RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
EARLY INTERVENTION SERVICES FOR THE INCARCERATED

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if diagnosed
  - Subrecipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

Program Guidance: The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

DSHS Definition:
EIS services 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. EIS services require coordination with providers of prevention services and should be provided at specific points of entry.

Counseling, testing, and referral activities are designed to bring individuals with HIV into Outpatient/Ambulatory Health Services (OAHS). The goal of EIS is to decrease the number of underserved individuals with HIV by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found not to have HIV should be referred to appropriate prevention services.

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between client and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate

agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Limitations: Ryan White HIV/AIDS Program (RWHAP) Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate and RWHAP funds will supplement, not supplant, existing funds for testing.

Local Definition:
Early Intervention Services (EIS) are designed to bring HIV-positive individuals into Outpatient Ambulatory Medical Care through counseling, testing, and referral activities. Support of Early Intervention Services (EIS) that include identification of individuals at points of entry [in this case, the Harris County Jail (HCJ)] and access to services and provision of:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to have HIV (provided by other funding at HCJ),
- Referral services to improve HIV care and treatment services at key points of entry (HCJ care coordination),
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care (HCJ care coordination), and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis (HCJ care coordination).

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. EIS services are limited to counseling and HIV testing (provided by other funding at HCJ), referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for PLWHs to help them navigate the HIV care system (provided through the funded care coordination services). EIS services require coordination with providers of prevention services and should be provided at specific points of entry (HCJ).

Note: All four components must be present in the EIS program.

Limitations: Funds for HIV testing must be in the budget approved in writing by TRG. Funds will only be approved by TRG for HIV testing only where existing federal, state, and local funds are not adequate and funds will supplement, not supplant, existing funds for testing. Funds cannot be used to purchase at-home testing kits.

Scope of Services:
Early Intervention Services (EIS) focuses on decreasing the number of underserved people living with HIV(PLWH) by increasing access to care, educating and motivating PLWHs on the importance and benefits of getting into care, through expanding key points of entry.

EIS for the Incarcerated specifically includes the connection of incarcerated PLWH 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 PLWH, provision of education regarding disease and treatment, education and skills building to increase

PLWH'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.

Primary Goals of EIS for the Incarcerated:

1. The primary goals of early intervention in HIV are to prevent or delay disease progression.1
2. After assessing the stage of the patient, the next goal of early intervention is to minimize the risk of progression.[1]

Service Intervention Goals of EIS for the Incarcerated:

1. *DSHS Standards of Care*: To bring people living with HIV (PLWH) into Outpatient/Ambulatory Health Services (OAHS).2
2. *DSHS Standards of Care*: To decrease the number of underserved PLWH by increasing access to care, educating and motivating PLWHs on the importance and benefits of getting into care, through expanding key points of entry.2
3. *DSHS Standards of Care*: To educate and motivate PLWH on the importance and benefits of getting into care.2
4. *HRSA Program Guidance*: To help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV.3
5. *HRSA Program Guidance*: To coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.3
6. To improve referral services for HIV care and treatment services at key points of entry. 3
7. To provided Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.3

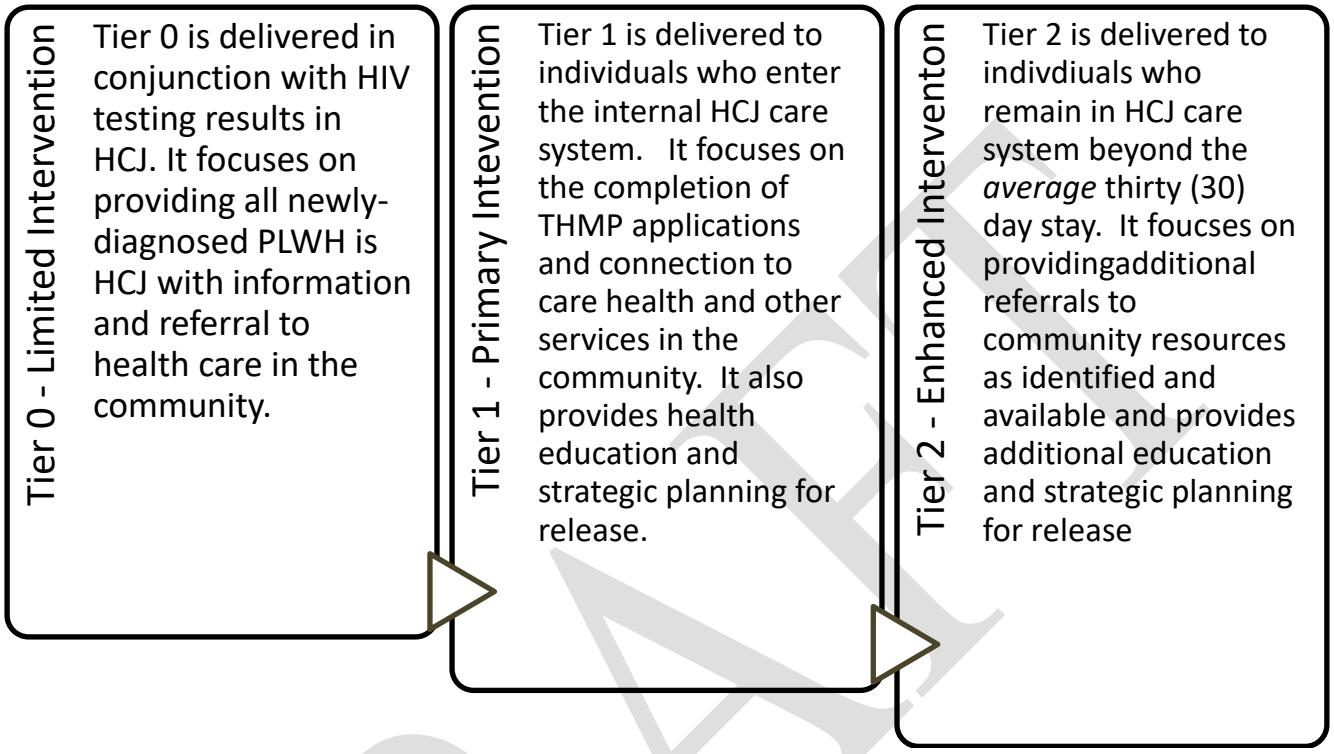
Tier-Concept for EIS for the Incarcerated:

EIS for the Incarcerated is provided at Harris County Jail. HCJ's population includes both individuals who are actively progressing through the criminal justice system (toward a determination of guilt or innocence), individuals who are serving that sentence in HCJ, and individuals who are awaiting transfer to Texas Department of Criminal Justice (TDCJ). The complexity of this population has proven a challenge in service delivery. Some individuals in HCJ have a firm release date. Others may attend and be released directly from court.

Therefore, EIS for the Incarcerated has been redesigned to consider the uncertain nature of length of stay in the service delivery. Three tiers of service provision haven been designated. They are:

- **Tier 0:** The individuals in this tier do **not** stay in HCJ long enough to receive a clinical appointment while incarcerated. The use of zero for this tier's designation reinforces the understanding that the interaction with funded staff will be minimal. The length of stay in this tier is traditionally less than 14 days.
- **Tier 1:** The individuals in this tier stay in HCJ long enough to receive a clinical appointment while incarcerated. This clinical appointment triggers the ability of staff to conduct sufficient interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days.
- **Tier 2:** The individuals in this tier remain in HCJ long enough to get additional interactions and potentially multiple clinical appointments. The length of stay in this tier is traditionally 30 or more days.

Service provision builds on the activities of the previous tier if the individual remains in HCJ. Each tier helps the staff to focus interactions to address the highest priority needs of the individual. Each interaction is conducted as if it is the only opportunity to conduct the intervention with the individual.



Guiding Principles for EIS Intervention:

1. Touch – Touch are the face-to-face opportunity for the EIS Team to implement the goals of the intervention. The term was chosen to remind the EIS Team of the intimate nature of the intervention and its goals.
2. Starting the Intervention "Where the PLWH Is At" – This phrase is often used in the provision of HIV services. It is extremely important for the EIS Team to assess those being served to ensure that EIS interventions are most effective for that PLWH. The intervention is designed with flexibility in mind. If the PLWH is receiving results from the testing team, the EIS Team may need to focus the initial touch assisting the PLWH to process their diagnosis. For PLWH returning to HCJ, the intervention may be focused on assessing follow-through with medical care and medications referrals in the "freeworld" and strategizing to improving compliance/adherence.
3. Trauma-Informed Approach - A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — in order to provide effective health care services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness.

Standard	Evidence
Program	
<u>Eligibility for Services</u> In order to be eligible for services, PLWH at any tier must meet the following:	• HIV diagnosis documented in the primary service record.

• Documentation of HIV Diagnosis • Language(s) spoken and Literacy level (self-report) *Due to PLWH's state of incarceration, this intervention is excluded from the requirement to document income and residency.*	
Tier 0 – (Less Than 14 days) – Limited Intervention	
Standard	**Evidence**
0.1 Inclusion/Exclusion Criteria: Identified PLWH released prior to initial medical appointment (i.e. visit with a provider with prescribing authority) are include in Tier 0. Note: Tier 0 individuals are excluded from the primary health outcomes for the intervention since no visit with a provider with prescribing authority occurred.	• Primary service record documents that PLWH should be included in this tier.
0.2 Benchmarks: • Notification of EIS Team by Prevention Team for "Joint" Session. • First EIS Intervention Touch. • Referral to community partners • Referral Follow-up • DIS Referral, if needed.	• Each benchmark obtained documented in primary service record.
0.3 Brief Intake: Intake conducted at first EIS "Touch" with the PLWH. Intake will include but is not limited to: CPCDMS Registration/CPCDMS Consents, identify level of knowledge of HIV, provide information about availability of health care, sign consent to refer to community resources, give Mini Blue Book. • Brief Intervention to provide targeted information on the importance of engaging in medical care and medical adherence. • New Diagnosed PLWH are prioritized in this tier if the number of PLWH to be seen exceeds the availability of staff. • PLWH returning to HCJ who have self-disclosed will have their consents verified (if still current) or updated (if expired).	• Completed brief intake documented in the primary service record via progress note.
0.4 CPCDMS Registration/Update As part of intake into service, staff will register new PLWHs into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing PLWHs.	• Current registration of PLWH documented in CPCDMS when consent can be obtained.
0.5 Education/Counseling - Newly Diagnosed (**EISED)**	• Provision of education/counseling

The EIS Team will reinforces prevention messaging/intervention received as part of HIV testing program. Additionally, the Team will target the following topics: • Living healthy with HIV • Reinforcing Living with HIV not Dying from HIV • Role of medications in healthy living, Resources available for medications and treatments based on PLWH's situation (i.e. Ryan White, third party payers, health insurance assistance, etc.)	documented in primary service record
0.6 Education/Counseling **(EISED)** When PLWH returned to HCJ, the EIS Team will target the following topics: • Living healthy with HIV • Reinforcing Living with HIV not Dying from HIV • Role of medications in healthy living, Provide education based on assessments of the PLWH's compliance with medical care and medication adherence	• Provision of education/counseling documented in primary service record
0.7 Health Literacy **(EISED)** The EIS Team will briefly assess the PLWH to determine level of health literacy so that the messaging can be tailored to "where the PLWH is at." Health literacy education will be limited during the Tier 0 intervention to increasing the potential for linkage to care.	• Provision of health literacy education/messaging documented in the primary service record.
0.8 Referrals (EISRC) The EIS Team will provide PLWH with the following: • A copy of the mini blue book that contains medical and supportive services, and • Obtain consent to refer the PLWH to a community partners for follow-up, if possible	• Signed Consents documented in primary service record when consents can be obtained. • Referral(s) documented in the primary service record.
0.9 Referral Tracking (EISFU) When consent has been obtained, the EIS Team will process and track the referral to community partners. All referrals made will have documentation of follow-up to the referral in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS Team offered to the PLWH	• At least two (2) attempts to complete referral follow-up documented in the primary service record. • Exceptions documented in the primary service record. • Referral outcome documented in primary service record when follow-up is successful.
0.10 Disengaged from Care/DIS Referral (EISRC) When no consent is obtained or referral follow-up indicates PLWH disengaged from care, EIS Team will notify their local Disease Intervention Specialist (DIS) workers so that public health follow-up can occur.	• DIS referral documented in the primary service record when: o No consent to refer was obtained o Newly diagnosed PLWH releases from HCJ prior to initial medical appointment o Referral follow-up identifies PLWH

	has disengaged from care.
0.11 Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of EIS intervention completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Closure summary documented in the primary service record. • Supervisor signature/approval on closure summary documented in the primary service record (electronic review is acceptable).
0.12 Progress Notes The EIS Team will maintain progress notes in each primary service record with thorough and accurate documentation of the assistance the EIS Team provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH documented in primary service record.
Tier 1 – (14 to 30 days) – Primary Intervention	
Standard	**Evidence**
1.1 Inclusion Criteria Identified PLWH who attend initial medical appointment (i.e. visit with a provider with prescribing authority). If EIS Team could not complete Tier 0 intervention, the remaining elements will be added to the Tier 1 intervention.	• Primary service record documents that PLWH should be included in this tier.
1.2 Benchmarks • Initial Medical Appointment • Completion of THMP Application • Second and Third EIS Touch (at a minimum) • Referral to Community Medical Care • Connection with Community Resource	• Each benchmark obtained documented in primary service record
1.3 Comprehensive Intake The EIS Team will complete an intake on PLWH who receive a medical provider visit. The intake will include: • Confirmation of identity, • Intake form, • Signed Consents, and • Comprehensive Assessment.	• Completed intake documented in the primary service record.
1.4 Comprehensive Assessment The EIS Team will complete comprehensive assessment for PLWH who receive a medical provider visit. The assessment will include: • Medication/Treatment Readiness, • History of treatment & compliance, • Healthcare assessment should include	• Completed comprehensive assessment documented in the primary services record.

