DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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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, March 8, 2018
Meeting Location: 2223 W. Loop South, Room 416
Houston, Texas 77027

I. Call to Order — Cecilia Oshingbade, Chair, RW Planning Council
   A. Welcome and Moment of Reflection
   B. Adoption of the Agenda
   C. Approval of the Minutes
   D. Training: 2018 HIV Comprehensive Plan: Council Responsibilities — Amber Harbolt, Health Planner RW Office of Support
   E. Training: How To Best Meet the Need Process — Denis Kelly and Gloria Sierra Co-Chairs, Quality Improvement Committee

II. Public Comments and Announcements — Carol Suazo, Secretary

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV 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 — Ted Artiaga and Steven Vargas, Co-Chairs
   Item: 2018 Committee Goals
   Recommended Action: FYI: The 2018 Committee voted to adopt the recommendation from the 2017 Committee of expanding Goal #1 in 2018 to read: "Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Prevention and Care Services Plan and corresponding areas of the End HIV Plan."

Item: 2018 Committee Timetable
Recommended Action: FYI: Please see the attached 2018 Committee Timetable.

Item: Update on Special Study – Out of Care
Recommended Action: FYI: As of the February Committee meeting, 12 key informant interviews were completed. The minimum sampling goal is 25 interviews completed. Please see Amber Harbolt for more information on the study and to refer potential study candidates.

Item: Comprehensive Plan Evaluation Workgroup
Recommended Action: FYI: The Evaluation Workgroup will meet in April to review Year 1 implementation of the 2017 Comprehensive Plan. This important process ensures the Comprehensive Plan is attuned and responsive to the changing healthcare landscape and local, state, and national HIV planning priorities. Please see Diane Beck if you are interested in joining the Workgroup or to receive meeting notices.

Item: Houston Health Department (HHD) Community Health Improvement Plan (CHIP) Priority Suggestions
Recommended Action: FYI: On February 27th, the Houston Health Department hosted a meeting for community partners to identify health priorities for HHD's CHIP. The Committee reviewed objectives from the 2017-2021 Comprehensive Plan and suggested the following two for inclusion in the CHIP priorities:
Objective 3: Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within one month of their HIV diagnosis to at least 85% from 66% (2015)
Objective 8: Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed from 57% (2015) to at least 80%

Item: Speaker's Bureau
Recommended Action: FYI: Since its inception in 2015, no Planning Council or Project LEAP applications have been received from individuals attending Speaker's Bureau presentations. The Committee moved to end the Speaker's Bureau, in favor of exploring new strategies for coordination and recruitment with business communities, and instructed staff to share process information from the Speaker's Bureau with the Perinatal HIV Prevention program for the program's speaking group.

Item: Verbal Update on Special Study – Social Determinants
Recommended Action: FYI: Dr. Mgbere reported to staff that, while most available data has been accessed, data tables are still being constructed.

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

Item: Committee Orientation
Recommended Action: FYI: All committees dedicated the first portion of their February meeting to general orientation, which included a review of the purpose of the committee, requirements, such as the Open Meetings Act training deadline, work products, meeting dates and more.

Item: 2018 Road 2 Success
Recommended Action: FYI: The committee has decided to postpone all educational events, such as Road 2 Success, until the EMA has received more information about the FY 2018 grant award.

Item: Project LEAP Recruitment
Recommended Action: FYI: Committee members will be distributing Project LEAP flyers at the AIDS Walk on Sunday, March 4, 2018.

C. Quality Improvement Committee — Denis Kelly and Gloria Sierra, Co-Chairs

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

- FY16 Chart Reviews
  1. Oral Health – Rural
  2. Primary Care
  3. Vision
- Selected Core Performance Measures by Gender, received 02/13/18
- Clinical Quality Management Quarterly Committee Report, 01/18/18

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

- TRG Consumer Interview Results 2017

Item: FY 2018/19 Standards of Care
Recommended Action: **Motion:** Approve the recommended changes regarding the FY 2018/19 Standards of Care for Ryan White Part B and State Services.

D. Priority and Allocations Committee — Peta-gay Ledbetter and Bruce Turner, Co-Chairs

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

- FY17 Service Utilization, dated 02/13/18
- FY17 Procurement, dated 11/15/17

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

- Procurement, FY17/18 SS – Rebate, dated 02/15/18
- Procurement, FY17/18 SS, dated 02/06/18
- Procurement, FY17/18 Part B, dated 02/05/18
- Service Utilization, FY16/17, Part B, dated 02/05/18
- Health Insurance Assistance Program Report (2), both dated 02/05/18

Item: FY 2019 Guiding Principles and Criteria
Recommended Action: **Motion:** Approve the attached FY 2019 Guiding Principles and Decision Making Criteria.

Item: FY 2019 Priority Setting Process
Recommended Action: **Motion:** Approve the attached FY 2019 Priority Setting Process.

Item: FY 2018 Policy for Addressing Unobligated and Carryover Funds
Recommended Action: **Motion:** Approve the attached FY 2018 Policy for Addressing Unobligated and Carryover Funds.

E. Operations Committee — Ella Collins-Nelson and Johnny Deal, Co-Chairs
Item: Petty Cash Policy, 900.01, revised January 1, 2018
Recommended Action: **Motion:** Approve the changes on line 40 of the Petty Cash Policy, 900.01.

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

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

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

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

VIII. New Business (30 seconds/report)

A. Ryan White Part C Urban and Part D — Dawn Jenkins
B. Community Development Advisory Council (CDAC) — Johnny Deal
C. HOPWA — Krystal Shultz
D. Community Prevention Group (CPG) — Denis Kelly

E. Update from Task Forces:

- Sexually Transmitted Infections (STI) — Herman Finley
- African American — Ella Collins-Nelson
- Latino — Gloria Sierra
- Youth — Gloria Sierra
- MSM — Ted Artiaga
- Transgender — Viviana Santibanez
- Hepatitis C — Steven Vargas
- Urban AIDS Ministry — Ella Collins-Nelson

F. HIV and Aging — Bruce Turner

G. Texas HIV Medication Advisory Committee — Bruce Turner

H. Positive Women's Network — Tana Pradia

I. Texas Black Women's Initiative — Sha'Terra Johnson-Fairly

J. Texas HIV Syndicate — Amber Harbolt

K. END HIV Houston — Venita Ray

L. Texans Living with HIV Network — Venita Ray

M. Legislative Updates — Denis Kelly

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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

MINUTES

12 noon, Thursday, February 8, 2018
Meeting Location: Ryan White Offices, 2223 W. Loop South, Rm 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Cecilia Oshingbade, Chair	John Poole	Zavion Knox
Skeet Boyle, Vice Chair	Tana Pradia	Nancy Miertschin
Carol Suazo, Secretary	Venita Ray	Cynthia Deverson
Ted Artiaga	Faye Robinson	
Ruth Atkinson	Viviana Santibanez	**STAFF PRESENT**
Ella Collins-Nelson	Gloria Sierra	*Ryan White Grant Administration*
Bobby Cruz	Bruce Turner	Carin Martin
Johnny Deal	Steven Vargas	Heather Keizman
Herman L. Finley III		Tasha Traylor
Ronnie Galley		
Angela F. Hawkins	**MEMBERS ABSENT**	*The Resource Group*
Dawn Jenkins	Connie L. Barnes, excused	Sha'Terra Johnson-Fairley
Daphne L. Jones	Rosalind Belcher, excused	
Denis Kelly	David Benson, excused	*Office of Support*
Peta-gay Ledbetter	Paul E. Grunenwald, excused	Tori Williams
Tom Lindstrom	Arlene Johnson	Amber Harbolt
Osaro Mgbere	J. Hoxi Jones, excused	Diane Beck
Rodney Mills	Robert Noble, excused	
Allen Murray	Shital Patel, excused	
Krystal Perez	Isis Torrente, excused	

Call to Order: Cecilia Oshingbade, Chair, called the meeting to order at 12:01 p.m.

During the opening remarks, Oshingbade welcomed all members of the 2018 Ryan White Planning Council and asked new members to introduce themselves. She thanked the members of the 2017 Operations Committee for developing and hosting the 2018 Mentor Luncheon and the 2018 all-day Council Orientation. Unfortunately, the Mentor Luncheon had to be cancelled due to inclement weather. The Council Orientation was well attended and, according to comments that were received, well done. Many thanks to the staff for doing the behind-the-scenes organizing for both events – especial Rod who

spent weeks preparing for both events. Unfortunately, two resignations from the Planning Council were received: Curtis Bellard and Evelio Escamilla.

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, Boyle) to approve the December 14, 2017 minutes.* **Motion carried.** Abstentions: Atkinson, Cruz, Finley, Galley, Jenkins, Jones, Murray, Perez, Poole, Ray, Robinson, Turner.

Training: Texas Open Meetings Act: Venita Ray, presented the attached PowerPoint presentation.

Public Comment and Announcements: None.

Reports from Committees
Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following:
Update on Special Study – Social Determinants: Dr. Mgbere reported that the Houston Health Department experienced difficulty with running the Medical Monitoring Project software due to license expiry, but the issue was resolved. Dr. Mgbere anticipated the requested data would be available by the holidays.

Update on Special Study – Out of Care: See attached flyer, interview guide, starter codebook, and emerging themes. As of today, twelve interviews have been completed, and staff are continuing to screen calls to schedule more interviews. Interviews have been conducted in various locations which seems to be helpful for participants.

2018 Epidemiological Profile: Staff is working on population level data from the American Community Survey from the US Census Bureau for Houston/Harris County, the EMA, and the HSDA. The committee will look at this today.

2018 Committee Goals: The Committee voted to recommend expanding Goal #1 in 2018 to read: "Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Prevention and Care Services Plan and corresponding areas of the End HIV Plan."

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

Affected Community Committee: No report.

Quality Improvement Committee: No report.

Priority and Allocations Committee: No report.

Operations Committee: Johnny Deal, Co-Chair, reported on the following:
2018 Mentor/Mentee Luncheon: The 2018 Mentor/Mentee Luncheon had to be cancelled due to inclement weather. Williams said that the mentors did reach out to their mentees via telephone and that the mentors will be more active this year.

2018 Council Orientation: The 2018 Council Orientation, which was hosted by the 2017 Operations Committee, was well attended. Harbolt reminded everyone that she needs the evaluations today in order to have them ready in time for the Operations Committee meeting.

2018 Council Activities: See attached. Williams asked if the members of the Steering Committee would have a problem moving their May 2018 meeting to Wednesday in order to allow the Project LEAP students to attend. Several members could not attend if the date were moved. Williams will let them know the final results of her request as soon as the Project LEAP curriculum has been finalized.

Report from Office of Support: Tori Williams, Director, reviewed the Petty Cash Memo, 2018 Timeline of Critical Council Activities, the Texas Open Meetings Act Training Memo and summarized the attached report.

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

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

Community Prevention Group (CPG): Kelly said that the next meeting is February 22nd at 190 Heights Boulevard. The committees meet at 3:30 p.m. and the CPG will meet at 4:30 p.m.

Updates from Task Forces

African American: Johnson-Fairly said that yesterday was National Black HIV Awareness Day and the street outreach team tested 32 individuals. The event provided coffee and food from McDonalds, condoms and they a DJ. The event was well attended. They will have a "lunch and learn" tomorrow at the Montrose Center. Collins-Nelson is the task force co-chair so she will be the person providing the report starting next month.

Latino: Sierra said their members are preparing for the Cesar Chavez parade in March.

MSM: Artiaga said the first meeting was on January 22, 2018, primarily to complete some basically housekeeping for the year. The next meeting will be on February 26, 2018.

Hepatitis C: Vargas submitted the attached report.

Youth: Sierra said they got approval from Madison High School to do testing in April 2018. The Chair will address the Houston City Council for National Youth HIV Awareness Day.

HIV and Aging Coalition: Turner submitted the attached report. They are working on a Long Term Survivors event/fundraiser which will include a luncheon, raffle, and games. If members are interested in volunteering please let him know.

Positive Women's Network (PWN): Pradia submitted the attached report. There were also two event flyers distributed.

END HIV Houston: Ray said that the workgroups are meeting again; members can sign up for a workgroup online. Vargas added that he is encouraging all task forces to send a representative to address the Houston City Council on HIV awareness days in order to demonstrate that HIV affects all populations.

Ryan White Part C Urban and Part D: Jenkins said that they received a partial notice of grant award for the Part C grant.

Texas HIV Medication Advisory Committee: Turner submitted the attached report.

Texas HIV Syndicate: Harbolt said that they held an Ending the Epidemic (EtE) Summit on January 30-31, 2018. On the first day, the EtE Steering committee discussed the structure of the EtE Plan. They also defined and created measures for defining success. On the second day, the full EtE group discussed the framework, areas of focus, and guiding principles of the Plan. The group ended the second day with designating areas of focus for the 459 EtE ideas generated in October. Please see the attached plan framework. If members would like to offer any input, please contact her.

Texans Living with HIV Network: Ray said that they have adopted governing documents and an organizational structure and will open for membership soon.

Community Development Advisory Council for Housing: Deal said they will meet on February 21, 2018 at 3 pm on Sawyer Street.

Texas Black Women's Initiative (TBWI): Johnson-Fairly said they meet at 6:30 p.m. on the third Thursday at The Resource Group. They are looking to partner with other women's groups for National Women and Girls HIV Awareness Day in March. They will also be hosting a high tea in March.

Announcements: Williams reminded everyone that the Texas Open Meetings Act training video can be viewed in the Office of Support this afternoon, popcorn will be provided. Harbolt reminded everyone to complete an evaluation for the 2018 Orientation before they leave today if they haven't done one already. Murray said he is in need of volunteers to staff tables at agencies in order to distribute flyers and application forms for Project LEAP 2018. Kelly said that the AIDS Walk is March 4th.

Adjournment: The meeting was adjourned at 1:19 p.m.

Respectfully submitted,

_____ Date _____
Victoria Williams, Director

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for February 8, 2018

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 #1** Agenda **Carried**				**Motion #2** Minutes **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Cecilia Oshingbade, Chair				C				C	John Poole		X						X
Skeet Boyle, Vice Chair		X				X			Tana Pradia		X				X		
Carol Suazo, Secretary		X				X			Venita Ray		X						X
Ted Artiaga		X				X			Faye Robinson		X						X
Ruth Atkinson		X						X	Viviana Santibanez		X				X		
Ella Collins-Nelson		X				X			Gloria Sierra		X				X		
Bobby Cruz		X						X	Bruce Turner		X						X
Johnny Deal		X				X			Steven Vargas		X				X		
Herman L. Finley III		X						X									
Ronnie Galley		X						X									
Angela F. Hawkins		X				X			**MEMBERS ABSENT**								
Dawn Jenkins		X						X	Connie L. Barnes								
Daphne L. Jones		X						X	Rosalind Belcher								
Denis Kelly		X				X			David Benson								
Peta-gay Ledbetter ja 12:24 pm	X				X				Paul E. Grunenwald								
Tom Lindstrom		X				X			Arlene Johnson								
Osaro Mgbere		X				X			J. Hoxi Jones								
Rodney Mills		X				X			Robert Noble								
Allen Murray		X						X	Shital Patel								
Krystal Perez		X						X	Isis Torrente								

Public Comment

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

PUBLIC COMMENT

Submitted 02-13, 2018
From email to Office of Support and Ryan White Grant Administration

Subject: Update on Substance Abuse Block Grant funds

There is legislation attached to this block grant that set aside 5% of the funding for HIV services for substance users. Due to poor wording in the enabling legislation from 1987 setting aside 5% of the block grant for HIV services, Texas has fallen under the AIDS case threshold for this set aside. (They used AIDS cases instead of HIV surveillance numbers.) The Center receives $1,332,214 for case management and outreach from this source. The set aside will end 8.31.19. We have been in conversations with the state about how this funding can be repurposed to capture the training and expertise that the staff has gained in the 22 years we have had this set aside but it will not be for HIV. We have 4 clinical case managers and part of a supervisor serving current or former substance users and those in treatment. AAMA has 1 plus part of a supervisor. We would like the council and grants administration to know this so that when the next round of allocations are done, they will understand that these positions will be lost starting 9.1.19. Please let me know what information you need to brief the council.

--

Ann J. Robison, PhD
Executive Director
The Montrose Center

Comprehensive HIV Planning Committee Report

2017 QUARTERLY REPORT
COMPREHENSIVE HIV PLANNING COMMITTEE

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

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

   Recommended **revision** from 2017 Committee: "Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Prevention and Care Services Plan **and corresponding areas of the End HIV Plan."**

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

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

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

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

_____ _____

Committee Chairperson **Date**

DRAFT

Houston Area HIV Services Ryan White Planning Council
Comprehensive HIV Planning Committee
2018 Committee Timetable
January – December 2018

Updated: 02-06-2018

	Jan	Feb	Mar	Apr ***Committee may not meet due to HTBMN***	May	June* ***Committee may not meet due to Council meeting off-site***	July	Aug	Sept	Oct	Nov	Dec* ***Committee may not meet if there is no new business***	NOTES
Epi Profile	No Committee Meeting in January		Committee approves 2018 Epi Profile	Council approves 2018 Epi Profile; 2018 Epi Profile used in HTBMN process							Committee approves 2019 Epi Profile Update	Council approves 2019 Epi Profile Update	
Needs Assessment / Special Studies				Special Study preliminary findings used in HTBMN process	Committee approves Special Study report	Council approves Special Study report	Rural Profile available	Women of Color Profile available	MSM Profile available	Unstably Housed / Homeless Profile available			Profiles based on 2017-21 Comp Plan Special pops.
Comprehensive HIV Plan		Committee discusses continuation of the Speaker's Bureau Workgroup & develops two CHIP suggestions	Committee reviews Y2 (2018) Council-related activities and Joint feedback from HRSA/CDC	Evaluation WG meets to review Y1 (2017) implementation	Committee approves Y1 (2017) Evaluation Report 2018 Q1 Activities Update	Council approves Y1 (2017) Evaluation Report	2018 Q2 Activities Update			2018 Q3 Activities Update			
EIIHA			EIIHA WG reviews FY18 EIIHA criteria; requests additional data types if needed			EIIHA WG ***tentatively*** meets to develop FY19 EIIHA Plan	EIIHA WG ***tentatively*** meets to develop FY19 EIIHA Plan Committee approves FY19 EIIHA Plan	Council approves FY19 EIIHA Plan					FY19 EIIHA plan subject to changes pending HRSA guidance (anticipated June 2018)

= Committee approval

= Council approval

From: Avila, Rodriga (County Judge's Office)
Sent: Monday, January 29, 2018 2:03 PM
To: RWPC
Subject: Invitation to HHD Planning Meeting- 2/27

Good afternoon,

Please note that the Houston Health Department (**HHD**) is hosting a meeting for community partners on Tuesday, February 27th at 3pm, located at 8000 N Stadium Drive, 2nd floor training room, Houston, 77054. The goal of the meeting is identify health priorities for HHD's Community Health Improvement Plan (**CHIP**). All Council members are invited to attend. This is an opportunity to ensure concerns of the HIV community are incorporated into a larger response to improve health in Houston. Please see the email invitation below or contact Camden Hallmark (camden.hallmark@houstontx.gov) for more details.

The Comprehensive HIV Planning Committee will develop two CHIP suggestions from the 2017-2021 Comprehensive Plan Objectives at their February meeting. Any interested Council members are welcome to stay after the February Council meeting to provide comment or send me their input to be shared with the Committee.

Thank you,

Amber L. Harbolt, MA
Health Planner
Ryan White Planning Council
Office of Support
2223 West Loop South, Ste 240
Houston, TX 77027
713 572-3729 ofc
713 572-3740 fax
www.rwpchouston.org

Dear CPG and RWPC Member,

The Houston Health Department (HHD) will be applying for health department reaccreditation conducted by the Public Health Accreditation Board.

As part of this effort, we are working with community partners on health priorities for our upcoming Community Health Improvement Plan (CHIP): 2018 - 2021. The CHIP is a long-term effort to address public health issues from the results of a community health assessment, The State of Health: Houston and Harris County 2015 – 2016 report, and a community health improvement process.

We are requesting to meet with RWPC and CPG members for their input on the CHIP. Specifically, we would like members to select 1-2 system objectives from the existing Houston Area Comprehensive HIV Prevention and Care Services Plan (2017 - 2021) to be highlighted in the CHIP.

- **Date/Time:** Tuesday, February 27, 2018 at 3pm
- **Location:** Houston Health Department, 8000 N Stadium Drive, 2nd floor training room, Houston, 77054
  - Please bring your parking ticket inside for validation (free parking validation).
  - Our building also requires some form of photo identification for entry, such as a driver's license.

Please feel free to contact me directly should you have any questions. We look forward to your participation and voice in selecting HIV priorities for Houston.

Camden

Camden Hallmark, MPH *(Pronouns: he/him/his)*
Analyst
Bureau of HIV/STD and Viral Hepatitis Prevention
Houston Health Department
8000 N. Stadium Dr., 5th Floor
Houston, TX 77054
Phone: 832-393-4545
camden.hallmark@houstontx.gov

#

2017 Comprehensive Plan Vision and Mission

The 2017 Comprehensive Plan Vision and Mission set a compelling and inspiring image for the Houston Area to achieve by 2021 that guided the development of the 2017 Comprehensive Plan overall goals, system objectives, and strategy specific goals, solutions, benchmarks, and activities.

Vision

The greater Houston area will become a community with an enhanced system of HIV prevention and care. New HIV infections will be reduced to zero. Should new HIV infections occur, every person, regardless of sex, race, color, ethnicity, national origin, age, familial status, marital status, military status, religion, disability, sexual orientation, genetic information, gender identity, pregnancy, or socio-economic circumstance, will have unfettered access to high-quality, life-extending care, free of stigma and discrimination.

Mission

The mission of the 2017-2021 Houston Area Comprehensive HIV Prevention & Care Services Plan is to work in partnership with the community to provide an effective system of HIV prevention and care services that best meets the needs of populations living with, affected by, or at risk for HIV.

2017 Comprehensive Plan Overall Goals and Systems Objectives

The 2017 Comprehensive Plan overall goals and system objectives were created to align the 2017 Comprehensive Plan with the goals of the National HIV/AIDS Strategy (NHAS) updated to 2020 as well as replicate specific, quantified, and time-phased (SMART) NHAS indicators at the local level in a way that was responsive to the unique HIV prevention and care needs of the Houston Area.

Overall Goals

To fulfill the mission and vision of the 2017 Comprehensive Plan and make progress toward an ideal system of HIV prevention and care for the Houston Area, the Houston HIV community must complete the following by 2021:

1. Increase community mobilization around HIV in the Greater Houston area (*aligned with NHAS 2020 Goal 1: Reducing New HIV Infections and Goal 4: Achieving a More Coordinated National [and Local] Response to the HIV Epidemic*);
2. Prevent and reduce new HIV infections (*aligned with NHAS 2020 Goal 1: Reducing New HIV Infections*);
3. Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services (*aligned with NHAS 2020 Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV)*;
4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care (*aligned with NHAS 2020 Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV and Goal 3: Reducing HIV-related Disparities and Health Inequities)*;
5. Reduce disparities in the Houston Area HIV epidemic and address the needs of vulnerable populations (*aligned with NHAS 2020 Goal 3: Reducing HIV-related Disparities and*

Health Inequities); and

6. Increase community knowledge around HIV in the Greater Houston area. (*aligned with NHAS 2020 Goal 1: Reducing New HIV Infections, Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV, and Goal 4: Achieving a More Coordinated National [and Local] Response to the HIV Epidemic*).

System Objectives

To replicate the specific, quantified, and time-phased (SMART) national NHAS 2020 indicators at the local level in way that is responsive to the unique HIV prevention and care needs of the Houston Area, the Houston HIV community will accomplish the following by 2021:

1. **Reduce the number of new HIV infections diagnosed in the Houston Area by at least 25% from 1,386 (2014) to ≤1,004** (*NHAS 2020 Indicator 2: Reduce the number of new diagnoses by at least 25% and Indicator 9: Reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States*);
2. **Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their positive HIV status, beginning at 93.8% (2014)** (*local target based on NHAS 2020 Indicator 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%);*
3. **Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within one month of their HIV diagnosis to at least 85% from 66% (2015)** (*NHAS 2020 Indicator 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%*);

4.1 **Decrease the percentage of new HIV diagnoses with an HIV stage 3 (AIDS) diagnosis within one year by 25% from 25.9% (2014) to 19.4%** (*DHAP target; reduction in late/concurrent diagnoses is anticipated to yield results pertaining to NHAS 2020 Indicator 8: Reduce the death rate among persons with diagnosed HIV infection by at least 33%*);

4.2 **Decrease the percentage of new HIV diagnoses with an HIV stage 3 (AIDS) diagnosis within one year among Hispanic and Latino men age 35 and up by 25% from 36.0% (2014) to 27.0%** (*local target based on FY15, FY16, and FY17 EIIHA Plans; reduction in late/concurrent diagnoses is anticipated to yield results pertaining to NHAS 2020 Indicator 8: Reduce the death rate among persons with diagnosed HIV infection by at least 33%*);

5. **Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care (at least two visits for HIV medical care in 12 months at least three months apart) from 75.0 % (2014) to at least 90.0%** (*local target based on NHAS 2020 Indicator 5: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%*);
6. **Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are retained in HIV medical care (at least two documented HIV medical care visits, viral load or CD4 tests in a 12 month period) from 60.0% (2015) to at least 90.0%** (*NHAS 2020 Indicator 5: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%*);
7. **Maintain, and if possible, increase the proportion of Ryan White HIV/AIDS Program clients who are virally suppressed from 80.4% (2014) to at least 90.0%** (*local target based on NHAS 2020 Indicator 6: Increase the percentage of persons with diagnosed HIV infection*

who are virally suppressed to at least 80% and Indicator 10: Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80 %);

8. **Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed from 57.0% (2015) to at least 80.0%** (*NHAS 2020 Indicator 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%*); and
9. **Increase the number of gay and bisexual men of color and women of color receiving pre-exposure prophylaxis (PrEP) education each year (baseline to be developed) to at least 2,000** (local target based on *NHAS 2020 Indicator 2: Reduce the number of new diagnoses by at least 25% and Indicator 9: Reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States*).

The 2017 System Objective Evaluation Tool was created to ensure the 2017 Comprehensive Plan system objectives are met or exceeded by 2021 by establishing annual progress targets as well as recommended data sources and notes (**Table 1**).

Affected Community Committee Report

Affected Community Committee Training

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

February 12, 2018

Purpose of the Planning Council

- What does the Planning Council do?
  - Conducts a Needs Assessment
  - Creates a plan to improve HIV services in Houston
  - Reviews data about existing Ryan White funded HIV services
  - Designs HIV services that will be provided using Ryan White funds in the Houston EMA/HSDA
  - Makes a list of the most important services
  - Decides the amount of Ryan White funding that will be allocated to each of the services

Purpose of the Planning Council

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

Participation in Health Fairs

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

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

Purpose of Public Hearings

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

Affected Community Committee

Training for Staffing a Ryan White Booth at a Health Fair or Other Event

Questions for Role Playing

(as of 03-21-17)

1. **Who is Ryan White?**

   ANSWER: See the attached description of Ryan White.

   Key words: Indiana teenager
   Person with HIV and hemophilia
   Not allowed to attend school because of his AIDS status
   Became a celebrity by asking for respect, compassion & the chance to live normally
   Died in 1990 - the year Congress named the CARE Act after him

2. **What does the Ryan White Program do?**

   ANSWER: The Ryan White Program is a Federal law that provides funds for local communities to develop and pay for core medical services for people living with HIV.

   Key words: Law created by Congress/Federal law
   $20 million/year for the Greater Houston area (Harris and surrounding counties)
   Provides medical services for people living with HIV
   Services include: primary medical care, drugs, dental care, mental health care, substance abuse treatment and case management.

3. **What does the Ryan White Planning Council do?**

   ANSWER: The Planning Council is a group of 39 volunteers appointed by Judge Ed Emmett who are responsible for:

   a.) Assessing the needs of PLWH (Needs Assessment & special studies)
   b.) Deciding which services are the most important (prioritizing services)
   c.) Creating a community plan to meet these needs (Comprehensive Plan)
   d.) Deciding how much money should be assigned (allocated) to services funded by Ryan White Parts A and B and State Services money.

   Key words: Design the system of care for people who are living with HIV
   Allocate funds to address the medical needs of PLWH

4. **How much money can I get?**

   ANSWER: If you get medical care, drugs or case management services from places like Thomas Street Health Center, Legacy Community Health Services, Avenue 360, or St. Hope Foundation then Ryan White dollars are probably paying for those services.

   Key words: You get it through the services you receive.

5. **Why did the Council take away or cut back on the _____ program, etc?**

   ANSWER: In 1990, Congress was not as strict about how Ryan White funds could be used. AND, people were also dying within six months of diagnosis. Now, because the drugs are better, more people are living longer and they have a better quality of life. But, the drugs are expensive and Congress is not allocating enough money to keep

up with the number of people who are newly coming into care or living with the disease 10, 20 years. The purpose of the Ryan White Program has always been to get people into medical care. In the last couple of years Congress has become more restrictive in the use of the funds. The Council risks losing funds if they do not allocate 75% of all the money to core medical services (drugs, primary care, dental care, mental health care, substance abuse treatment and case management) and they must allocate the other 25% of the funds to things like transportation to and from medical appointments.

Key words: People with HIV are living longer
Fewer dollars available to care for more and more people
Purpose of the money is to provide MEDICAL care

6. Are you positive?

ANSWER: That is a personal question and I don't talk about my personal health with people I don't know well. OR, if I am, does it matter? OR, Why is it of interest to you? The important thing is for all people to be tested and know their own status.

Key words: None of your business OR
I do know my status, do you know yours?

7. Where do I get help?

ANSWER: The Blue Book lists services available to people with HIV in the 10-county area. Let's look up case management and I will show you where someone can go to get a social worker that will help a PLWH get services they are eligible for.

Key words: The Blue Book

8. How can I sign up to be an HIV volunteer?

ANSWER:
1.) If you want to work one-on-one with PLWH, look in the Blue Book under "Volunteer Opportunities" (page 86) and call any of the agencies listed.
2.) To apply to become a member of the Ryan White Planning Council you can:
   a.) Fill out a yellow application form to become an external committee member. If there is a vacancy and you are assigned to a committee, you will be asked to attend a meeting approximately once a month.
   b.) Fill out a green application form to apply to become a member of the Planning Council. If there is a vacancy and Judge Emmett appoints you to the Council you will have to attend monthly Council meetings and at least one monthly committee meeting. It can take many years to be appointed to the Council and sometimes there are not enough vacancies to appoint an applicant. So, we recommend that you apply for both and get to know how the Council works through your involvement on a committee.

