in response to another user's posting)	25	2.98

Table 2 continued

Support category	Definition	Example	Number of posts	% of total posts
Relief of blame	Conveys that a particular action is not the fault or complete fault of the recipient		0	0
D. Informational support (gives information on a particular subject, including medical or health-related advice, guidance, news, or findings)			55	6.55
Advice	Suggestions or gnidance for coping with difficulties associated with HIV or AIDS	"[X] they have curches that helps with food check out sum churches in ur area because its very important that you stay on trac with ur meds"	21	2.50
Situation appraisal	Reassesses or redefines a situation, often in a way that makes it more positive or shows new information that could be helpful	"…that's right [X] and believe it or not it could b worst…"	17	2.02
Sharing own experience	Conveys experience in a way that demonstrates specific knowledge of particular condition, such as changes in CD4 count or viral load	"[X], my cd4 was also very low, didn't find out I was hiv positive until a month ago. I was the walkingdead, still working and didn't know why I was so tired…"	12	1.43
Referrals to experts	Includes directing the member to a specific source, community resource, or website	"I asked the doctor about the zside effects to my med and got her to print out all the imfo on them. U should do so as well"	8	0.95
Teaching	Includes feedback that gives information or facts about the disease		0	0
E. Instrumental support (provides or offers to provide performance of a task, goods, or services directly related to the stress)			8	0.95
Active participation	Offers to join the recipient in an activity; includes concrete plans or planning to do something together	"[X] Hay bro hiking sounds awesome… Lets get something started for a Spring outing…"	5	0.60
Perform a task	Member actually performs an action on behalf of the recipient or the group	"1-800-555-5555 this numer is for those who need help. I talked with her. Please call if you need help"	2	0.24
Express willingness	Expressing willingness to help recipient	"If you think I can help you then please let me know how I can help"	1	0.12
Loan	Member loans money or object to another member		0	0

capture the prominence of spiritual expressions of support on the CMB.

Network support was offered in 27 % of messages providing support (14 % of total messages). These messages included posts establishing access (such as welcome messages to new members) and posts affirming the presence of community members available to listen and help. The subcategory of community companionship (62 % of messages providing network support; 8 % of total messages) was added during codebook development to include posts demonstrating the community's unique position to share experiences, the importance of community closeness, and gratitude for community support. The original subcategory of "relationship" under emotional support was incorporated into "community companionship" due to significant overlap between these concepts in the CMB posts. An example of this was observed in the evolution of a community identity, referred to by participants as the "Positive Links Posse" (PLP) or "Positive Links family".

Esteem support (24 % of messages providing support; 9 % of total messages) included posts giving positive feedback or communicating respect and confidence in other participants' abilities. Most of these were compliments, followed by validation. The subcategory of relief of blame was included in the codebook, as part of the categorization scheme used in other studies of social support, but no messages of this type were posted on the CMB.

Informational support was offered in 18 % of messages providing support (9 % of total messages). Most of these were advice, situational appraisal, or sharing of experience. A few posts did include referral to experts, such as directing others to seek input from their clinicians or staff at local support organizations. None were classified as teaching posts.

For each message coded as seeking support, an average of three responses was posted in reply from other participants providing support. For example, one exchange among participants began with a post seeking emotional support: "times are not easy doing it on my own I try to smile to hide my pain sometimes it's not that easy it's easy to just want to give up." Within a few minutes, other participants responded with multiple forms of support, including encouragement, prayer, virtual affection, empathy and expression of care, for example: "Its okay cry, just remember that god loves you & so do I, hugs I KNOW your day will get better"; "I know how u feel I but one thing I can say there is light at the end of the tunnel but all ur troubles on god shoulders and he will get u through trust me I know". The first participant followed up with more detail on struggles with adherence and meeting basic needs: "trying to stay on my meds but it-s hard with no food to eat". Others responded with additional emotional support, such as "When u feel u feel like this burden is to much to bare and u feel there is no hope say a silent prayer god does not gives us wat we cant handle we all have comc along way and givin up is not a choice so stay strong keep the faith and lets continue to fight we will overcome our struggles", and informational support with advice, such as "they have churches that helps with food check out sum churches in ur area because its very important that u stay on track with ur meds".