location/accessibility • Insurance • Life Event Checklist (Trauma Assessment) • Disease Understanding/Health literacy, • Self-Care, • Mental health and substance use issues, • Housing/living situation, • Support system, • Desired community medical providers, • Assessment of challenges and roadblocks, • Assessment of resources (SSI, Food Stamp, etc.), • Free-world contact information, • Free-world support system, and • Other identified needs upon release	
1.5 Reassessment Criteria The EIS Team will reassess PLWH based on the following criteria: • If the PLWH returns to HCJ within three (3) months of release, EIS Team assesses PLWH for any changes. If minimal changes are identified, the results should be documented in the progress notes. If significant changes are identified, the EIS assessment form should be updated. • If the EIS Team does not find evidence of medical care in the client-level data systems, then EIS Team will complete new comprehensive assessment	• Completed reassessments per established criteria documented in the primary service record.
1.6 CPCDMS Registration/Update As part of intake into service, staff will register new PLWHs into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing PLWHs	• Current registration of PLWH documented in CPCDMS.
1.7 Internal Linkage to Care Identified PLWH will be linked to and assisted in scheduling an appointment with a medical provider in HCJ. Identified PLWH will receive medications with in HCJ. Successful linkage to outpatient/ambulatory health services is measured as attendance to the actual medical appointment with a prescribing provider while in HCJ	• Completed medical appointments with a clinical provider while in the correctional facility documented in the primary service record. • Access to medication while in the correctional facility documented in the primary service record.
1.8 Texas HIV Medication Program Application (EISAP) All PLWH in HCJ who have seen a medical provider will have a current application on file with the Texas HIV Medication Program (THMP). For newly diagnosed PLWH, the EIS Team will complete the THMP application	• THMP application upload for PLWH who have received a medical provider visit documented in ARIES/HRAR. • Screening for current THMP applications for returning PLWH

as part of the first medication appointment and have the provider complete the medical certification form. When PLWH return to HCJ, the EIS Team will verify the THMP application is still current in ARIES (using birth month and half-birth month criteria). If not, an updated THMP application/attestation will be completed	documented in primary service record. • THMP application/attestation upload for returning PLWH based on birth month and half-birth month criteria documented in ARIES.
<u>1.9 ARIES Document Upload Process</u> (EISAP) ARIES Document Upload is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • Completed ADAP Applications (with supportive documentation) must be uploaded into ARIES for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be uploaded according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be uploaded into ARIES within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed upload to ARIES. • Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction	• THMP application documents secondary review via appropriate signature documented. • THMP application documented in ARIES. • Primary service record documents receipt by THMP within (3) business days of application completion
<u>1.10 Education/Counseling – Newly Diagnosed</u> (EISED) The EIS Team will reinforces prevention messaging/intervention received as part of HIV testing program. Additionally, the Team will target the following topics: • Living healthy with HIV • Treatment As Prevention • Early Intervention as a strategy to reduce disease progression • Role of medications in healthy living • Maintenance of immune system • Disclosure to partners and support systems • Messages/interventions outlined in Standard 1.? below. • Additional messages/interventions as determined by assessment.	• Education/counseling consistent with the PLWH's identified need documented in primary service record.

Education/Counseling should be provided in manageable messages. The EIS Team should not attempt to cover all the necessary topics in one Touch. Instead, prioritization should be used to guide which messages should be delivered first. Additionally, the PLWH's lab values and readiness assessment should be used to guide the intervention.	
1.11 Education/Counseling – All (EISED) Based on the comprehensive assessment, the EIS Team will target the following topics for all PLWH served by the intervention: • Living healthy with HIV • Treatment As Prevention • Early Intervention as a strategy to reduce disease progression • Role of medications in healthy living • Maintenance of immune system • Medication Adherence • THMP Process • Provision of the Mini Blue Book • Disclosure to partners and support systems Education/Counseling should be provided in manageable messages. The EIS Team should not attempt to cover all the necessary topics in one Touch. Instead, prioritization should be used to guide which messages should be delivered first. Additionally, the PLWH's lab values and readiness assessment should be used to guide the intervention.	• Education/counseling consistent with the PLWH's identified need documented in primary service record.
1.12 Health Literacy (EISED) The EIS Team will provide the PLWH with health literacy messaging that is tailored to "where the PLWH is at" as determined by the comprehensive assessment. Examples of health literacy messaging include: • For newly diagnosed (i.e. treatment naïve), discussion about the importance of medical care, access third party payor options, and Ryan White care services. • Discussion of navigating care system • Discussion of medical home concept • Mapping out best option for community care based on future residence/work • Discussion of community support (EXCLAIM i.e. MAI	• Provision of health literacy education/messaging documented in the primary service record.

Project) • Discussion about relationships (including U=U, viral suppression, and self-care) • Discussion about Hope (decreasing stigma and misinformation about living with HIV)	
1.13 Coordination of Community Care The EIS Team will make a referral to community care based on the PLWH's selection of a medical home. This referral will include the arrange appointment for PLWH prior to release to community partners. The referral process with comply with the preferred method of scheduling appointments established with the community partner.	• Scheduling of community medical appointment documented in primary service record. • When scheduling is not possible, referral to community agency (MAI, case management, etc.) for follow-up with PLWH upon release documented in the primary service record.
1.14 Medication Regimen The EIS Team will meet with treatment "naïve" PLWH to assess readiness for the medication regimen. The Team will provide information about the readiness assessment as part of the MDT review. The EIS Team will discuss medication regimen with treatment "established" PLWH and communicate any challenges during the MDT review.	• Medication discussions documented in the primary service record.
1.15 Transitional Multidisciplinary Team The EIS Team will be part for the multidisciplinary care team (MDT) within HCJ. The Team meet and review each PLWH's information with the medical team to improve the quality of care provided while in HCJ. Additionally, the Team will act as the conduit to deliver the information from the internal MDT to community partners, as appropriate.	• MDT reviews documented in the primary service record. • Communication and/or coordination with community partners documented in primary service record.
1.16 Discharge Planning EIS Team 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 • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a strategy plan. Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. EIS Staff, MAI, MHMR, DSHS Prevention)	• Discharge planning activities documented in the primary service record.

1.17 PLWH Strategy Planning The EIS Team and the PLWH should discuss honestly the challenges with obtaining resources in the freeworld/ community and develop strategies to minimizing those challenges. The Team should focus the PLWH on strengths that they have that con contribute to successes in the freeworld/community.	• Strategies developed for obtaining services in the freeworld documented in the primary service record.
1.18 Consent to Release/Exchange Information The EIS Team will obtain signed consent to release and exchange information from the PLWH to assist in the process of making referrals to community resources	• Signed consent documented in the primary service record.
1.19 Internal Referrals Internal referrals: HIV care; substance use; mental health; referral to other clinic for comorbidities Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • Mental Health, as applicable • Substance Use Treatment, as applicable	• Connection to internal care services documented in the primary service record, as applicable
1.20 External Referrals Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help maintain PLWH in medical care in the freeworld. The Team will schedule an appointment for PLWH who will be returning to the community with a medical provider of the PLWH's choosing. For PLWH who will be transferring to TDCJ, no appointments will be scheduled. If PLWH is awaiting transfer to TDCJ, EIS Team will ensure a note is placed in primary service record and external referrals will not occur.	• Referral to community medical care documented in primary service record. • Referral to support services documented in primary service record. • Additional referrals made on behalf of the PLWH documented in primary service record. • Exceptions (when PLWH is awaiting transfer to TCDJ, etc.) documented in primary service record.
1.21 Referral Packet (EISRC) Staff makes referrals to agencies for all PLWHs to be released from Harris County Jail. The referral packet will include: a. A copy of the Harris County Jail Intake/Assessment	• Provision of a referral packet to support external referrals documented in primary service record.

Form, b. Copy of Medication Certification Form (whenever possible) or otherwise i. Proof of HIV diagnosis, ii. A list of current medications, and c. Copy of ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV services in the community.	
1.22 Referral Tracking/Follow-Up (EISFU) All referrals made will have documentation of follow-up to the referral in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS Team offered to the PLWH. Successful linkage to care is measured as attendance to the actual medical appointment with a provider with prescribing privileges.	• Referral follow-up activities conducted to ensure that the external referrals were completed, and the outcome of the referral documented in primary service record.
1.23 Disengaged from Care/ DIS Referral After three unsuccessful attempts are made to contact and re-engage the PLWH, EIS Team will notify their local Disease Intervention Specialist (DIS) workers so that public health follow-up can occur.	• Attempts to reengaged PLWH documented in the primary service record. • Referral to DIS documented in the primary service record.
1.24 Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of EIS intervention completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Closure summary documented in the primary service record. • Supervisor signature/approval on closure summary documented in the primary service record (electronic review is acceptable).
1.25 Progress Notes The EIS Team will maintain progress notes in each primary service record with thorough and accurate documentation of the assistance the EIS Team provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH documented in primary service record.
Tier 2 – (More Than 30 days) – Enhanced Intervention	
# Standard	**Evidence**
2.1 Inclusion Criteria Identified PLWH who remain in HCJ beyond 30 days (i.e. potentially seeing a provider with prescribing authority multiple times).	• Primary service record documents that PLWH should be included in this tier
2.2 Benchmarks • Additional Touches as Length of Stay Permits to	• Each benchmark obtained documented in primary service record.

reinforce Messaging • Coordination of Additional Medical Appointments • Coordination of Referrals to Community Care and Resources. • Increased provision of health literacy, treatment adherence, and other education	
2.3 Reassessment EIS Team will conduct reassessments at six (6) months and annually thereafter if individuals remain in HCJ long-term. These assessments can be conducted at the time of clinic appointments. If minimal changes are identified, the results should be documented in the progress notes. If significant changes are identified, the EIS assessment form should be updated.	• Completed reassessments per established criteria documented in the primary service record.
2.4 Continued Education/Counseling (EISED) Based on the comprehensive assessment, the EIS Team will target the following topics for all PLWH served by the intervention: • Living healthy with HIV • Treatment As Prevention • Early Intervention as a strategy to reduce disease progression • Role of medications in healthy living • Maintenance of immune system • Medication Adherence • THMP Process (revisit the need for updated application/attestation) • Provision of the Mini Blue Book • Disclosure to partners and support systems Education/Counseling should be provided in manageable messages. The EIS Team should not attempt to cover all the necessary topics in one Touch. Instead, prioritization should be used to guide which messages should be delivered first. Additionally, the PLWH's lab values and readiness assessment should be used to guide the intervention.	• Education/counseling consistent with the PLWH's identified need documented in primary service record.
2.5 Health Literacy (EISED) The EIS Team will provide the PLWH with health literacy messaging that is tailored to "where the PLWH is at" as determined by the comprehensive assessment. Examples of health literacy messaging include: • Enhanced knowledge- accessing care; navigating care system	• Provision of health literacy education/messaging documented in the primary service record.