Key words: Do you want to work one-on-one with clients or design the system that serves 13,000 clients?

Who was Ryan White?

Ryan White was born December 6, 1971 in Kokomo, Indiana. At three days old he was diagnosed with severe Hemophilia and doctors began treating his condition with a new clotting medication that was made from blood. In December 1984, while in the hospital with pneumonia, Ryan was diagnosed with AIDS – at some point he had been infected with HIV by a tainted batch of medication. His T-cell count was 25.

Ryan on ABC News with Ted Koppel

When his health improved he wanted to return to school, but school administrators voted to keep him out for fear of someone getting AIDS. Thus began a series of court battles lasting nine months, while Ryan attended class by phone. Eventually, he won the right to attend school but the prejudice was still there. He was not welcome anywhere, even at church.

The controversy brought him into the spotlight and he became known as the 'AIDS boy'. Many celebrities supported his efforts. He made numerous appearances around the country and on television promoting the need for AIDS education to fight the stigma faced by those infected by the disease; his hard work resulted in a number of prestigious awards and a made for TV movie.


Ryan at home with his mother, Jeanne, in 1987

For the most part, Ryan was a normal, happy teenager. He had a job and a driver's license, he attended sports functions and dances and his studies were important to him. He looked forward to graduating high school in 1991.

On April 8, 1990, Ryan passed away at Riley Hospital for Children in Indianapolis. He was 18 years old.

In honor of this courageous young man, the United States Congress named the federal law that authorizes government funds for medical care to people living with HIV and AIDS the Ryan White Care Act.

Since 1990, the Houston area has received over $300 million in Ryan White Program funds.

Project L.E.A.P.
Learning, Empowerment, Advocacy and Participation

What is Project L.E.A.P.?

Project LEAP is a free 17-week class that teaches people how they can help plan for and design the HIV prevention and care services that are provided in the greater Houston area. The class is open to everyone, especially those who are HIV positive.

The goal is to train people living with HIV/AIDS so that they can participate in local HIV/AIDS planning activities by serving on a planning body, such as the Ryan White Planning Council or the City of Houston HIV Prevention Community Planning Group (CPG).

What will I Learn?

Some of the topics covered in class include:

- Parliamentary Procedure (Robert's Rules of Order)
- HIV 101
- The History of HIV in the Houston Area
- HIV trends in the Houston area for populations such as African Americans, Hispanics, Women, Youth, Heterosexuals, Transgender, etc.
- HIV trends in the Houston area and available services for people with mental health issues, substance abuse issues, the homeless and the incarcerated/recently released.
- HIV and Co-infections, HIV and Chronic Diseases, HIV and Stigma
- Designing HIV Services
- The Ryan White Program Service Prioritization and Funding Allocation Process
- HIV Prevention in the Houston Area

Additional class activities may include:

- Attend a Ryan White Planning Council and Committee meeting.
- Attend an HIV Prevention Community Planning Group (CPG) Meeting.
- Attend a community meeting of your choice.
- Leadership skills and team building.
- Introduction to National, State, and Local HIV plans.
- Class Needs Assessment project and presentation to the Planning Council.

When Does the Class Meet?

Wednesdays, 10:00 am – 2:00 pm OR 5:30 pm – 9:30 pm

Lunch or dinner will be provided. Assistance with transportation and child care is available.

How Do I Apply?

A brief application and in-person interview are required. Applications are available by mail, fax, email, and can also be picked up in person or completed online.

If you have questions about Project L.E.A.P. or the application process, please contact the Ryan White Planning Council Office of Support at 713-572-3724 or visit www.rwpcHouston.org

Quality Improvement Committee Report

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Oral Health Care-Rural Target Chart Review FY 2016

Ryan White Part A Quality Management Program–Houston EMA

December 2017

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health & Environmental Services. During FY 16, a comprehensive review of client dental records was conducted for services provided between 3/1/16 to 2/28/17. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 16 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

Table 1. Data Collection Parameters

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

The Sample Selection Process

The sample population was selected from a pool of 284 unduplicated clients who accessed Part A oral health care between 3/1/16 and 2/28/17. The medical charts of 75 of these clients were used in the review, representing 26% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/16 and 2/28/17 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 16 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	35	46.7%	122	43%
White	39	52%	159	56%
Asian	1	1.3%	2	.7%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	0	0%	0	0%
Multi-Race	0	0%	1	.4%
	75		**284**	
Hispanic Status				
Hispanic	17	22.7%	71	25%
Non-Hispanic	58	77.3%	213	75%
	75		**284**	
Gender				
Male	47	62.7%	189	68.6%
Female	26	34.7%	93	32.8%
Transgender	2	2.7%	2	.7%
	75		**284**	
Age				
18 – 24	4	5.3%	15	5.3%
25 – 34	15	20%	58	20.4%
35 – 44	21	28%	82	28.9%
45 – 54	20	26.7%	74	26.1%
55 – 64	11	14.7%	45	15.9%
65+	3	4%	10	3.5%
	75		**284**	

Findings

Clinic Visits

Information gathered during the 2016 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

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

Assessment of Medical History

	2014	2015	2016
Primary Care Provider	67%	88%	93%
Dental Health History*	97%	93%	87%
Medical Health History*	81%	83%	87%
Medical History 6 month Update	59%	94%	100%
Medication Review	61%	91%	88%
Allergies Recorded	81%	93%	88%
Documentation of HIV Status	6%	71%	88%
Documentation of Opportunistic Infection Status	53%	93%	88%
Tobacco Use	81%	95%	87%
Substance Abuse	80%	95%	87%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2014	2015	2016
Vital Signs	96%	99%	95%
CBC documented	59%	63%	78%
Screening for Antibiotic Prophylaxis	83%	91%	52%

Prevention and Detection of Oral Disease

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

	2014	2015	2016
Oral Health Education*	87%	80%	88%
Clinical Tooth Chart	100%	99%	94%
Intraoral Exam	92%	88%	88%
Extraoral Exam	91%	88%	86%
Periodontal screening*	91%	92%	84%
X-rays present	94%	92%	91%
Treatment plan*	89%	81%	94%

*HIV/AIDS Bureau (HAB) Performance Measures

Procedures Performed

	2014	2015	2016
Extractions	32%	29%	29%
Fillings	59%	60%	37%
Root Canals	7%	11%	4%
Dentures	13%	11%	15%
Crowns	11%	17%	15%

Conclusions

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

Appendix A – Resources

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

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

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

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

U.S. Department of Health and Human Services Health Resources and Services Administration. (2014). *Guide for HIV/AIDS Clinical Care.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

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

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Primary Care Chart Review Report FY 2016

Ryan White Part A Quality Management Program – Houston EMA

December 2017

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2016 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Medical Services to five organizations. Approximately 7,800 unduplicated-HIV positive individuals are serviced by these organizations.

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

Introduction

On March 27, 2016, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/16 and 2/28/17. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV: January 28, 2016*, were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Improvement (CQI) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, 2016* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

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

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

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

Tale 1. Data Collection Parameters

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

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

The Sample Selection Process

The sample population was selected from a pool of 7,299 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/16 and 2/28/17. The medical charts of 635 clients were used in this review, representing 8.7% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 45.7% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

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

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/16-2/28/17

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	308	48.5%	5,383	73.75%
Female	290	45.7%	1,833	25.11%
Transgender Male to Female	37	5.8%	81	1.11%
Transgender Female to Male	0	0%	2	.03%
TOTAL	**635**		**7,299**	
Race				
Asian	9	1.4%	99	1.36%
African-Amer.	306	48.2%	3,718	50.94%
Pacific Islander	0	0%	5	.07%
Multi-Race	2	.3%	50	.69%
Native Amer.	1	.2%	28	.38%
White	317	49.9%	3,399	46.57%
TOTAL	**635**		**7,299**	
Hispanic				
Non-Hispanic	392	61.7%	4,756	65.16%
Hispanic	243	38.3%	2,543	34.84%
TOTAL	**635**		**7,299**	
Age				
18-24	27	4.3%	469	6.43%
25-34	166	26.1%	2,090	28.63%
35-44	182	28.7%	2,036	27.89%
45-54	169	26.6%	1,815	24.87%
55-64	79	12.4%	775	10.62%
65 and older	12	1.9%	114	1.56%
Total	**635**		**7,299**	

Report Structure

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

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

Findings

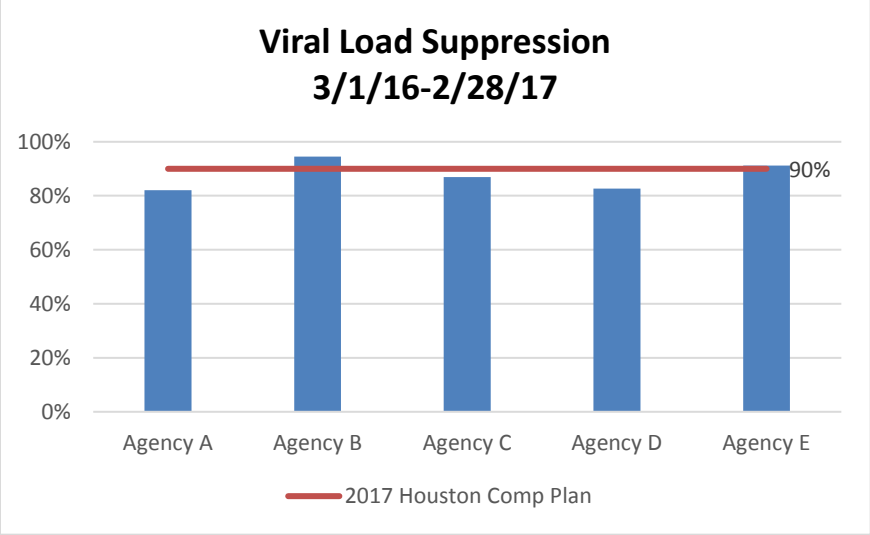
Core Performance Measures

Viral Load Suppression

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

	2014	2015	2016
Number of clients with viral load below limits of quantification at last test during the measurement year	539	519	544
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	586	601	615
Rate	**92%**	**86.4%**	**88.5%**
	4.1%	**-5.6%**	**2.1%**

2016 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	238	216	80
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	277	240	88
Rate	**85.9%**	**90%**	**90.9%**



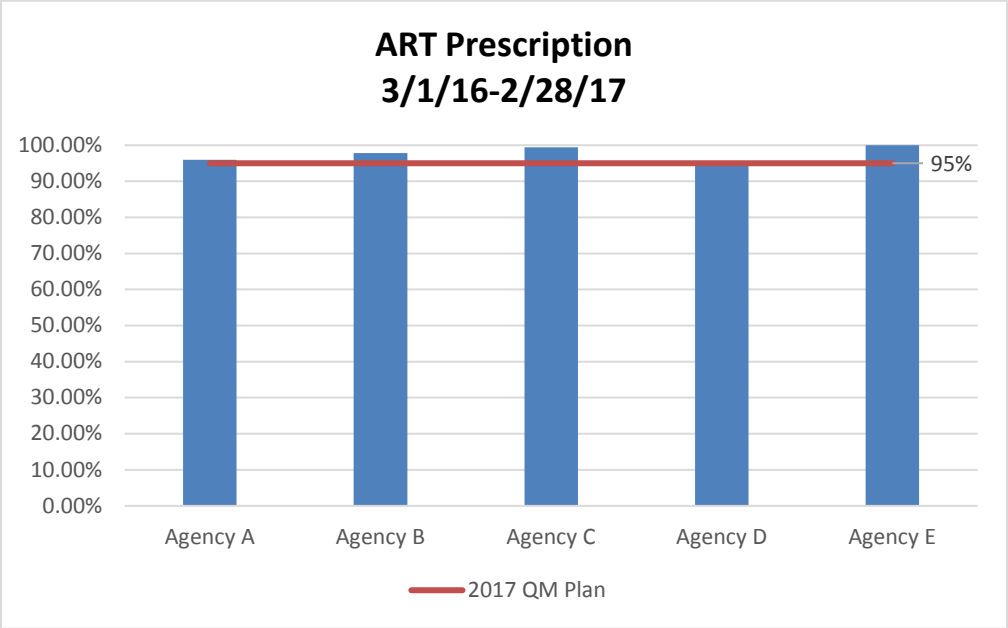
ART Prescription

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

	2014	2015	2016
Number of clients who were prescribed an ART regimen within the measurement year	605	613	620
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**95.3%**	**96.5%**	**98.6%**
Change from Previous Years Results	**-.6%**	**1.2%**	**2.1%**

- Of the 15 clients not on ART, none had a CD4 <200

2016 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	279	241	90
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	291	243	91
Rate	**95.9%**	**99.2%**	**98.9%**

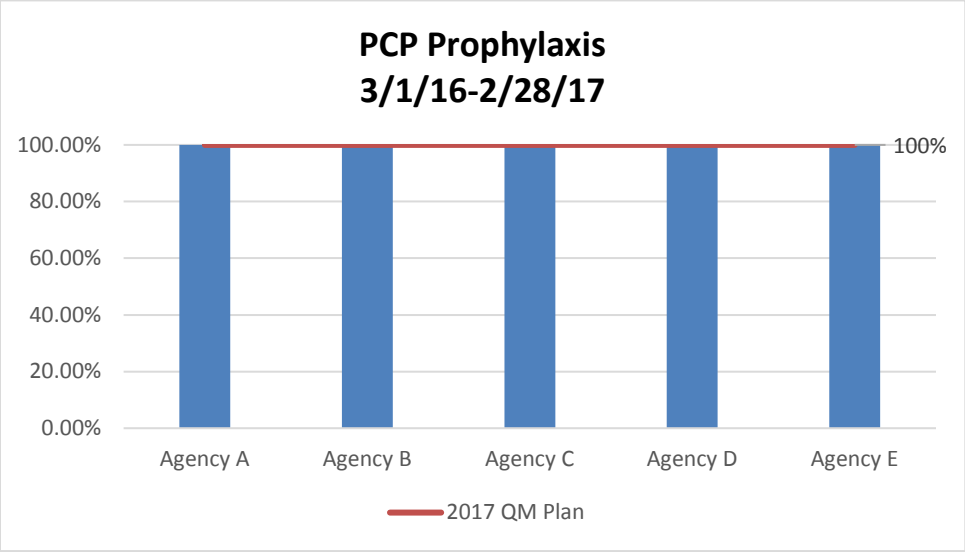


PCP Prophylaxis

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

	2014	2015	2016
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	45	53	48
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	45	57	48
Rate	**100%**	**93%**	**100%**
Change from Previous Years Results	**1.3%**	**-7%**	**7%**

2016 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	19	20	7
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	19	20	7
Rate	**100%**	**100%**	**100%**



All Ages Performance Measures

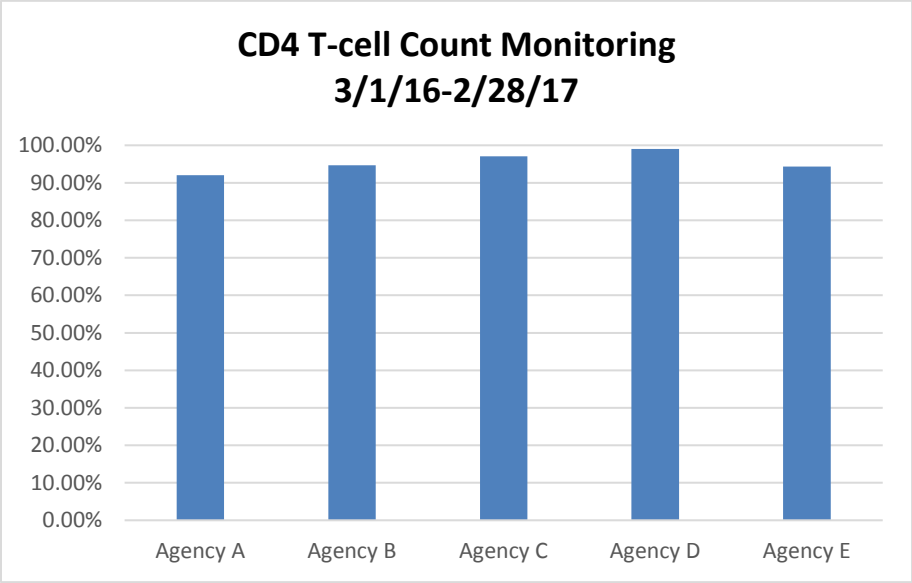
CD4 T-Cell Count

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

	2014	2015	2016
Number of clients who had a CD4 T-cell count performed at least every six months during the measurement year	581	590*	607*
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**91.5%**	**92.9%**	**95.6%**
Change from Previous Years Results	**.9%**	**1.4%**	**2.7%**

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

2016 CD4 by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a CD4 T-cell count performed at least every six months during the measurement year	277	234	86
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	291	243	91
Rate	**95.2%**	**96.3%**	**94.5%**

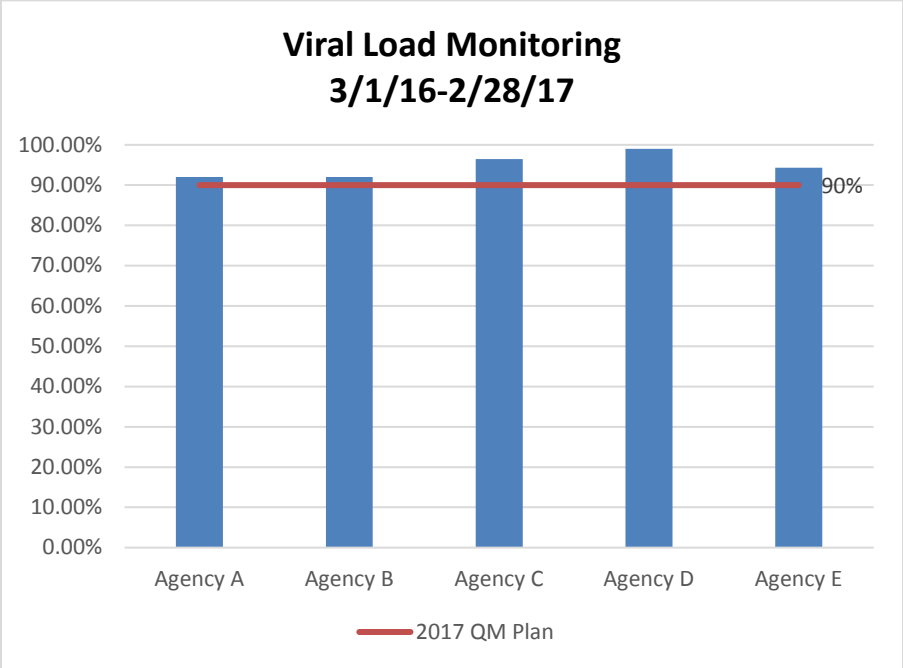


Viral Load Monitoring

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

	2014	2015	2016
Number of clients who had a viral load test performed at least every six months during the measurement year	580	590	601
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**91.3%**	**92.9%**	**94.6%**
Change from Previous Years Results	**1.1%**	**1.4%**	**1.7%**

2016 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	273	233	85
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	291	243	91
Rate	**94.8%**	**95.9%**	**93.4%**



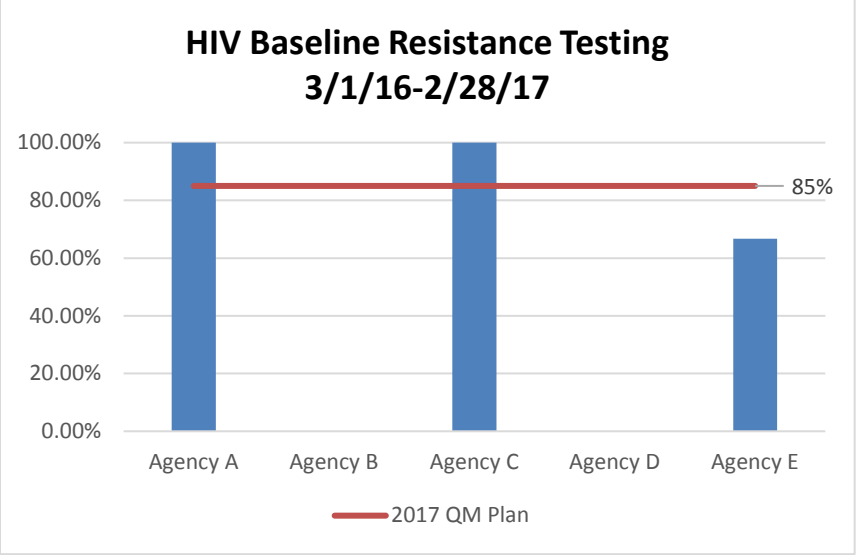
HIV Drug Resistance Testing Before Initiation of Therapy

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

	2014	2015	2016
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	17	7	9
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	20	10	13
Rate	**85%**	**70%**	**69.2%**
Change from Previous Years Results	**18.3%**	**-15%**	**-.8%**

2016 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	5	3	1
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	7	3	3
Rate	**71.4%**	**100%**	**33.3%**

*Agency B did not have any clients that met the denominator



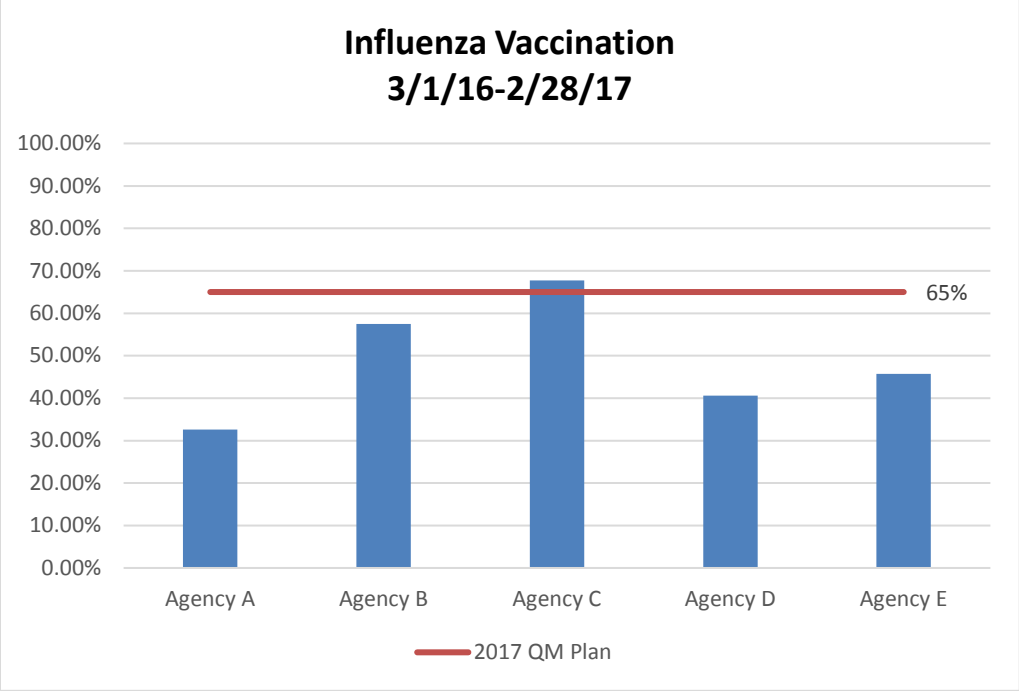
Influenza Vaccination

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

	2014	2015	2016
Number of clients who received influenza vaccination within the measurement year	404	326	312
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	607	579	588
Rate	**66.6%**	**56.3%**	**53.1%**
Change from Previous Years Results	**4.3%**	**-10.3%**	**-3.2%**

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

2016 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	125	131	49
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	262	230	86
Rate	**47.7%**	**57%**	**57%**

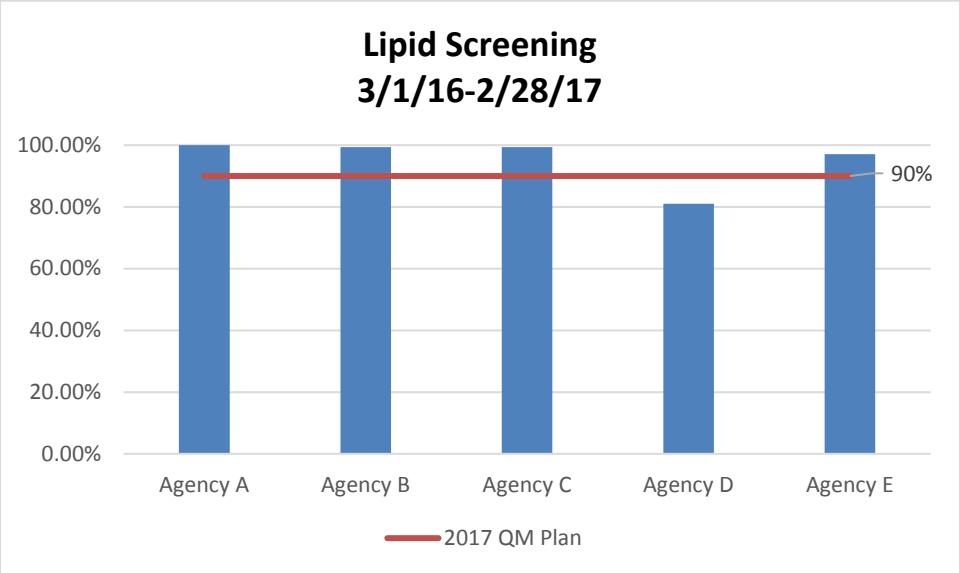


Lipid Screening

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

	2014	2015	2016
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	563	542	551
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	605	613	620
Rate	**93.1%**	**88.4%**	**88.9%**
Change from Previous Years Results	**.8%**	**-4.7%**	**.5%**

2016 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	238	225	79
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	279	241	90
Rate	**85.3%**	**93.4%**	**87.8%**

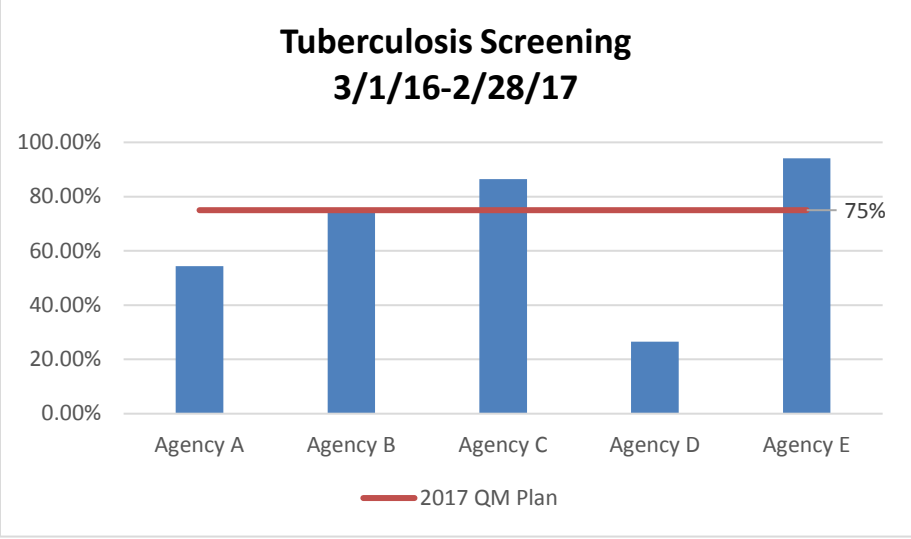


Tuberculosis Screening

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

	2014	2015	2016
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	404	376	382
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	568	560	571
Rate	**71.1%**	**67.1%**	**66.9%**
Change from Previous Years Results	**9.1%**	**-4%**	**-.2%**

2016 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	168	162	45
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	262	219	81
Rate	**64.1%**	**74%**	**55.6%**



Adolescent/Adult Performance Measures

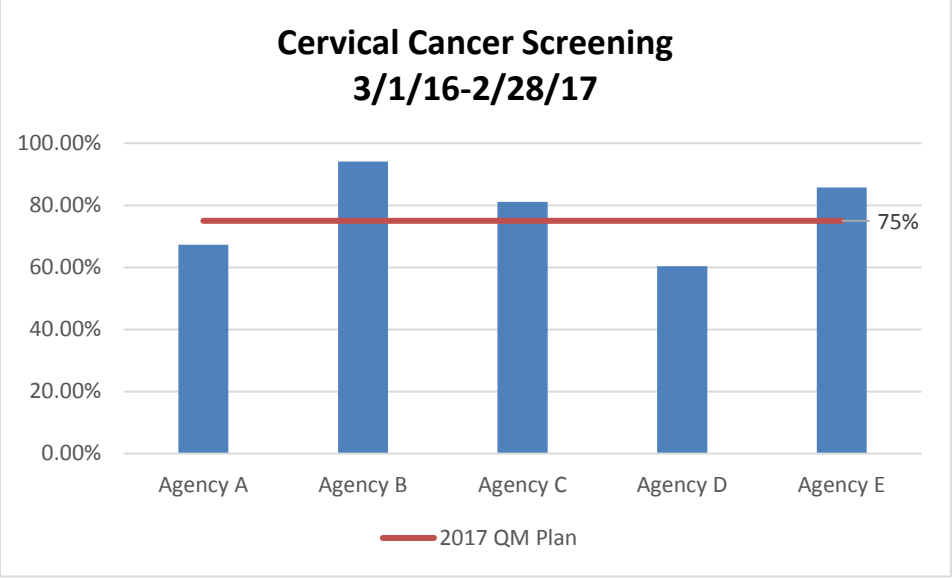
Cervical Cancer Screening

- Percentage of women living with HIV who have Pap screening results documented in the previous three years

	2014	2015	2016
Number of female clients who had Pap screen results documented in the previous three years	183*	197	229
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	288	289	286
Rate	**63.5%**	**68.2%**	**80.1%**
Change from Previous Years Results	**2.3%**	**5.3%**	**11.9%**

- 18.8% (43/229) of pap smears were abnormal
- *Includes women who had screening in the previous year only

2016 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	127	81	20
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	160	94	29
Rate	**79.4%**	**86.2%**	**69%**



