FY 2022 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 7/26/2022)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 5. Emergency Financial Assistance/Pharmacy: $0.00 6. Outreach: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older

	iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See current fiscal year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Subrecipients may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston Ryan White Planning Council (RWPC) guidelines for Local Pharmacy Assistance Program (LPAP) services: Subrecipient shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Subrecipient shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services

	must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **EFA-Pharmacy Assistance:** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s: **RWGA Only**	**Outpatient/Ambulatory Medical Care:** One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. **Outpatient Psychiatric Services:** 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. **Nutritional Assessment and Plan:** 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary

	supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. **AIDS Pharmaceutical Assistance (local):** A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. **Medical Case Management:** 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. **Service Linkage (non-Medical Case Management):** 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. **Outreach:** 1 unit of service = 15 minutes of direct client service providing outreach services by an Outreach Worker for eligible HIV-infected clients, including other allowable activities (includes staff trainings, meetings, and assessments at determined by Ryan White Grant Administration).
HRSA Service Category Definition: **RWGA Only**	**Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

	AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options,

	Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Subrecipients must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Subrecipient must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Subrecipient must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV disease; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Subrecipient must demonstrate on an ongoing basis the ability

to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Subrecipient provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible.

- On-site Outpatient Psychiatry services.
- On-site Medical Case Management services.
- On-site Medication Education.
- Physical therapy services (either on-site or via referral).
- Specialty Clinic Referrals (either on-site or via referral).
- On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral.
- On site Nutritional Counseling by a Licensed Dietitian.

Services for women must also provide:

- Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications.
- Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA),

Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.

- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24-hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Subrecipient must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Local Pharmaceutical Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only

	those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Subrecipient must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Subrecipient must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. **Emergency Financial Assistance – Pharmacy Assistance:** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those HIV medications on the Houston EMA Ryan White Part A Formulary. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan.

	Service Linkage: The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Subrecipient must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWH who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and

	strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Subrecipient must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA Services:** Subrecipient must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for

	accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Subrecipient must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV service providers are informed of this program and how the client referral and enrollment processes functions and must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWH, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Subrecipient and receive ongoing supervision that meets or exceeds published Standards of Care. A MCM may supervise SLWs.

Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWH. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers

	who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWH. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Subrecipient must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HIA) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HIA provider for assistance. Under no circumstances may the Subrecipient bill the County for the difference between the reimbursement from Medicaid, Medicare or Third-Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Subrecipient based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to

	the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphtx.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Subrecipient must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Subrecipient and appropriate point of entry entities and are subject to audit by RWGA. Subrecipient and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new

	referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Subrecipient must comply with CPCDMS business rules and procedures. Subrecipient must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Subrecipient must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Subrecipient is client's CPCDMS record-owning agency. Subrecipient must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Subrecipient with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Subrecipient may only issue METRO bus pass vouchers to clients wherein the Subrecipient is the CPCDMS record owning Subrecipient. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situations wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Subrecipient must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Subrecipient may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Subrecipient has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Subrecipients must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Subrecipients without prior approval by RWGA.

FY 2024 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/2023**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2023**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

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Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWH residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See current fiscal year (FY) Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions:	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public*

RWGA Only	*Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State

	licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWH performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWH performed by a qualified service linkage worker. • Outreach: 1 unit of service = 15 minutes of direct client service providing outreach services by an Outreach Worker for eligible clients, including other allowable activities (includes staff trainings, meetings, and assessments at determined by Ryan White Grant Administration).
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are

	not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

	• **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV.**

Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV disease; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for

	the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Women's Services must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed

	Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit

control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Local Medication Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee.

Medical Case Management Services: Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical

	service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Emergency Financial Assistance – Pharmacy Assistance:** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those HIV medications on the Houston EMA Ryan White Part A Formulary. Does not include

	drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWH who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA.

	Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWH, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific

	Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided

	by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWH. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWH. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.

Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.HCPH.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as

	long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue

	METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2024 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/2023**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2023**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2023 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural** (Revision Date: 7/26/2022)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance (Pharmacy Assistance)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 5. Emergency Financial Assistance: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Subrecipients may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Subrecipient shall offer HIV

	medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Subrecipient shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **EFA-Pharmacy Assistance:** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s:	**Outpatient/Ambulatory Medical Care:** One (1) unit of service = One (1) primary care office/clinic visit or telehealth which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit.

	Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit or telehealth wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. **Nutritional Assessment and Plan:** 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. **AIDS Pharmaceutical Assistance (local):** A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. **Medical Case Management:** 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. **Service Linkage (non-Medical Case Management):** 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	**Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV

	infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication.

	Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Standards of Care:	Subrecipients must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Subrecipient must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Subrecipient must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Subrecipient must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care

	medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Subrecipient provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must

	be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Subrecipient must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of

	Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Subrecipient must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Subrecipient must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. **Emergency Financial Assistance – Pharmacy Assistance:** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those HIV medications on the Houston EMA Ryan White Part A Formulary. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which

	information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Subrecipient must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Subrecipient must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA Services:** Subrecipient must:

	Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Subrecipient must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Subrecipient must maintain documentation of such marketing efforts.

	Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Subrecipient and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Subrecipient is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Subrecipient must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board-Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be available upon request. Documentation of the Allied Health professional licensures and certifications must be included in the personnel file.

	Medication and Adherence Education: The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Subrecipient must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Subrecipient must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/31/22, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Subrecipient must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Subrecipient must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/31/22, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Subrecipient and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care

	for Service Linkage and Medical Case Management as applicable. A MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Subrecipient must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Subrecipient bill the County for the difference between the reimbursement from Medicaid, Medicare or Third-Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Subrecipient based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes:

	www.hcphtx.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Subrecipient must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Subrecipient and appropriate point of entry entities and are subject to audit by RWGA. Subrecipient and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Subrecipient must comply with CPCDMS business rules and procedures. Subrecipient must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Subrecipient must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Subrecipient is client's CPCDMS record-owning agency. Subrecipient must utilize an

	electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Subrecipient with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Subrecipient may only issue METRO bus pass vouchers to clients wherein the Subrecipient is the CPCDMS record owning Subrecipient. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Subrecipient must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Subrecipient may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Subrecipient has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Subrecipients must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Subrecipients without prior approval by RWGA.

FY 2024 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/2023**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2023**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2020 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

Highlights from FY 2020 Performance Measures

Measures in this report are based on the *2021-2022 Houston Ryan White Quality Management Plan*, *Appendix B. HIV Performance Measures*. The document can be referenced here: https://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Medical Case Management

- During FY 2020, 5,416 clients utilized Part A medical case management. According to CPCDMS, 2,704 (50%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these clients, 21% of clients accessed mental health services at least once during this time period after utilizing medical case management.
- For clients who have lab data in CPCDMS, 68% were virally suppressed.

Outreach

- During FY 2020, 247 (34%) clients accessed primary care within three months of their first outreach visit.
- 45% to 61% of FY 2019 clients moved from an unsuppressed to suppressed viral load status within six to twelve months after their first outreach visit.

Primary Medical Care

- During FY 2020, 8,609 clients utilized Part A primary medical care. According to CPCDMS, 6,355 (80%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 17% had a CD4 < 200 within the first 90 days of initial enrollment in primary medical care.
- Among these clients, 70% had a viral load test performed at least every six months during this time period. Among clients with viral load tests, 79% were virally suppressed during this time period, while 84% of retained-in-care clients were virally suppressed.
- 66% of new clients were engaged in care during this time period.
- During FY 2020, the average wait time for an initial appointment availability to enroll in primary medical care was 9 days, while the average wait time for an appointment availability to receive primary medical care was 6 days.

Service Linkage (Non-Medical Case Management)

- During FY 2020, 8,331 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 4,048 (49%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, 50% of clients utilized primary medical care for the first time after accessing service linkage for the first time.
- The median number of days between the first service linkage visit and the first primary medical care visit was 9 days during this time period.

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2019	FY 2020	Change
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	3,537 (79.1%)	3,705 (77.8%)	**-1.3%**

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Medical Case Management
All Providers

For FY 2020 (3/1/2020 to 2/28/2021), 5,416 clients utilized Part A medical case management.

HIV Performance Measures	**FY 2019**	**FY 2020**	**Change**
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,644 (49.9%)	2,704 (49.9%)	**0.0%**
15% of medical case management clients will utilize mental health services	680 (12.8%)	1,117 (20.6%)	**7.8%**
45% of clients who have third-party payer coverage (e.g. Medicare, Medicaid, private insurance) after accessing medical case management	1,580 (29.8%)	1,459 (26.9%)	**-2.9%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	1,996 (72.7%)	1,856 (68.4%)	**-4.3%**
50% of clients will have at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	801 (35.1%)		
Less than 20% of clients will have more than a six month gap in medical care in the measurement year	605 (23.4%)	628 (22.5%)	**-0.9%**
Less than 5% of clients will be homeless or unstably housed	760 (14.3%)	680 (12.6%)	**-1.7%**

According to CPCDMS, 118 (2.2%) clients utilized primary care for the first time and 302 (5.6%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	**FY 2019**
60% of medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	2%