• Discussion about the Patient/Provider relationship and the importance of developing self-efficacy for quality care • Co-morbidities and other health concerns • Continued discussion of medical home concept • Continued discussion about relationships (including U=U, viral suppression, and self-care) • Continued discussion about Hope (decreasing stigma and misinformation about living with HIV) • Discussion about navigating care system.	
2.6 Medication Regimen The EIS Team will meet with the PLWH to reinforce adherence with the established medication regimen, discuss any side effects, and help strategize for taking medications in the freeworld/community. The Team will provide challenges or issues identified with the medication regimen to the MDT	• Discussions to reinforcement of medication adherence documented in the primary service record.
2.7 Transitional Multidisciplinary Team The EIS Team will be part for the multidisciplinary care team (MDT) within HCJ. The Team meet and review each PLWH's information with the medical team to improve the quality of care provided while in HCJ. Additionally, the Team will act as the conduit to deliver the information from the internal MDT to community partners, as appropriate	• MDT reviews documented in the primary service record. • Communication and/or coordination with community partners documented in primary service record.
2.8 Discharge Planning EIS Team 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 • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a strategy plan. Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. EIS Staff, MAI, MHMR, DSHS Prevention)	• Discharge planning activities documented in the primary service record.
2.9 PLWH Strategy Planning The EIS Team and the PLWH should discuss honestly the challenges with obtaining resources in the freeworld/ community and develop strategies to minimizing those challenges. The Team should focus the PLWH on strengths that they have that con contribute to successes in	• Strategies developed for obtaining services in the freeworld documented in the primary service record.

the freeworld/community.	
2.10 Internal Referrals Internal referrals: HIV care; substance use; mental health; referral to other clinic for comorbidities Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • Mental Health, as applicable • Substance Use Treatment, as applicable	• Connection to internal care services documented in the primary service record, as applicable.
2.11 External Referrals Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help maintain PLWH in medical care in the freeworld. The Team will schedule an appointment for PLWH who will be returning to the community with a medical provider of the PLWH's choosing. For PLWH who will be transferring to TDCJ, no appointments will be scheduled. If PLWH is awaiting transfer to TDCJ, EIS Team will ensure a note is placed in primary service record and external referrals will not occur.	• Referral to community medical care documented in primary service record. • Referral to support services documented in primary service record. • Additional referrals made on behalf of the PLWH documented in primary service record. • Exceptions (when PLWH is awaiting transfer to TCDJ, etc.) documented in primary service record.
2.12 Referral Packet (EISRC) Staff makes referrals to agencies for all PLWHs to be released from Harris County Jail. The referral packet will include: a. A copy of the Harris County Jail Intake/Assessment Form, b. Copy of Medication Certification Form (whenever possible) or otherwise i. Proof of HIV diagnosis, ii. A list of current medications, and c. Copy of ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV services in the community	• Provision of a referral packet to support external referrals documented in primary service record.
2.13 Referral Tracking/Follow-Up	• Referral follow-up activities conducted

All referrals made will have documentation of follow-up to the referral in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS Team offered to the PLWH. Successful linkage to care is measured as attendance to the actual medical appointment with a provider with prescribing privileges.	to ensure that the external referrals were completed, and the outcome of the referral documented in primary service record
2.14 Disengaged from Care/DIS Referral (EISRC) After three unsuccessful attempts are made to contact and re-engage the PLWH, EIS Team will notify their local Disease Intervention Specialist (DIS) workers so that public health follow-up can occur.	• Attempts to reengaged PLWH documented in the primary service record. • Referral to DIS documented in the primary service record.
2.15 Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of EIS intervention completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Closure summary documented in the primary service record. • Supervisor signature/approval on closure summary documented in the primary service record (electronic review is acceptable).
2.16 Progress Notes The EIS Team will maintain progress notes in each primary service record with thorough and accurate documentation of the assistance the EIS Team provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH documented in primary service record.

Administrative	
Standard	**Evidence**
3.1 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	• Copy of Agency Licensure provided as part of Contract Submissions Process.
3.2 Program Policies and/or 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 PLWHs to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Standards of Care ▪ Collection of Performance Measures

• 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 Additionally, the EIS Program will have policies and procedures that comply with applicable DSHS Universal Standards.	
3.3 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.	• Assessment of staff qualifications documented in personnel file. • Training to increase staff qualifications documented in personnel file.
3.4 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.
3.5 Case Reviews Agency must have and implement a written plan for supervision of EIS Team. Supervisors must review a 10 percent sample of each team member's primary service records each ninety (90) days 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	• Case reviews by supervisor documented with signed and dated by supervisor and/or quality assurance personnel and EIS Team member
3.6 MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted	• Signed MOUs verified during annual quality compliance review.

at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting PLWHs into ongoing care.	• Communication and referrals with agencies covered in MOUs documented in primary service record.

Citations:
1. DSHS Early Intervention Services Service Standard (https://dshs.texas.gov/hivstd/taxonomy/eis.shtm)
2. Intervention In Early HIV Infection Santangelo J., Todays OR Nurse. 1992 Jul;14(7):17-21. PMID: 1636202

References:

- DSHS HIV/STD Policy #2013.02, "The Use of Testing Technology to Detect HIV Infection" Revision date September 3, 2014. Accessed on October 12, 2020 at: https://www.dshs.texas.gov/hivstd/policy/policies/2013-02.shtm
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 10-11. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. P. 10-11. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters Accessed on October 12, 2020.
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 PERFORMANCE MEASURES
EARLY INTERVENTION SERVICES
FOR THE INCARCERATED

1. Percentage of HIV positive tests in the measurement year.
2. Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year.
3. Percentage of clients offered results counseling as documented in the primary client record.
4. Percentage of clients who tested positive who were linked to outpatient/ambulatory health services in the measurement year.
5. Percentage of people living with HIV, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis.
6. Percentage of people living with HIV, who were homeless or unstably housed in the measurement period, who attended a routine HIV medical care visit within three (3) months of HIV diagnosis.
7. Percentage of clients accessing EIS services that have a care plan developed as documented in the primary client record.
8. Percentage of clients accessing EIS services that have a care plan updated and/or revised as documented in the primary client record.
9. Percentage of clients accessing EIS services that have documented progress notes showing assistance provided to the client in the primary client record.
10. Percentage of clients accessing EIS services with documented referrals in the primary client record initiated in a timely manner with client agreed participation upon identification of client needs.
11. Percentage of clients with documented referrals declined by the client in the primary client record.
12. Percentage of clients accessing EIS services that have documentation of follow-up to the referral including appointment attended and the result of the referral in the primary client record.
13. Percentage of EIS clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system.
14. Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).

Intervention-Specific Performance Measures:

1. Percentage of newly diagnosed PLWH offered EIS Touch as part of results counseling.
2. Percentage of PLWH returning to the community who were linked to outpatient/ambulatory health services in the measurement year.
3. Percentage of PLWH returning to the community who attended a routine HIV medical care visit within three (3) months of HIV diagnosis.
4. Percentage of PLWH who achieve one or more benchmarks for the applicable tier.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
HOME AND COMMUNITY-BASED HEALTH SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Home and Community-Based Health Services are provided to an eligible PLWH in an integrated setting appropriate to a PLWH's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services,
- Day treatment or other partial hospitalization services,
- Durable medical equipment,
- Home health aide services and personal care services in the home,
- Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy),
- Routine diagnostic testing, and
- Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities.

Program Guidance: Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing Home and Community-Based Health Services.

DSHS Definition:
Services: 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 licensed/certified home or community-based setting (e.g. adult daycare center) in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following:

- Para–professional care is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help PLWH remain in their homes.
- Professional care is the provision of services in the home by licensed providers for mental health, development health care, and/or rehabilitation services.

Home and Community-Based Health Providers work closely with the multidisciplinary care team that includes the case manager, primary care provider, and other appropriate health care professionals.

Local Definition:
Home and Community-based Health Services (facility-based) is defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are not included.

Scope of Services:
Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of PLWH through the provision of treatment and activities of daily living. Services will be available at least Monday through Friday for a minimum of 10 hours/day. 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.

Standard	Evidence
Program	
1.1 Doctor's Orders 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 PLWH.	• Doctor's order documented in the primary service record.
1.2 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 PLWH's condition, the PLWH requires a higher level of care than would be considered reasonable in a home/community setting. • The agency has attempted to complete an initial assessment and the referred PLWH has been away from home on three occasions. • The home or current residence is determined to not be physically safe (if not residing in a community facility) before services can be offered or continued. The agency must document the situation in writing and immediately contact the PLWH's primary medical care provider.	• Refusal of referral documented in the primary service record. • Reason for refusal meets established criteria. • Primary medical care provider notification documented.
1.3 Initial Assessment A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. PLWH will be contacted within one (1) business day of the referral, and services should be initiated at the	• Initial contact documented in the primary service record. • Initial contact attempted within established timeframe. • Completed initial assessment documented in the primary service record.

time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.	
1.4 Comprehensive Assessment A comprehensive PLWH assessment, including nursing, therapeutic, and educational is completed for each PLWH within seven (7) days of intake and every six (6) months thereafter. A measure of PLWH acuity will be incorporated into the assessment tool to track PLWH's increased functioning. A comprehensive evaluation of the PLWH's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of PLWH'saccess to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine PLWH's ability to perform activities of daily living and the level of attendant care assistance the PLWH needs to maintain living independently.	• Completed comprehensive assessment documented in the primary service record. • Comprehensive assessment completed within established timeframe. • Acuity level documented in comprehensive assessment.
1.5 Nutritional Evaluation Each PLWH shall receive a nutritional evaluation within fifteen (15) days of initiation of care. Nutritional evaluation updated as necessary.	• Nutritional evaluation documented in primary services record. • Nutritional evaluation updates documented in the primary service record. • Nutritional evaluation completed within established timeframes.
1.6 Meal Plans Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
1.7 Care Plan A written care plan is completed for each PLWH within seven (7) days of intake and updated at least every sixty (60) calendar days thereafter. Development of care plan incorporates a multidisciplinary team approach. The care plan will include: • Current assessment and needs of the PLWH, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services • Types, quantity, and length of time services are to be provided.	• Completed care plan documented in the primary service record. • Care plans updated documented in primary service record. • Care plan completed and updated within established timeframes.
1.8 Implementation of Care Plan	• Service provision consistent with the care plan documented in the primary service record.

In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the PLWH's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the PLWH and revising it as necessary based on any changes in the PLWH's situation. • Advocate for the PLWH when necessary (e.g., advocating for the PLWH with a service agency to assist the PLWH in receiving necessary services). • Monitor changes in PLWH's physical and mental health, and level of functionality. • Work closely with PLWH's other health care providers and other members of the care team in order to effectively communicate and address PLWH service-related needs, challenges, and barriers. • 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 PLWH's self-administration of medication. • Promptly report any problems or questions regarding the PLWH's adherence to medication. • Report any changes in the PLWH's condition and needs.	
<u>1.9 Provision of Service/Progress Notes</u> Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services. • Progress notes will be kept in the primary service record and must be written the day services are rendered. • Progress notes will then be entered into the PLWH record within (14) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines.	• Completed progress notes documented in the primary service record. • Ongoing communication with primary medical care provider and care coordination team documented in the primary service record.

The Home and Community-Based Provider will document in the primary service record progress notes throughout the course of the treatment, including evidence that the PLWH is not in need of acute care.	
1.10 Coordination of Services/Referrals If referrals are appropriate or deemed necessary, the agency will: • Ensure that service for PLWH will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging PLWH access to integrated health care. • Consistently report referral and coordination updates to the multidisciplinary medical care team. • Assist PLWH in making informed decisions on choices of available service providers and resources.	• Referrals to other services (as applicable) documented in the primary service record. • Referral follow-up documented in the primary service record. • Multidisciplinary team coordination documented in the primary service record.
1.11 Completion of Services/Discharge Services will end when one or more of the following takes place: • PLWH acuity indicates self-sufficiency and care plan goals completed, • PLWH expresses desire to discontinue/transfer services, • PLWH is not seen for ninety (90) days or more, • PLWH has been referred on to a higher level of care (such as assisted living or skilled nursing facility), • PLWH is unable or unwilling to adhere to agency policies, • PLWH relocates out of the service delivery area, and • When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a PLWH's home, in the company of an escort or not. The agency may discontinue services or refuse the PLWH for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances (if applicable) must be accompanied by a referral to an appropriate service provider agency.	• Discharge documented in the primary service record. • Discharge/Transfer plan developed with PLWH documented in the primary service record, if applicable.

Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the HCBHS service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Standards of Care ▪ Collection of Performance Measures
2.2 Facility 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.	• License and/or certification available at the site(s) where services are provided. • License and/or certification posted in a highly visible place at site(s) where services are provided.
2.3 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.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 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	• Assessment of staff qualifications documented in personnel file. • Exceptions documented in personnel file. • Training to increase staff qualifications documented in personnel file.

➢ the use of individualized plans of care in the provision of services and achievement of goals • Effective crisis management skills • Effective assessment skills	
2.5 Billing Requirement/Payment of Last Resort Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payer sources.	• Third-Party payer screening documented in the primary service record. • Evidence of third-party billing

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 14-16. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 13-15. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Standards of Care for HIV/AIDS Services 2009
- San Francisco EMA Home-Based Home Health Care Standards of Care February 2004
- Texas Administrative Code, Title 40, Part 1, Chapter 97, Subchapter B, Rule 97.211
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters Accessed on October 16, 2020.

RYAN WHITE PART B/DSHS STATE SERVICES
22 -23 PERFORMANCE MEASURES
HOME AND COMMUNITY-BASED HEALTH SERVICES

1. Percentage of PLWH with documented evidence of agency refusal of services with detail on refusal in the primary service record **and** if applicable, documented evidence that a referral is provided for another home or community-based health agency.
2. Percentage of PLWH with documented evidence of needs assessment completed in the primary service record.
3. Percentage of PLWH with documented evidence of a comprehensive evaluation completed by the Home and Community-Based Health Agency Provider in the primary service record.
4. Percentage of PLWH with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the primary service record.
5. Percentage of PLWH with documented evidence of care plans reviewed and/or updated as necessary based on changes in the PLWH's situation at least every sixty (60) calendar days as evidenced in the primary service record.
6. Percentage of PLWH with documented evidence of completed progress notes in the primary service record.
7. Percentage of PLWH with documented evidence of ongoing communication with the primary medical care provider and care coordination team as indicated in the primary service record.
8. Percentage of PLWH accessing Home and Community-Based Health Services with documented evidence of referrals, as applicable, to other services as indicated in the primary service record.
9. Percentage of PLWH accessing Home and Community-Based Health Services have follow up documentation to the referral offered in the primary service record.
10. Percentage of PLWH with documented evidence, as applicable, of a transfer plan developed and documented with referral to an appropriate service provider agency as indicated in the primary service record.
11. Percentage of PLWH with documented evidence of a discharge plan developed with PLWH, as applicable, as indicated in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible people living with HIV (PLWH) to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services (OAHS), and pharmacy benefits that provide a full range of HIV medications for eligible PLWH; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible PLWH; and/or
- Paying cost sharing on behalf of PLWH.

To use HRSA Ryan White HIV/AIDS Program (RWHAP) funds for health insurance premium and cost sharing assistance (not standalone dental insurance assistance), a HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- PLWH obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate Outpatient/Ambulatory Health Services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate OAHS.

To use funds for standalone dental insurance premium assistance, agencies must implement a methodology that incorporates the following requirement:

- Agencies must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to HIA only when determined to be cost effective.

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

- DSHS Policy 260.002 (Revised 11/2/2015): Health Insurance Assistance,

- DSHS HIV/STD Ryan White Part B Program Universal Standards: Health Insurance Premium and Cost Sharing Assistance,
- PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance,
- PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance,
- PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid,
- PCN 14-01 (Revised 4/3/2015): Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act, and
- PCN 16-02: Eligible Individuals & Allowable Uses of Funds and FAQ for Standalone Dental Insurance

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

The cost of insurance plans must be lower than the cost of providing health services through grant-supported direct delivery (be "cost-effective"), including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Please refer to Texas Department of State Health Services (DSHS) Policy 270.001

(Calculation of Estimated Expenditures on Covered Clinical Services) for further clarification and guidance. Additionally, an annual cost-effective analysis can be located as an attachment to the aforementioned policy.

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

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance

Local Definition:

Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible PLWH to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

Allowable Use of Funds:

1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental) that provides comprehensive primary care and pharmacy benefits for PLWH that provide a full range of HIV medications
2. Paying co-pays for medical and dental plans on behalf of PLWH including:
    a. Deductibles
    b. Medical/Pharmacy co-payments
    c. Co-insurance, and
    d. Tax reconciliation up to of 50% of the tax due up to a maximum of $500
    e. Standalone dental insurance premiums to provide comprehensive oral health care services for eligible PLWH (As of 4/1/2017)
    f. Medicare Part D true out-of-pocket (TrOOP) costs,

Restricted Use of Funds:

1. HIA excludes plans that do not cover HIV-treatment drugs; specifically, insurance plans 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 to be eligible for premium payments under HIA.
2. HIA excludes any cost associated with liability risk pools.
3. Tax reconciliation due, if the PLWH failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period.
4. HIA funds may not be used to support Out of Pocket payments for inpatient hospitalization, emergency department care or catastrophic coverage.
5. HIA funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.
6. Funds may not be used for payment of services delivered by providers out of network. Exception: When an 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.
7. HIA cannot be in the form of direct cash payments to PLWH.
8. HIA 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.
9. HIA funds may not be used to pay fines or tax obligations incurred by PLWH for not maintaining health insurance coverage required by the Affordable Care Act (ACA).
10. HIA must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage
11. HIA funds may not be used for COBRA coverage if a PLWH is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.
12. HIA funds cannot be used to cover costs associated with Social Security.
13. Life insurance and other elective policies are not covered.
14. HIA funds may not be used if a PLWH is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.

Scope of Services:
The Health Insurance Assistance (HIA) service category is intended to help PLWH 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, standalone dental insurance, 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 is 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.

Income Guidelines:
- Marketplace (ACA) Plans: 100-400% of Federal Poverty Level
- All other plans: 0-400% of Federal Poverty Level

Exception: PLWH who were enrolled (and have maintained their plans without a break in coverage), 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	
1.1 Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine eligibility for this program to ensure that these funds are used as a last resort in order for the PLWH 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.	• Comprehensive Intake/Assessment documented in the primary services record.
1.2 Cost Effectiveness Assessment The cost of insurance plans must be lower than the cost of providing health services through DSHS-funded delivery of care including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Agency must	• Cost effectiveness Assessment and results documented in the primary service record.

implement a methodology that incorporates the following requirement: 1. Health Insurance Premium: Agency must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services and only provide assistance when determined to be cost effective. 2. Standalone Dental Premium: Agency must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and only provide assistance when determined to be cost effective	
<u>1.3 Health Insurance Plan Assessment</u> The following criteria must be met for a health plan to be eligible for HIA assistance: 1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 2. Health Insurance coverage must be evaluated for cost effectiveness 3. 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. 4. COBRA plans must be evaluated based on cost effectiveness and PLWH benefit. Additional Requirements for ACA plans: 1. If a PLWH between 100%-250% FPL, only SILVER level plans are eligible for HIA payment assistance (unless PLWH enroll prior to November 1, 2015). 2. PLWH under 100% FPL, who present with an ACA plan, are NOT eligible for HIA payment assistance (unless enroll prior to November 1, 2015). 3. All PLWH who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL).	• Health Insurance Plan Assessment and results documented in the primary service record.

All PLWH receiving HIA assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change	
1.4 Payment of Last Resort PLWH accessing services are screened for potential third-party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist PLWH in enrollment.	• Third-party payment screening documented in the primary service record.
1.5 Co-payments, Premiums, Deductibles and Co-Insurance Eligible PLWH with job or employer-based insurance coverage, Qualified Health Plans (QHP), or Medicaid plans, can be assisted in offsetting any cost-sharing programs may impose. PLWH must be educated on the cost and their responsibilities to maintaining medical adherence. Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.	• Provision of cost sharing assistance documented in the primary service record • Payments completed and documented in the primary service record within the established timeframe.
1.6 Education Education must be provided to PLWH specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP can assist with to ensure healthcare coverage is maintained. Cost Sharing Education 1. Education is provided to PLWH, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. 2. PLWH who are not eligible for cost-sharing reductions (i.e. PLWH under 100% FPL or above 400% FPL; PLWH who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the PLWH's health care needs. Premium Tax Credit Education 1. Education should be provided to the PLWH regarding tax credits and the requirement to file income tax returns.	• Education, including but not limited to Cost-Sharing and Premium Tax Credit education documented in the primary service record.

2. PLWH must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline	
1.7 Prescription Eyewear Documentation from physician must be obtained stating that the eye condition is related to the PLWH's HIV infection when HIA funds are used to cover co-pays for prescription eyewear	• Physician statement documented in primary service record.
1.8 Medical Visits PLWH accessing health insurance premium and cost sharing assistance services should demonstrate adherence with their HIV medical or dental care and have documented evidence of attendance of HIV medical or dental appointments in the primary service record. Note: For PLWH who use HIA to enable their use of medical or dental care outside of the RW system: HIA providers are required to maintain documentation of PLWH's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months	• At least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits documented for PLWH with applicable data in ARIES or other data system used at the provider location. • Adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months documented for PLWH who use HIA to enable their use of medical care outside of the RWHAP system.
1.9 Viral Suppression PLWH receiving Health Insurance Premium and Cost Sharing Assistance services have evidence of viral suppression as documented in viral load testing. *NOTE: Achieving viral suppression is not required to access HIA.*	• Viral Suppression via HIV viral load test during the measurement year documented for PLWH with applicable data in ARIES or other data system used at the provider location, percentage of PLWH, regardless of age.
1.10 Referrals and Tracking Program receives referrals from a broad range of HIV service providers, community stakeholders and clinical providers. Program makes appropriate referrals out when necessary.	• Referral source documented in the primary service record. • Referrals made documented in the primary service record
1.11 Waiver Process Waivers from the AA is required for the following circumstances: 1. HIA payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers,	• Approved waiver documented in the primary service record.

3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary, 4. Discontinuing HIA payment assistance due to PLWH conduct or fraud, 5. Refusing HIA assistance for a PLWH who is eligible and whom HIA provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted, and Assisting an eligible PLWH with the entire cost of a group policy that includes coverage for persons not eligible for HIA payment assistance	
<u>1.12 Vigorous Pursuit</u> Program must vigorously pursue any excess premium tax credit received by the PLWH from the IRS upon submission of the PLWH's tax return. To meet the standard of "*vigorously pursue*", PLWH 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	• Efforts to conduct vigorous pursuit documented in the primary service record.
Administrative	
<u>2.1 Program Policies and/or Procedures</u> Program will develop and maintain policies and/or procedures that outline the delivery of HIA service including, but not limited to, the marketing of service to applicable community stakeholders, cost-effectiveness and expenditure policy, and PLWH contributions. Program must maintain policies on the assistance that can be offered for PLWH who are covered under a group policy. Program must have P&P in place detailing the required process for reconciliation and documentation requirements. Program must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual PLWH, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace. Program	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Regional Health Insurance Assistance Policy ▪ Standards of Care ▪ Collection of Performance Measures

will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards	
2.2 Regional Health Insurance Assistance Policy Program will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Program policies and/or procedures document compliance with Regional HIA Policy. • Program Review documents compliance with Regional HIA Policy.
2.3 Ongoing Staff 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 identify advance premium tax credits and liabilities	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.4 Staff Experience A minimum of (1) year documented HIV/AIDS work experience is preferred.	• Work experience documented in personnel file with exceptions to work experience noted.
2.5 Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Supervision of staff members by coordinator or manager documented.
2.6 Decreasing Barriers to Care 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 PLWH 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 PLWH to physically present to Health Insurance provider.)	• Policies and/or procedure document compliance. • Review of primary service records document compliance. • Staff interviews

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

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 PERFORMANCE MEASURES
HEALTH INSURANCE ASSISTANCE

1. Percentage of PLWH with documented evidence of health care coverage that includes at least one drug in each class of core ART from HHS treatment guidelines along with OAHS and Oral Health Care services that meet the requirements of the ACA law for essential health benefits as indicated in the primary service record.
2. Percentage of PLWH with documented evidence of education provided regarding reasonable expectations of assistance available through RWHAP Health Insurance to assist with healthcare coverage as indicated in the primary service record.
3. Percentage of PLWH with documented evidence of insurance payments made to the vendor within five (5) business days of the approved request.
4. Percentage of PLWH with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the primary service record.
5. Percentage of PLWH with documented evidence of education provided regarding premium tax credits as indicated in the primary service record.
6. Percentage of PLWH files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the PLWH's HIV as indicated in the primary service record.
7. or PLWH with applicable data in ARIES or other data system used at the provider location*, percentage of PLWH, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (HRSA HAB Measure)
8. For PLWH who use HIA to enable their use of medical care outside of the RWHAP system, percentage of PLWH with documentation of PLWH's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 month.
9. For PLWH with applicable data in ARIES or other data system used at the provider location, percentage of PLWH, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
HOSPICE SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Hospice Services are end-of-life care services provided to PLWH in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling,
- Nursing care,
- Palliative therapeutics,
- Physician services, and
- Room and board.