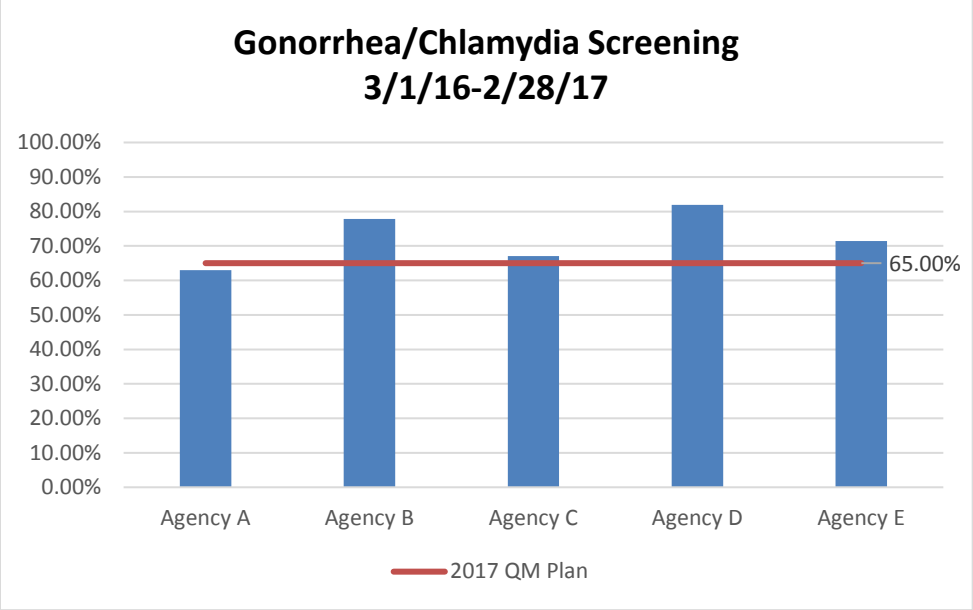
Gonorrhea/Chlamydia Screening

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

	2014	2015	2016
Number of clients who had a test for Gonorrhea/Chlamydia	424	442	463
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	631	635	635
Rate	**67.2%**	**69.6%**	**72.9%**
Change from Previous Years Results	**4.8%**	**2.4%**	**3.3%**

- 13 cases of CT and15 cases of GC were identified

2016 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	220	178	59
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**75.6%**	**73.3%**	**64.8%**



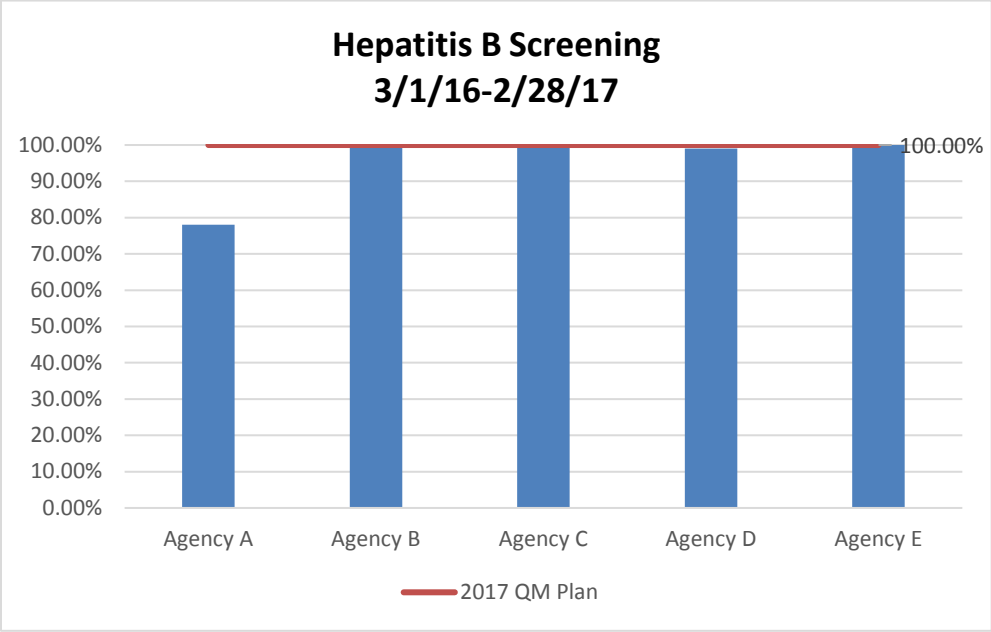
Hepatitis B Screening

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

	2014	2015	2016
Number of clients who have documented Hepatitis B infection status in the health record	627	634	610
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**98.7%**	**99.8%**	**96.1%**
Change from Previous Years Results	**1.1%**	**1.1%**	**-3.7%**

- 1.9% (12/635) were Hepatitis B positive

2016 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	286	226	88
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**98.3%**	**93%**	**96.7%**

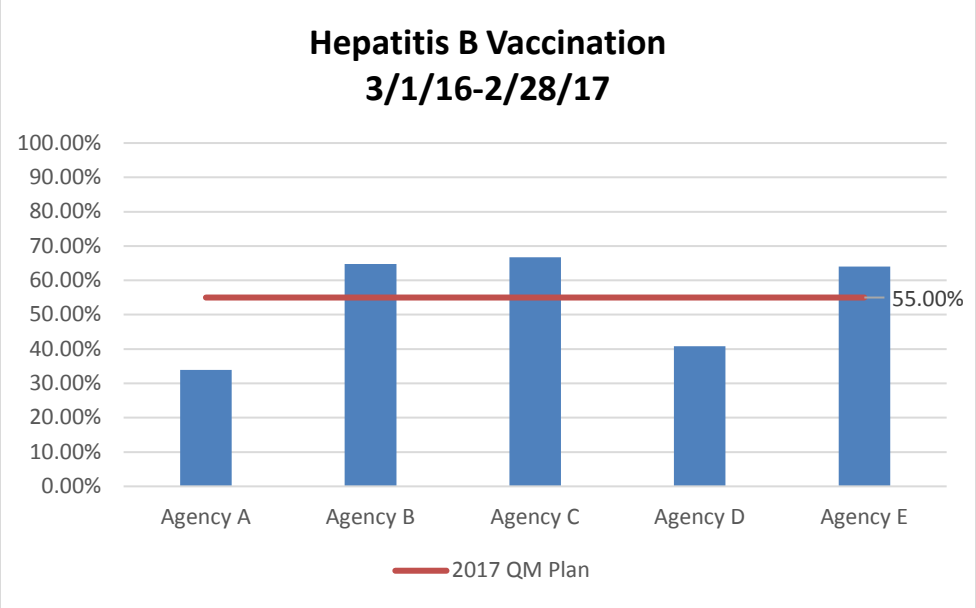


Hepatitis B Vaccination

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

	2014	2015	2016
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	179	184	179
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	322	307	322
Rate	**55.6%**	**59.9%**	**55.6%**
Change from Previous Years Results	**5.3%**	**4.3%**	**-4.3%**

2016 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	67	92	16
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	131	147	38
Rate	**51.1%**	**62.6%**	**42.1%**



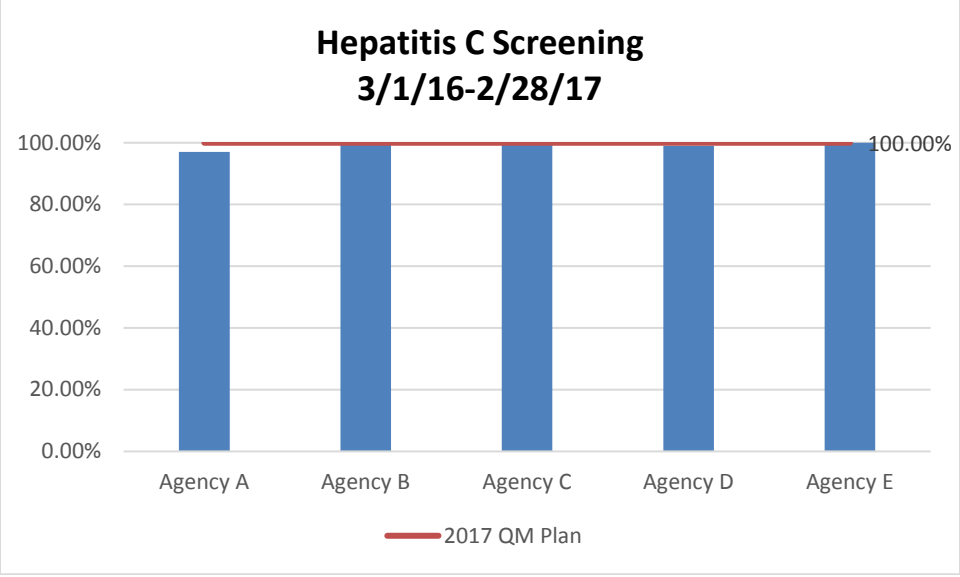
Hepatitis C Screening

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

	2014	2015	2016
Number of clients who have documented HCV status in chart	626	633	629
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**98.6%**	**99.7%**	**99.1%**
Change from Previous Years Results	**3%**	**1.1%**	**-.6%**

- 8% (51/635) were Hepatitis C positive, including 14 acute infections only and 21 cures

2016 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	287	241	91
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**98.6%**	**99.2%**	**100%**

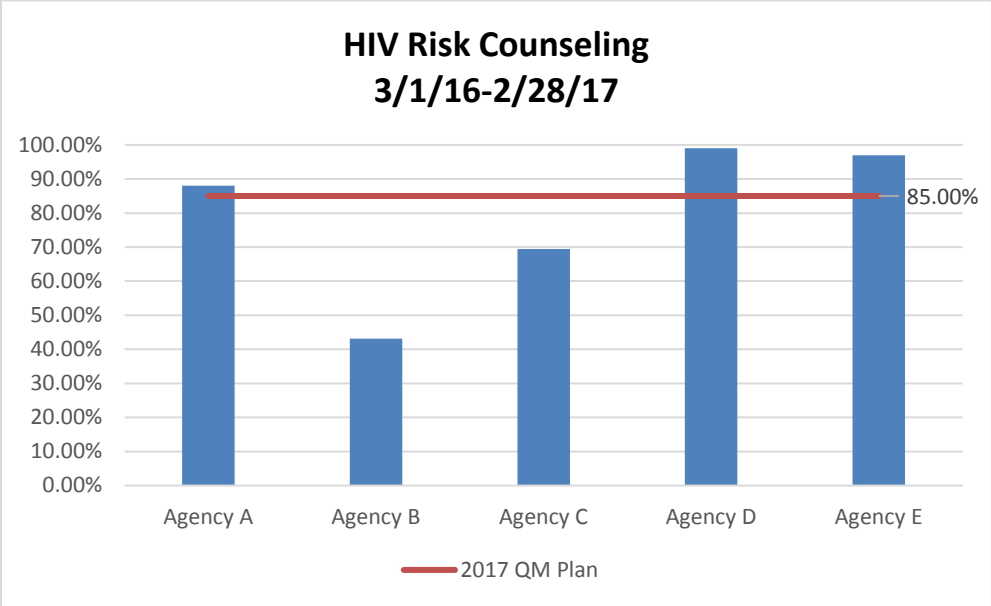


HIV Risk Counseling

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

	2014	2015	2016
Number of clients, as part of their primary care, who received HIV risk counseling	489	453	441
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**77%**	**71.3%**	**69.4%**
Change from Previous Years Results	**-5.8%**	**-5.7%**	**-1.9%**

2016 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	197	171	68
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**67.7%**	**70.4%**	**74.7%**

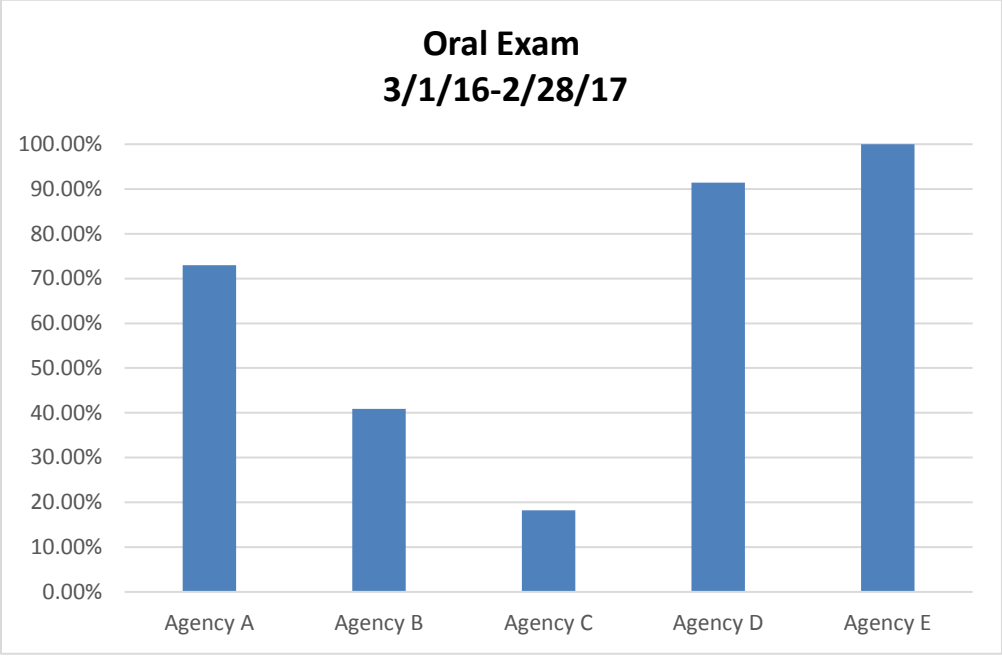


Oral Exam

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

	2014	2015	2016
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	356	340	327
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**56.1%**	**53.5%**	**51.5%**
Change from Previous Years Results	**-.8%**	**-2.6%**	**-2%**

2016 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	146	128	47
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	291	243	91
Rate	**50.2%**	**52.7%**	**51.6%**



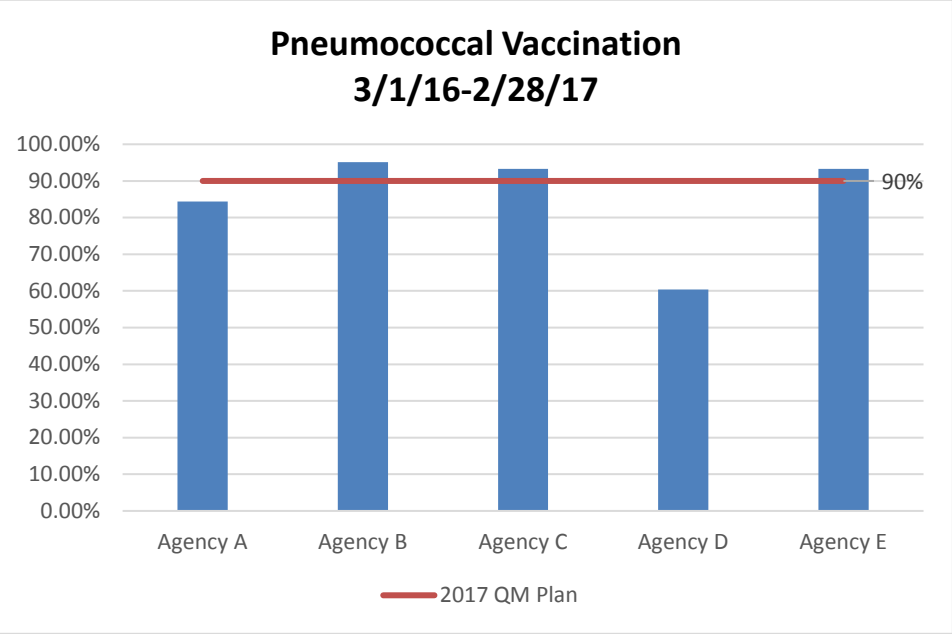
Pneumococcal Vaccination

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

	2014	2015	2016
Number of clients who received pneumococcal vaccination	556	546	534
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	623	622	616
Rate	**89.2%**	**87.8%**	**86.7%**
Change from Previous Years Results	**4.5%**	**-1.4%**	**-1.1%**

- 304 clients (49.4%) received both PPV13 and PPV23 (FY15- 43.3%,FY14- 36.9%)

2016 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	230	213	65
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	291	243	91
Rate	**79%**	**87.7%**	**71.4%**

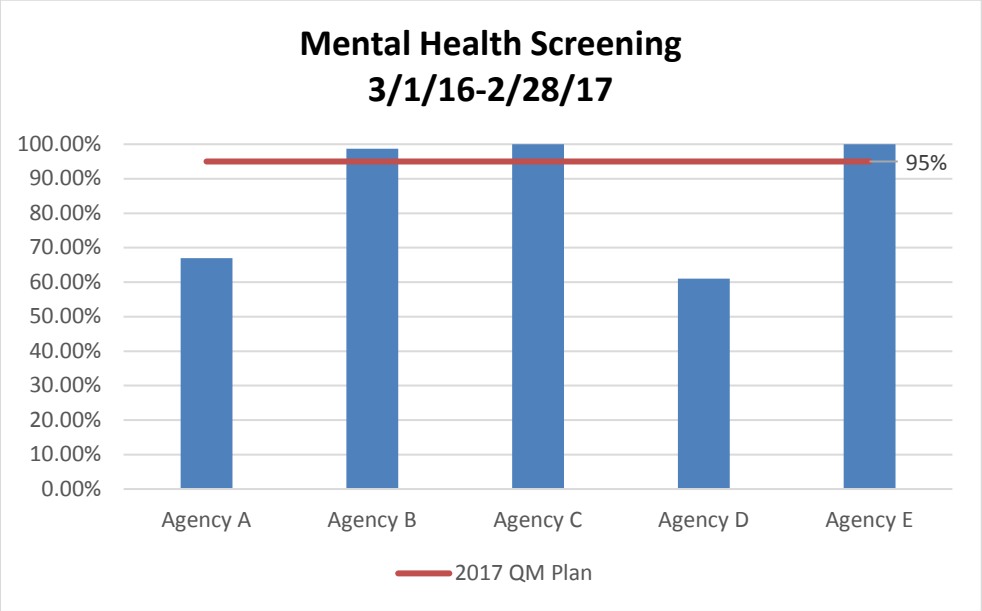


Preventative Care and Screening: Mental Health Screening

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

	2014	2015	2016
Number of clients who received a mental health screening	567	586	558
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**89.3%**	**92.3%**	**87.9%**
Change from Previous Years Results	**7.4%**	**3%**	**-4.4%**

- 28.3% (180/635) had mental health issues. Of the 69 who needed additional care, 62 (90%) were either managed by the primary care provider or referred; 4 clients refused a referral.

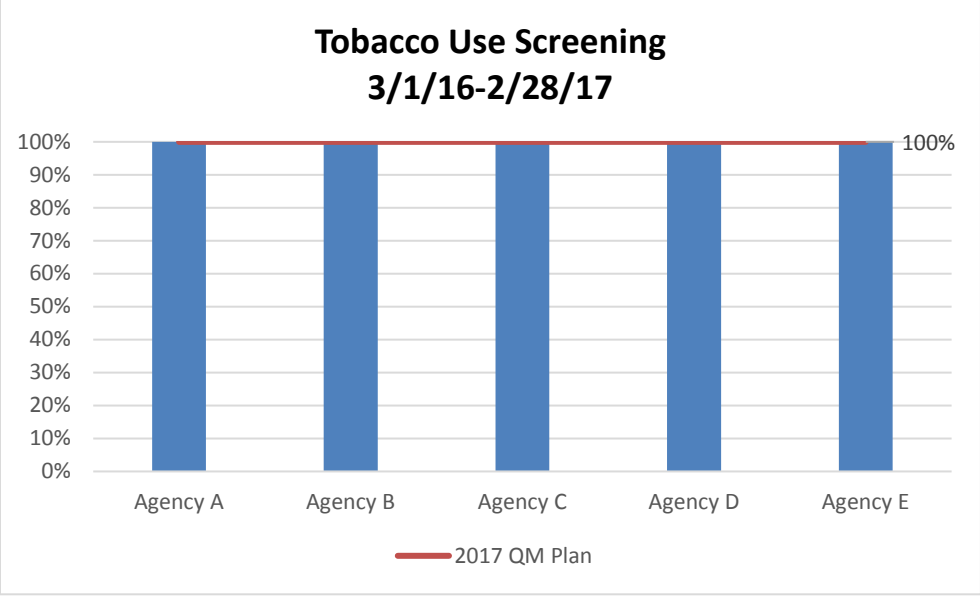


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

	2014	2015	2016
Number of clients who were screened for tobacco use in the measurement period	631	635	631
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.4%**	**100%**	**99.4%**
Change from Previous Years Results	**-.3%**	**.6%**	**-.6%**

- **HIVQUAL-US Mean 86%**
- Of the 631 clients screened, 175 (27.7%) were current smokers.
- Of the 175 current smokers, 101 (57.7%) received smoking cessation counseling, and 9 (5.1%) refused smoking cessation counseling



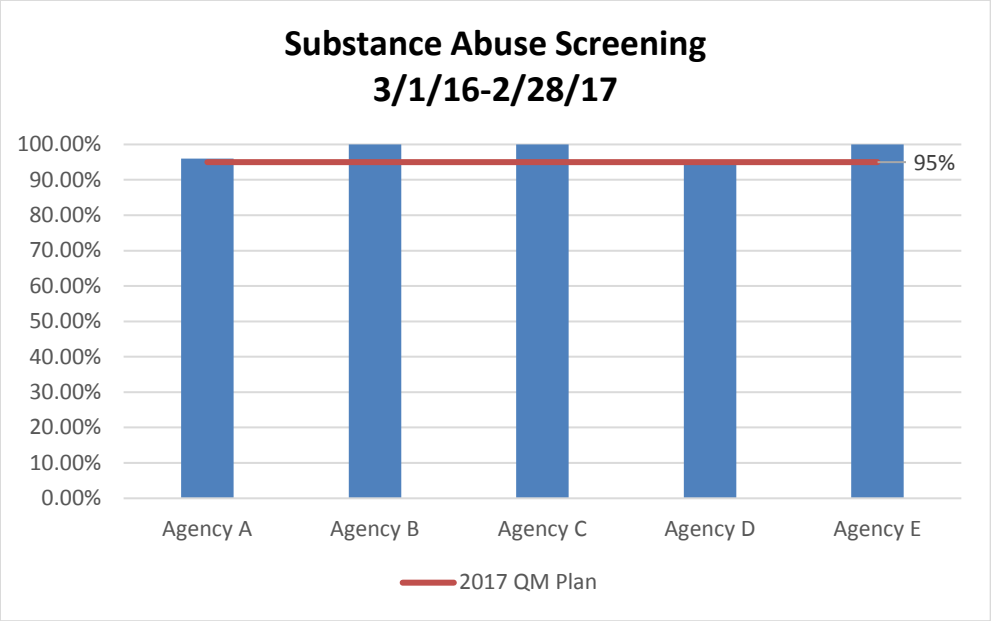
Substance Abuse Screening

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

	2014	2015	2016
Number of new clients who were screened for substance use within the measurement year	624	627	626
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.3%**	**98.7%**	**98.6%**
Change from Previous Years Results	**.7%**	**.4%**	**-.1%**

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

- 4.3% (27/635) had substance abuse issues. Of the 27 clients who needed referral, 22 (81.5%) received one, and 4 (1.5%) refused.

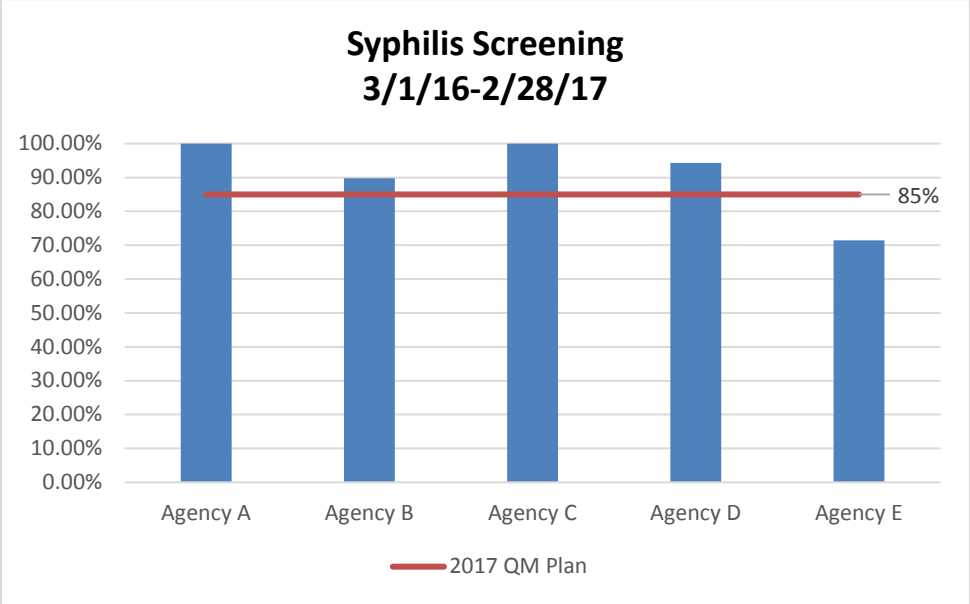


Syphilis Screening

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

	2014	2015	2016
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	594	599	597
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**93.5%**	**94.3%**	**94%**
Change from Previous Years Results	**0%**	**.8%**	**-.3%**

- 6% (38/635) new cases of syphilis diagnosed

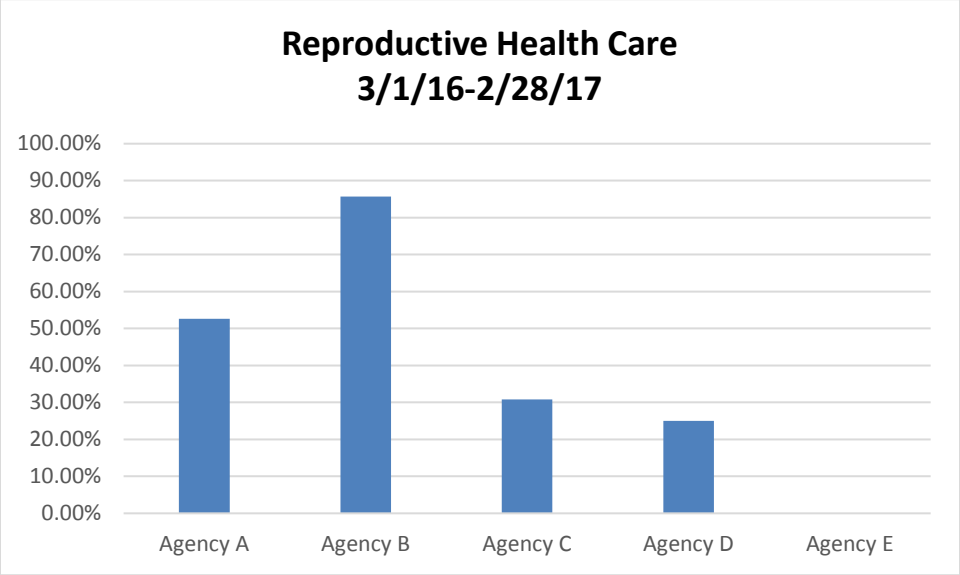


Other Measures

Reproductive Health Care

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

	2014	2015	2016
Number of reproductive-age women who received reproductive health assessment and care	30	34	34
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	73	69	63
Rate	**41.7%**	**49.3%**	**54%**
Change from Previous Years Results	**-6.1%**	**7.6%**	**4.7%**

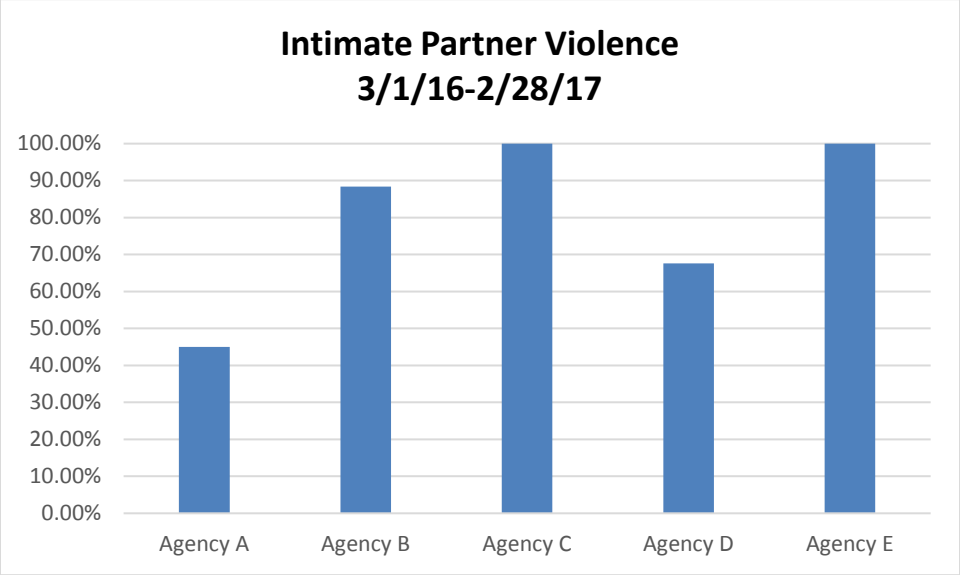


Intimate Partner Violence Screening

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

	2014	2015	2016
Number of clients who received screening for current intimate partner violence	570	569	520
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**89.8%**	**89.6%**	**81.9%**
	17%	**-.2%**	**-7.7%**