Participant Perceptions of the Community Message Board

All study participants completed usability interviews 3 weeks after enrollment, even if they did not post on the CMB or use other app features. Of the 55 participants, 51 (93 %) reported a benefit from the app, 50 (91 %) described a potential barrier to using the app, and 24 (44 %) reported a negative aspect of using the app. Table 3 shows categories of benefits, barriers, and negative aspects. Participants could mention more than one category, which were not mutually exclusive, so frequencies may add up to more than 100 %.

In their interviews, 64 % of participants cited connecting with others and 42 % cited support as a benefit of the app. Connection was defined as expressions of user's ability to connect with others going through a similar experience or increased feelings of universality. Support was defined as expressions of giving, receiving, and observing others give or receive support.

In discussing the perception of connection, one participant said: "Like if I need someone to talk to, I can talk to someone, like someone is there, right there". Another said: "getting to see other people's perspective on life, let me know that I'm not going through this by myself, there is other people out there like me, it's good". One participant described difficulty in communicating with counselors, stating that "I don't feel connected to them only because they can guess at the situation but without them actually living the situation it's hard for them to really understand what's going on", whereas other users of the app could directly share the experience of living with HIV. This participant also reported that "I have a hard time expressing myself vocally anyway so it's always better that I can type out something have them type back". Making connections with others electronically appeared to be particularly important for those who had trouble doing so in person.

When asked what they liked most about the app, one participant said: "If I'm having a bad day, I can get on there and vent or whatever and then like it's real people that actually reply to my post and stuff and reply to how I'm feeling making me feel better...it's good to have somebody to talk to, even if it's just a text it's good to have

Table 3 Types of impact reported by participants, with definitions and frequencies

Categories of impact	Definition	Number of people (n, %)
Benefits		
Self-monitoring	Describes benefit from ability to monitor mood and stress; describes increased self-awareness after monitoring	41 (74.55)
Keeping track of meds	Describes being more capable of keeping track of meds daily, finds that app supports adherence that was already good, or feels improved adherence to treatment regimen as a result of the app	39 (70.91)
Privacy	Feels that app is very secure and private and safe to have on a phone	35 (63.64)
Connecting with others	Likes ability to connect with others going through a similar experience; user has experienced increased feelings of universality	35 (63.64)
Connecting to the clinic	Benefits from appointment reminders, has improved engagement in HIV care, feels more connected to the clinic, benefits from the phone numbers for clinic being readily available	34 (61.82)
Easy to use	Reports that the application and/or the phone is easy to use	32 (58.18)
Benefits of phone	Reports using the phone for a variety of purposes in addition to the app	32 (58.18)
Resources	Reports learning from posted resources on the app, including resources on the CMB	26 (47.27)
Support	Benefits in giving, receiving, and seeing others give/receive support	23 (41.82)
Positive outlook	Develops more positive outlook as a result of the program	16 (29.09)
Experiences	Reports learning from the experience of other participants	9 (16.36)
Improved outside interactions	Describes that the application helps them better interact with people that do not have HIV, their partners, or people outside of the app	7 (12.73)
Fun	Describes that app can be entertaining, mentally stimulating, and/or fun	6 (10.91)
Goals	Reports liking the goal setting feature or having more success because goal-setting feature	3 (5.45)
Improved self- care	Reports improved self- care, outside of medication adherence; for example, user reports eating better or exercising more	2 (3.64)
Writing	Reports they find it easier to express self through writing or texting than they do vocally, and the app enables them to do so	2 (3.64)
Negative aspects		
Feelings of obligation	Describes feeling "forced" or obligated to use the app	10 (18.18)
Complaining	Discusses how CMB posts can seem to have a lot of complaining	9 (16.36)
Suicidal posts	Describes negative impacts of suicidal posts	5 (9.09)
Outsider	Describes disappointment with not receiving responses to posts	5 (9.09)
Vulgarity	Describes discomfort with vulgarity, poor language, or taboo topics on CMB	1 (1.81)
Too personal	Describes feeling uncomfortable with amount of personal information posted	1 (1.81)
Religiosity	Describes feeling uncomfortable with the level of religiosity on the CMB	1 (1.81)
Barriers		
Technical problems with application	Describes problems with application, such as difficulty navigating between screens, difficulty following conversations on CMB, having to scroll through screens, clearing notifications, appearance of newsfeed vs substance of message. They might also describe lack of awareness, such as not knowing about particular features	36 (65.45)
Phone problems	Describes difficulty with things related to the actual phone, like battery life or texting	24 (43.64)
Privacy concerns	Describes user concerns about privacy	12 (21.82)
Time constraints	Describes that user doesn't have time to participate or review features of the app	10 (18.18)
Personal readiness	Describes a feeling of having no limitations except themselves, for example not feeling personally ready to discuss their HIV, not yet ready to interact on the application, or that they are in the process of "getting comfortable"	7 (12.73)
Communication rules	Describes limitations in participation on the CMB due to defined "cliques" within the CMB or unclear communication etiquette	7 (12.73)
No immediate feedback	Expresses frustration with lack of immediacy in feedback	3 (5.45)
Own phone	Describes that having two phones makes the Positive Links phone seem redundant	3 (5.45)
Other users	Describes knowing another user personally and feeling uncomfortable interacting with them	2 (3.64)
Participation	Describes being frustrated with lower levels of participation of other users	2 (3.64)