Program Guidance: Services may be provided 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 services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the state of Texas. Services must be provided with appropriate and valid licensure of provider as required by the State of Texas, as applicable. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under Texas Medicaid.

DSHS Definition:
Provision of end-of-life care provided by licensed hospice care providers to PLWH in the terminal stages of an HIV-related 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.

Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are:

- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics

Hospice services must have physician certification of the PLWH's terminally ill status as defined by Texas Medicaid documented in the primary service record.

Limitations: Ryan White Part B/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services. Services cannot be provided in skilled nursing facilities or nursing homes.

Local Definition:
Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH 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 PLWH or a PLWH'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.

Scope of Services:
Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH 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 PLWH or a PLWH'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 services are:
- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics

Services not allowed under this service:
- HIV medications under hospice care unless paid for by the PLWH.
- 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
- Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the PLWH's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services per legislation.

Standard	Evidence
Program	
~~Eligibility for Services~~ ~~In addition to general eligibility criteria, individuals must meet the following criteria in order to be eligible for services. The PLWH'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~~ •	
1.1 Physician Certification • The attending physician must certify that a PLWH is terminal, defined under Texas Medicaid hospice regulations as having a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification must specify that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification statement must be based on record review or consultation with the referring physician. • 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. • 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.	• Physician certification documented in the primary service record. • Reassessment documented in the primary service record.

1.2 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 PLWH based on inability to provide appropriate level of skilled nursing care	• Denial of Services documented in the primary service record. • Notification of the Administrative Agency regarding issue of denying admission for PLWH based on inability to provide appropriate level of skilled nursing care documented.
1.3 Intake Information Information will be obtained at intake (from the referral source, PLWH or other source) and will include, but is not limited to: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (PLWH 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 PLWH's rights~~	• Intake information documented in the primary service record.
1.4 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.	• Completed comprehensive health assessment document in the primary service record and dated within 48 hours of admission. • Required elements are included in the comprehensive health assessment.

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. Hospice provider documents each PLWH's scheduled medications, including dosage and frequency. • HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects. • Hospice provider documents as needed medications for PLWH and includes PLWH's name, dose, route, reason, and outcome.	
1.5 Care Plan 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 seven (7) calendar days of admission and reviewed monthly. Care Plans will be updated once every six (6) months thereafter or more frequently as clinically indicated. Hospice care should be based on the professional guidelines for supportive and palliative care. Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Completed care plan based on physician's orders documented in the primary service record within 7 calendar days of admission. • Monthly care plan reviews documented in the primary service record. • Care Plan updates documented in the primary service record at least every 6 months.

1.6 Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure. Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider	• Palliative therapy as ordered by the referring provider documented on the care plan in the primary service record. • Provision of palliative therapy documented in the primary service record.
1.7 Counseling Services for Family 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.	• Assessment and referrals documented in the primary service record.
1.8 Bereavement Counseling The need for bereavement counseling services for family members must be consistent with the definition of mental health counseling. Bereavement counseling must be 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, • Ensure that bereavement services reflect the needs of the bereaved. Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled	• Discussion of bereavement counseling with family members upon admission to Hospice services documented in the primary service record. • Bereavement care plan documented in the primary services record. • Provision of bereavement counseling documented in the primary services record.

nursing facility or nursing home, Ryan White funding cannot pay for these services in a skilled nursing facility or nursing home per legislation.	
1.9 Mental Health Counseling 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. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's ~~psychosocial~~ assessment • The patient's acceptance of these services	• Provision of mental health counseling documented in the primary service record. • Qualifications of mental health professional documented in personnel file.
1.10 Dietary Counseling 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 PLWH are met.	• Dietary counseling documented on the care plan in the primary service record. • Provision of dietary counseling documented in primary service record.
1.11 Spiritual Counseling A hospice must provide spiritual counseling that meets the PLWH'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 PLWH'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 PLWH's spiritual needs, and	• Discussion of spiritual counseling with PLWH and family members upon admission to Hospice services documented in the primary service record. • Provision of spiritual counseling documented in the primary service record. • Referral to spiritual counseling documented.

• Advise the PLWH and family of the availability of spiritual counseling services.	
1.12 Medical Social Services Medical social services must be provided by a qualified social worker. and is based on: • The PLWH's and family's needs as identified in the patient's ~~psychosocial~~ assessment • The PLWH's and family's acceptance of these services	• Medical social services documented on the care plan in the primary service record. • Provision of medical social services documented in the primary service record.
1.13 Multidisciplinary Team Approach Program 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.	• Multidisciplinary team documented in the primary service record. • Provision of multidisciplinary coordination documented in the primary service record.
1.14 Medication Administration Record Staff 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.	• Medication administration documented in the primary service record.
1.15 PRN Medication Record Staff documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, outcome, and signature and title of staff.	• PRN medication administration documented in the primary service record.
1.16 Referrals and Tracking Program receives referrals from a broad range of HIV service providers, community stakeholders and clinical providers. Program makes appropriate referrals out when necessary.	• Referral source documented in the primary service record. • Referrals made documented in the primary service record
1.17 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, based on	• Discharge documented in primary service record. • One or more discharge criteria met.

attending physician's plan of care and a referral to Medical Case Management or OAHS must be documented Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility	
Administrative	

Program Policies and/or Procedures
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
 	
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG Contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

2.1 Facility Licensure Agency 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 available at the site(s) where services are provided. • License and/or certification posted in a highly visible place at site(s) where services are provided.
2.2 Services Requiring Licensed Personnel All services requiring licensed personnel shall be provided by appropriate licensed personnel in accordance with State of Texas regulations. Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• License documented in the personnel file. • Staff interviews document compliance.
2.3 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. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of PLWH. Agency provides access to training activities, including but not limited to:	• Agency documents the dissemination of HIV information and training activities relevant to the needs of PLWH to paid staff and volunteers. • Agency documents attendance at training activities. • Materials for training activities (agendas, handouts, etc.) are on file.

• Updated HIV information, including current treatment methodologies and promising practices • In-service education • DSHS-sponsored trainings	
2.4 Ongoing Staff Training • Eight (8) hours of training in HIV 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)~~.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.5 Staff Experience A minimum of one-year documented hospice and/or HIV work experience is preferred	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 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	• Work experience for professional supervisory providers documented in personnel file. • Supervision consistent with licensure documented. • Supervision of other staff members by supervisory provider or advanced practice registered nurse documented.
2.7 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	• Policy and/or procedure documents duties and activities conducted by volunteers and oversight. • Signed job descriptions documented in volunteer file. • Service provision by volunteers are documented in the primary service record.
2.8 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. For volunteers	• Trainings and education documented in volunteer file.

who are licensed practitioners, training addresses documentation practices	

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 15-17. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services located at: https://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook/mhps- title-40-texas-administrative-code-chapter-30
- Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook. Located at http://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

RYAN WHITE PART B/DSHS STATE SERVICES
PERFORMANCE MEASURES
HOSPICE SERVICES

1. Percentage of PLWH receiving Hospice services with attending physician certification of PLWH's terminal illness documented in the primary service record.
2. Percentage of PLWH receiving Hospice care with documentation in the primary record of all physician orders for initiation of care.
3. Percentage of PLWH in Hospice care with a documented comprehensive health assessment completed within 48 hours of admission in the primary service record.
4. Percentage of PLWH in Hospice care with documentation of all scheduled and as needed medications, including dosage and frequency, noted in the primary service record.
5. Percentage of PLWH in Hospice care with a written care plan based on physician's orders completed within seven calendar days of admission documented in the primary service record.
6. Percentage of PLWH in Hospice care with documented evidence of monthly care plan reviews completed in the primary service record.
7. Percentage of PLWH in Hospice care with a written care plan that documents palliative therapy as ordered by the referring provider documented in the primary service record.
8. Percentage of PLWH accessing Hospice care with documented evidence of bereavement counseling offered to family members upon admission to Hospice services in the primary service record.
9. Percentage of PLWH in Hospice care with documented evidence of dietary counseling provided, when identified in the written care plan, in the primary service record.
10. Percentage of PLWH in Hospice care that are offered spiritual counseling, as appropriate, documented in the written care plan in the primary service record.
11. Percentage of PLWH in Hospice care with documented evidence of mental health counseling offered, as medically indicated, in the primary service record.
12. Percentage of PLWH with documented evidence in the primary record of all refusals of attending physician referrals by hospice providers with evidence indicating an allowable reason for the refusal.
13. Percentage of PLWH in Hospice care with documented evidence of discharge status in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC INTERPRETIVE SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Linguistic Interpretive Services include interpretation and translation activities, both oral and, written, to eligible people living with HIV (PLWH). These activities must be provided by a qualified linguistic services provider as a component of HIV service delivery between the healthcare provider and the PLWH. These services are to be provided when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of HRSA Ryan White HIV/AIDS Program (RWHAP) eligible services.

Program Guidance: Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Linguistic services include sign language linguistics

DSHS Definition:
Linguistic services are provided as a component of HIV service delivery to facilitate communication between the PLWH and provider, as well as support service delivery in both group and individual settings. These standards ensure that language is not a barrier to any PLWH seeking HIV-related medical care and support, and that linguistic services are provided in a culturally appropriate manner.

Services are intended to be inclusive of all individuals and not limited to any population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations living with HIV receive quality, unbiased services.

Limitations: Linguistic services, including interpretation (oral) and translation (written) services, must be provided by a qualified linguistic provider.

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Local Definition:
Support for Linguistic Interpretive Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the PLWH, when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of Ryan White-eligible services. Types of service include, but are not limited to, sign language for deaf and/or hard of hearing PLWH and native language interpretation for monolingual PLWH.

Scope of Services:
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 PLWH. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.

Limitation: Eligible languages exclude Spanish as it is an expectation that all funded providers have the internal capacity to communicate with PLWH in English and Spanish.

Subcontractor Exclusion:
Due to the nature of service delivery, the staff training outlined in the Houston General Standards is not required for interpreters at subcontracted linguistic service agencies.

Standard	Evidence
Program	
1.1 Provision of Services Service referral will document assessment of need for linguistic services for interpretation and/or translation needs to communicate with the healthcare provider and/or receive appropriate services. Program shall provide translation and/or interpretation services for the date of scheduled appointment per request submitted and will document the type of linguistic service provided in the primary service record. Linguistic services may be provided in person or via telephonic or other electronic means (see telehealth/telemedicine information above). Program will offer services to the PLWH only in connection with other HRSA approved services (such as clinic visits).	• Referral for service documents need of linguistic services for interpretation and/or translation • Provision of linguistic services for interpretation and/or translation documented in primary service record.