* 3/635 screened positive

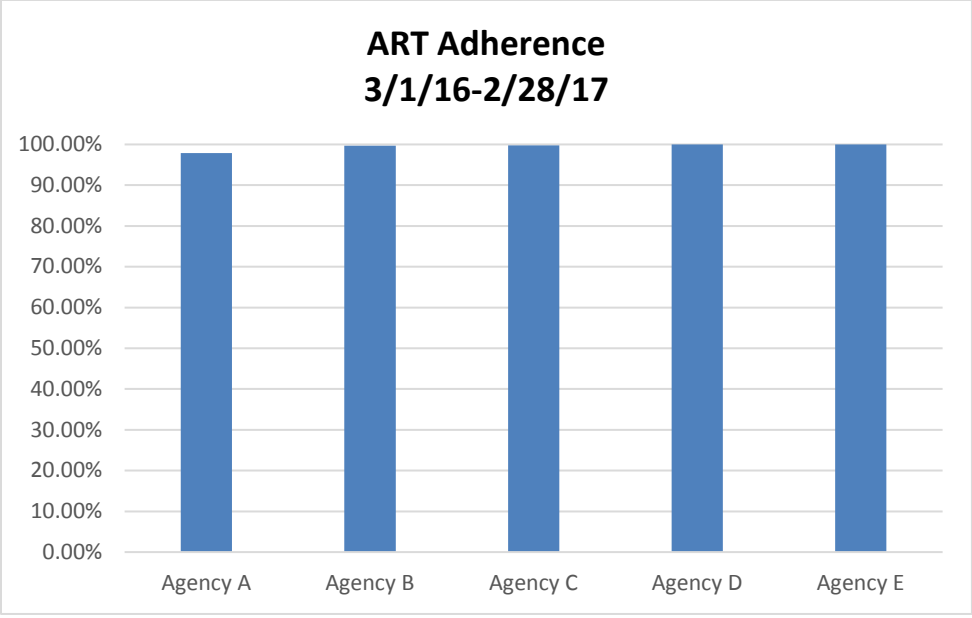


Adherence Assessment & Counseling

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

	Adherence Assessment		
	2014	2015	2016
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	599	607	617
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	605	613	620
Rate	**99%**	**99%**	**99.5%**
Change from Previous Years Results	**4.6%**	**0%**	**.5%**

Adherence Assessment Per Visit	
	2016
Number of primary care visits where ART adherence was assessed	2,016
Number of primary care visits for clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	2,041
Rate	**98.8%**



ART for Pregnant Women

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

	2014	2015	2016
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	4	5	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	4	5	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

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

	2014	2015	2016
Number of diabetic clients whose last HbA1c in the measurement year was <8%	41	27	51
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	68	47	70
Rate	**60.3%**	**57.4%**	**72.9%**
Change from Previous Years Results	**-3.9%**	**-2.9%**	**15.5%**

- 635/635 (100%) of clients where screened for diabetes and 70/635 (11%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2014	2015	2016
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	125	131	133
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	172	173	180
Rate	**72.7%**	**75.7%**	**73.9%**
Change from Previous Years Results	**4.4%**	**3%**	**-1.8%**

- 180/635 (28.3%) of clients where were diagnosed with hypertension

Primary Care: Breast Cancer Screening

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

	2014	2015	2016
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	138	140	146
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	158	168	184
Rate	**87.3%**	**83.3%**	**79.3%**
Change from Previous Years Results	**3.9%**	**-4%**	**-4%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year. There have been several positive trends over the past few years: cervical cancer screening, sexually transmitted infection screening, and ART prescription rates have continued to improve. However, there have been slight decreases in influenza vaccination, IPV screening and HIV risk counseling. RWGA will continue to monitor these measures closely and initiate quality improvement initiatives as needed. In addition, racial and ethnic disparities continue to be seen for most measures, with African-Americans having lower rates than White and Hispanic clients. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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Vision Care Chart Review Report FY 2016

Ryan White Part A Quality Management Program–Houston EMA

December 2017

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health & Environmental Services. During FY 16, a comprehensive review of client vision records was conducted for services provided between 3/1/16 to 2/28/17.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 16 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

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

The Sample Selection Process

The sample population was selected from a pool of 2,010 unduplicated clients who accessed Part A vision care between 3/1/16 and 2/28/17. The medical charts of 150 of these clients were used in the review, representing 7.5% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/16 and 2/28/17 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 16 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		Ryan White Part A EMA	
Race/Ethnicity	Number	Percent	Number	Percent
African American	75	50%	980	49%
White	71	47.3%	975	49%
Asian	2	1.3%	23	1%
Native Hawaiian/Pacific Islander	2	0%	3	<1%
American Indian/Alaska Native	0	0%	10	<1%
Multi-Race	0	0%	19	<1%
TOTAL	**150**		**2,010**	
Hispanic Status				
Hispanic	51	34%	1,306	35%
Non-Hispanic	99	66%	704	65%
TOTAL	**150**		**2,010**	
Gender				
Male	110	73.3%	1,471	73%
Female	39	26%	521	26%
Transgender Male to Female	1	.7%	18	<1%
Transgender Female to Male	0	0%	0	0
TOTAL	**150**		**2,010**	
Age				
<= 24	6	4%	84	4%
25 – 34	29	19.3%	412	21%
35 – 44	36	24%	456	23%
45 – 54	47	31.3%	618	31%
55 – 64	26	17.3%	364	18%
65+	6	4%	76	4%
TOTAL	**150**		**2,010**	

Findings

Laboratory Tests

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

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

	2013	2014	2015	2016
CD4	49%	48%	64%	91%
VL	49%	48%	64%	91%

Client Intake Form (CIF)

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

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

	2013	2014	2015	2016
Primary Care Provider	51%	52%	50%	50%
Medication Allergies	93%	100%	100%	100%
Medical History	99%	100%	100%	100%
Current Medications	96%	100%	100%	100%
Reason for Visit	99%	100%	100%	100%
Ocular History	99%	100%	100%	100%

Eye Examinations (Including CEE/DFE) and Exam Findings

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

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

	2013	2014	2015	2016
Complete Eye Exam	100%	99%	100%	100%
Dilated Fundus Exam	53%	94%	95%	98%
Internal Eye Exam	100%	100%	100%	100%
Documentation of Diagnosis	100%	99%	100%	100%
Documentation of Treatment Plan	100%	99%	100%	100%
Visual Acuity	100%	100%	100%	100%
Refraction Test	99%	98%	100%	99%
Observation of External Structures	56%	100%	100%	100%
Glaucoma Test	99%	100%	100%	100%
Cytomegalovirus (CMV) screening	55%	94%	95%	98%

Ocular Disease

Thirteen clients (8.7%) demonstrated ocular disease, including blindness, amyloid pterygium, cataracts, glaucoma, and foreign body. Two clients received treatment for ocular disease, 6 clients were referred to a specialty eye clinic, and 5 clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 95% (97%-FY15) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 16 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 16-Vision Chart Review Data Collection Tool

Mar 1, 16 to Feb 28, 17

Pt. ID # _____ Site Code:_____

CLIENT INTAKE FORM (CIF)

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

CD4 & VL

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

EYE CARE:

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

Revised March, 2013

Appendix B – Resources

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

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

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

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

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Selected Core Performance Measures by Gender

Viral Load Suppression

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

2016 Viral Load Suppression by Gender			
	Female	Male	Transgender
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	242	270	32
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	277	302	36
Rate	**87.4%**	**89.4%**	**88.9%**

ART Prescription

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

2016 ART Prescription by Gender			
	Female	Male	Transgender
Number of clients who were prescribed an ART regimen within the measurement year	281	303	36
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	290	308	37
Rate	**96.9%**	**98.4%**	**97.3%**

- Of the 15 clients not on ART, none had a CD4 <200

Received 02/13/18

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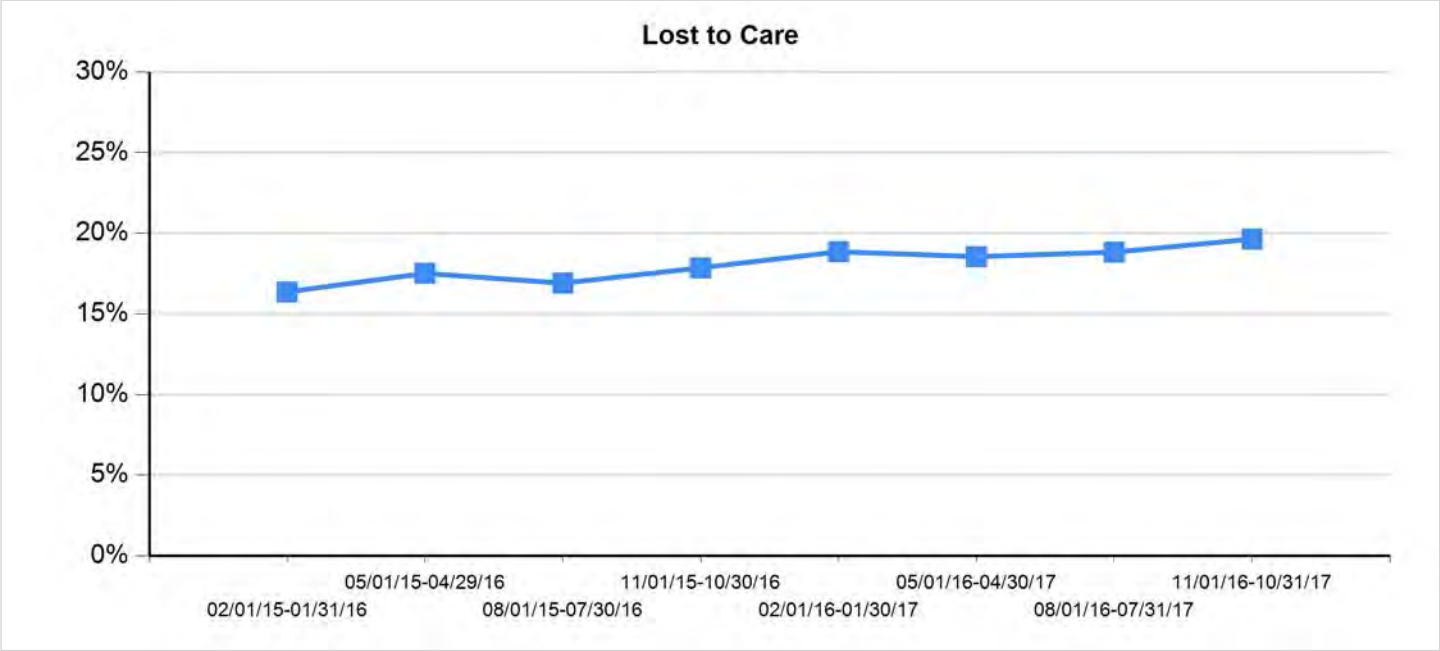
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

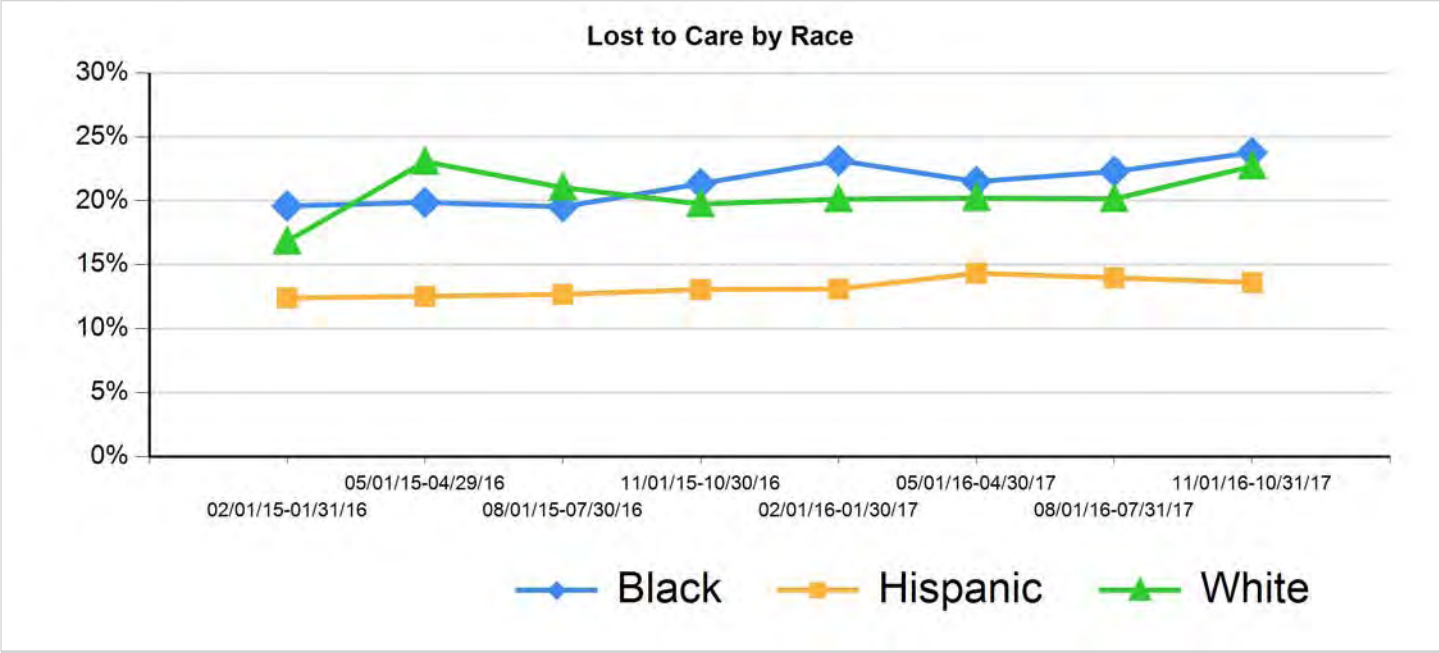
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **11/1/2016**

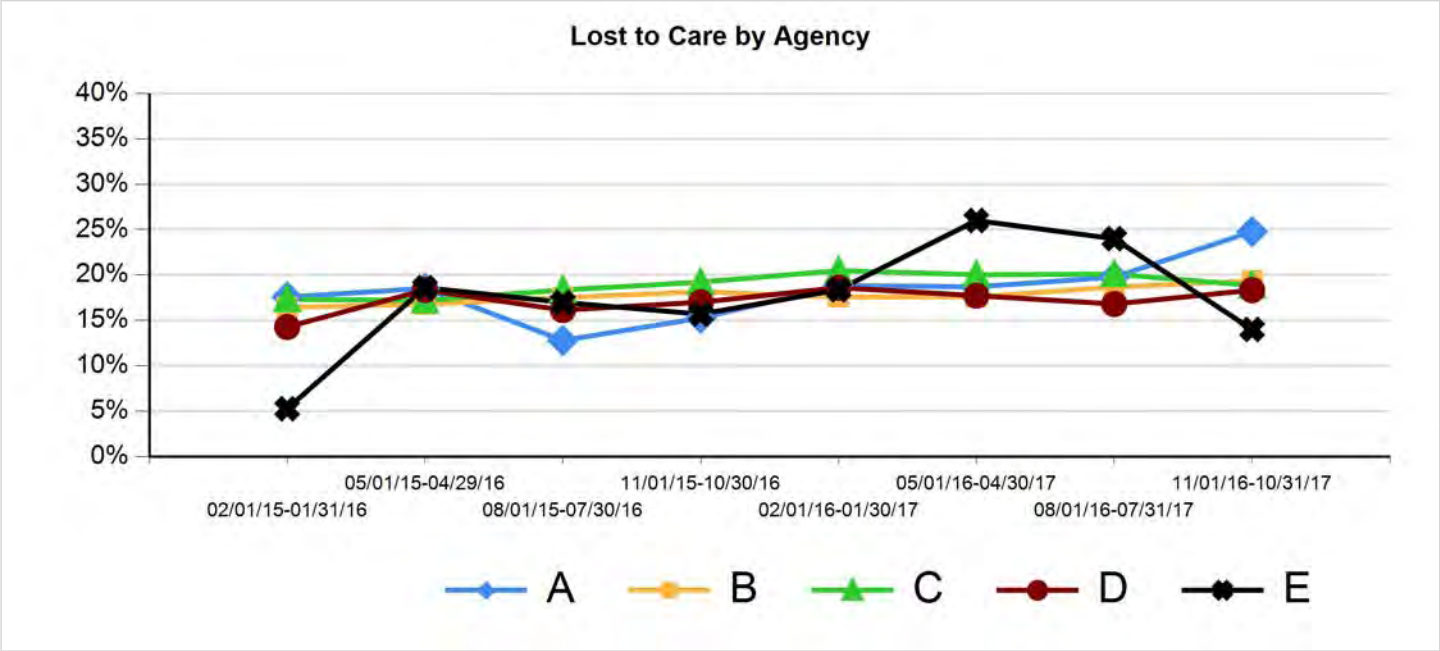
Lost to Care				
In+Care Campaign Gap Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	959	964	1,004	1,068
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	5,087	5,196	5,333	5,438
Percentage	18.9%	18.6%	18.8%	19.6%
Change from Previous Quarter Results	1.0%	-0.3%	0.3%	0.8%



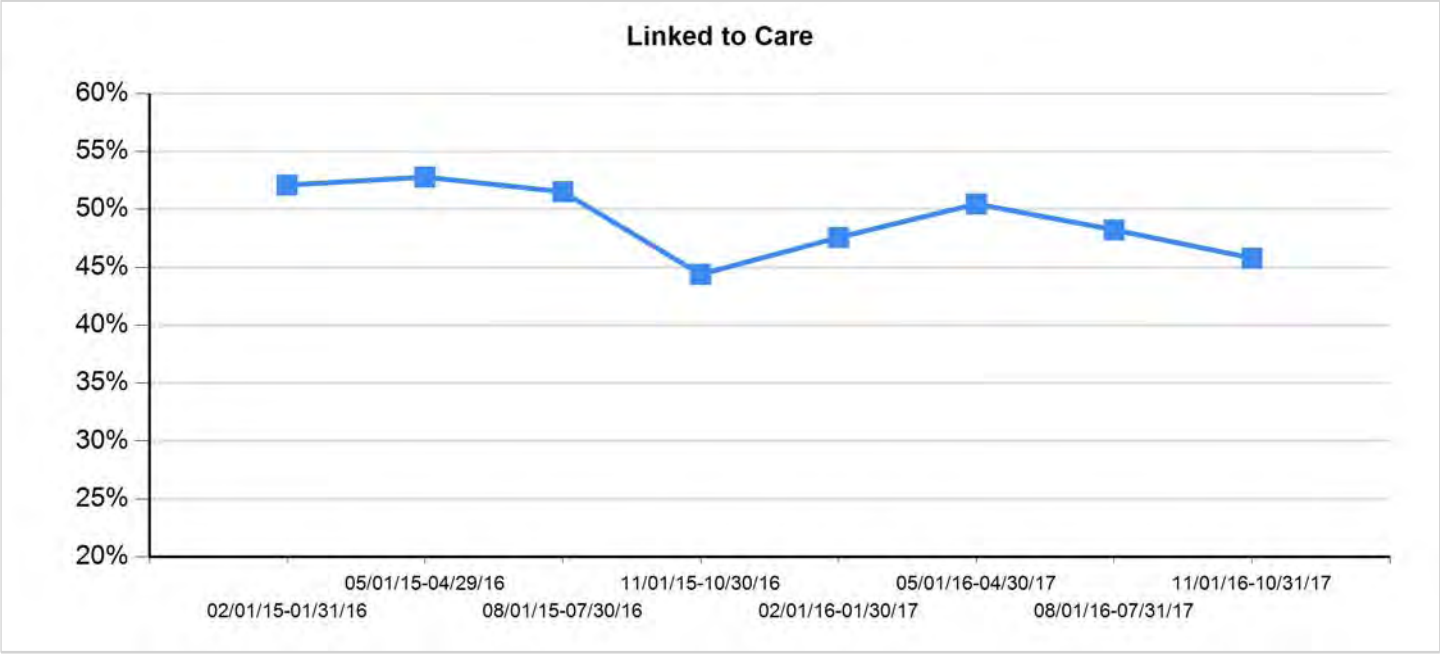
Lost to Care by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	533	278	134	560	279	141	617	278	155
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,479	1,940	663	2,512	1,996	700	2,596	2,043	683
Percentage	21.5%	14.3%	20.2%	22.3%	14.0%	20.1%	23.8%	13.6%	22.7%
Change from Previous Quarter Results	-1.6%	1.2%	0.1%	0.8%	-0.4%	-0.1%	1.5%	-0.4%	2.6%



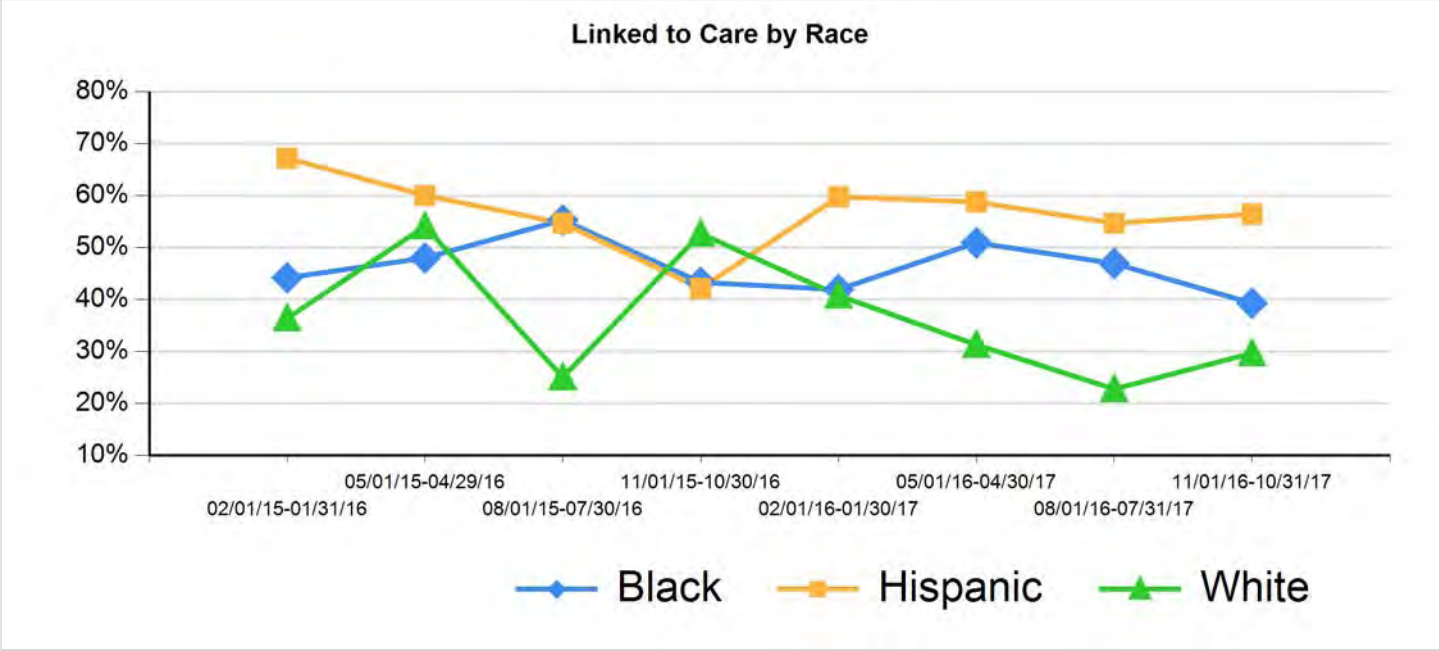
Lost to Care by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	133	353	310	204	12	166	375	293	232	7
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	673	1,892	1,543	1,214	50	670	1,937	1,555	1,266	50
Percentage	19.8%	18.7%	20.1%	16.8%	24.0%	24.8%	19.4%	18.8%	18.3%	14.0%
Change from Previous Quarter Results	1.1%	1.1%	0.1%	-0.9%	-2.0%	5.0%	0.7%	-1.2%	1.5%	-10.0%



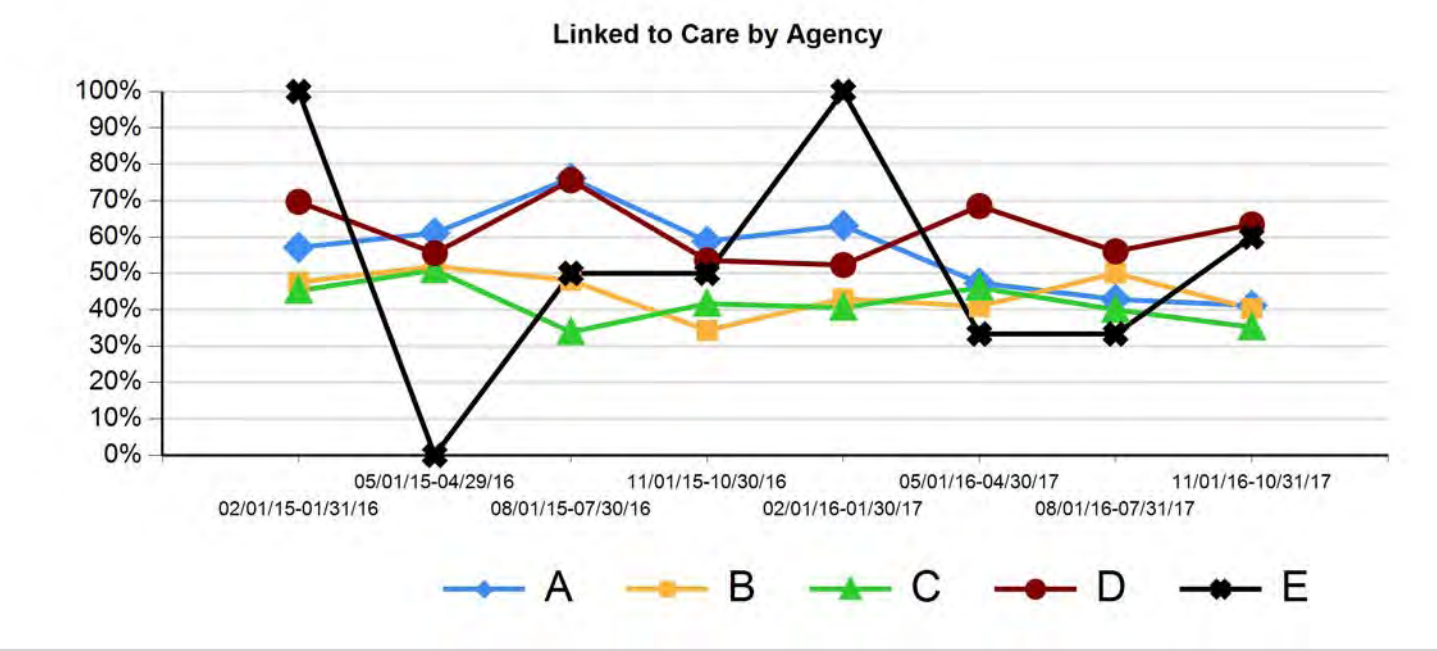
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of newly enrolled uninsured HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	108	108	109	87
Number of newly enrolled uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	227	214	226	190
Percentage	47.6%	50.5%	48.2%	45.8%
Change from Previous Quarter Results	3.2%	2.9%	-2.2%	-2.4%
* exclude if vl<200 in 1st 4 months				



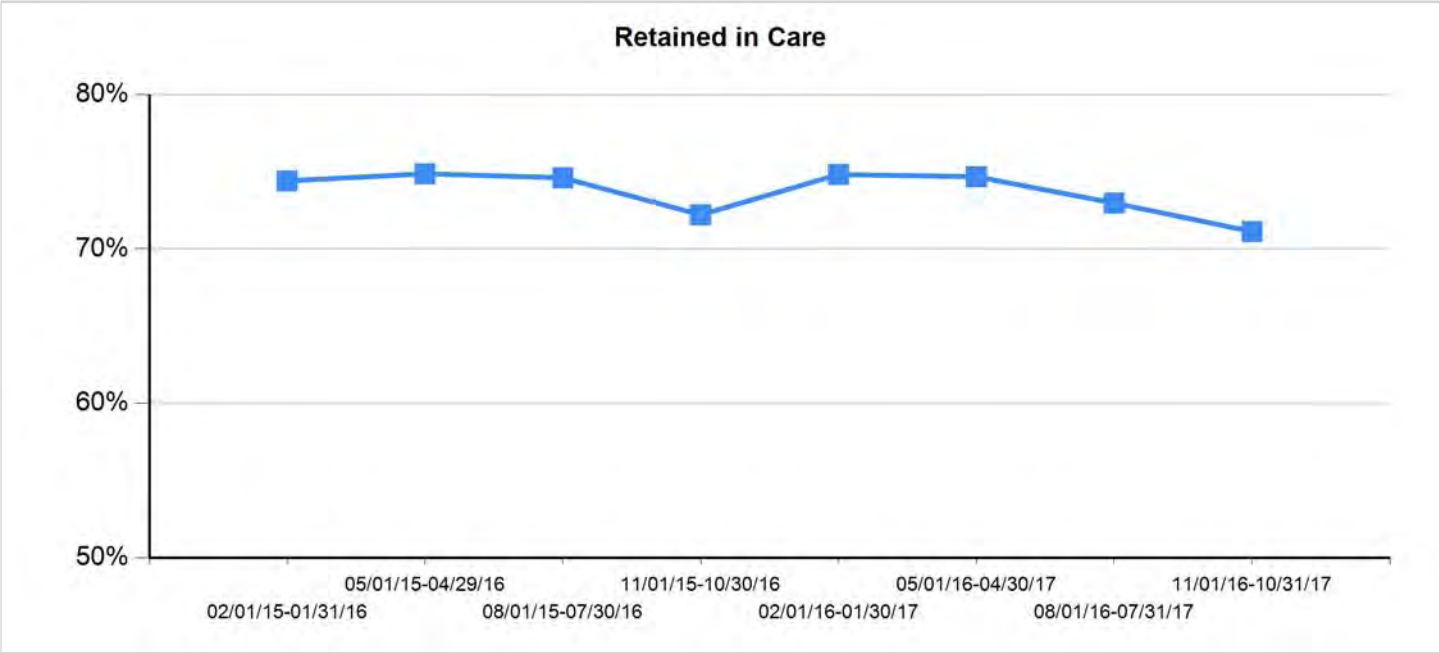
Linked to Care by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled uninsured HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	57	37	10	53	47	5	31	44	8
Number of newly enrolled uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	112	63	32	113	86	22	79	78	27
Percentage	50.9%	58.7%	31.3%	46.9%	54.7%	22.7%	39.2%	56.4%	29.6%
Change from Previous Quarter Results	9.0%	-1.0%	-9.5%	-4.0%	-4.1%	-8.5%	-7.7%	1.8%	6.9%
* exclude if vl<200 in 1st 4 months									