Table 3 continued

Categories of impact	Definition	Number of people (n, %)
Forced anonymity	Describes wishing being able to talk directly with others or in person	2 (3.64)
Potential loss	Describes the potential of lost relationships once the study has been completed	1 (1.81)

somebody there that supports you." Others expressed similar sentiments, such as: "You get to talk to people who are going through exactly what you are going through. When you are down somebody uplifts you, when somebody else is down you can uplift them, it's basically like one big family." In addition to receiving support, participants appreciated the opportunity of providing support for others. One expressed this concept by saying: "Yeah it's very beneficial to everybody and me personally what helps me is helping others so if I can help somebody that helps me 10 times." Another said: "you try and uplift someone else cuz they might be having a down day so I really look for all the positive things".

Reading other users' posts also provided a sense of support. One participant said: "I mean I may not post like all the time but most of the time I see what everybody is saying and I can relate". Another expressed that "reading some of the things that the other people post really has opened my eyes that I'm not alone when there have been times when I have felt that I'm sort of in this darker box and alone". Observing other participants helping each other was "very uplifting to see other people reach out to people they don't know and literally lift them up and that shows that we are like all in this together".

Participants were also asked about possible negative aspects of the app during their interviews. Some users felt that by participating in the study, they felt obligated to use the app, making it feel like a job (18 %). Although interactions on the CMB were predominantly positive, some participants did have concerns about posts perceived as too negative or "complaining" (16 %). The study team monitoring the CMB reached out to participants privately regarding posts that reflected mental health concerns, including suicidal content. Some users cited suicidal posts as having negative impacts on themselves, as participants reading the posts (9 %). Participants sometimes perceived some posts as "attacking" other users (9 %) or "too personal" in the content that was shared (2 %). Others felt like "outsiders" in the community (9 %) or felt excluded by the religious content on the CMB (2 %).

Some participants encountered barriers to using the app. The most commonly cited were technical problems with the app (65 %) and technical problems with the phone itself (44 %). Other concerns included privacy (21 %) and personal time constraints (18 %). Some participants reported they did not feel personally ready to discuss topics on the CMB, even though it would be anonymously (13 %). Some participants reported not using the CMB due to concerns about communication etiquette within the community (13 %). Another potential barrier was the avoidance of forming connections due to concern of future loss of the community at the study's conclusion (2 %). One participant said: "Well since I really haven't posted yet, it really hasn't affected me but I have thought you if you start posting if you start to build a friendship with some of these people, there is no way of knowing who they are even after the program is over". The anonymity of the CMB was perceived as a benefit in ensuring privacy, but some users desired to meet in person and expressed frustration that this was not possible.

Discussion

People living with HIV sought social support from and provided social support to their peers through a clinic-affiliated smartphone app with a community message board. Our findings suggest that online support groups on a smartphone can reach PLWH and help them engage in self-management and community building beyond their clinic visits. Strengths of this study include the use of 2 independent coders to enhance reliability of the qualitative analysis and complementing the content analysis with participant interviews, which have not been possible in prior studies of online social support for PLWH [27, 33]. In addition, our intervention targeted PLWH in the rural southern U.S., predominantly of racial/ethnic minorities and socioeconomic disadvantage, who bear a disproportionate burden of HIV and barriers to favorable clinical outcomes [36–38]. Positive Links shows promise in helping to address many of these barriers, including geographic and social isolation, and fostering social support as a means to improve mental and physical health for PLWH.