Program will deliver services to the PLWH 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 PLWH. Based on need, agency shall provide the following types of linguistic services in the PLWH's preferred language: • Oral interpretation • Written translation • Sign language	
1.2 Timeliness of Scheduling Program will schedule service within one (1) business day of the request.	• Request date documented. • Scheduling of service documented.
Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders, the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Agency should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the PLWH seeking assistance Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG contract and Attachments • Standards of Care • Collection of Performance Measures
2.2 Staff Qualifications and Training To ensure highest quality of communication: • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of	• Program Policies and Procedures will ensure the contracted agency complies with Legislation and Regulations: • (Americans with Disabilities Act (ADA), Section 504 of the

Certification for Medical Interpreters (NBCMI). Where CCHI and NBCMI certification for a specific language do not exist, an equivalent certification (MasterWord, etc.) may be substituted for the CCHI and NBCMI certification. • 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), the National Interpreter Certification (NIC), or the State of Texas 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.	Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act • Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency scheduling documents appropriate levels of interpreters are requested.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 37-38. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 37-38. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP). Located at: http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- National Culturally and Linguistically Appropriate Services (CLAS) Standards: https://thinkculturalhealth.hhs.gov/clas/standards

RYAN WHITE PART B/DSHS STATE SERVICES
22 -23 PERFORMANCE MEASURES
LINGUISTIC INTERPRETIVE SERVICES

1. Percentage of PLWH with documented evidence of need of linguistic services as indicated in the service assessment.
2. Percentage of primary service records with documented evidence of interpretive/translation services provided for the date of service requested.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Mental Health (MH) Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to people living with HIV (PLWH). Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized with the state to render such services. Such professionals typically include psychiatrists, advanced practice nurses, psychologists, licensed professional counselors, and licensed clinical social workers.

Limitations: Mental Health Services are allowable only for PLWH who are eligible for HRSA Ryan White HIV/AIDS Program (RWHAP) services.

DSHS Definition:
Mental health counseling services include outpatient mental health therapy and counseling provided solely by mental health practitioners licensed in the State of Texas.

Mental health services include:
- Mental health assessment
- Treatment planning
- Treatment provision
- Individual psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription, and monitoring
- Psychotropic medication management
- Drop-in psychotherapy groups
- Emergency/crisis intervention

All mental health interventions must be based on proven clinical methods and in accordance with legal, licensing, and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on federal, state, and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI).

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies,

telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance

Local 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. Mental Health Services include:

- Individual Therapy/counseling is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible PLWH.
- Family/Couples Therapy/Counseling is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible PLWH.
- Support Groups are defined as professionally led (licensed therapists or counselor) groups that comprise PLWH, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for PLWH.

Scope of Services:
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 professional's judgment) bereavement support is available for affected family members or significant others.

Therapy/counseling and/or bereavement counseling may be conducted in the PLWH's home.

Program	
1.1 Orientation Orientation is provided to PLWH who access services 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 include written or verbal information on the following: • Services available	• Orientation documented in the primary service record • Annual PLWH feedback documents compliance.

• Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • PLWH responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	
1.2 Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless PLWH 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. The assessment must document DSM-IV diagnosis or diagnoses, utilizing at least Axis I. The initial and comprehensive PLWH assessment (or agency's equivalent) forms must be signed and dated. Updates to the information included in the initial assessment will be recorded in the comprehensive PLWH assessment.	• Documentation of mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the primary service record • If pressing mental health needs emerge during the mental health assessment requiring immediate attention results in the assessment not being finalized by the third session, the exception must be documented in the primary services record.
1.3 Treatment Plan Treatment plans are developed jointly with the counselor and PLWH and must contain all the elements for mental health including: • Description of the diagnosed mental health issue • Statement of the goal(s) and objectives of counseling • 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	• Treatment plan that meets the established criteria documented in the primary service record. • Treatment plans signed by the licensed mental health professional rendering services documented in the primary service record. • Exceptions noted in the primary service record.

• Any recommendations for follow up • Mechanism for review Treatment plans must be completed within 30 days from the Mental Health Assessment. Supportive and educational counseling should include prevention of HIV related risk behaviors including risk reduction and health promotion, substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a PLWH's life, disability, death and dying and exploration of future goals as clinically indicated. The treatment plan must be signed by the mental health professional rendering service. Electronic signatures are acceptable. Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated.	
1.4 Treatment Plan Review Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated. The plan must reflect ongoing reassessment of PLWH's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures	• Evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality documented in the primary service record. • Exceptions noted in the primary service record.
1.5 Psychiatric Referral PLWH are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the primary service record.	• Referrals for psychiatric intervention documented in the primary service record.
1.6 Psychotropic Medication Management Psychotropic medication management services are available for all PLWH either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the PLWH's concerns with the PLWH about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the PLWH to discuss concerns about prescribed medications	• Education regarding medications documented in the primary service record. • Changes to psychotropic/ psychoactive medications documented in the primary service record. • Changes to medications shared with the HIV-prescribing provider, as permitted by the PLWH's signed

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*	consent to share information, in the primary service record.
1.7 Provision of Service/Progress Notes Services will be provided according to the individual's treatment plan and documented in the primary service record. Progress notes are completed according to the agency's standardized format, completed for each counseling session, and must include: • PLWH 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	• Service provision in accordance with the individual's treatment plan documented in the primary service record. • Signed progress notes documented in primary service record.
1.8 Coordination of Care Care will be coordinated across the mental health care coordination team members. The PLWH is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the PLWH, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for PLWH 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.	• Coordination of care with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
1.9 Referrals As needed, mental health providers will refer PLWH to full range of medical/mental health services including: • Psychiatric evaluation	• Referrals made documented in the primary service record.

• Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the PLWH's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the PLWH to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s)	
1.10 Discharge Services may be discontinued when the PLWH 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 Discharge planning will be done with each PLWH when treatment goals are met or when PLWH has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable.	• Discharge reason meeting the established criteria documented in primary service record. • Exceptions documented in the primary service record.
1.11 Discharge Summary Discharge summary is completed for each PLWH after 30 days without PLWH 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	•
Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments

applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards. The agency must develop and implement Policies and Procedures that include but are not limited to the following: • PLWH 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, timeline for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active PLWH at least once every 6 months.	• Standards of Care • Collection of Performance Measures
<u>2.2 Crisis Situations and Behavioral Emergencies</u> Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • 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 PLWH during the orientation process.	• Agency Policy and/or procedure meets established criteria. • Staff Training on the policy is documented. • Crisis situations and behavioral emergencies documented in primary service record.

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 PLWH to another organization that can provide the requested services.	
2.3 Services Requiring Licensed Personnel 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 PLWH.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 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.	• Clinical supervision qualifications documented in personnel file.
2.5 Family Counseling Experience Professional counselors must have two years' experience in family counseling if providing services to families.	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 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.	• Completion of orientation documented in personnel file. • Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.

2.7 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.	• Assessment documented in personnel file. • Training per assessment documented in personnel file.
2.8 Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Professional Liability Insurance documented. • Annual Reviews documents compliance.
2.9 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.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.

References

- American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS, Washington, DC, 2001. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids.pdf
- American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids-watch.pdf
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- New York State Department of Health, Mental Health Standards of Care, Delivery of Care. Available at: https://www.health.ny.gov/diseases/aids/providers/standards/mental_health/delivery_of_care.htm

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 PERFORMANCE MEASURES
MENTAL HEALTH SERVICES

1. Percentage of new PLWH with documented evidence of orientation to services available in the primary service record.
2. Percentage of PLWH with documented mental health assessment completed by the third counseling session, unless otherwise noted, in the primary service record.
3. Percentage of PLWH with documented detailed treatment plan and documentation of services provided within the primary service record.
4. Percentage of PLWH with treatment plans completed and signed by the licensed mental health professional rendering services in the primary service record.
5. Percentage of PLWH 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 primary service record.
6. Percentage of PLWH with documented need for psychiatric intervention are referred to services as evidenced in the primary service record.
7. Percentage of PLWH accessing medication management services with documented evidence in the primary service record of education regarding medications.
8. Percentage of PLWH with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
9. Percentage of PLWH with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the primary service record.
10. Percentage of PLWH who have documented evidence in the primary service record of care coordination, as permissible, of shared mental health treatment adherence with the PLWH's prescribing provider.
11. Percentage of PLWH with documented referrals, as applicable, for other medical/mental health services in the primary service record.
12. Percentage of PLWH with documentation of discharge planning when treatment goals being met as evidenced in the primary service record.
13. Percentage of PLWH with documentation of case closure per agency non-attendance policy as evidenced in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING
SUBSTANCE USE DISORDERS

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Non-Medical Case Management Services (NMCM) is the provision of a range of person-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible people living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. health insurance Marketplace plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

DSHS Definition:
Non-Medical Case Management is a service based on need and is not appropriate or necessary for every PLWH accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). Non-Medical Case Management should not be used as the only access point for medical care and other agency services. People living with HIV (PLWH) who do not need guidance and assistance in improving/gaining access to needed services should not be enrolled in NMCM services. When PLWH can maintain their care, PLWH should be graduated. PLWH with ongoing existing needs due to impaired cognitive functioning, legal issues, or other documented concerns meet the criteria for NMCM services.

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

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

Key activities include:
- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Individualized advocacy and/or review of utilization of services

- Continuous monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six (6) months with adaptations as necessary
- Ongoing assessment of the PLWH's and other key family members' needs and personal support systems

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

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

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

Scope of Service
The purpose of Non-Medical Case Management (N-MCM) Services targeting Substance Use Disorders (SUD) is to assist people living with HIV (PLWH) who are also facing the challenges of substance use disorder to procure needed services so that the problems associated with living with HIV and/or SUD are mitigated.

N-MCM targeting SUD is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is community based (i.e. both office-based and field based). N-MCMs are expected to coordinate activities with referral sources where newly diagnosed PLWH or PLWH who have disengaged from care may be identified, including

substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes activities to re-engage PLWH who have disengaged from care. PLWHs who have disengaged from care are those who have not returned for scheduled appointments with a medical and/or the NMCM provider. NMCM must document efforts to re-engage PLWH who have disengaged from care prior to closing PLWH on their caseload. There are many reasons why PLWH disengage from care. NMCM should partner with the PLWH to determine how to address those reasons as part of re-engagement. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are facing the challenges of SUD.

Key activities include:

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

Non-Medical Case Management is a service based on need and is not appropriate or necessary for every PLWH accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). Non-Medical Case Management **should not** be used as the only access point for medical care and other agency services. PLWH who do not need guidance and assistance in improving/gaining access to needed services **should not** be enrolled in NMCM services. When PLWH can maintain their care, they should be graduated. PLWH with ongoing existing needs due to impaired cognitive functioning, legal issues, or other documented concerns meet the criteria for NMCM services.

Case Management services provided via telehealth platforms are eligible for reimbursement.

Limitations:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes. Non-Medical Case Management services **do not** involve coordination and follow up of medical treatments.

Direct Medical Costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.

Standard	Evidence
Program	
1.1 Eligibility for Services N-MCM targeting SUD is intended to serve eligible PLWH who are also facing the challenges of substance use disorder	• Additional eligibility criteria documented in primary service record.

1.2 Initial Assessment The Initial Assessment is required for PLWHs who are enrolled in Non-Medical Case Management (N-MCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer- standing access and/or barriers to medical and/or psychosocial needs. The thirty (30) day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: b) PLWH's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner Services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (CPS/APS referral as indicated) • Family Violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, SSDI applications) • Linguistic Services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education c) Additional information • PLWH strengths and resources • Other agencies that serve PLWH and household • Brief narrative summary of assessment session(s) Reassessments should be conduct at least annually for PLWH remaining in case management services.	• Completed Initial Assessment is documented in the primary service record. • Assessment completed within thirty (30) days of the initiation of case management services. • Any special circumstances for not completing the Initial Assessment with thirty (30) day timeframe are noted in the primary service record. • Annual Reassessments are documented in the primary service record.
1.3 Care Planning The PLWH and the N-MCM will actively work together to develop and implement the care plan. Care plans include at a minimum: • Problem Statement (Need)	• Completed initial Care Plan documented in the primary service record. • Updated Care Plans documented in the primary service record.

• Goal(s) – suggest no more than three goals
• Intervention
  o Task(s)
  o Assistance in accessing services (types of assistance)
  o Service Deliveries
• Individuals responsible for the activity (N-MCM, PLWH, other team member, family)
• Anticipated time for each task
• PLWH acknowledgment
 	
The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every six (6) months. Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed – not at set intervals.	