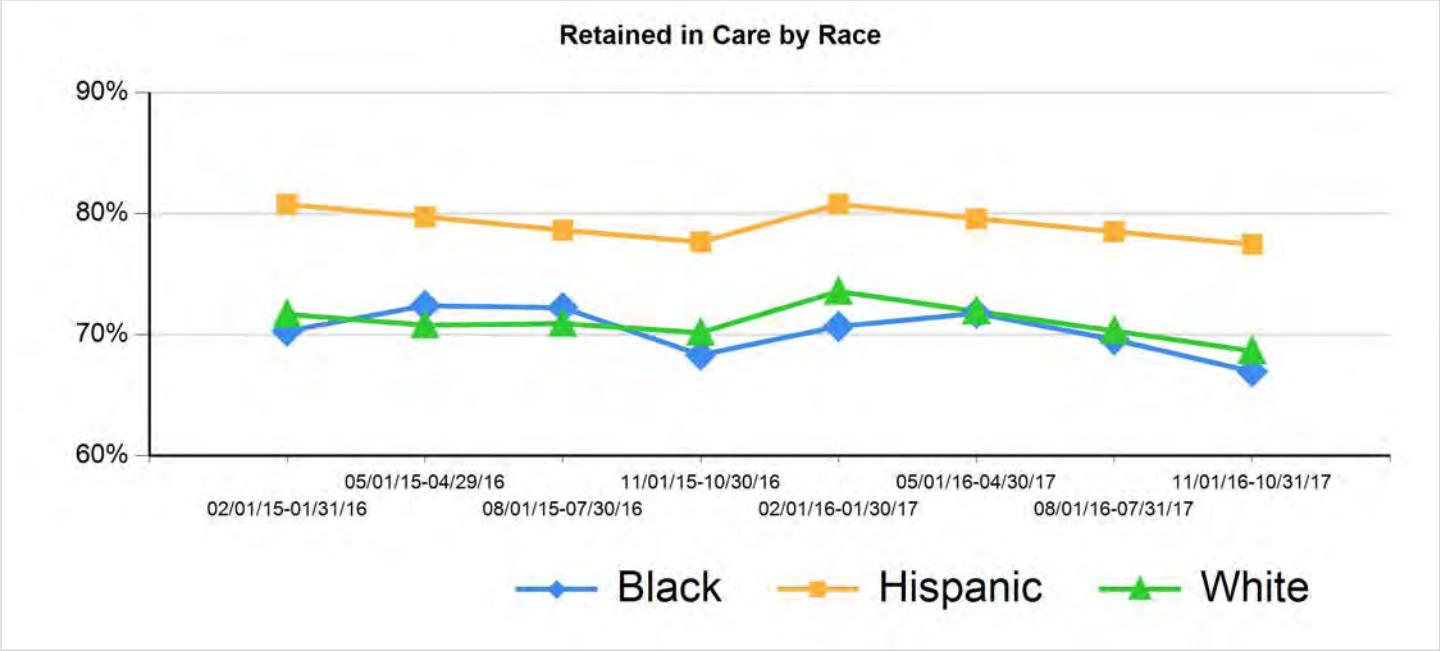
Linked to Care by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of newly enrolled uninsured HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	6	39	26	37	1	7	25	19	33	3
Number of newly enrolled uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	14	78	65	66	3	17	62	54	52	5
Percentage	42.9%	50.0%	40.0%	56.1%	33.3%	41.2%	40.3%	35.2%	63.5%	60.0%
Change from Previous Quarter Results	-4.5%	9.1%	-6.1%	-12.5%	0.0%	-1.7%	-9.7%	-4.8%	7.4%	26.7%
* exclude if vl<200 in 1st 4 months										



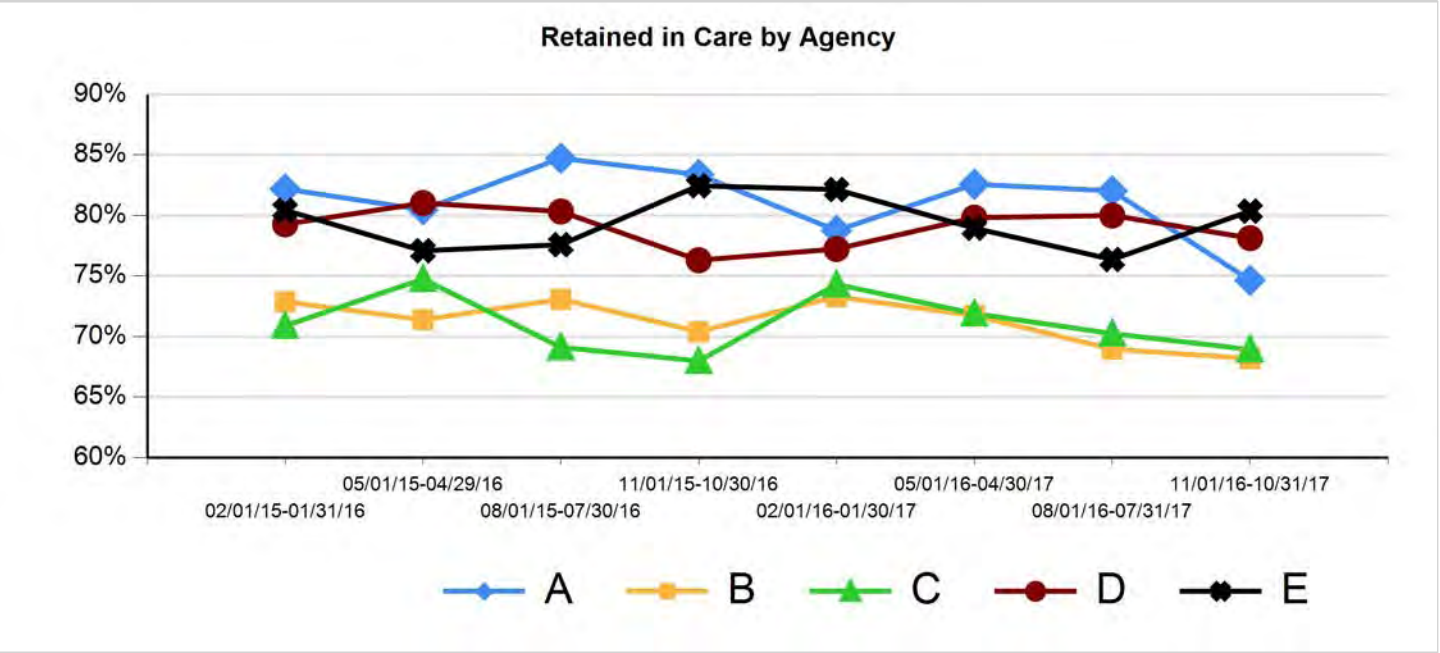
Retained in Care				
Houston EMA Medical Visits Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year*	4,187	4,253	4,285	4,225
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	5,596	5,695	5,872	5,940
Percentage	74.8%	74.7%	73.0%	71.1%
Change from Previous Quarter Results	2.6%	-0.1%	-1.7%	-1.8%
* Not newly enrolled in care				



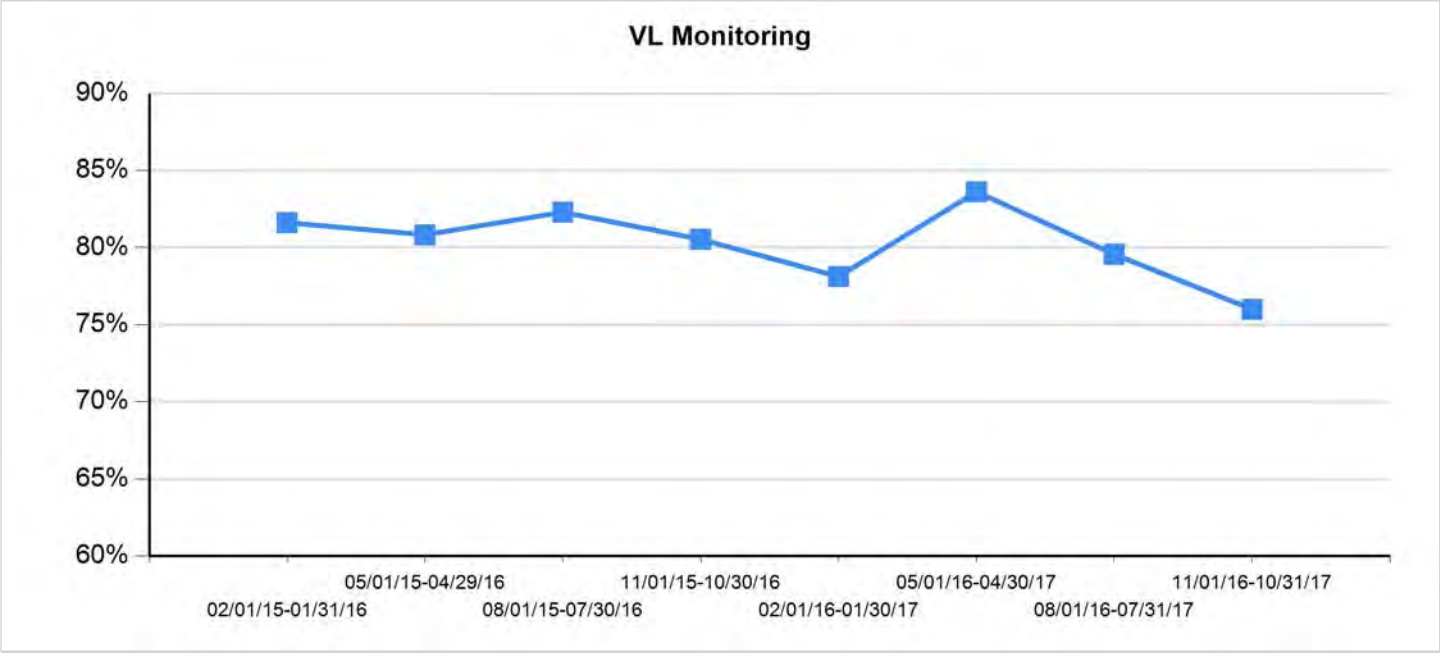
Retained in Care by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	1,991	1,636	530	1,964	1,671	549	1,921	1,685	525
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	2,775	2,056	737	2,823	2,129	781	2,870	2,176	765
Percentage	71.7%	79.6%	71.9%	69.6%	78.5%	70.3%	66.9%	77.4%	68.6%
Change from Previous Quarter Results	1.1%	-1.2%	-1.6%	-2.2%	-1.1%	-1.6%	-2.6%	-1.1%	-1.7%



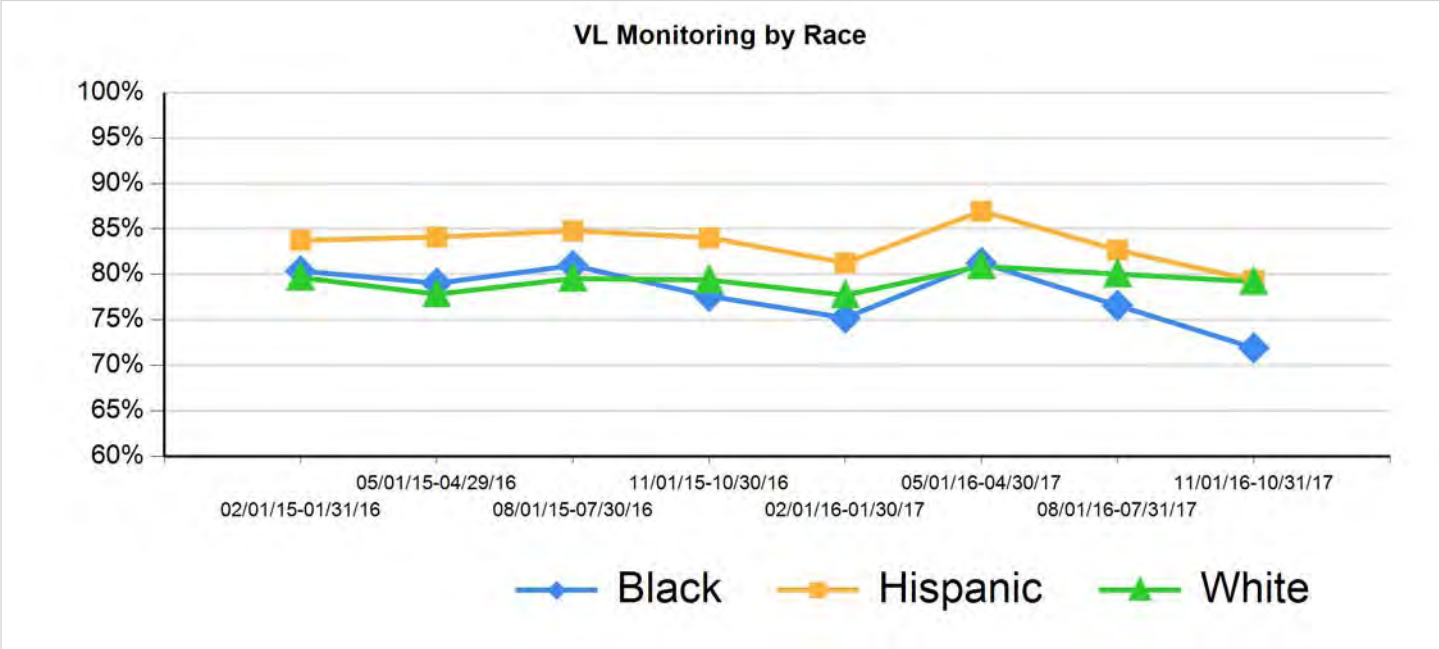
Retained in Care by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	580	1,428	1,253	1,104	42	524	1,431	1,213	1,118	45
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	707	2,071	1,784	1,380	55	702	2,099	1,760	1,431	56
Percentage	82.0%	69.0%	70.2%	80.0%	76.4%	74.6%	68.2%	68.9%	78.1%	80.4%
Change from Previous Quarter Results	-0.5%	-2.8%	-1.7%	0.2%	-2.6%	-7.4%	-0.8%	-1.3%	-1.9%	4.0%



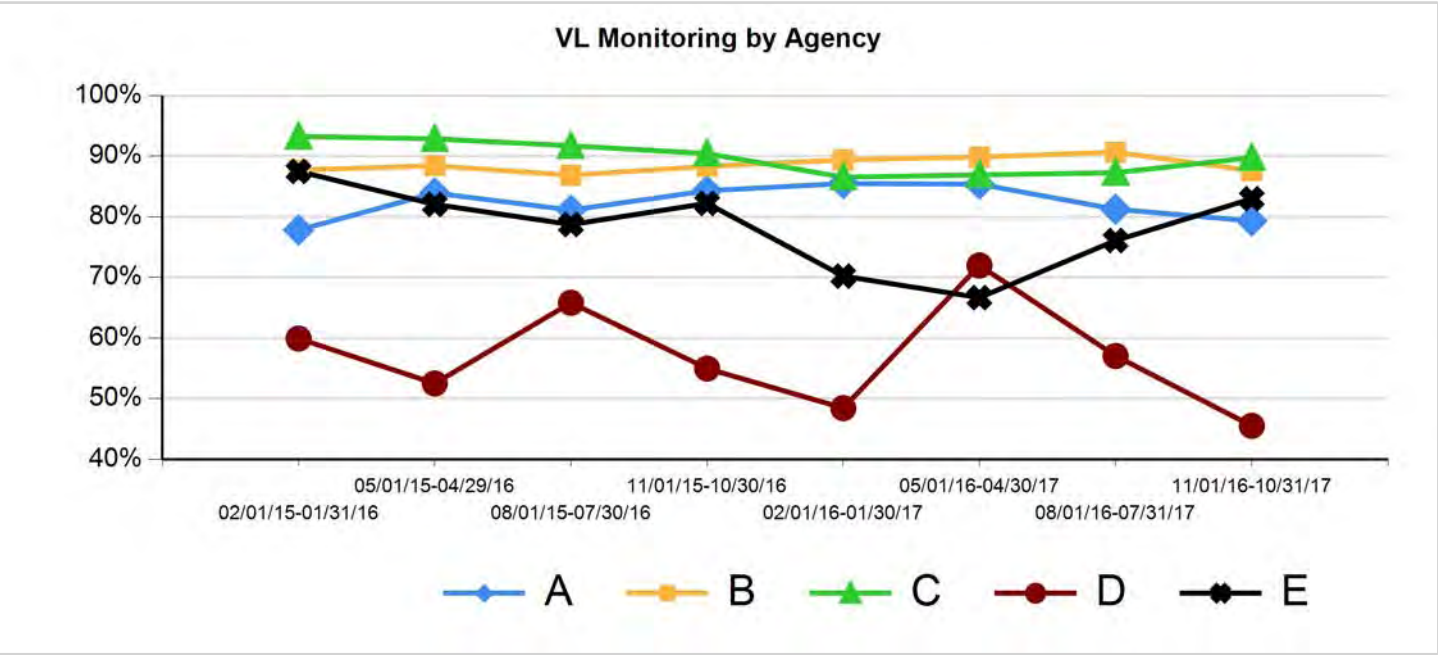
Viral Load Monitoring				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	3,524	3,812	3,652	3,439
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	4,511	4,559	4,590	4,525
Percentage	78.1%	83.6%	79.6%	76.0%
Change from Previous Quarter Results	-2.4%	5.5%	-4.1%	-3.6%



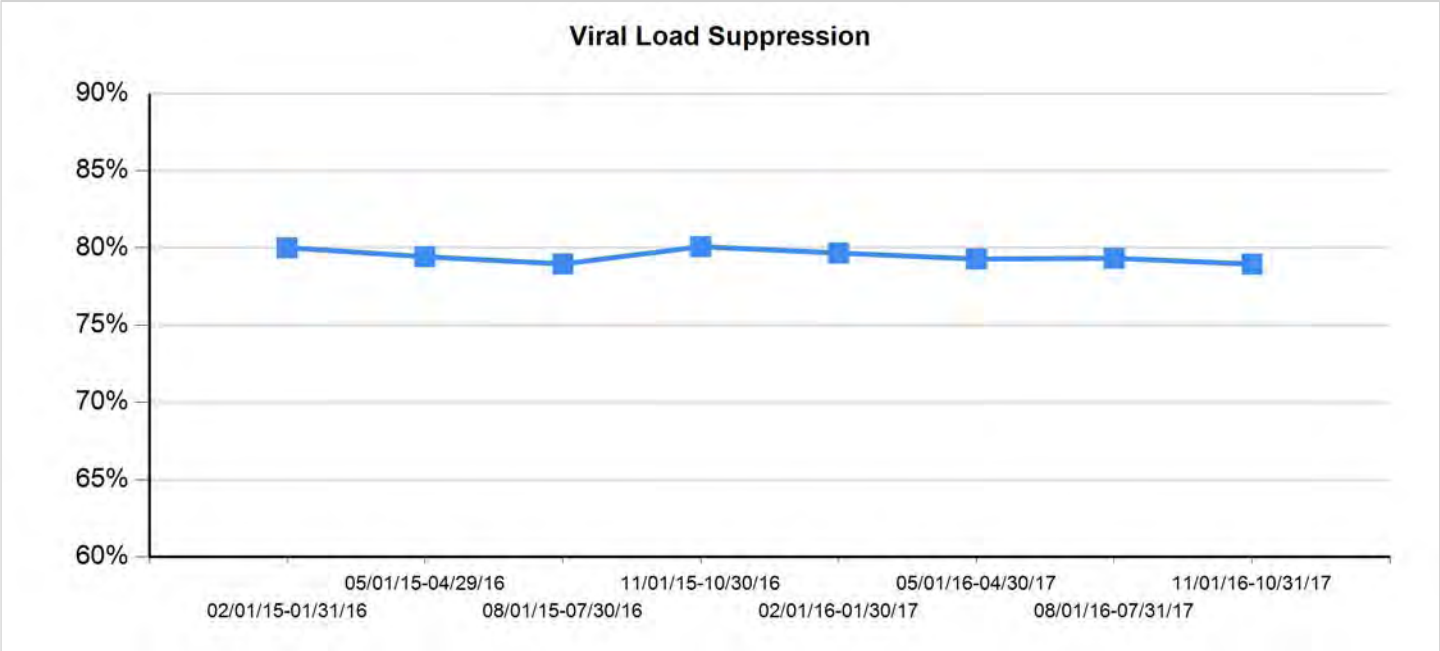
VL Monitoring Data by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	1,743	1,506	466	1,625	1,464	473	1,485	1,421	449
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	2,145	1,732	576	2,122	1,771	591	2,065	1,791	567
Percentage	81.3%	87.0%	80.9%	76.6%	82.7%	80.0%	71.9%	79.3%	79.2%
Change from Previous Quarter Results	6.0%	5.7%	3.2%	-4.7%	-4.3%	-0.9%	-4.7%	-3.3%	-0.8%



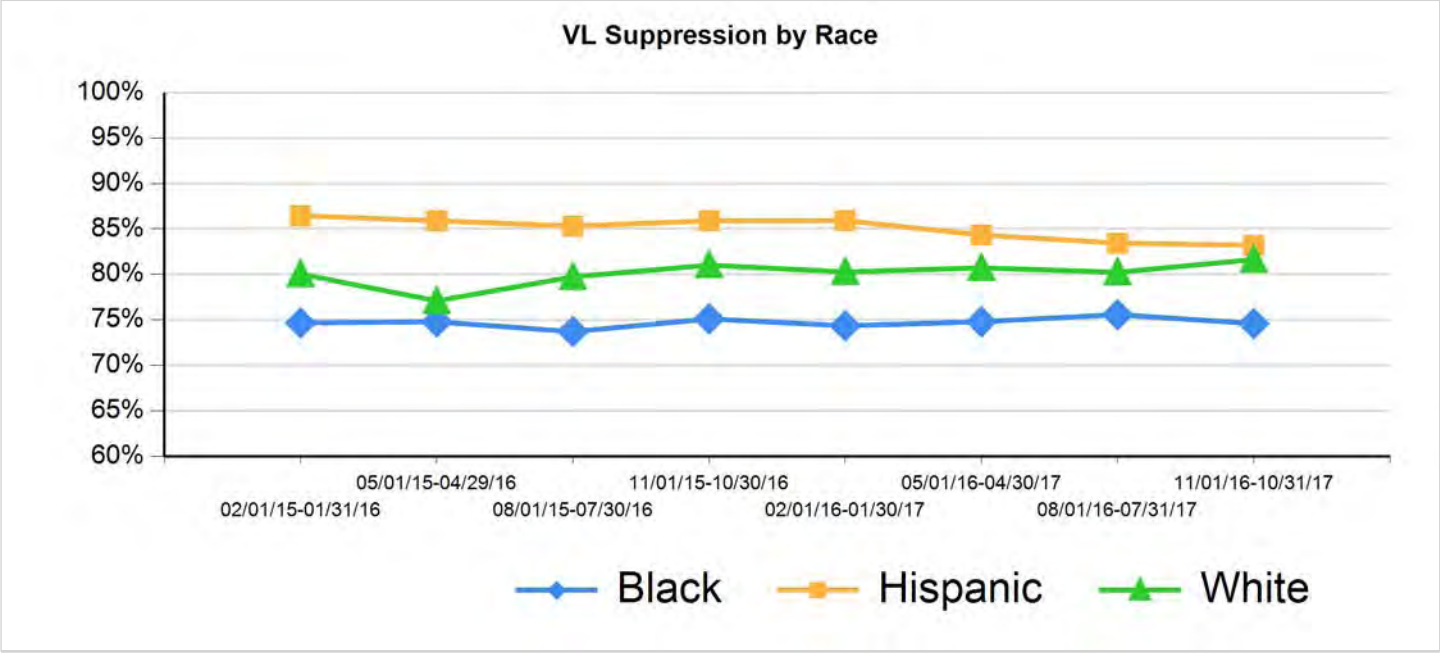
VL Monitoring by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	468	1,348	1,110	665	35	418	1,294	1,140	537	39
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	576	1,487	1,272	1,166	46	527	1,477	1,270	1,180	47
Percentage	81.3%	90.7%	87.3%	57.0%	76.1%	79.3%	87.6%	89.8%	45.5%	83.0%
Change from Previous Quarter Results	-4.1%	0.8%	0.3%	-14.9%	9.4%	-1.9%	-3.0%	2.5%	-11.5%	6.9%



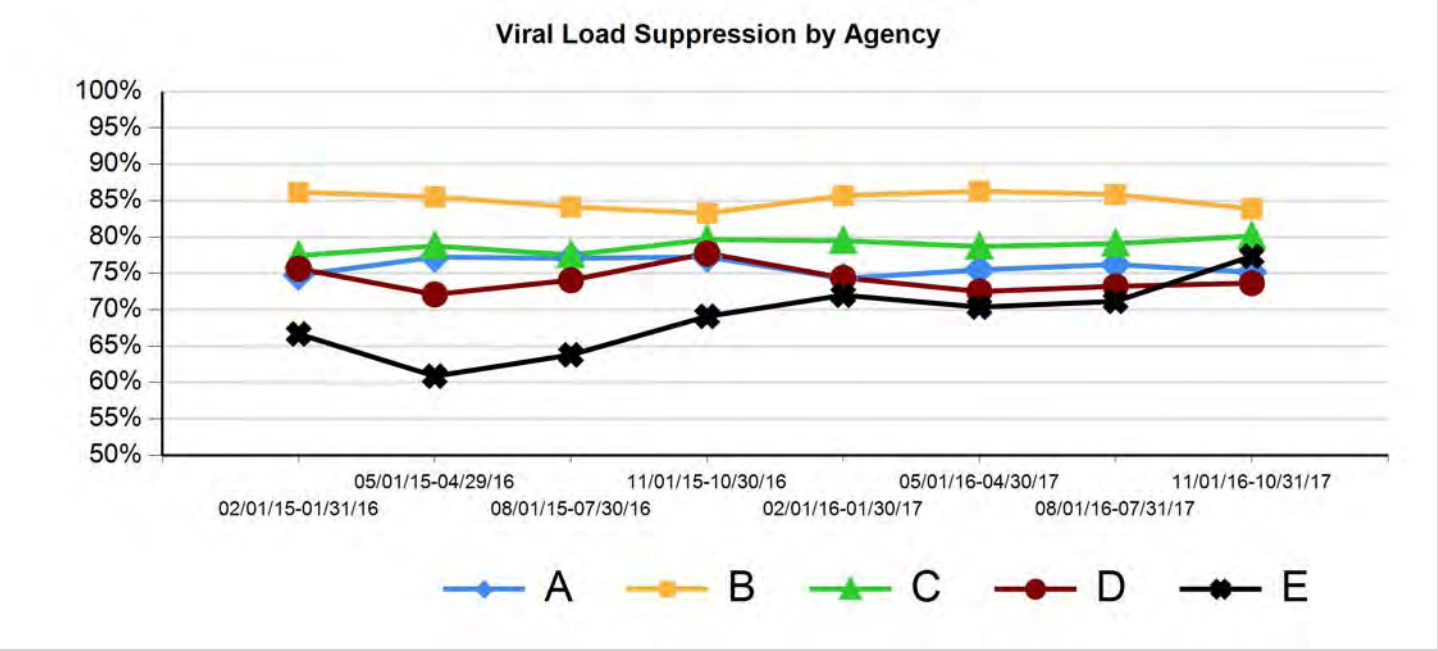
Viral Load Suppression				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	4,174	4,218	4,250	4,157
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	5,239	5,320	5,357	5,265
Percentage	79.7%	79.3%	79.3%	79.0%
Change from Previous Quarter Results	-0.4%	-0.4%	0.0%	-0.4%



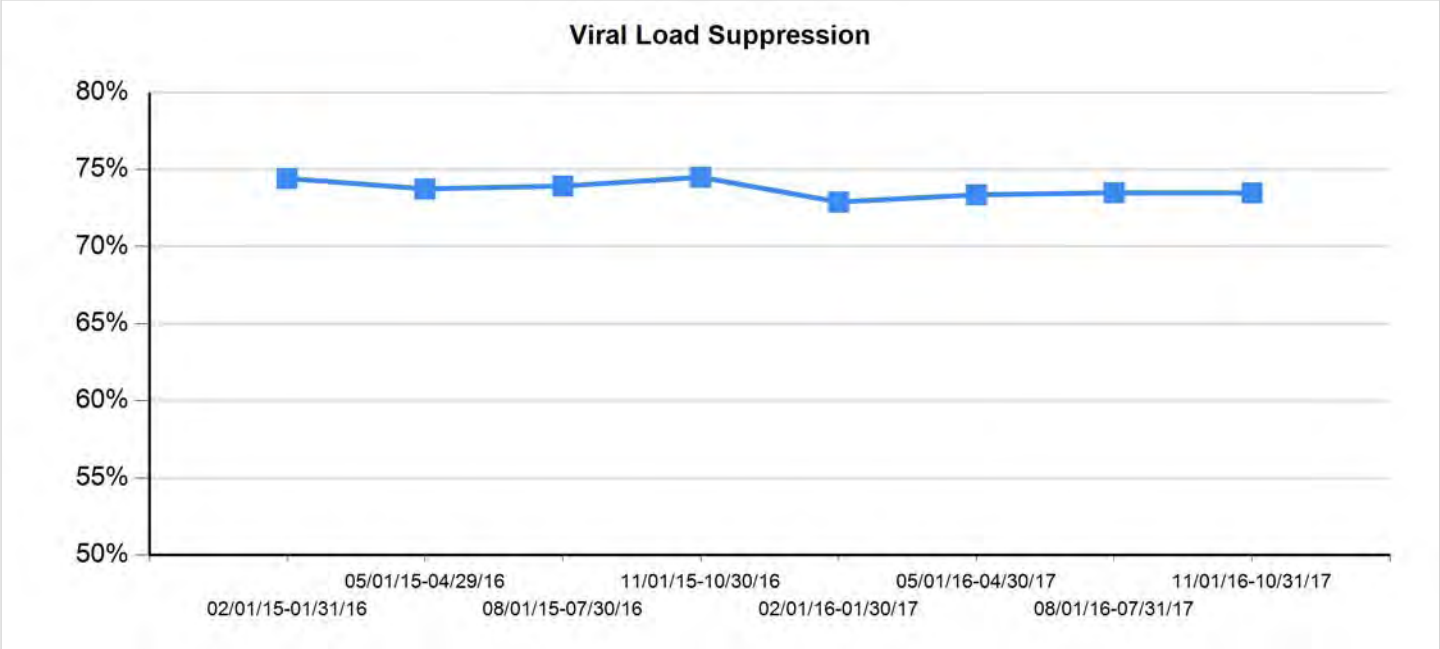
VL Suppression by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	1,932	1,625	561	1,933	1,652	560	1,864	1,643	551
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,583	1,927	695	2,558	1,980	698	2,499	1,975	675
Percentage	74.8%	84.3%	80.7%	75.6%	83.4%	80.2%	74.6%	83.2%	81.6%
Change from Previous Quarter Results	0.5%	-1.6%	0.5%	0.8%	-0.9%	-0.5%	-1.0%	-0.2%	1.4%