In our study, emotional support was the most commonly requested and provided form of social support observed. In contrast, a publicly accessible online support group for PLWH was dominated by information support [27]. On a private Facebook group affiliated with an HIV clinic's young adult program, the most commonly requested type of support was emotional, while the most commonly given

was esteem support [33]. The relatively low proportion of information support exchanged on our CMB may indicate that participants relied on other sources besides their peers for information. Although the sharing of misinformation is a potential risk of online support groups, this was not observed. The involvement of the Positive Links study team may also mitigate this risk, as the team routinely monitored board content and could answer questions or clarify biomedical information.

Some subcategories of social support seen in other studies were not found on our CMB, such as posts seeking instrumental support [33] or posts providing teaching or relief of blame [27]. Subcategories were added to our coding scheme, which were prominent on our CMB but not in prior studies. In particular, community companionship and prayer were surprisingly important to many of our participants. On the CMB, participants appeared to value the community as a group united by shared experiences and referred to the group as the "Positive Links family" or "Positive Links Posse". Although prayer was not universal to all participants, those who did seek and provide spiritual encouragement were able to support each other. In our sample, most patients identified themselves as religious or spiritual. This likely reflects the demographics and culture of our clinic population in the rural southern United States, which differs from the predominantly urban populations of prior studies of social support among PLWH. Many African-American PLWH in the southern United States report unmet needs for social support from faith communities [39] and may seek this support from more informal connections with peers who are also PLWH. However, it should be noted that religious content on the CMB was perceived as a barrier to some users, who felt excluded rather than supported by it.

Participants perceived connection and support as important benefits of the app. In particular, the CMB allowed people who previously felt alone to find others who could share their experiences. Participants' comments about support primarily focused on emotional support, expressing appreciation for the empathy, sympathy, encouragement, and care communicated on the CMB. Network support was also perceived by participants, especially the importance of community companionship. The community felt like a "family" who cared about each other and were present to help. Even those who did not post on the CMB perceived benefit from observing others giving and receiving support in the community. This aspect of the CMB was not visible in the posts themselves but became clear in the usability interviews. Similarly, the value of providing support to others emerged from the interviews, as participants expressed a sense of fulfillment and more positive outlook from their ability to help others in the community.

However, negative interactions on the CMB also occurred and may undermine the potential benefits. Most interactions were positive, but some posts were perceived as complaining too much, attacking others, sharing too much information, or excluding those who did not feel like a part of the group. Barriers to participation were also reported, which may prevent full utilization of the CMB. Technical issues were the majority of barriers discussed, but personal barriers were perceived as well. In particular, some participants may be reluctant to form connections through the CMB, without the ability to meet in person or maintain the community beyond the study period.

This study has several limitations to consider. The project is in a pilot phase with a relatively small sample size. Also, the project remains ongoing, with rolling enrollment since the CMB and interview data were captured for this analysis. The app continues its iterative development process with changes made based on participant feedback in order to optimize its function and usability. With rolling enrollment and changing features of the board, not all users had equivalent amounts of time as a participant in the study. Additionally, various features to improve usability were added as a result of the ongoing development process, making comparison between users challenging. Some participants did not use the board and some within the board posted more frequently than others. Further analysis of patterns of use is planned, for the board and other app features, to delineate how participants interact with the app and with the community over time and to determine if certain patterns of use are more beneficial than others. Finally, the app is affiliated with the clinic and monitored by the study team, which may limit generalizability to other populations or contexts. Generalizability may also be limited by the fact that the phones and data plans were provided to participants with the cost supported by grant funding. Next steps for this project include development of plans for adapting the app for installation on users' own phones (if they already possess one) and subsidies for phones and service (if needed) in order to make the app accessible to more users. A full cost-effectiveness analysis is also planned at the conclusion of follow-up. This paper presents an interim analysis, for which detailed cost data and longitudinal clinical outcomes are not yet available. These analyses are pending and expected to provide further information on the efficacy of the program and considerations for implementation and dissemination at other sites.

The Positive Links app offers an innovative way to address needs for social support among PLWH. Patients with barriers to accessing in-person support may particularly benefit from the ability to form virtual communities, in which they can seek and provide support to others with shared experiences. Next steps include further longitudinal

follow-up to assess clinical outcomes in participants and implementation of the app in other populations for reproducibility and optimization. Ultimately, the use of technology to connect people and offer social support may be a valuable tool in improving quality of life and outcomes for PLWH.

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Compliance with Ethical Standards

Conflicts of interest None of the authors declare any conflicts of interest.