<u>1.4 Transtheoretical Model of Change</u> N-MCMs shall use the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change) to promote improved health outcomes and achievement of care plan goals.	• Stage of Change documented in the primary service record. • Incorporation of Stage of Change incorporated into the Care Plans in the primary service record.
<u>1.5 Referrals and Tracking</u> N-MCM will work with the PLWH to determine barriers to accessing services and will assist in accessing needed services. N-MCM will ensure that PLWH are accessing needed services and will identify and resolve any barriers PLWH may have in following through with their Care Plan. When PLWHs are assisted with referral for services, the referral should be documented and tracked. Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: OAHS, MCM, Medical transportation, Mental Health, Substance Use Treatment, and any additional services necessary to help PLWH engage in their medical care. All referrals made will have documentation of follow-up in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the N-MCM offered to the PLWH.	• Referrals to service are documented in the primary service record. • Referral follow-up and outcome documented in the primary service record.
<u>1.6 Increase Health Literacy</u>	• Health Literacy assessment documented in the primary service record.

N-MCM assesses PLWH ability to navigate medical care systems and provides education to increase PLWH ability to advocate for themselves in medical care systems.	• Health Literacy education documented in the primary service record • Knowledge, Attitudes, and Practice (KAP) evaluation documented in the primary service record.
1.7 Overdose Prevention & SUD Reduction N-MCMs should provide activities, strategies and education that enhance the motivation of PLWH to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors.	• Provision of overdose prevention and SUD reduction education and activities documented in primary service record.
1.8 Substance Use Treatment N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations.	• Treatment or other recovery support services discussion and education documented in primary service record. • Referrals to treatment or other recovery support services documented in the primary service record. • Referral follow-up documented in the primary service record.
1.9 Harm- and Risk-Reduction N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction.	• Harm- and Risk-Reduction evaluation, methods and activities documented in the primary service record.
1.10 Case Closure/Graduation PLWH who are no longer actively accessing case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • PLWH is referred to another case management	•

program • PLWH relocates outside of service area • PLWH chooses to terminate services • PLWH is no longer eligible for services due to not meeting eligibility requirements • PLWH is no longer actively accessing service • PLWH incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • PLWH death Graduation criteria: • PLWH completed case management goals for increased access to services/care needs • PLWH is no longer in need of case management services (e.g. PLWH is capable of resolving needs independent of case management assistance) NMCM should attempt to contact PLWH who disengaged from service at least three (3) times via phone, e-mail and/or written correspondence. If these attempts are unsuccessful, the PLWH has been given at least thirty (30) days from initial contact to respond. Case closure can be initiated thirty (30) days following the 3rd attempt. All attempts to re-engage the PLWH should be documented in the primary service record. Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a PLWH, as appropriate. Agencies must ensure that they have signed releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI) NMCM should complete a case closure summary/progress note to provide a brief overview of the activities conducted with the PLWH and the reason why the case is being close.	
1.11 Community-Based Service Provision N-MCM targeting SUD is a community-based service (i.e. both office-based and field based). Agency policies should support the provision of service outside of the office and/or medical clinic. Agencies should have systems in place to ensure the security of staff and the protections of PLWH information.	• Agency policies and/or procedures allow and support community-based service provision • Community-based service provision documented in primary service record.

Administrative	
1.1 Program Policies and Procedures Agency will have a policy that: • Defines and describes N-MCM targeting SUD services (funded through Ryan White or other sources) that complies with the standards of care outlined in this document. • Specifies that services shall be provided in the office and in the field (i.e. community based). • Specifies required referral to and coordination with HIV medical services providers. • Requires referral to and coordination with providers of substance use treatment/counseling, as appropriate. • Requires monitoring of referrals into services	• Program's Policies and Procedures address systems to comply with ▪ Scope of Services ▪ TRG Contract and Attachments ▪ Performance Measures ▪ Standards of Care
1.2 Agency Licensure The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of substance use treatment/counseling	• Copy of Agency Licensure and/or Certification provided as part of Contract Submissions Process
1.3 Staff Qualifications Non-Medical Case Managers must have at a minimum a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented work experience in providing services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Agency will provide Non-Medical Case Manager a written job description upon hiring.	• Degree documented in personnel file. • Work experience documented in personnel file. • Signed job description documented in personnel file.
1.4 Staff Training Staff must complete the following trainings: • Within thirty (30) days of hire, complete HHS-mandated Cybersecurity training and DSHS Data Security and Confidentiality training (or approved equivalent) • Within sixty (60) days of hire, complete TRG Standards of Care orientation. • Within six (6) months of hire, complete the DSHS HIV Care Coordination Training Curriculum (https://www.dshs.texas.gov/hivstd/contractor/cm.shtm) • After first year, a minimum of 12 hours of continuing education in relevant topics annually.	• Certificates of completion and/or attendance documented in the staff personnel file. • Any special circumstances for not meeting the timeframes are noted in the staff personnel file.

1.5 Supervision A minimum of four (4) hours of supervision per month must be provided to each N-MCM by a master's level health professional. At least one (1) hour of supervision must be individual supervision. Supervision activities includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments	• Supervision activities documented and provided for review during the Quality Compliance Review
1.6 Caseload Coverage – N-MCMs Supervisor ensures that there is coverage of the caseload in the absence of the N-MCM or when the position is vacant. N-MCM may assist PLWHs who are routinely seen by other CM team members in the absence of the PLWH's "assigned" case manager.	• • Assignment of case coverage documented in supervisory records. • Activities conducted by staff providing case coverage documented in primary service record.
1.7 Case Reviews – N-MCMs Supervisor reviews a random sample equal to 10% of unduplicated PLWHs served by each N-MCM at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Case reviews documented in primary service record, signed and dated by supervisor and/or quality assurance personnel and N-MCM

References:

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. P. 25-26. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. P. 24-26. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 PERFORMANCE MEASURES
NON-MEDICAL CASE MANAGEMENT TARGETING
SUBSTANCE USE DISORDERS

1. Percentage of PLWHs who access N-MCM services that have a completed assessment within 30 calendar days of the first appointment to access N-MCM services and includes all required documentation.
2. Percentage of PLWHs that received at least one face-to-face meeting with the N-MCM staff that conducted the initial assessment.
3. Percentage of PLWHs who have documented Initial Assessment in the primary service record.
4. Percentage of non-medical case management PLWHs, regardless of age, with a diagnosis of HIV who had a non-medical case management care plan developed and/or updated two or more times in the measurement year.
5. Percentage of primary service records with documented follow up for issues presented in the care plan.
6. Percentage of Care Plans documented in the primary service record.
7. Percentage of N-MCM PLWHs with documented types of assistance provided that was initiated upon identification of PLWH needs and with the agreement of the PLWH. Assistance denied by the PLWH should also be documented in the primary service record system
8. Percentage of N-MCM PLWHs with assistance provided have documentation of follow up to the type of assistance provided.
9. Percentage of N-MCM PLWHs assessed for health literacy.
10. Percentage of PLWH with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary).
11. Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).
12. Percentage of PLWH notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the PLWH from case management services.
13. Percentage of PLWH with written documentation explaining the reason(s) for discharge and the process to be followed if PLWH elects to appeal the discharge from service.
14. Percentage of PLWH with information about reestablishment shared with the PLWH and documented in primary service record system.
15. Percentage of PLWH provided with contact information and process for reestablishment as documented in primary service record system.
16. Percentage of PLWH with documented Case Closure/Graduation in the primary service record system

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
ORAL HEALTH CARE

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Oral Health Care (OH) activities include outpatient diagnostics, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

DSHS Definition:
Services will include routine dental examinations, prophylaxes, radiographs, restorative therapies, basic oral surgery (e.g., extractions and biopsy), endodontics, and prosthodontics. Referral for specialized care should be completed if clinically indicated.

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 PLWH's annual benefit balance.

Oral health services are an allowable core service with an expenditure cap of $3,000/PLWH per calendar year. Local service regions may set additional limitations on the type or number of procedures covered and/or may set a lower expenditure cap, so long as such criteria are applied equitably across the region and the limitations do not restrict eligible individuals from receiving needed oral health services outlined in their individualized dental treatment plan.

In the cases of emergency need and/or where extensive care is needed, the maximum amount may exceed the above cap. Dental providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval from the local Administrative Agency (AA) for the purposes of funds only, but not the appropriateness of the clinical procedure.

Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.

Local Definition:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Scope of Services:
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), endodontics and oral medication (including pain control) for HIV PLWH 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 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 PLWH's annual benefit balance. If a provider cannot provide adequate services for emergency care, the PLWH should be referred to a hospital emergency room.

Limitations:
Cosmetic dentistry for cosmetic purposes only is prohibited.

Tele-dentistry allowable per H.B. 2056 as of September 1, 2021 and subject to applicable rules and guidance from the Board (see References).

Standard	Evidence
Program	
1.1 Dental and Medical History To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the PLWH's health and medication status. Provider obtains and documents HIV primary care provider contact information for each PLWH. Provider obtains from the primary care provider or obtains from the 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 • PLWH's chief complaint, where applicable • Current Medications (including any osteoporotic medications) • Pregnancy status, where applicable • 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	• Dental and medical health history per established criteria documented in primary service record. • Health history update per established timeframe documented in primary service record.

• 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. An update to the health history should be completed as medically indicated or at least annually.	
1.2 Limited Physical Exam 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 PLWH 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 PLWH. 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 PLWH's vital signs, the dental practitioner must document in the primary service record an acceptable reason why the attempt to obtain vital signs was unsuccessful.	• Limited physical examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.3 Oral Examination PLWH 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 PLWH • D0120-Periodic Oral Evaluation to include bitewing x-rays, established PLWH, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established PLWH; not post-operative visit) • Comprehensive Periodontal Evaluation, new or established PLWH. Source: http://ada.org	• Oral examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.4 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. PLWH must have a periodontal screening once per year. A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants.	• Agency policies and/or procedures document when a comprehensive periodontal examination should occur. • Comprehensive periodontal examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.

Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the PLWH'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. (Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. PLWH may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with PLWH).	
<u>1.5 Treatment Plan</u> A dental treatment plan should be developed appropriate for the PLWH's health status, financial status, and individual preference should be chosen. A comprehensive, multi-disciplinary treatment plan will be developed and updated in conjunction with the PLWH. PLWH'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 PLWH. 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. • Invasive Procedure Risk Assessment (prior to oral surgery, extraction, or other invasive procedure) • Dental treatment plan will be signed by the oral care health professional providing the services. (*Electronic signatures are acceptable*) Dental treatment plan will be updated annually.	• Treatment plan per established criteria documented in primary service record. • Updated dental treatment plan per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.

1.6 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 The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	• Phase 1 treatment plan per stablished criteria documented in the primary service record. • Phase 1 treatment plan per established timeframe documented in the primary service record. • Completion of Phase 1 treatment plan per established timeframe documented in the primary service record. • Updated Phase 1 treatment plan per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.
1.7 ~~Annual~~ Hard/Soft Tissue Examination The following elements are part of each PLWH's annual hard/soft tissue examination and are documented in the primary service record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of PLWH 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 PLWH may not exceed two (2) years.	• Hard/soft tissue examination per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.
1.8 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 oral health education once each year which includes but is not limited to the following: • D1330 Oral hygiene instructions • Daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the PLWH. If deemed appropriate, the reason is stated in the primary service record • D1320 Smoking/tobacco cessation counseling as indicated	• Oral health education per established criteria documented in the primary service record. • Oral health education per established timeframe documented in the primary services record. • Exceptions documented in the primary service record.

• Additional areas for instruction may include Nutrition (D1310). • For pediatric PLWH, oral health education should be provided to parents and caregivers and be age appropriate for pediatric PLWH. The content of the oral health education will be documented in the primary service record.	
1.9 Referrals and Tracking Referrals for other services must be documented in the primary service record. Outcome of the referral will be documented in the primary service record.	• Referrals made documented in the primary service record. • Outcome of referrals documented in primary service record.
1.10 Coordination of Care The provider will consult with PLWH's medical care providers when indicated. Consultations will be documented in the primary service record.	• Consultations documented in the primary service record.
1.12 Annual Cap of Charges Maximum amount that may be funded by Ryan White/State Services per PLWH 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.	• Approved waiver for charges exceeding annual cap documented in the primary service record.
Administrative	

1.1 Program Policies and/or Procedures
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
 	
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG Contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

1.2 Services Requiring Licensed Personnel 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.	• License documented in the personnel file. • Staff interviews document compliance.