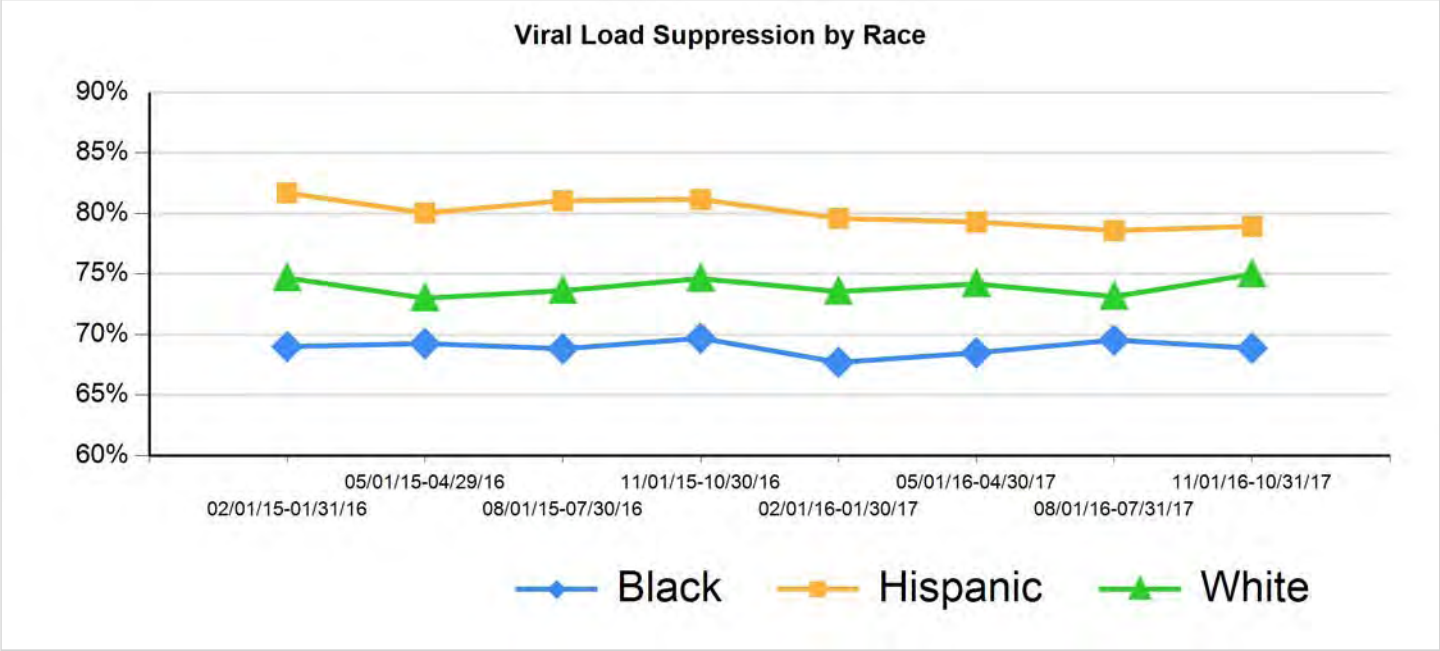
VL Suppression by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	532	1,528	1,184	998	37	490	1,447	1,165	1,040	41
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	698	1,780	1,497	1,363	52	652	1,725	1,454	1,412	53
Percentage	76.2%	85.8%	79.1%	73.2%	71.2%	75.2%	83.9%	80.1%	73.7%	77.4%
Change from Previous Quarter Results	0.7%	-0.5%	0.4%	0.7%	0.8%	-1.1%	-2.0%	1.0%	0.4%	6.2%



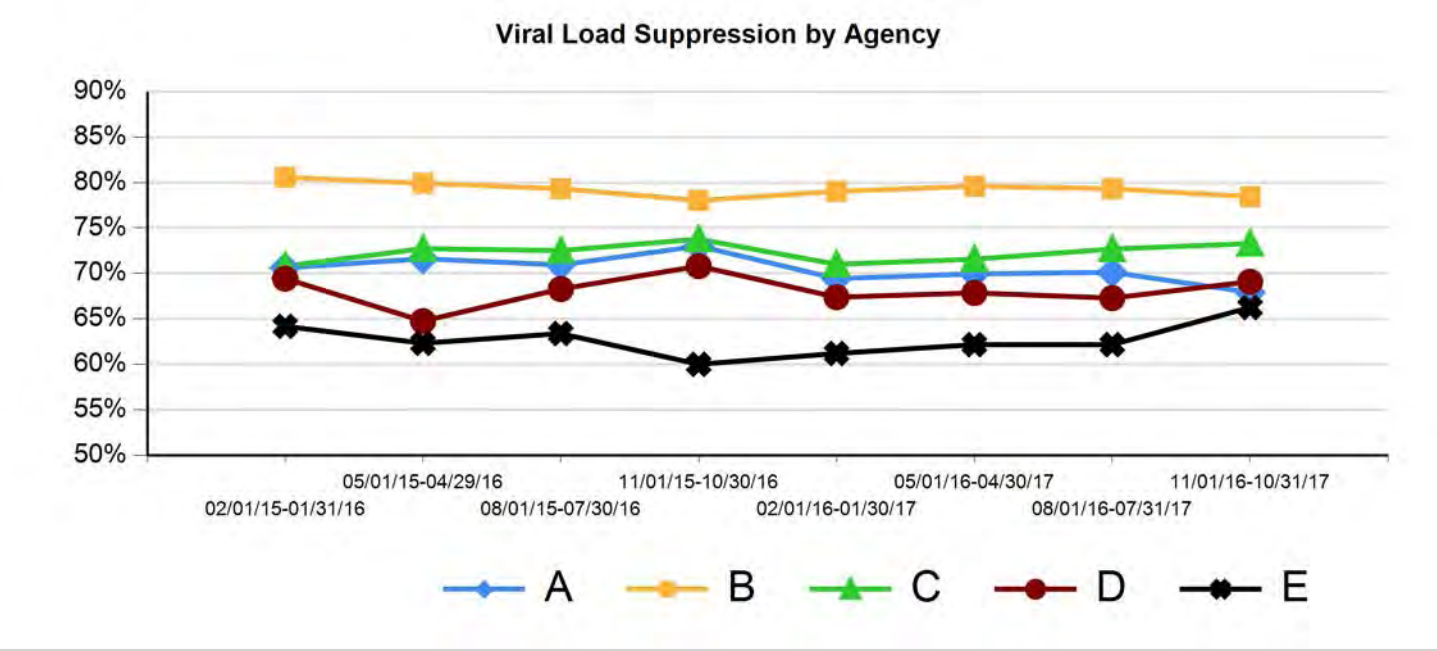
Viral Load Suppression 2- HAB Measure				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	5,400	5,527	5,647	5,586
Number of HIV-infected clients who have had at least 1 medical visit with a provider with prescribing privileges	7,408	7,534	7,684	7,602
Percentage	72.9%	73.4%	73.5%	73.5%
Change from Previous Quarter Results	-1.6%	0.5%	0.1%	0.0%



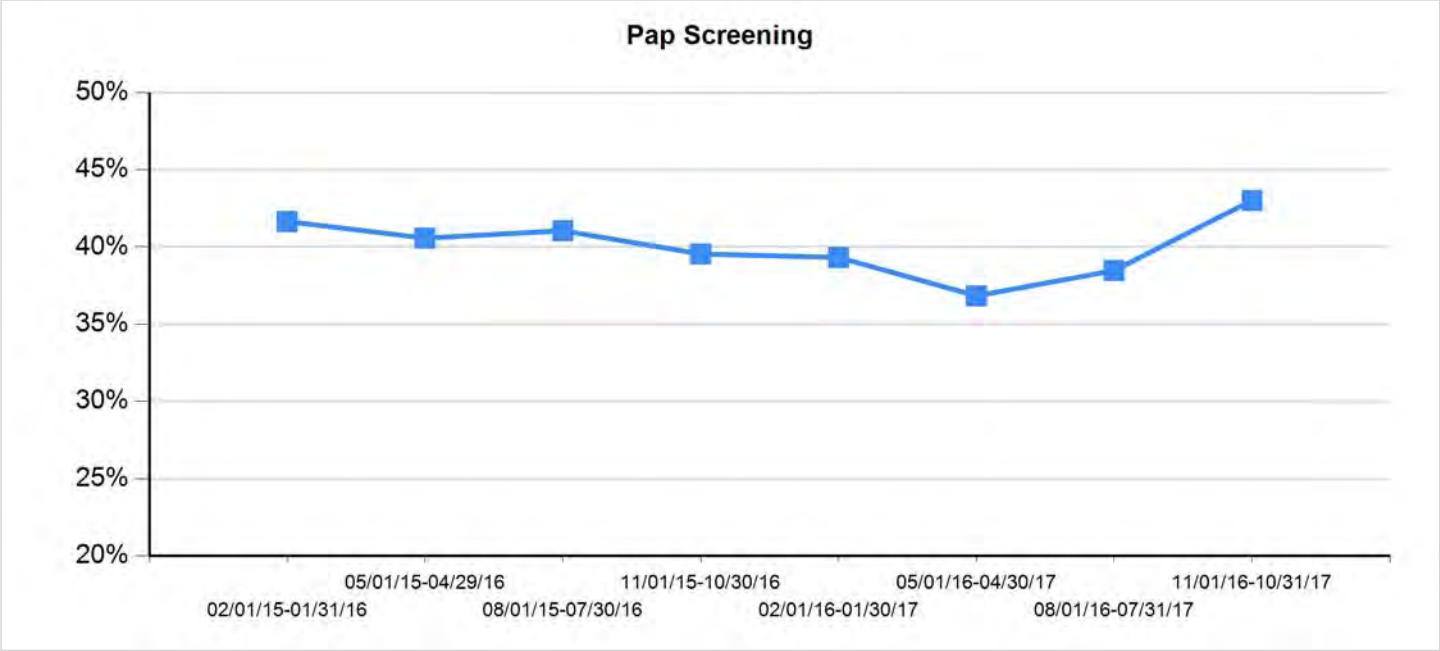
VL Suppression by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	2,549	2,099	741	2,632	2,128	743	2,586	2,113	752
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	3,722	2,647	999	3,785	2,708	1,016	3,755	2,677	1,003
Percentage	68.5%	79.3%	74.2%	69.5%	78.6%	73.1%	68.9%	78.9%	75.0%
Change from Previous Quarter Results	0.8%	-0.3%	0.6%	1.1%	-0.7%	-1.0%	-0.7%	0.3%	1.8%



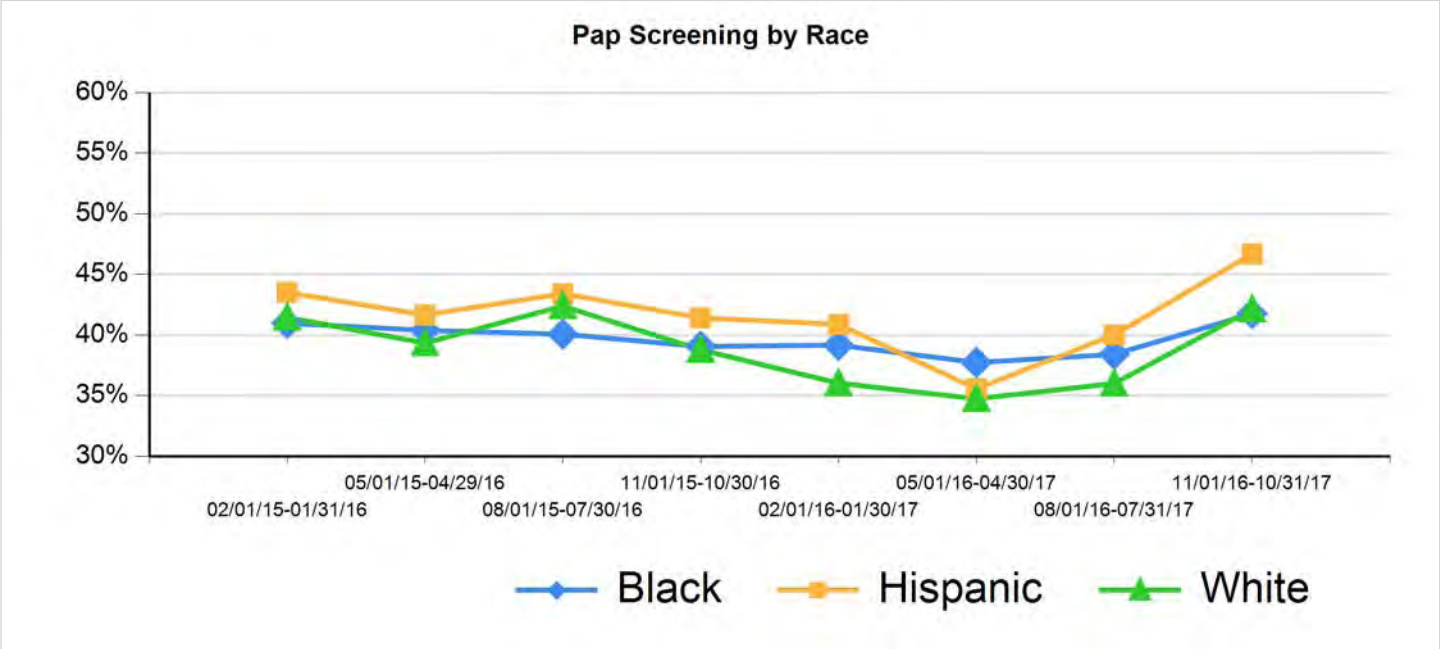
Viral Load Suppression by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	603	2,220	1,676	1,197	46	561	2,146	1,670	1,245	53
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	860	2,799	2,306	1,779	74	826	2,736	2,279	1,802	80
Percentage	70.1%	79.3%	72.7%	67.3%	62.2%	67.9%	78.4%	73.3%	69.1%	66.3%
Change from Previous Quarter Results	0.2%	-0.3%	1.1%	-0.6%	0.0%	-2.2%	-0.9%	0.6%	1.8%	4.1%



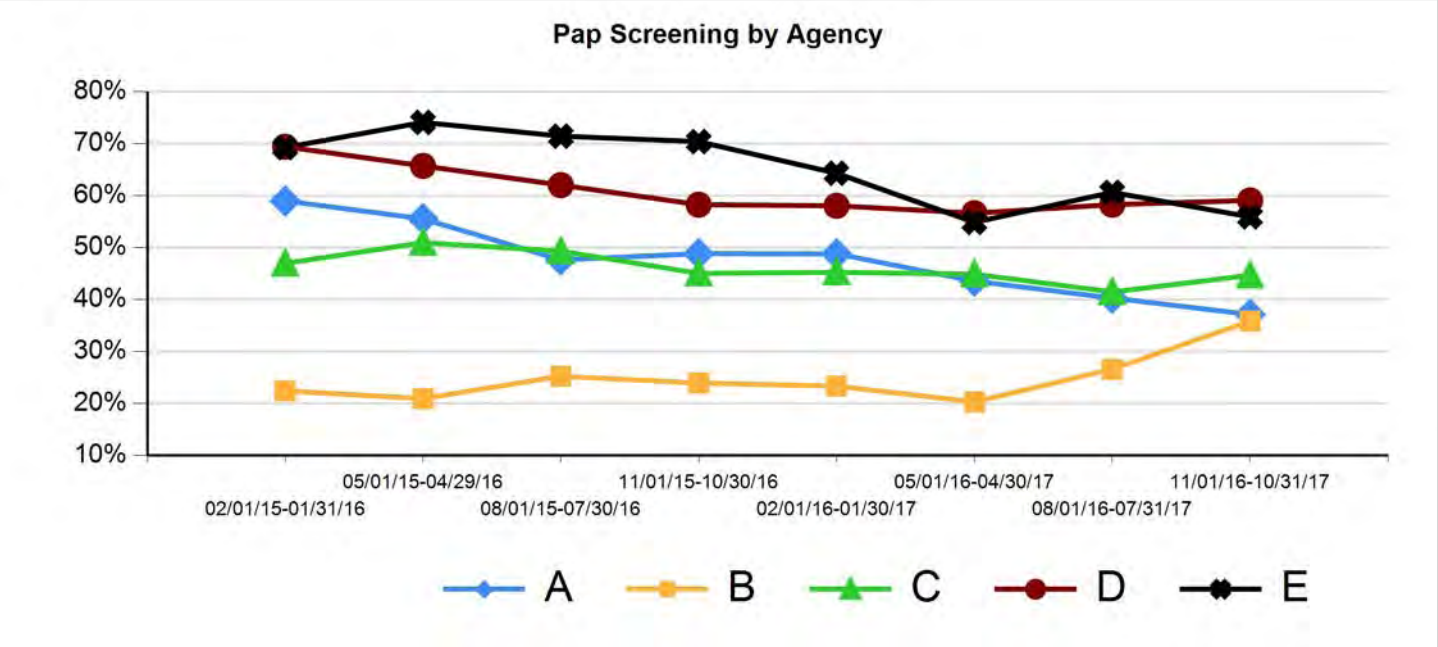
Cervical Cancer Screening				
	02/01/16 - 01/30/17	05/01/16 - 04/30/17	08/01/16 - 07/31/17	11/01/16 - 10/31/17
Number of HIV-infected female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	733	705	751	822
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,864	1,914	1,952	1,911
Percentage	39.3%	36.8%	38.5%	43.0%
Change from Previous Quarter Results	-0.2%	-2.5%	1.6%	4.5%



Cervical Cancer Screening Data by Race/Ethnicity									
	05/01/16 - 04/30/17			08/01/16 - 07/31/17			11/01/16 - 10/31/17		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	452	181	58	467	208	63	496	240	72
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,198	509	167	1,216	520	175	1,188	514	171
Percentage	37.7%	35.6%	34.7%	38.4%	40.0%	36.0%	41.8%	46.7%	42.1%
Change from Previous Quarter Results	-1.4%	-5.3%	-1.3%	0.7%	4.4%	1.3%	3.3%	6.7%	6.1%



Pap Smear Screening by Agency										
	08/01/16 - 07/31/17					11/01/16 - 10/31/17				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	97	234	162	258	20	82	305	174	261	19
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	241	881	391	443	33	221	852	390	442	34
Percentage	40.2%	26.6%	41.4%	58.2%	60.6%	37.1%	35.8%	44.6%	59.0%	55.9%
Change from Previous Quarter Results	-3.3%	6.3%	-3.4%	1.6%	5.8%	-3.1%	9.2%	3.2%	0.8%	-4.7%



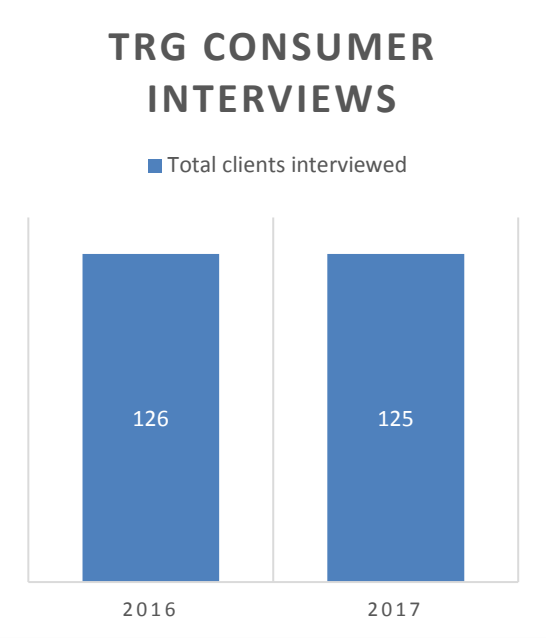
Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v3.5.0 6/2/17 [MAI=ALL]", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

TRG Consumer Interview Results 2017

Interview and feedback Period February 2017-December 2017

Overview

The Consumer Interview Process is used by The Resource Group (TRG) to determine client satisfaction and collect additional feedback from consumers. Client interviews are required as part of the Quality Compliance Reviews (QCR) at each agency in Houston and the fifty-one county areas of East Texas. During the 2017 QCR season one hundred and twenty-five (125) client participated in the interview process including monolingual Spanish clients, youth as young as 13 with caregivers/guardians. HIV positive clients have been in care ranging from two months though thirty years. The majority of sessions conducted were individual based interviews, while a few were conducted as group interviews. Below is a comparison between the 2016 and 2017 reporting process showing a decrease in participation. The total interviews do not include the nine (9) additional feedback form visiting out of state interns during the Home and Community-Based Health Care Services review.



Cross-Service Trends

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

- "A list of private doctors who accept insured HIV + patients would be helpful as a reasonable alternative clinic and dental providers"

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

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

Clients who had complaints expressed their complaints have been addressed and resolved. While a few clients worried that if they complained, it may affect their service or that it may take them longer to get an appointment. Clients expressed an explanation of "why they are waiting" was a good way to communicate. In instances, such as the doctor is running late or when calling letting clients know if some is out for the day or for a week. One client stated "I don't mind the waiting, but communication would be helpful, so I can decide if I am willing to wait or if I need to reschedule and appointment. I would like my time respected." A few clients expanded the same recommendation to include "the staff should check on clients in the lobby and in the exam rooms about every fifteen minutes. Especially if the clinic is crowded, busy or backed up the communication would ease my nerves." Phone system problems such as getting a live person and getting medication refills were discussed as problems. One client suggests an exit survey to ask about any complaints or comments at the end of a visit.

The lessons learned and questions which will be added to the questionnaire for 2018 include:

- Demographic information
    - Age category to capture youth participation for age Youth 12-17 and Young Adult 18-24
    - School district category for planning purpose based on school calendar and districts outside HISD
    - Basic gender identity category: Male, Female, and Transgender
- Dental specific questions
    - How many dental appointments have you had in the last 6 months?
    - Were you given a treatment plan? Yes/No/Don't remember
    - How many visits will it take to complete your service or treatment?
    - What were you told you need to have done?
- HRSA requested question add June 2017: Has anyone at this agency talked to you about the where to get care after hours?
- Incarcerated specific questions:
    - How many times have you been in Harris County Jail since being diagnosed?
    - How many times have you seen the doctor since you have been here?
    - Were you diagnosed in jail or outside on jail?
    - Have you received care /services from an agency outside of jail?
    - Which agency?

The client satisfaction questions are reviewed by TRG consumers and feedback is utilized to improve the evaluation process. The Client Interview Process has identified the need for Ryan

White agencies to create and facilitate agency specific/customized trainings for their consumers which may include but are not limited to:

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

SERVICE-SPECIFIC TRENDS

Part D Specific

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

- Very supportive a lot of information I was not aware of (new diagnosis)
- All the Doctors and team of healthcare they help me and give me a good reflection
- A list of Oral Health for clients with insurance
- A list for clients with insurance
- Education options of meds and resources
- Staff relates to kids and doctors explain things makes me want to come back.

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

- Thirteen caregiver/parents and children/ youth were present during the discussion. Participants represented the youth Consumer Advisory Board (CAB), have been associated with clinical trials, pediatric care and HIV treatment.
- The participants identified that the group serves as a extended family for them when it comes to support for living with HIV.
- Statements used to describe what keeps them coming back to the service and what is important about the services included;
  - Staff friendly, helpful they give me resources
  - They are helpful and medically they are on top of everything
  - Everything is amazing its easy on my brain coming here. It's a great program.
  - My chart app is great helpful for medication.
- Participants expressed high levels of comfort addressing problems. Participants gave specific examples where problems had been encountered within hospital system and the Ryan White program staff addressed and resolved the problem.
  - Parking lot have to run out to check parking is overcrowded.
  - Being out of medication-mom and child out of meds. Mom out of meds 2 months concerns about next moths refill for daughter.
- Participants request more education about medications be presented.
- Participants also request a list of services or agencies who accept specific insurance.

Part D Patient Navigation Services

Clients were satisfied with this service. Clients stated that the service was useful and needed.

Mental Health Services

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

Collective feedback included;

- "The staff is really good at matching clients and therapist." One client stated "a staff member called me and said there was someone she thought could better fit my needs. I had not met or talked to the therapist yet. Whatever their process is it is great because I have the best therapist for me. My therapist helps me grow."
- Clients commented on the ease of changing therapist when needed.
- "The therapy is effective. I feel like I have grown and I'm getting results."
- "I used to see my therapist once a week. Now I come once a month. My therapist said they have seen me making progress."
- "I am able to talk openly, and they listen."
- Once a month, the support group has a licensed therapist attend the group.
- The members identified that the group serves as a surrogate family for them when it comes to support for living with HIV.
- Members of the Part D group identified that they wanted to increase their collaboration with the service provider to increase membership and support the mutual goals of the group and the service provider.
- Male clients identified and suggested that "if you are a man that cares a backpack or bag you may not want to sit it on the floor and hooks in the male restrooms would be helpful"

Oral Health Care

Clients continued to be concerned with multiple appointments to receive dental care. The interview process identified one trending topics clients would like more information and education on dental services. Clients expressed a need for more information regarding time frames to complete dental procedures. "How long does it take to get a crown? I am not sure if scheduling delays were my fault or the clinics availability."

Home and Community-Based Health Care Services

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

Interviews were conducted as one large group, which included a group of interns from out of state on a weeklong assignment in the day treatment center. The participants identified that the group serves as a extended family for them when it comes to support for living with HIV.
Statements used to describe what keeps them coming back to the service and what is important about the services included;

There were multiple comments of appreciation and compliments for the staff; "The transportation driver is such a safe driver"

Clients were asked other than staff "what do you like best or what keeps you coming back to this program. Below are comments

- Field trips and opportunities to try some new stuff or just get out of the everyday existence.
- Opportunities to meet different people (clients as well as staff and volunteers)
- Art therapy and crafts are helpful and fun
- Different speakers and education topics presented to learn about.
- "Coming here airs my mind out and keeps me from being depressed"
- "My income is limited and this program helps me save on my monthly bills like lights and food. Plus coming here keeps me from being at home lonely, missing meals and getting more depressed."

Recommendations or suggestions for the day treatment program;

- "Can the program extend to Saturdays?"
- "I would like to see more visitors and volunteers"
- "I wish we could take trips to Galveston or Kemah"
- "It would be nice if they had some condoms available in here. We still need them"
- "It would be nice if we had some dictionaries. Some of us like to look up words."

When asked what topics or information do you need to be better involved in your care? The following were given as responses;

- Information on home health care
- Alzheimer's
- Dementia
- Exercise equipment
- More art supplies
- More volunteers
- Computers

<u>Early Intervention Services – Incarcerated (EIS)</u>

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

- "The Doctor makes sure I get my medications so that's the best part for me"
- "They are trying to help me stay alive"
- "They are caring and dedicated, professional and they listen"
- One client informed the interviewer, that a Doctor asked, "How long have you had HIV?" where other inmates could hear. The client went on to state, "I did say something to the doctor and he apologized. I think they need to be more aware to try to remember that is private. I do think he handled it well with his apology because he could have had an "so what I don't care attitude".

<u>Linguistic Services</u>

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

<u>Hospice Care Services</u>

There were no issues of note related to this service and due to the nature of the service delivered; consumer interviews were not conducted for this service.

Health Insurance Premium (HIP)

HIP clients were satisfied and appreciative for the availability of the service. Clients stated that HIP was simple to get and easy to use. One client stated" I thought I would lose my insurance because I could no longer afford it. This service was lifesaving and I do not know what I would have done without it. I have never needed any service before. I was embarrassed, ashamed and even scared they would not help me. But the staff was warm friendly and comforting. They did everything they said they would and I really appreciate that."

Rural Specific Service

Statements used to describe what keeps them coming back to the service and what is important about the services included;

- "The front desk girl is sweet and good"
- "The Receptionist never has an attitude "
- "I love the reminder calls"
- "The service is excellent. They do a great job
- " Any time I need help I know I can come here

Medical Care

- "The doctor and NP are easy to talk to I like how they explain things to me they are very knowledgeable, they are good at referrals. There are no questions they can answer. The staff give information openly and honestly. There are no questions they will not answer."
- "The doctor is great I recommend her highly."
- "The staff is nice and they notice if you are upset and ask question to try and help"
- "They take their time but they get you in to the back quickly".
- "The nurses are like a friend or relative"
- "The lab person is good."
- "the doctor and the nurses are awesome"
- There were concerns about waiting time in the exam rooms. "I get claustrophobic because I am alone in there so long."
- "It is hard to get refills. Calling 24 hours prior is not working. I have to physically come here to move the process."
- "They don't communicate with the clients in the lobby if there are delays. I had a12:30 appointment and didn't get seen until 3pm"

Mental Health

- "The Therapist is great'
- "I used to be scared someone would know about my health because I would be out with friends but still take my medications. I told my friends I take medications for seizures which is partly true. Now if they don't see me take my medications they will ask about them and that helps me stay on schedule. I learned confidence from the staff and the support group. I don't have to tell my friends everything, but I can also stay adherent with their help."

- "I usually talk to the support group about my problems and it is helpful"
- "I like the support, privacy, the service is a blessing. I can get my medications with help"
- "The staff is friendly and understanding and that helps a lot."
- "They do a great job"
- "They listen and they offer me options"
- "I get moral support from the staff, call and reminders. Those things help a lot"
- "How they treat you makes a huge difference in my health. My Doctor cares and got me back on track now I am undetectable"
- "I cried a lot and the staff treated me good. They were very caring"
- "One doctor seemed stiff at first like he was homophobic, but he opened up and he's great."
- "The staff is helpful most of the time"

Client statements of concerns or recommendations are listed below;

- "They should have condoms in the exam room and case management office"
- "I would like to see Bilingual males- as case managers and medical staff."
- "A list of area food pantries that identifies HIV and Gay friendly locations"
- "We need vision services"
- "Discounts to a local fitness center would be nice maybe somewhere like Planet Fitness"
- "They should check on clients who have waited more than 15 minutes (in the lobby and the exam rooms) and communicate what's going on."