Ethical approval All procedures performed in this study that involved human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. All participants in this study provided informed consent prior to entering the study.

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Proposed Evaluation of the Houston Area Positive Links App Project

Short-term (process/launch) evaluation:

The Administrative Agent and the contractor conduct, with recommendations from the Committee. This evaluation will look at:

1. Staffing
2. Equipment procurement
3. IT linkage
4. Recruitment of users
5. Training of staff
6. Training of users
7. Policies and procedures
8. Adherence to (divergence from) implementation guide
9. Best practices / challenges / lessons learned

Long-term (output/outcome) evaluation:

Ideally, Positive Links would:

Measure to what extent Positive Links accomplishes the following. Relevant evaluation measures should include:

1. Improve retention in care
   a. Appt adherence rate
   b. Missed appts
   c. Visit constancy
   d. Retention among special pops.
2. Increase medication adherence
   a. Medication adherence rate (cross tab stress and mood)
   b. 100% reported medication adherence rate for 4 consecutive weeks
3. Decrease viral loads
   a. Viral load values in EMR chart reviews
4. Consistent use over time
   a. Overall response rate
   b. Number of launches
   c. Number of quizzes answered
   d. Number of users
5. Foster connection and informational/social support between users
   a. CMB qualitative analysis (see articles in mtg packet)
   b. Number of posts (changes over time?)
6. Help users manage mood and stress
   a. Average mood and stress scores (over time)
7. Preserve personal connection with provider staff
   a. Number of messages sent / received

PositiveLinks Data Elements

Report Type	Member Activity	Provider Activity	System Activity	Member Achievements	Appointment Data	Clinical Data
Source	PositiveLinks Webportal	PositiveLinks Webportal	PositiveLinks Webportal	PositiveLinks Webportal	EMR: Chart Review	EMR: Chart Review
Data Elements	Overall Response Rate	Number of Dashboards Viewed	Number of Member Users	Days as a PL Member	Appointment Adherence Rate	CD4 values
	Medication Adherence Rate	System Logins	Number of Sessions	Number of App Logins	Missed Appointments	Viral Load values
	Average Mood	Messages Sent	Number of Screen Views by App Feature	Number of Quizzes Answered	Visit Constancy	
	Average Stress	Number of Messages Received		100% reported Medication Adherence Rate for four consecutive weeks	HRSA-1	
	Number of Community Message Board Posts			Number of Community Message Board Posts		
	Number of App Launches					
	Number of Quiz Responses					
	Number of Messages Sent					

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Enrolling in an Affordable Health Care Plan

The Affordable Care Act (ACA) helps middle- to low-income people afford health insurance through subsidies called **Cost Sharing Reductions** (CSR). CSRs help lower the upfront cost of buying and using a Silver plan on the Marketplace. Even though the government stopped reimbursing insurers for these subsidies, CSRs are still available to consumers.

If you received subsidies last year, and your income and family size are the same, you will most likely receive subsidies again when you enroll in a Silver health plan.

Because insurers are no longer reimbursed for these costs, many have raised the monthly cost of plans more than usual. **Most enrollees, however, are protected thanks to the ACA.** The ACA provides consumers of a certain income with Tax Credits that can be used to pay for a Marketplace plan. The Tax Credit gets bigger if the monthly cost of Silver plans go up. So even though the sticker price of a plan looks high, **the price you actually pay will be lower**.

Exactly what this means for you depends on your income and family size.

If...	Then...
You make less than $48,240 (or are a family of four making less than $98,400)	**You may not see a big increase in costs. You will still receive a Tax Credit that you can apply to the monthly cost of a Marketplace Plan.**
You make more than $48,240 (or are a family of four making more than $98,400)	**You might see an increase in costs, but will likely still find a plan within your budget. If you don't get a Tax Credit, consider the Gold, Platinum, or Bronze plans. While the monthly cost may be high, the money you pay *during the year* for health care may go down.** **In some states, Silver plans are available off the Marketplace at a lower sticker price. Ask your Enrollment Specialist for help identifying the best option for you and your family.**

Note: Tax Credits are provided upfront, based on your estimated salary. They are reconciled when you file your taxes the following year. If your estimated salary is less than your actual salary, or if your family size decreases, you may end up ineligible for a Tax Credit. Please be sure to discuss this possibility with an Enrollment Specialist.

To better understand your options, contact your local organization below:

Community Lead — Phone Number

We are open Times Open