1.3 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)~~	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
1.4 Staff Experience 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.	• Work experience documented in personnel file with exceptions to work experience noted.
1.5 Supervisor Qualifications Supervision of clinical staff shall be provided by a practitioner with at least two years' experience in dental health assessment and treatment of persons living with HIV.	• Clinical supervision qualifications documented in personnel file.
1.6 Staff Supervision All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
1.7 Confidentiality Each dental employee will sign a confidentiality statement.	• Signed Confidentiality Statement documented in personnel file.
1.8 Universal Precautions All health care workers should adhere to protective practices as defined by Texas Administrative Code, Title 22, Part 5, Chapter 108, Subchapter B, Rule §108.25, and OSHA Standards for Bloodborne Pathogens (29 CFR 1910.1030), and OSHA Personal Protective Equipment (29 CFR 1910 Sub Part 1.	•

References

- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April 2011, page 9-10. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, page 9-10. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Subchapter A, Rule §108.7 Minimal Standards of Care, General located at https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Administrative Code. Title 22, Part 5, State Board of Dental Examiners, Chapter 108, Subchapter A, Rule §108.8, Records of the Dentist located at: https://texreg.sos.state.tx.us/public/readtac$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=8
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at https://statutes.capitol.texas.gov/Docs/HS/htm/HS.85.htm

- HRSA/HAB Clinical Care & Quality Management. HAB Oral Health Performance Measures located at https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio Accessed January 11, 2018.
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- New York State Department of Health AIDS Institute, Management of Periodontal Disease located at: https://www.hivguidelines.org/hiv-care/hiv-related-periodontal-disease/ Accessed October 14, 2020
- New York State Department of Health AIDS Institute, Oral Health Complications located at: https://www.hivguidelines.org/hiv-care/oral-health/. Accessed October 14, 2020
- HB2056: https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB2056

RYAN WHITE PART B/DSHS STATE SERVICES
PERFORMANCE MEASURES
ORAL HEALTH CARE

1. Percentage of PLWH with documented evidence that oral health care services provided met the specific limitations or caps as set forth for dollar amount and any additional limitations as set regionally for type of procedure, limits on number of procedures or combination of these.
2. Percentage of PLWH with documented evidence if the cost of dental care exceeded the annual maximum amount for Ryan White/State Services funding, reason is documented in the primary service record.
3. Percentage of PLWH who had a dental and medical health history (initial or updated) at least once in the measurement year.
4. Percentage of PLWH with a documented limited physical examination completed in the primary service record.
5. Percentage of PLWH with a documented oral examination completed within the measurement year in the primary service record.
6. Percentage of PLWH who had a periodontal screen or examination as least once in the measurement year.
7. Percentage of oral health PLWH who had a dental treatment plan developed and/or updated at least once in the measurement year.
8. Percentage of PLWH with a Phase 1 treatment plan that is completed within 12 months.
9. Percentage of PLWH who received oral health education at least once in the measurement year.
10. Percentage of PLWH with documented referrals provided have outcomes and/or follow-up documentation in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
REFERRAL FOR HEALTH CARE
ADAP ENROLLMENT WORKERS

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Referral for Health Care and Support Services directs a PLWH to needed core medicalor support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist people living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category. Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management servicecategory (i.e., Medical Case Management or Non-Medical Case Management).

DSHS Definition: (If Applicable)
Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible PLWH to obtain access to other public and private programs for which they may be eligible.

Benefits counseling: Services should facilitate a PLWH's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting PLWH in identifying all available health and disability benefits supported by funding streams other RWHAP Part B and/or State Services funds. PLWH should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs.

Health care services: PLWH should be provided assistance in accessing health insurance or Marketplace health insurance plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting PLWH's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Local Definition:
AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include:

- Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed.
- Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible.

AIDS Drug Assistance Program (ADAP) Enrollment Workers will be co-located at Ryan-White Part A funded primary care providers to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).

Scope of Services:
Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible PLWH to obtain access to other public and private programs for which they may be eligible.

AEW Benefits Counseling: Services should facilitate a PLWH's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting PLWH in identifying all available health and disability benefits supported by funding streams other than RWHAP Part B and/or State Services funds. PLWH should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs.

Health Care Services*:* PLWH should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting PLWH's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.

Standard	Evidence
Program	
1.1 Provision of Service Staff will educate PLWH about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources. ADAP Enrollment Workers (AEW) will meet with new potential and established ADAP enrollees to: 1. Explain ADAP program benefits and requirements 2. Assist PLWH and or staff with the submission of complete, accurate ADAP applications 3. Ensure there is no lapse in ADAP eligibility and loss of benefits, and 4. AEW will maintain relationships through the Ryan White ADAP Network (RWAN)	• Provision of service per established criteria documented in the primary service record.
1.2 Initial Provision of Education The initial education to PLWH regarding the THMP process should include, but not limited to: • Discussion of confidentiality, specific to the THMP process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the PLWH. • Applicants should realize that their physician and pharmacist would also be aware of their diagnosis. • Discussion outlining that approved medication assistance through THMP may require a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee. • Discussion outlining the recertification process, specific to THMP eligibility, including birth month recertification, half-birth month attestation and consequences of lapse.	• Initial education per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.3 Benefits Counseling Activities should be individualized to the PLWH and facilitate access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure PLWH are receiving all needed public	• Benefits counseling documented in the primary service record. • Completed applications as appropriate and per established timeframe documented in the primary service record.

and/or private benefits and/or resources for which they are eligible. Staff will explore the following as possible options for PLWH, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/ Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (SSI, SSDI, SDI) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible PLWH with completion of benefits application(s) as appropriate within fourteen (14) business days of the eligibility determination date. Conduct a follow-up within ninety (90) days of completed application to determine if additional and/or ongoing needs are present.	• Follow-up per established timeframe and result(s) of application documented in the primary service record. • Exceptions documented in the primary service record.
<u>1.4 Healthcare Services</u> PLWH should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. • Eligible PLWH will be referred to Health Insurance Premium and Cost-Sharing Assistance (HIA) to assist PLWH in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible PLWH should be referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the PLWH's needs, with education provided to the PLWH on how to access these services. • Eligible PLWH are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the PLWH's needs, with education provided to the PLWH on how to access these services.	• Assistance accessing healthcare documented in the primary service record. • Referral education on how to access the service documented in the primary service record. • Follow-up for referrals per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.

Staff will follow-up within (10) business days of an applicable referral provided to HIA, any core or support service to ensure the PLWH accessed the service(s).	
1.5 THMP Intake Process Staff are expected to meet with new/potential PLWH to complete a comprehensive THMP intake including explanation of program benefits and requirements. The intake will also include the determination of PLWH eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI). Staff should identify and screen PLWH for third party payer and potential abuse Staff should obtain, maintain, and submit the required documentation for PLWH application including residency, income, and the THMP Medical Certification Form (MCF).	• THMP education to new/potential PLWH documented in the primary service record. • Completed THMP application and supporting documentation (including proof of residency, income and MCF) documented in the primary service record.
1.6 Benefits Continuation Process (ADAP) ADAP Enrollment Workers are expected to meet with new/potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist PLWH and or staff with the submission of complete, accurate ADAP applications. Birth Month/Recertification • Staff should conduct annual recertifications for enrolled PLWH in accordance with THMP policies. Recertification should include completion of the ADAP application, obtaining and verifying all eligibility documentation and timely submission to THMP for approval. • Recertification process should include screening PLWH for third party payer to avoid potential abuse. • Complete ADAP application includes proof of residency, proof of income, and the THMP Medical Certification Form (MCF). • Staff must ensure Birth Month/Recertifications are submitted by the last day of PLWH's birth month to ensure no lapse in program benefits. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's recertification deadline to ensure all	• Attempts to contact PLWH for attestations and recertifications per established timeframe documented in the primary service record. • Completed attestations and recertifications documented in the primary service record. • Lapse benefits due to non-completion of timely recertification/attestation documented in the primary service record. • Exceptions documented in the primary service record.

necessary documentation is collected and accurate to complete the recertification process on or before the deadline. Half-Birth Month/6-month Self Attestation • Staff should conduct a 6-month half-birth month/self-attestation for all enrolled PLWH in accordance with THMP policies. Staff will obtain and submit the PLWH's self-attestation with any applicable updated eligibility documentation. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's attestation deadline to ensure all necessary documentation is collected and accurate to complete the attestation on or before the deadline. Half-birth/6-month self-attestations must be submitted by the last day of the PLWH's half-birth month to ensure no lapse in program benefits	
<u>1.7 ARIES Document Upload Process</u> ARIES Document Upload is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • Completed ADAP Applications (with supportive documentation) must be uploaded into ARIES for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be uploaded according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be uploaded into ARIES within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed upload to ARIES. • Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction. ~~Houston Only: Medication Certification forms for changes to medication should be faxed to THMP for approval.~~	• Uploaded THMP application per established timeframe documented in ARIES. • Notification of THMP upload per established timeframe documented in primary service record.

1.8 Tracking of THMP Application Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible	• Tracking of application status documented. • Follow-up for missing or other information documented in primary service record.
1.9 Case Closure Summary PLWH who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the primary service record. The case closure summary must include a brief synapsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.' A supervisor must sign the case closure summary. Electronic signatures are acceptable.	• Case closure summary per established criteria documented in primary service record.
Administrative	
2.1 Program Policies and/or Procedures Program will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the AEW service. Program will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards.	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Standards of Care ▪ Collection of Performance Measures
2.2 Staff Education Education can be defined locally, but must at minimum require a high school degree or equivalency	• Staff education documented in the personnel file.
2.3 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 with Persons Living With HIV/AIDS or other chronic health conditions	• Assessment of staff qualifications documented in personnel file. • Exceptions documented in personnel file. • Training to increase staff qualifications documented in personnel file.

• Ability to (demonstrate) or learn health care insurance literacy, (Third Party Insurance and Affordable Care Act (ACA) Marketplace plans). • Ability to perform intake/eligibility, referral/ linkage and/or basic assessments of PLWH needs preferred. ➢ Data Entry • Quickly establish rapport in respectable manner consistent with the health literacy, preferred language, and culture of prospective PLWH	
2.4 Staff Training AEWS must complete the following: • THMP Training Modules within 30 days of hire • Complete the DSHS ADAP Enrollment Worker (AEW) Regional update at earliest published date after hire • DSHS ARIES Document Upload Training (to include TRG upload observation module), completed no later than (45) days after completing ARIES certificate process • Data Security and Confidentiality Training • Complete all training required of Agency new hires, including any training required by DSHS HIV Care	• Completion of training requirements documented in personnel file. • Materials for training and continuing education (agendas, handouts, etc.) are on file.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 43-44. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
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- DSHS Policy 591.000, Section 5.3 regarding Transitional Social Service linkage.
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 PERFORMANCE MEASURES
REFERRAL FOR HEALTH CARE
ADAP ENROLLMENT WORKERS

1. Percentage of PLWH with documented evidence of education provided on other public and/or private benefit programs in the primary service record.
2. Percentage of PLWH with documented evidence of other public and/or private benefit applications completed as appropriate within 14 business days of the eligibility determination date in the primary service record.
3. Percentage of eligible PLWH with documented evidence of the follow-up and result(s) to a completed benefit application in the primary service record.
4. Percentage of PLWH with documented evidence of assistance provided to access health insurance or Marketplace plans in the primary service record.
5. Percentage of PLWH who received a referral for other core services who have documented evidence of the education provided to the PLWH on how to access these services in the primary service record.
6. Percentage of PLWH who received a referral for other support services who have documented evidence of the education provided to the PLWH on how to access these services in the primary service record.
7. Percentage of PLWH with documented evidence of referrals provided for HIA assistance that had follow-up documentation within 10 business days of the referral in the primary service record.
8. Percentage of PLWH with documented evidence of referrals provided to any core services that had follow-up documentation within 10 business days of the referral in the primary service record.
9. Percentage of PLWH with documented evidence of referrals provided to any support services that had follow-up documentation within 10 business days of the referral in the primary service record.
10. Percentage of PLWH who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary service record.