<u>Oral Health</u>

- "The dentist talks a lot and his sight is bad"

<u>Case Management</u>

- "I don't like the high turnover" (Multiple comments)
- "Mrs. Craig is very attentive. She crosses her T's and dots her I's with a great personality and opened minded."
- "I would like a list of referrals for some services in the community that includes which ones are fee, reduced cost/copay and accept insurance. It would also be helpful to know which insurances are accepted" (at the community agency)
- "I would like to see the buddy system (peer support) at Special Health'
- "Pamphlets should be available at Dr. appointments (when they tell you some new information)"
- "HIV support groups at night would be nice. I want to come but I work in the daytime"
- "Mammograms are needed and hard to get".
- "I am confused about referrals that are community agencies. I was referred out for a service and the service was not completed and I am confused as to why? I was not sure if they didn't want to do the procedure because of my HIV status. I still don't have an answer."
- "Dr. Yates has a negative attitude."
- "Labs in Tyler are referred out of Special Health. The staff at the lab is insensitive."

When asked "If there are topics clients would like more information and training on?" Below are the responses?

- Understanding Diabetes
- Understanding Cancers
- A list of herbs that may interfere with medications. (identifying the med and the herb)
- Cyst Removal Information
- Mental health- What do therapist do and what are the options at Special Health?
- Understanding Blood Pressure

Additional Information from 2017

Intern Feedback- Home and Community-Based Health Care Services had inters present during the audit week. As a method, of gathering feedback from various perspectives the interns who were present for the group interview with clients. Nine (9) evaluations were collected for a five-question hand out.

1) Did you learn anything new during your time at working with this program? 9 out of 9 responded with varied responses.
   - I learned about the impact HIV has on people's lives
   - I have learned a lot about this particular community and more about treatment and how people diagnosed with HIV/AIDS live their lives. I enjoyed learning about how the program works and what it has to offer.
   - I learned a lot about the people that come to day treatment.
   - I learned a lot when the auditor was talking to the clients. Ex: the difference between the therapist and the psychiatrist and separating drug abuse from mental health
   - Yes, active listening and talking through things can really help people with problems they may have experienced in life. A laugh or smile goes a long way.
   - I learned about the lives of those who are HIV positive and how they go on with their daily lives.
   - The auditor spoke about separating mental illness from drug abuse. This seemed to be relevant to clients.
   - I learned about the side effects and life styles of HIV positive people.
   - Yes, a client taught me to breath exercise is important. I learned to make candles and organize.
   - Yes, I learned a lot about how organizations like this function. The audit was very educational.

2) What did you enjoy the most about the program? 9 out of 9 responded with varied responses.
   - I really enjoyed getting to know all of the great people
   - Talking with the clients and getting to know them
   - The people I've learned a lot about myself this week
   - The people and the atmosphere seeing how the program really impacted the clients
   - Doing something new with someone new everyday
   - It was great to get to know everyone and their unique backgrounds.
   - I love the family dynamic and open atmosphere of the day center

- I enjoyed that the clients were offered the opportunity to socialize with other clients that share a common ground. I really enjoyed getting to know the clients.
- I really enjoyed getting to know the clients. Their stories kept me engaged and laughing. I enjoyed the family atmosphere and the friendly staff. The of HIV patients has completely disappeared for me.

3) What did you like least? 3 out of 9 responded. Overall there were very few responses indicating problems or dissatisfaction.
   - Honestly it was all great.
   - I had no complaints
   - Being able to stay only 5 hours instead of longer, but I understand the clients probably don't want to stay longer.

4) Do you have any recommendations for ways to improve the program? 8 out of 9 responded with responses indicating the one major theme of having more volunteer opportunities.
   - Maybe have alternative options available for those that don't want to participate in the main activities
   - Bring more volunteers and more community outreach
   - It seems like they enjoy having new faces come in and do activities so maybe have more volunteers/ visitors come in and do more activities with them.
   - They seem to enjoy a break from the monotony with having new volunteers. The service provider could maybe reach out to local universities to get new volunteers on a regular basis to provide the clients more people to talk to.
   - The clients seemed to like having us this week. Get college aged volunteers to come and hang out.
   - Bring in more volunteers that so that the clients can talk to more people and share their stories. This could offer new perspectives and opportunity to encourage the public health education
   - Taylor activities for each individual to optimize involvement and enjoyment. They all have their own strengths to build upon.

5) Additional comments (regarding program, facilitator, ect)7 out of 9 responded with responses indicating the one major theme of satisfaction with the staff.
   - The direct service staff rocks at her job
   - It was awesome! All of the and clients were great.
   - This is an amazing program and really makes a difference in the clients lives.
   - All the employees care so much and put so much work and heart into their jobs
   - All of the staff is amazing.
   - The direct service staff is the best
   - The direct service staff is awesome! All employees seem to really enjoy their jobs and engage with the clients.

Dated 10/23/17

THE RESOURCE GROUP

1819 Standard of Care
Table of Contents

1819 HOUSTON HSDA STANDARDS OF CARE
SUMMARY OF CHANGES

HEALTH INSURANCE ASSISTANCE

9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)* 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. *Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017)*	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIC funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a clients failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIP funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price. 8. Life insurance and other elective policies are not covered.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

MENTAL HEALTH SERVICES

9.1	Scope of Work Agency will provide the following services: **Individual Therapy/counseling** is defined as 1-on-1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person. Mental health services include Mental Health Assessment; Treatment Planning; Treatment Provision; Individual psychotherapy; Family psychotherapy; Conjoint psychotherapy; Group psychotherapy; Drop-In Psychotherapy Groups; and Emergency/Crisis Intervention. Also included are Psychiatric medication assessment, prescription and monitoring and Psychotropic medication management. General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for non-HIV infected family members or significant others. Mental health services can be delivered via Telehealth subject to federal guidelines, Texas State law, and DSHS policy.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.10	Client Orientation Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will be provided to all clients and include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's	• Documentation in client record indicates compliance. • Annual Client Interviews indicates compliance. • Percentage of new clients with documented evidence of orientation to services available in the client's primary record

	responsibilities for delivering them • Patient rights including the grievance process	
9.11	Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self Assessment/Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation.	• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment. • Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record
9.12	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: • Statement of the goal(s) of counseling and description of the mental health issue • Goals and objectives • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review	• Documentation in client record. • Exceptions noted in client file. • Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. • Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. • Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

9.14	Psychiatric Referral Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	• Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.
9.15	Psychotropic Medication Management: Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10	• Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. • Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.
9.16	Progress Notes Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment	• Legible, signed and dated documentation in client record. • Percentage of client's with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.

	• Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	
9.17	Coordination of Care: Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.
9.18	Referrals: As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

9.20	Discharge Summary Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	• Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record. • Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.

RYAN WHITE PART B/DSHS-STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
COMMUNITY-BASED HEALTH SERVICES

Definition:
Home and Community-Based Health Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Services Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of clients through the provision of treatment and activities of daily living. Services must include: **Skilled Nursing** including medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physician(s), personal care, and diagnostics testing; **Other Therapeutic Services** including recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation; **Nutrition** including evaluation and counseling, supplemental nutrition, and daily nutritious meals; and **Education** including instructional workshops of HIV related topics and life skills. Services will be available at least Monday through Friday for a minimum of 10 hours/day.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	Licensure Agency must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider. Agency maintains other certification for facilities and personnel, if applicable. Services are provided in accordance with Texas State regulations.	• Documentation of license and/or certification posted in a highly-visible place at the site where services are provided to clients.

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

#	STANDARD	MEASURE
9.7	Comprehensive Client Assessment A comprehensive client assessment, including nursing, therapeutic, and educational is completed for each client within seven (7) days of intake and every six (6) months thereafter. A measure of client acuity will be incorporated into the assessment tool to track client's increased functioning. A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of client's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine client's ability to perform activities of daily living and the level of attendant care assistance the client needs to maintain living independently.	• Review of client files indicates compliance. • Acuity levels documented as part of assessment.
9.8	Nutritional Evaluation Each client shall receive a nutritional evaluation within 15 days of initiation of care.	• Documentation is on file.
9.9	Meal Plan Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
9.10	Plan of Care A written plan of care is completed for each client within seven (7) days of intake and updated every six (6) months thereafter. Development of plan of care incorporates a multidisciplinary team approach. Care plan is signed by both case manager and clinical health care professional.	• Review of client files indicates compliance
9.11	Implementation of Care Plan In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation. • Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services). • Monitor changes in client's physical and mental health, and level of functionality. • Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service related needs, challenges and barriers.	• Documentation in the client chart indicates services provided were consistent with the treatment plan.

#	STANDARD	MEASURE
9.11	Implementation of Care Plan (Cont'd • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with client's self administration of medication. • Promptly report any problems or questions regarding the client's adherence to medication. • Report any changes in the client's condition and needs.	• Documentation in the client chart indicates services provided were consistent with the treatment plan.
9.12	Refusal of referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home/community setting. The agency must document the situation in writing and immediately contact the client's primary medical care provider.	• Documentation in the client chart will indicate the reason for refusal
9.13	Completion of Services/Discharge Services will end when one or more of the following takes place: • Client acuity indicates self-sufficiency and care plan goals completed; • Client expresses desire to discontinue services; • Client is not seen for ninety (90) days or more; and • Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility) • Client is unable or unwilling to adhere to agency policies.	• Documentation in client chart of specific criteria indicating appropriateness of discharge

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
EARLY INTERVENTION SERVICES FOR THE INCARCERATED

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

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

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

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

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

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

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE - DRAFT

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service **Health Insurance Assistance:** The Health Insurance Assistance (HIP) service category is intended to help HIV positive individuals maintain a continuity of medical benefits without gaps in health insurance coverage or discretion of treatment. This financial assistance program enables eligible individuals who are HIV positive to utilize their existing third party or public assistance (e.g. Medicare) medical insurance, not to exceed the cost of care delivery. Under this provision an agency can provide assistance with health insurance premiums, co-payments, co-insurance, deductibles, Medicare Part D premiums, and tax reconciliation. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Tax Reconciliation: A refundable credit will be given on an individual's federal income tax return if the amount of advance-credit payments is *less* than the tax credit they should have received. Conversely, individuals will have to repay any excess advance payments with their tax returns if the advance payments for the year are *more* than the credit amount. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500. Revised Income Guidelines: Marketplace Plans: 100-400% of Federal Poverty Level All other plans: 0-400% of Federal Poverty Level Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Compliance with Regional Health Insurance Assistance Policy The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Annual Review of agency shows compliance with established policy.
9.3	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary. Agencies must maintain referral relationships with organizations or individuals who can provide income tax preparation assistance.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
9.4	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required. Minimum of two (2) hours training for all relevant staff on how to indentify advance premium tax credits and liabilities.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.5	Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
9.6	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.7	Program Policies Agency will develop policies and procedures regarding HIP assistance, cost-effectiveness and expenditure policy, and client contributions. Agencies must maintain policies on the assistance that can be offered for clients who are covered under a group policy. Agency must have P&P in place detailing the required process for reconciliation and documentation requirements. Agencies must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual clients, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of personnel files indicates training on the policies.
9.8	Prioritization of Cost-Sharing Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agencies use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles 3. Co-payments for provider visits (e.g. physician visit and/or lab copayments) 4. Medicare Part D (Rx) premiums 5. APTC Tax Liability 6. Out of Network out-of-pocket expenses	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental)* 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. *Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017).*	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIC funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a clients failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIP funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price. 8. Life insurance and other elective policies are not covered.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Health Insurance Premium Assistance The following criteria must be met for a health plan to be eligible for HIP assistance: ! Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 1. Health Insurance coverage must be evaluated for cost effectiveness 2. Health insurance plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 3. COBRA plans must be evaluated based on cost effectiveness and client benefit. Additional Requirements for ACA plans 1. If a clients between 100%-250% FPL, only SILVER level plans are eligible for HIP payment assistance (unless client enroll prior to November 1, 2015). 2. Clients under 100% FPL, who present with an ACA plan, are NOT eligible for HIP payment assistance (unless enroll prior to November 1, 2015). 3. All clients who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL). All clients receiving HIP assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client records indicates compliance.
9.12	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client intake/assessment for service indicates compliance.
9.13	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client intake/assessment for service indicates compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.14	Waiver Process In order to ensure proper program delivery, a waiver from the AA is required for the following circumstances: 1. HIC payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers, 3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary, 4. Discontinuing HIC payment assistance due to client conduct or fraud, 5. Refusing HIC assistance for a client who is eligible and whom HIC provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted and; 7. Assisting an eligible client with the entire cost of a group policy that includes coverage for persons not eligible for HIC payment assistance.	•
9.15	Payer of Last Resort Agencies must assure that all clients are screened for potential third party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist clients in enrollment.	•
9.16	Vigorous Pursuit All contracted agencies must vigorously pursue any excess premium tax credit received by the client from the IRS upon submission of the client's tax return. To meet the standard of "*vigorously pursue*", all clients receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must: 1. Designate premium tax credit be taken in advance during enrollment 2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal 3. Submit prior year tax information no later than May 31st. 4. Reconciliation of advance premium tax credits or liabilities.	•

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HOSPICE SERVICES

Definition: Provision of Hospice Care provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics	• Program's Policies and Procedures indicate compliance with expected Scope of Services • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Scope of Service (Cont'd) Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the client. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services.	
9.3	Client Eligibility In addition to general eligibility criteria, individuals must meet the following criteria in order to be eligible for services. The client's eligibility must be recertified for the program every six (6) months. • Referred by a licensed physician • Certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course • Must be reassessed by a physician every six (6) months. • Must first seek care from other facilities and denial must be documented in the resident's chart.	• Documentation of HIV+ status, residence, identification and income in the client record. • Documentation in client's chart that an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
9.4	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received. • Documentation of referrals out • Staff reports indicate compliance
9.5	Staff Education Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV/AIDS. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of persons living with HIV/AIDS.	• Staff will attend and has continued access to training activities: • Staff has access to updated HIV/AIDS information • Agency maintains system for dissemination of HIV/AIDS information relevant to the needs of PLWHA to paid staff and volunteers. • Agency will document provision of in-service education to staff regarding current treatment methodologies and promising practices.

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

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Medication Administration Record Agency documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	• Documentation in client's record
9.16	PRN Medication Record Agency documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.	• Documentation in client's record
9.17	Physician Orders The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse.	• Documentation in client's record
9.18	Intake and Service Eligibility Agency will receive referrals from a broad range of HIV/AIDS service providers. Information will be obtained from the referral source and will include: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (client self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information • Documentation of insurance status • Documentation of income (including a "zero income" statement) • Documentation of state residency • Documentation of proof of HIV positivity • Photo ID or two other forms of identification • Acknowledgement of client's rights	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's records

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.19	Comprehensive Health Assessment A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Documentation in client's record
9.20	Plan of Care Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. A written Plan of Care is completed for each patient within 48 hours of admission and reviewed monthly. Care Plans will be updated once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV/AIDS (http://hab.hrsa.gov/tools/palliative/contents.html) and professional guidelines Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Documentation in client's record

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.21	Counseling Services The need for counseling services for family members must be assessed and a referral made if requested. The need for bereavement and counseling services for family members must be consistent with definition of mental health counseling.	• Documentation in client's record
9.22	Bereavement Counseling Bereavement counseling must bwe provided. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery; • make bereavement services available to a patient's family and other persons in the bereavement plan of care for up to one year following the death of the patient; • extend bereavement counseling to residents of a skilled nursing facility, a nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions when appropriate and as identified in the bereavement plan of care; • ensure that bereavement services reflect the needs of the bereaved.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.23	Dietary Counseling Dietary counseling must be provided. Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a hospice patient's condition progresses. Dietary counseling, when identified in the plan of care, must be performed by a qualified person. • A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a client are met.	• Assessment present in the client's record. • Referral and/or service provision documented.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.24	Mental Health Counseling Mental health counseling must be provided. Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.25	Spiritual Counseling A hospice must provide spiritual counseling that meets the patient's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the client's and family's spiritual needs; • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a client's spiritual needs; and • Advise the client and family of the availability of spiritual counseling services.	• Assessment present in the client's record. • Referral and/or service provision documented.
9.26	Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.	• Assessment present in the client's record. • Documentation in client's records.
9.27	Medical Social Services Medical social services must be provided by a qualified social worker, and is based on: • The patient's and family's needs as identified in the patient's psychosocial assessment • The patient's and family's acceptance of these services.	• Assessment present in the client's record. • Documentation in client's records.
9.28	Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves and hospice care is no longer necessary. • Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's records.

References:
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 201, p. 15-17.
Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services
Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

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

#	STANDARD	MEASURE
9.0	**Services are part of the coordinated continuum of HIV/AIDS and social services**	
9.1	Scope of Service The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual HIV positive clients. Services exclude Spanish Translation Services.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	Staff Qualifications and Training • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI). Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), or the National Interpreter Certification (NIC) at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting	• Program Policies and Procedures will ensure the contracted agency is in compliance with legislation/regulations • Legislation and Regulations • (Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act
9.3	Program Policies Agency will develop policies and procedures regarding the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and procedures to providers seeking to utilize the service.	• Review of Program Policies.

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

9.4	Provision of Services
	• Agency/providers will offer services to the client only in connection with other HRSA approved services (such as clinic visits).
	• Providers will deliver services to the client only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the client
	• Based on provider need, agency shall provide the following types of linguistic services in the client's preferred language:
	  • Oral interpretation
	  • Written translation
	  • Sign language
	• Agency/providers should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the client seeking assistance
	• Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area
		• Review of Program's Policies and Procedures indicate compliance.
		• Documentation of provision of services present in client files indicates compliance.

9.5	Timeliness of Scheduling Agency will schedule service within one (1) business day of the request.	• Review of client files indicates compliance.
9.6	Interpreter Certifications All American Sign Language interpreters will be certified in the State of Texas. Level II and III interpreters are recommended for medical interpretation.	• Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency requests denote appropriate levels of interpreters are requested.
9.7	Subcontractor Exclusion: Due to the nature of subcontracts under this service category, the staff training outlined in the General Standards are excluded from being required for interpreters.	• No Measure

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Definition:
Mental Health Services are the provision of outpatient psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Work Agency will provide the following services: **Individual Therapy/counseling** is defined as 1-on-1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person. Mental health services include Mental Health Assessment; Treatment Planning; Treatment Provision; Individual psychotherapy; Family psychotherapy; Conjoint psychotherapy; Group psychotherapy; Drop-In Psychotherapy Groups; and Emergency/Crisis Intervention. Also included are Psychiatric medication assessment, prescription and monitoring and Psychotropic medication management. General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for non-HIV infected family members or significant others. Mental health services can be delivered via Telehealth subject to federal guidelines, Texas State law, and DSHS policy	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Licensure Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking clients.	• A file will be maintained on each professional counselor. Supportive documentation of credentials is maintained by the agency in each counselor's personnel file. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.3	Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	• Personnel record will reflect all orientation and required continuing education training. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.4	Family Counseling Experience Professional counselors must have two years experience in family counseling if providing services to families.	• Experience is documented via resume or other method. Exceptions noted in personnel files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.5	Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Documentation of liability insurance coverage is maintained by the agency.
9.6	Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Documentation of training is maintained by the agency in each counselor's personnel file
9.7	Crisis Situations and Behavioral Emergencies Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the client during the orientation process. In urgent, non-life-threatening circumstances, an appointment will be scheduled within twenty four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the client to another organization that can provide the requested services.	• Review of Agency Policies and Procedures Manual indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	Other Policies and Procedures The agency must develop and implement Policies and Procedures that include but are not limited to the following: • Client neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, time line for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months.	• Review of Agency Policies and Procedures Manual indicates compliance.
9.9	In-Home Services Therapy/counseling and/or bereavement counseling may be conducted in the client's home.	• Program Policies and Procedures address the provision of home visits.
9.10	Client Orientation Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will be provided to all clients and include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	• Documentation in client record indicates compliance. • Annual Client Interviews indicates compliance. • Percentage of new clients with documented evidence of orientation to services available in the client's primary record

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self Assessment/Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation.	• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment. • Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record
9.12	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: • Statement of the goal(s) of counseling and description of the mental health issue • Goals and objectives • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review	• Documentation in client record. • Exceptions noted in client file. • Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. • Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. • Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Treatment Plan (Cont'd) Initial treatment plans must be completed no later than the third counseling session. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals as clinically indicated. The treatment plan will be signed by the mental health professional rendering service.	
9.13	Treatment Plan Review Treatment plans shall be reviewed and modified at least every 90 days or more frequently as clinically indicated. -The plan must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures.	• Review of Agency Policies and Procedures Manual indicates compliance. • Client's records • Exceptions noted in client files.
9.14	Psychiatric Referral Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	• Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.
9.15	Psychotropic Medication Management: Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	• Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications • Percentage of clients with changes to psychotropic psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

9.16	Progress Notes Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	• Legible, signed and dated documentation in client record. • Percentage of client's with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.
9.17	Coordination of Care: Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.
9.18	Referrals: As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.19	Discharge Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death	• Agency will develop discharge criteria and procedures.
9.20	Discharge Summary Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	• Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record • Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record
9.21	Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Documentation of supervisor credentials is maintained by the agency.
9.22	Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Documentation in supervision notes. • Each mental health service agency must have and implement a written policy for regular supervision of all licensed staff.

RYAN WHITE PART B/DSHS STATE SERVICES
1819 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Work Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, routine dental examinations, diagnosis and treatment of HIV-related oral pathology, restorative dental services, root canal therapy, prophylaxis, x-rays, fillings, and basic oral surgery (simple extractions), endodontistry and oral medication (including pain control) for HIV patients 15 years old or older based on a comprehensive individual treatment plan. Referral for specialized care should be completed if clinically indicated. Additionally, the category includes prosthodontics services to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room. Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
	Staff Qualifications All oral health care professionals, such as general dental practitioners, dental specialists, and dental hygienists shall be properly licensed by the State of Texas Board of Dental Examiners while performing tasks that are legal within the provisions of the Texas Dental Practice including satisfactory arrangements for malpractice insurance. Dental Assistants who make x-rays in Texas must register with the State Board of Dental Examiners. Dental hygienists and assistants will be supervised by a licensed dentist. Students enrolled in a College of Dentistry may perform tasks under the supervision	• Documentation of qualifications for each dental provider present in personnel file.
9.2	Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV/AIDS is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
9.3	Experience – HIV/AIDS Service provider should employ individuals experienced in dental care and knowledgeable in the area of HIV/AIDS dental practice. A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Documentation of work experience in personnel file
9.4	Confidentiality Confidentiality statement signed by dental employees.	• Signed statement in personnel file.
9.5	Universal Precautions All health care workers should adhere to universal precautions as defined by Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. It is strongly recommended that staff are aware of the following to ensure that all vaccinations are obtained and precautions are met: • Health care workers who perform exposure-prone procedures should know their HIV antibody status • Health care workers who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status. • Tuberculosis tests at least every 12 months for all staff. • OSHA guidelines must be met to ensure staff and patient safety.	• Documentation of review in personnel file.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
9.7	Annual Cap On Services Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year. • In cases of emergency, the maximum amount may exceed the above cap • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap. Dental providers must document ***via approved waiver*** the reason for exceeding the yearly maximum amount.	• Annual review of reimbursements indicates compliance • Signed waiver present in patient record for each patient.
9.8	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
9.9	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record
9.10	Dental and Medical History Information To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the patient's health and medication status Provider obtains and documents HIV primary care provider contact information for each patient. Provider obtains from the primary care provider or obtains from the patient health history information with updates as medically appropriate prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within in last 12 months) CBC laboratory test • Current (within the last 12 months) CD4 and Viral Load laboratory test results or more frequent when clinically indicated • Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level (e.g., Factor VIII activity) and inhibitor titer (e.g., BIA) • Tuberculosis screening result • Patient's chief complaint, where applicable • Current Medications	• Documentation of health history information in the client record. Reasons for missing health history information are documented

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
	Dental and Medical History Information (Cont'd) This information should include, but not be limited to, the following: • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis A, B, C status • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems Any predisposing conditions that may affect the prognosis, progression and management of oral health condition	
9.11	Client Health History Update An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
9.12	Limited Physical Examination Initial limited physical examination should include, but shall not necessarily be limited to, blood pressure, and pulse/heart rate as may be indicated for each patient according to the Texas Board of Dental Examiners. Dental provider will obtain an initial baseline blood pressure/pulse reading during the initial limited physical examination of a dental patient. Dental practitioner should also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a patient's vital signs, the dental practitioner must document in the patient's oral health care record an acceptable reason why the attempt to obtain vital signs was unsuccessful.	• Review of client records indicate compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	Oral Examination Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established patient • D0120-Periodic Oral Evaluation to include bitewing x-rays, established patient, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established patient; not post-operative visit)	• Review of client records indicate compliance
9.14	Comprehensive Periodontal Examination Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines. Patient must have a periodontal screening once per year. A periodontal screen should include: • Assessment of medical and dental histories • Quantity and quality of attached gingival • Bleeding • Tooth mobility • Radiological review of the status of the periodontium and dental implants. Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the patient's dental and medical history and general health assessment. • It may include the evaluation and recording or dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Treatment Plan A dental treatment plan should be developed appropriate for the patient's health status, financial status, and individual preference should be chosen. A comprehensive, multi disciplinary Oral Health treatment plan will be developed and updated in conjunction with the patient. Patient's primary reason for dental visit should be addressed in treatment plan. Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. A comprehensive dental treatment plan that includes preventive care, maintenance and elimination of oral pathology will be developed and updated annually. Various treatment options should be discussed and developed in collaboration with the patient. Treatment plan should include as clinically indicated: • Provision for the relief of pain • Elimination of infection • Preventive plan component • Periodontal treatment plan if necessary • Elimination of caries • Replacement or maintenance of tooth space or function • Consultation or referral for conditions where treatment is beyond the scope of services offered • Determination of adequate recall interval.	• Treatment plan dated and signed by both the provider and patient in patient file • Annually updated treatment plan dated and signed by both the provider and patient in patient file
9.16	Phase 1 Treatment Plan In accordance with the National Monitoring Standards a Phase 1 treatment plan includes prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. Phase 1 treatment plan will be established and updated annually to include what diagnostic, preventative, and therapeutic services will be provided. Phase 1 treatment plan will be established within 12 months of initial assessment. Treatment plan should include as clinically indicated: • Restorative treatment • Basic periodontal therapy (non-surgical) • Basic oral surgery (simple extractions and biopsy) • Non-surgical endodontic therapy • Maintenance of tooth space • Tooth eruption guidance for transitional dentition	• Phase 1 Treatment plan dated and signed by both the provider and patient in patient file • Annually updated Phase 1 treatment plan dated and signed by both the provider and patient in patient file

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.17	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
9.18	**Oral Health Education** Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager. Provider must provide patient oral health education once each year which includes but is not limited to the following: • D1330 Oral hygiene instructions • D1320 Smoking/tobacco cessation counseling as indicated • Additional areas for instruction may include Nutrition (D1310). • For pediatric patients, oral health education should be provided to parents and caregivers and be age appropriate for pediatric patients.	•
9.19	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record
9.20	Referrals Referrals for other services must be documented in the patient's oral health care chart. Outcome of the referral will be documented in the patient's oral health care record.	• Documentation in the client record

References

- American Dental Association. Dental Practice Parameters. Patients requiring a comprehensive oral evaluation. Available at: http://www.ada.org/prof/prac/tools/parameters/eval_comprehensive.asp. Accessed on May 8, 2009.
- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2011, page 9-10.
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 9-10.

- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Rule 7.Minimal Standards of Care. located at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm

Priority and Allocations Committee Report

Prepared by: Ryan White Grant Administration

FY 2017 Ryan White Part A and MAI Service Utilization Report

SUR - 3rd Quarter Cumulative (3/1-11/30)																	
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	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%	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%	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%	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%	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%	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%	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%	62%	8%	1%	29%	0%	0%	2%	14%	32%	17%	32%	4%
1.g	Primary Care - Pediatric (a)	7	8	75%	25%	75%	13%	0%	13%	38%	50%	13%	0%	0%	0%	0%	0%
1.h	Vision	1,600	944	74%	26%	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%	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%	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%	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%	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%	0%	88%	12%	1%	0%	0%	4%	22%	22%	20%	29%	4%
2.f	Med CM - Targeted to Rural (a)	150	387	69%	31%	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%	57%	10%	3%	30%	0%	2%	10%	14%	32%	11%	25%	5%
2.h	Med CM - Targeted to Pedi (a)	125	67	49%	51%	78%	7%	0%	15%	52%	42%	6%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	114	96%	4%	72%	20%	0%	8%	0%	0%	0%	2%	4%	4%	71%	20%
2.j	Med CM - Targeted to Youth	120	68	99%	1%	60%	6%	1%	32%	0%	13%	87%	0%	0%	0%	0%	0%
3	Local Drug Reimbursement Program (a)	2,845	2,858	78%	22%	47%	16%	2%	35%	0%	0%	5%	29%	29%	14%	21%	1%
4	Oral Health	200	170	65%	35%	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
4.b	Oral Health - Rural Target	200	170	65%	35%	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%	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%	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%	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%
13	Non-Medical Case Management	7,045	3,658														
13.a	Service Linkage Targeted to Youth	320	93	81%	19%	58%	10%	3%	29%	0%	14%	86%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	86	66%	34%	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%	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%	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%	55%	11%	2%	31%	0%	1%	9%	28%	18%	10%	29%	5%
14.b	Transportation Services - Rural	130	39	77%	23%	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%	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%	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)

Printed: 2/13/2018

FY 2017 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	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%	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%	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 (3/1/17 - 2/28/18)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	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%	55%	13%	2%	29%	0%	2%	8%	35%	27%	11%	16%	2%
2	LPAP	1,200	250	81%	19%	53%	18%	1%	28%	0%	2%	6%	38%	29%	12%	13%	0%
3.a	Clinical Case Management	400	64	91%	9%	48%	25%	2%	25%	0%	3%	8%	41%	16%	14%	19%	0%
3.b-3.h	Medical Case Management	1,600	344	77%	23%	54%	13%	3%	30%	0%	3%	10%	31%	27%	10%	16%	2%
3.i	Medical Case Manangement - Targeted to Veterans	60	31	97%	3%	65%	23%	0%	13%	0%	0%	0%	3%	3%	3%	65%	26%
4	Oral Health	40	10	40%	60%	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%	56%	14%	2%	28%	1%	1%	7%	31%	25%	12%	21%	2%
12.b	Service Linkage at Testing Sites	260	25	72%	28%	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

(f) Total MCM served does not include Clinical Case Management

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**	[redacted]	**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**	[redacted]	**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**	[redacted]	**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**	[redacted]	**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%**
BER27516	**Total Service Dollars**	**18,617,626**	**-190,275**	**444,642**	**0**	**0**	**18,871,993**	**89.09%**	**18,689,771**	**182,222**	[redacted]	**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%**

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
[redacted]	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%
[redacted]PC	RWPC Support*	512,439	16,220		0	0	528,659	2.56%	528,659	0	N/A	243,686	46%	58%
[redacted]	**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**	[redacted]	**9,561,898**	**45%**	**58%**
								Unallocated	Unobligated		[redacted]			[redacted]
	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	[redacted]
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**	[redacted]	**18,401,993**	[redacted]	
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

riority	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**	[redacted]	**1,197,350**	**58%**	**25%**
) (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%
: (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%
[redacted]	**Total MAI Service Funds**	**2,057,949**	**59,936**	**631,496**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**	[redacted]	**1,197,350**	**58%**	**25%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	[redacted]	**0**	**0%**	**0%**
[redacted]	**Total MAI Funds**	**2,057,949**	**59,936**	**631,496**	**0**	**0**	**2,351,635**	**100.00%**	**2,057,949**	**293,686**	[redacted]	**1,197,350**	**58%**	**25%**
	MAI Grant Award	**2,117,885**	***Carry Over:***	**0**		***Total MAI:***	**2,117,885**							[redacted]
	Combined Part A and MAI Orginial Allocation Total	**22,829,402**												

otnotes:

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

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 December 2017

Spending Target: 75%

Revised 2/6/2018

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	$1,038,203	44%
7	Health Insurance Premiums and Cost Sharing*,*	$726,885	22%	($16,122)	$710,763	22%	4/1/2017	$645,969	89%
9	Home and Community Based Health Services**	$232,000	7%	($3,840)	$228,160	7%	4/1/2017	$86,544	37%
	Total Houston HSDA	3,329,231	100%	($54,743)	$3,274,488	100%		1,770,716	53%

* 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. An agency has vacany in data positions which has lead to lov

**** 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 1718 DSHS State Services

Procurement Report

September 1, 2017- August 31, 2018

Chart reflects spending through December 2017

Spending Target: 33%

Revised 2/6/2018

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	16%		$300,000	16%	9/1/2017	$51,970	17%
7	Health Insurance Premiums and Cost Sharing	$937,694	50%		$937,694	50%	9/1/2017	$429,803	46%
9	Hospice **	$414,832	22%		$414,832	22%	9/1/2017	$108,020	26%
11	EIS - Incarcerated	$170,000	9%		$170,000	9%	9/1/2017	$42,554	25%
16	Linguistic Services	$51,211	3%		$51,211	3%	9/1/2017	$14,052	27%
Total Houston HSDA		1,873,737	100%	$0	$1,873,737	100%		646,400	34%

* Service utilization is lagging

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

2016 - 2017 Ryan White Part B Service Utilization Report
4/1/2016 - 3/31/2017 Houston HSDA (4816)
4th Quarter

Revised 2/5/2018

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*945*	1,202	81.8%	17.9%	0.0%	0.3%	42.3%	29.7%	25.7%	2.3%	0.1%	0.0%	2.2%	15.1%	21.4%	15.8%	40.3%	5.1%
Home & Community Based Health Services	*55*	33	60.6%	36.4%	0.0%	3.0%	69.7%	12.1%	15.2%	3.0%	0.0%	0.0%	0.0%	3.0%	21.2%	21.2%	45.5%	9.1%
Oral Health Care	*3,810*	3,018	72.2%	27.1%	0.0%	0.7%	50.7%	17.2%	30.6%	1.5%	0.0%	0.1%	2.2%	15.4%	20.6%	14.1%	40.8%	6.8%
Unduplicated Clients Served By RW Part B Funds:	*NA*	3,933	74.3%	25.0%	0.1%	0.6%	48.8%	20.1%	29.3%	1.7%	0.0%	0.1%	2.2%	15.7%	21.3%	14.3%	40.2%	6.2%

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1718 DSHS State Services Rebate

Procurement Report

September 1, 2017- August 31, 2018

Chart reflects spending through January 2018

Spending Target: 41%

Revised 2/15/2018

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	ADAP Eligibility Worker	$375,000	38%		$375,000	38%	9/1/2017	$34,021	9%
7	Emergency Financial Assistance	$600,000	62%		$600,000	62%	9/1/2017	$64,988	11%
Total Houston HSDA		$975,000	100%	$0	$975,000	100%		$99,009	10%

AEW: Two agencies have not submitted reports and one position unassigned for $ 75,000

EFA: The public clinic is yet to utilize services

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2017-11/30/2017

Revised: 2/5/2018

	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	418	$52,814.52	272			*0*
Medical Deductible	0	$0.00	0			*0*
Medical Premium	1463	$575,191.27	655			*0*
Pharmacy Co-Payment	930	$116,356.60	464			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	13	$1,370.00	8	*NA*	*NA*	*NA*
Totals:	2824	$742,992.39	1399	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2017-10/31/2017

Revised: 2/5/2018

	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	273	$32,507.69	201			*0*
Medical Deductible	0	$0.00	0			*0*
Medical Premium	1075	$422,679.98	633			*0*
Pharmacy Co-Payment	594	$78,526.21	392			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	9	$1,190.00	6	*NA*	*NA*	*NA*
Totals:	1951	$532,523.88	1232	0	$0.00	

Comments: This report represents services provided under all grants.

Priority and Allocations Committee Report

Priority and Allocations
FY 2019 Guiding Principles and Decision Making Criteria

(Priority and Allocations Committee approved 02-22-18)

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

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

Principles

A. Ensure ongoing client access to a comprehensive system of core services as defined by HRSA

B. Eliminate barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)

C. Meet the needs of diverse populations as addressed by the epidemiology of HIV

D. Identify individuals newly aware of their status and link them to care. Address the needs of those that are aware of their status and not in care.

Allocations only

E. Document or demonstrate cost-effectiveness of services and minimization of duplication

F. Consider the availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies

G. Reduce the time period between diagnosis and entry into HIV medical care to facilitate timely linkage.

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

(Continued)

DECISION MAKING CRITERIA STEP 1:

A. Documented service need with consumer perspectives as a primary consideration

B. Documented effectiveness of services with a high level of benefit to people and families living with HIV, including quality, cost, and outcome measures when applicable

C. Documented response to the epidemiology of HIV in the EMA and HSDA

D. Documented response to emerging needs reflecting the changing local epidemiology of HIV while maintaining services to those who have relied upon Ryan White funded services.

E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services

F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan, the Continuum of Care, the National HIV/AIDS Strategy, the Texas HIV Plan and their underlying principles to the extent allowable under the Ryan White Program to:

- build public support for HIV services;
- inform people of their serostatus and, if they test positive, get them into care;
- help people living with HIV improve their health status and quality of life and prevent the progression of HIV;
- help reduce the risk of transmission; and
- help people with advanced HIV improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

DECISION MAKING CRITERIA STEP 2:

A. Services have a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable

B. Services are accessible to all people living with or affected by HIV, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines

C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).

D. Services emphasize access to and use of primary medical and other essential HRSA defined core services

E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs

F. Services are available to meet the needs of all people living with HIV and families, as applicable under Part A and B guidelines

G. Services meet or exceed standards of care

H. Services reflect latest medical advances, when appropriate

I. Services meet a documented need that is not fully supported through other funding streams

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

FY 2019 Priority Setting Process

(Priority and Allocations Committee approved 02-22-18)

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

(Continued on next page)

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

2018 Policy for Addressing Unobligated and Carryover Funds

(Priority and Allocations Committee approved 02-22-18)

Background

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

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

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

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

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

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

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

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

Recommendations for Addressing Unobligated and Carryover Funds:

1.) Requests from Currently Funded Agencies Requesting an Increase in Funds in Service Categories where The Agency Currently Has a Contract: These requests come at designated times during the year.

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

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

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

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

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

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

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

Williams, Victoria (County Judge's Office)

Subject: FW: Communication - Part A Funding Update

Importance: High

From: Hecht, Elaine (HRSA) [mailto:EHecht@hrsa.gov]
Sent: Tuesday, January 23, 2018 9:01 AM
Subject: FW: Communication - Part A Funding Update
Importance: High

Ryan White HIV/AIDS Program Part A Colleagues -

We want to share with you two important informational items related to Part A funding.

Ryan White HIV/AIDS Program Part A Funding Update

The Ryan White HIV/AIDS Program Part A Program has been operating under a series of continuing resolutions (CRs) that funds the U.S. government. Under the CRs, only a prorated amount of grant funding has been made available for the Part A program. Without a full-year appropriation, HRSA is not able to fully fund the fiscal year 2018 awards.

HRSA will issue a funding memo to all 52 Part A jurisdictions with a partial award based on the FY17 Part A formula and Minority AIDS Initiative award levels. This partial award will be made by February 1, 2018 for the new budget period start date of March 1, 2018. The partial formula award will be 31.5% of the FY17 formula award and the Minority AIDS Initiative award will be 20.6% of the FY17 Minority AIDS Initiative award. Given the HAB DMHAP approach to budget submission and review for the FY18 award year, this partial notice of funding award will indicate the review/approval of your full year proposed budget and any applicable program terms/resubmission requirements.

HRSA will issue further FY 2018 notice of funding awards as soon as additional funds become available.

Ryan White HIV/AIDS Program Part A FY 2019 Notice of Funding Opportunity (NOFO) Timeline

The Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau has received the timeline for the FY 2019 Part A NOFO and we want to share some important dates to facilitate planning in Part A jurisdictions. Overall, a plan has been developed to provide a ninety-day application window for all Health Resources and Services Administration competitive NOFOs. For the Ryan White HIV/AIDS Program Part A program, key dates for FY 2019 include a mid June 2018 NOFO release date and mid September 2018 application due date. Please modify your planning and application development activities as necessary.

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Operations Committee Report

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL. 15, 1997 **REV JANUARY 1, 2018** **POLICY No. 900.01**

PETTY CASH

PURPOSE

This policy establishes the guidelines by which petty cash reimbursements of expenses to attend Houston Area HIV Health Services (Ryan White) Planning Council meetings are made. The purpose of these funds is to encourage a wide range of community participation. While all members of the RWPC are eligible for reimbursement, all members are encouraged to pay for their own expenses out of their own funds if possible. This policy includes both internal as well as external members.

AUTHORITY

"Guidelines for Reimbursement of People on a Ryan White Title I Planning" dated January 21, 1997, and the Ryan White HIV/AIDS program Part A Manual - Revised 2013. The RWPC voted on February 10, 1996 to set as a priority the reimbursement of expenses to attend RWPC meetings (including subcommittee and related meetings). Those eligible to receive reimbursement of expenses to attend committee, subcommittee and related meetings include Council and external committee members.

DEFINITIONS

Meetings - are defined as outlined in the RWPC adoption of its Bylaws, Article IX. Rev. 01/18.

Meals - are those that are related to and occur as the result of attending any scheduled Houston area HIV/AIDS Health Services (Ryan White) Planning Council meeting, including Ryan White committee and workgroup meetings, and outreach events.

PROCESS

Review – Annually, the Operations Committee will review RWPC petty cash policies and forms.

Transportation - Expenses will be reimbursed as a result of a Planning Council or external committee member attending a scheduled meeting. If travel is conveyed through the use of the members own vehicle the rate will be the same as the county rate per mile. Council and external committee members are reimbursed for mileage to and from a consistent, designated starting point (either home or work). The start point will be documented in the member's file and mileage will be determined by an Internet site selected annually by the Office of Support. Members are encouraged to carpool. When members carpool, only the member who is the driver of the automobile can request mileage reimbursement from his or her designated starting point.

If a member is employed (full time) and work hours are Monday through Friday during regular business hours (approximately 8 a.m. until 5 p.m.), the member must provide the requested employment-related information on the Petty Cash Transportation Form. If work hours typically

overlap with Ryan White meetings, then the member must use their primary work address as their designated starting point for determining mileage reimbursement. Harris County may contact an employer to confirm employment information provided on the Petty Cash Transportation Form. When an individual uses their work address as the point of origin for their travel reimbursement, then they are not eligible for childcare reimbursement.

If the member travels by cab, then an official cab company receipt must accompany the request for reimbursement. Traveling by cab should be the option of last resort, with the following exceptions. Council and external committee members who are accompanied by children are allowed to take a cab to and from work, home and/or the child care provider. Members are also allowed to use a cab if no other means of transportation is available or there are barriers to existing transportation. Bus expenses will be reimbursed at the prevailing METRO rate (round trip).

Meals - Snacks are provided at all Council related meetings to assist individuals with dietary needs. Individuals will not be reimbursed for purchasing a meal if staff notifies members that a meal is being provided at a particular meeting. Exceptions will be made for individuals with special dietary needs. If a meeting takes place near a meal time and the Office of Support has not announced that a meal will be provided, members are allowed to purchase a meal one hour before the scheduled start time of the meeting. Members will not be reimbursed if the receipt indicates that a meal was purchased after the scheduled start time for the meeting. Members will be reimbursed for food as well as transportation and childcare when representing the Council at off-site events such as health fairs, unless a meal is provided at the event.

Expenses for meals are to be reimbursed for "in-town" and "out-of-town" meetings. In-town meetings are those that occur as a result of a regularly scheduled meeting and a meal reimbursement is requested. The maximum amount allowed will be in accordance with current Harris County reimbursement rate for meals and receipts will be required.

Child Care - Expenses for childcare will be $35 per child per visit, not to exceed $100 per day (total). An exception to this would be an activity that takes place outside of normal business hours (6 am – 6 pm) in which case a volunteer could be reimbursed for an additional $35 per child per visit, not to exceed $100 (total). A Council approved Child Care Expense Receipt must be attached to the Claim for Reimbursement. Child Care reimbursements are based on RWPC meetings or committee related events.

Other - Council and External Committee members who choose to attend a non-assigned meeting or event will not be reimbursed from petty cash for their participation in that meeting. Also, members will not be reimbursed for transportation, childcare and/or food if they arrive 20 minutes after the scheduled start time for the meeting. Within the calendar year, members are allowed two exemptions if they arrive at a meeting 20 minutes late. If necessary, members are allowed to ask the Operations Committee for additional exemptions for reimbursement if they are more than 20 minutes late to a meeting.

REIMBURSEMENT

Reimbursement requests are to be submitted to the Office of Support for payment. Receipts must be submitted any time within 45 days of the date of the event or they will not be approved. End of year reimbursements must be submitted within 30 days after the end of the Ryan White Part A fiscal year. Reimbursement requests presented 30 days after the end of the fiscal year will not be approved. Any request that does not fall within the time frames outlined above needs to be

submitted in writing to the RWPC Director for approval. All reimbursements are available from the Ryan White Office of Support Staff.

If a check is lost or stolen, as long as the check has not been cashed, the Office of Support will replace one check per year as a courtesy to the member and Ryan White will pay the administrative fee. If more than one check is lost or stolen within a calendar year, the lost or stolen check will not be replaced.

Per Harris County policy, petty cash is not allowed to be taken off site. Therefore, members will be reimbursed for off-site meetings the next time they are at the Office of Support. Members will not be reimbursed for travel to the Office if the sole reason for coming to the Office is to be reimbursed for an off-site meeting.

The RWPC will not reimburse members for loss of wages as a result of attending meetings.

Members are allowed to ask the Operations Committee for exemptions from any portion of the above policy by submitting a letter to the Director of the Ryan White Office of Support stating why personal circumstances should allow them to be exempt. The Director will share the letter with the Operations Committee at their next scheduled meeting. The Operations Committee will respond to the request in writing.

MAXIMUM REIMBURSEMENT RATES

All Ryan White Council and external committee members can receive up to the following amount in petty cash reimbursement within a 12 month calendar year, unless the member receives a waiver for an increased amount from the Operations Committee based upon personal circumstances.

The allowable amount for all members is:

11 committee meetings
+ 2 trainings
+ 3 workgroups or Public Hearings
16 meetings/year x $100/meeting = $1,600

Council Chair: up to $5,000/year
($1,600 + 12 Council meetings + 12 Steering Committee meetings + 10 additional misc. meetings)

Officers & Committee Chairs: up to $4,000/year
($1,600 + 12 Council meetings + 12 Steering Committee meetings)

Council Members: up to $2,800/year
($1,600 + 12 Council meetings)

External Committee Members: up to $1,600/year

Written requests for exceptions can be submitted to the Operations Committee for review and approval.

If it becomes clear that an individual is going to exceed the amount listed above within a calendar year, the following steps are to be taken:

Step 1: The Director of the Office of Support will verbally bring the matter to the

attention of the member and document the conversation in the member's folder.

Step 2: If the situation continues after two conversations with the member, the member will receive a letter signed by the Chair of the Planning Council and the Director of the Office of Support. The letter will document the total amount the member has received in petty cash reimbursement and request a meeting to outline ways in which the individual can begin to limit reimbursement.

Step 3: If the member is unable or unwilling to limit reimbursement than the Council Chair will review and possibly reappoint the member to a committee that has fewer meetings and/or fewer outside activities.

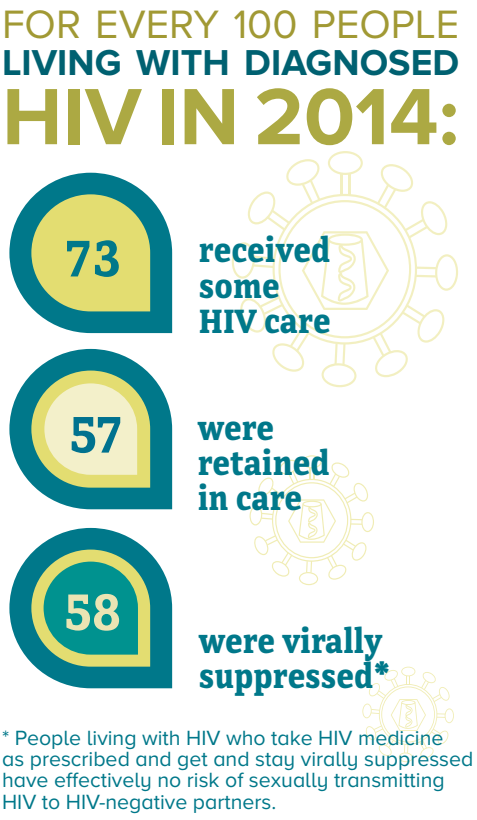
Step 4: If the individual member reaches the cap outlined above, they can request a waiver from the policy from the Operations Committee. The Operations Committee will review the request and, after consulting with the Chair of the Ryan White Planning Council and the Director of the Office of Support, the Committee will have final approval regarding the response to the request for a waiver and will notify the individual of their decision in writing. If the request for a waiver is denied, the member will not be reimbursed for mileage, childcare and/or meals for the remainder of the calendar year. The member will be eligible to receive petty cash reimbursement for activities that take place in the next calendar year, once the new year begins.

FYI

Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV

HIV treatment has dramatically improved the health, quality of life, and life expectancy of people living with HIV (Cohen, 2011; Farnham, 2013; Farnham, 2013; Samji, 2013). Moreover, since breakthrough research in 2011 also showed the profound impact of HIV treatment in preventing the sexual transmission of HIV among heterosexual HIV-discordant couples, HIV treatment has transformed the HIV prevention landscape (Cohen, 2011). The Centers for Disease Control and Prevention (CDC) has worked with prevention partners across the nation to prioritize efforts to maximize the impact of HIV treatment in prevention and has responded with new initiatives that help diagnose HIV-infected individuals earlier, link or re-engage them to effective HIV care and treatment, and support adherence to HIV treatment, with the ultimate goal of achieving viral suppression (https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-ps18-1802-factsheet.pdf).

These interventions across the care continuum (https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf) are essential to help those living with HIV stay healthy, live longer, and reduce the risk of further transmission to partners. Additionally, to increase awareness of the full range of prevention strategies now available, CDC has worked to implement multiple education campaigns and provide online risk reduction tools and resources with information on different prevention strategies and their effectiveness (https://www.cdc.gov/actagainstaids/index.html; https://wwwn.cdc.gov/hivrisk/; https://effectiveinterventions.cdc.gov/).



Over the past year, as new research has provided even stronger evidence on the prevention benefit of HIV treatment and viral suppression, CDC has joined with other federal agencies as part of an effort led by the U.S. Department of Health and Human Services (HHS) to review the latest evidence and ensure that these findings are communicated in a way that is consistent and accurate. As part of CDC's continued efforts to communicate evidence around effective prevention strategies, this fact sheet summarizes the latest scientific evidence regarding the effectiveness of HIV treatment and viral suppression in preventing the sexual transmission of HIV, and provides an update on evolving prevention messages developed by the HHS workgroup,[1] as well as CDC's next steps to evaluate and update messages in our communications and prevention activities.

The Evidence

In 2011, the interim results of the HPTN052 clinical trial were released (Cohen, 2011) demonstrating a 96% reduction in HIV transmission risk among heterosexual HIV-discordant couples for those starting antiretroviral therapy (ART) versus those delaying ART initiation. In addition to the powerful initial results, subsequent analyses published in 2016 demonstrated that there were no HIV transmissions between these couples when the HIV-positive partner had a suppressed viral load (defined as having a viral load less than 400 copies per milliliter) (Cohen, 2016).

Some HIV infections were observed among couples in the treatment condition; however, most of these were not genetically linked to the primary HIV-positive partner in the study, indicating that they came from another partner outside the study. Only a limited number of linked sexual transmissions of HIV were observed; however, this

1. The HHS workgroup includes senior leaders, communicators, and subject matter experts from the Office of HIV/AIDS Infectious Disease Policy (OHAIDP) in HHS, the Centers for Disease Control and Prevention (CDC), National Institutes for Health (NIH), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA).

All content is based on the most recent data available in December 2017.

was while the HIV-positive partner was not virally suppressed. In other words, linked HIV transmissions only occurred either:

- In the months *after* the HIV-positive partner began ART but *before* the HIV-positive partner was virally suppressed, or
- When the ART regimen failed and the HIV-positive partner did not maintain viral suppression.

Two recently conducted studies, PARTNER and Opposites Attract, have reported similar results on the effectiveness of taking ART and achieving and maintaining viral suppression in preventing the sexual transmission of HIV — that is, no linked infections were observed while the HIV-positive partner was virally suppressed while the couples engaged in condomless sex with no exposure to pre-exposure prophylaxis (PrEP) (Rodger, 2016; Bavinton, 2017). In these two studies, viral suppression was defined as less than 200 copies per milliliter, although most HIV-positive participants were undetectable in the PARTNER study (<50 copies/mL; Rodger, 2016). These studies also quantified the extent of sexual exposure. Over 500 heterosexual couples, with about half having a male HIV-infected partner (PARTNER), and more than 650 male-male couples (Opposites Attract) from 14 European countries, Australia, Brazil, and Thailand engaged in over 70,000 episodes of condomless vaginal or anal intercourse, while also not taking PrEP, during approximately 1,500 couple years of observation.

The studies reported transmission risk estimates and their corresponding 95% confidence intervals as:

- PARTNER study (Rodger, 2016): 0.0 (0.00 – 0.30) per 100 couple years
- Opposites Attract study (Bavinton, 2017): 0.0 (0.00 – 1.56) per 100 couple years

When combining the data from both PARTNER and Opposites Attract studies, the combined transmission risk estimate is 0.0 (0.0 – 0.25) per 100 couple years (unpublished data). Relevant person-time data have not been reported for HPTN052 to be combined with these two studies. CDC is now working with HPTN052 investigators to examine these data. When HPTN052 data can be combined with these two studies, the upper bound of a combined transmission risk estimate is expected to be smaller than 0.25 per 100 couple years including additional years of follow-up time.

Updating Prevention Messages

Given the significance of these recent findings, HHS convened scientific and communication leadership across several federal agencies to review the latest evidence and develop updated messages to communicate that evidence to the public in a clear, concise, consistent, and accurate manner.

In September 2017, the HHS workgroup agreed on the following interim message, to be tested with multiple audiences, which summarizes the scientific evidence of the effectiveness of HIV treatment and viral suppression in preventing the sexual transmission of HIV:

> **People living with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners.**

The term “effectively no risk” was selected by the HHS workgroup as the interim language to describe the magnitude of the estimated risk of transmitting HIV to a sexual partner when an HIV-positive individual is taking ART daily as prescribed and then achieves and maintains an undetectable viral load. “Effectively no risk” was chosen to reflect the fact that there have been no linked infections observed in studies among thousands of sexually active HIV-discordant couples engaging in female-male and male-male sex without a condom or PrEP over several thousand person-years of follow-up, while the HIV-positive partner is virally suppressed.

Although these studies provide extremely strong evidence, they are based on a finite number of observations that result in point estimates (zero) and corresponding 95% confidence intervals that indicate the precision or uncertainty associated with those estimates. In these studies, the lower bounds of confidence intervals are all zero, but the upper bounds of the confidence intervals are very small but greater than zero, which implies the possibility of a non-zero risk. Although these three studies found no cases of HIV transmission over several thousand person-years of follow-up, these data, even when combined, cannot statistically rule out the possibility that the true risk is greater than zero.

Because "effectively no risk" might have different meanings in different audiences or populations, the HHS workgroup agreed that message testing was critical to evaluate the understanding of this interim message and to determine how best to communicate the evidence and potential challenges with successfully implementing this prevention strategy among people living with HIV and their sexual partners.

Maximizing the Effectiveness of the Prevention Strategy in Practice

The success of this prevention strategy is contingent on achieving and maintaining an undetectable viral load. Data show, however, that not all HIV-positive individuals on ART are virally suppressed, while even fewer maintain viral suppression over time. CDC's national surveillance data estimate that 58% of persons living with diagnosed HIV in the United States in 2014 were virally suppressed, defined as less than 200 copies/mL at most recent test (CDC, 2017). In addition, while most (about 80%) HIV-positive persons in the United States in HIV clinical care (defined as either receiving HIV medical care or having a viral load test) were virally suppressed at their last test, almost 20% were not (CDC, 2016; CDC, 2017; Marks, 2016). Also, about two-thirds achieved and maintained viral suppression over twelve months, which means about one-third (or about 33%) did not maintain viral suppression over that time period (CDC, 2016; Marks, 2016).

To help all individuals living with HIV and their partners get maximal benefit from this prevention strategy, it will be important to give providers, those living with HIV, and their partners clear information regarding the challenges with achieving and maintaining viral suppression. These challenges include the following:

- **Time to viral suppression:** Most people will achieve an undetectable viral load within 6 months of starting ART. Many will become undetectable very quickly, but it could take more time for some.
- **Importance of regular viral load testing:** Regular viral load testing is critical to confirm that an individual has achieved and is maintaining an undetectable viral load. Just because someone was virally suppressed in the past does not guarantee they are still virally suppressed. It is not known if viral load testing should be conducted more frequently than currently recommended for treatment to achieve maximal protection if relying on treatment and viral suppression as a prevention strategy.
- **Adherence challenges:** Taking HIV medicines as prescribed is the best way to achieve and maintain an undetectable viral load. Poor adherence, such as missing multiple doses in a month, could increase a person's viral load and their risk for transmitting HIV. People who are having trouble taking their HIV medicine as prescribed can work with health care providers to improve their adherence. If an individual is experiencing adherence challenges, other prevention strategies could provide additional protection until the individual's viral load is confirmed to be undetectable.
- **Stopping HIV medication:** If an individual stops taking their HIV medicine, their viral load can increase very quickly (e.g., within a few days) and eventually returns to around the same level it was before starting their HIV medicine. People who have stopped taking their HIV medicine should talk to their health care provider as soon as possible about their own health and consider using other strategies to prevent sexual HIV transmission.
- **Protection against other STIs:** Taking HIV medicine and achieving and maintaining an undetectable viral load does not protect you or your partner from getting other sexually transmitted infections. Other prevention strategies are needed to provide protection from STIs.

Next Steps in Communicating the Evidence

To help ensure prevention partners are aware of the effectiveness of this powerful HIV prevention strategy, CDC summarized the scientific evidence and the interim HHS-wide prevention message in a Dear Colleague Letter (https://www.cdc.gov/hiv/library/dcl/dcl/092717.html) for National Gay Men's HIV/AIDS Awareness Day (NGMHAAD) on September 27, 2017. CDC is currently updating key web pages to summarize the evolving science and message updates (https://www.cdc.gov/hiv/risk/art/index.html).

CDC is currently conducting message testing to better understand how to most effectively communicate the science on optimal use of HIV treatment and viral suppression for prevention and the real world requirements for its success. We will continue to update campaigns, websites, and other communications materials as messaging evolves and is improved based upon research findings.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

References

Bavinton B, Grinsztejh B, Phanuphak N, et al. HIV treatment prevents HIV transmission in male serodiscordant couples in Australia, Thailand and Brazil. Presented at the 9th IAS Conference on HIV Science (IAS 2017), Paris, France; July 25, 2017.

Centers for Disease Control and Prevention. Behavioral and clinical characteristics of persons receiving medical care for HIV infection—Medical Monitoring Project, United States, 2014 Cycle (June 2014–May 2015). *HIV Surveillance Special Report* 17. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published December 2016. Accessed November 1, 2017.

Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2015. *HIV Surveillance Supplemental Report 2017*;22(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published July 2017. Accessed November 1, 2017.

Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2011;365:493-505.

Cohen MS, Chen YQ, McCauley M, et al. Antiretroviral therapy for the prevention of HIV-1 transmission. N Engl J Med 2016;375:830-9.

Farnham PG, Holtgrave DR, Gopalappa C, Hutchinson AB, Sansom SL. Lifetime costs and quality-adjusted life years saved from HIV prevention in the test and treat era. J Acquir Immune Defic Syndr 2013;64(2):e15-8.

Farnham PG, Gopalappa C, Sansom SL, et al. Updates of lifetime costs of care and quality-of-life estimates for HIV-infected persons in the United States: Late versus early diagnosis and entry into care. J Acquir Immune Defic Syndr 2013;64:183-9.

Marks G, Patel U, Stirratt MJ, et al. Single viral load measurements overestimate stable viral suppression among HIV patients in care: Clinical and public health implications. J Acquir Immune Defic Syndr 2016;73:205-12.

Rodger AJ, Cambiano V, Bruun T, et al. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. JAMA 2016;316(2):171-81.

Samji H, Cescon A, Hogg RS, et al. Closing the gap: Increases in life expectancy among treated HIV-positive individuals in the United States and Canada. PLoS ONE 8(12): e81355. Doi:10.1371/journal.pone.0081355.