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Outreach Services
All Providers

HIV Performance Measures	FY 2019	FY 2020	Change
Percentage of clients who attended a primary care visit within three months of the first Outreach visit	214 (34.2%)	247 (33.6%)	**-0.6%**
Percentage of clients who attended a primary are visit within three months of the first Outreach visit and a subsequent visit 6 to 12 months thereafter	131 (61.2%)	*N/A	**N/A**
Percentage of clients who went from an unsuppressed VL (>=200 copies/ml) to a suppressed viral load (<200 copies/ml) within 12 months of the first Outreach visit	182 (44.6%)	*N/A	**N/A**

*Please note that due to the time parameters for this measure, data can only be produced for the previous fiscal year.

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Primary Medical Care
All Providers

For FY 2020 (3/1/2020 to 2/28/2021), 8,609 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2019	FY 2020	Change
90% of clients will have two or more medical encounters, at least 90 days apart, in an HIV care setting in the measurement year	6,440 (82.4%)	6,355 (80.4%)	**-2.0%**
Less than 20% of clients will have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care	273 (17.7%)	227 (17.1%)	**-0.6%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since HIV diagnosis	6,050 (70.2%)	5,577 (64.7%)	**-5.5%**
30% of clients will receive an oral exam by a dentist at least once during the measurement year	2,179 (25.3%)	1,879 (21.8%)	**-3.5%**
85% of clients will have a test for syphilis performed within the measurement year	7,127 (82.7%)	7,439 (86.3%)	**3.6%**
95% of clients will be screened for Hepatitis B virus infection status at least once since HIV diagnosis	7,337 (85.1%)	7,282 (84.5%)	**-0.6%**
90% of clients will have a viral load test performed at least every six months during the measurement year	4,647 (86.3%)	3,660 (69.5%)	**-16.8%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	6,742 (78.2%)	6,804 (78.9%)	**0.7%**
90% of retained-in-care clients will be virally suppressed (<200)	5,126 (83.2%)	5,045 (83.5%)	**0.3%**
35% of clients will have at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,788 (25.4%)		
Less than 10% of clients will have more than a six month gap in medical care in the measurement year	1,855 (27.7%)	1,810 (27.5%)	**-0.2%**
90% of newly enrolled clients in the first six months of the measurement year will have at least one medical visit in the second six months of the measurement year	383 (68.5%)	277 (66.3%)	**-2.2%**

100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	**Data below**
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	**Data below**

For FY 2020, 67% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care:
EMA = 9 Days (some are multi-site providers)

Agency 1: 16
Agency 2: 5
Agency 3: 12
Agency 4: 6
Agency 5: 18
Agency 6: 7

For FY 2020, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care:
EMA = 6 Days (some are multi-site providers)

Agency 1: 6
Agency 2: 3
Agency 3: 10
Agency 4: 3
Agency 5: 10
Agency 6: 5

Clinical Chart Review Measures*	FY 2018	FY 2019
100% of eligible clients will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	93.9%	89.5%
100% of pregnant women living with HIV will be prescribed antiretroviral therapy	100%	100%
75% of female clients will have received cervical cancer screening in the past three years	81.6%	82.3%
55% of clients will complete the vaccination series for Hepatitis B	49.3%	51.8%
85% of clients will receive HIV risk counseling within the measurement year	83.9%	81.9%
95% of clients will be screened for substance abuse (alcohol and drugs) in the measurement year	99.4%	99.5%
90% of clients who were prescribed antiretroviral therapy will have a fasting lipid panel during the measurement year	89.9%	88.4%
65% of clients at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	78.9%	79.7%
75% of clients will have documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since HIV diagnosis	71.0%	74.7%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	62.9%	68.2%
95% of clients will be screened for clinical depression using a standardized tool with follow-up plan documented	98.1%	95.1%
90% of clients will have ever received pneumococcal vaccine	83.1%	85.5%
100% of clients will be screened for tobacco use at least one during the two-year measurement period	98.7%	99.8%
Percentage of clients who received cessation counseling intervention if identified as a tobacco user	67.8%	68.0%
95% of clients will be prescribed antiretroviral therapy during the measurement year	99.4%	98.7%
85% of clients will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	75.0%	71.4%
75% of eligible reproductive-age women will receive reproductive health care (fertility desires assessed and client counseled on conception or contraception)	53.7%	56.1%
90% of clients will be screened for Intimate Partner Violence	93.2%	90.9%
100% of clients on ART will be screened for adherence	100%	100%

* To view the full FY 2019 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Service Linkage / Non-Medical Case Management
All Providers

For FY 2020 (3/1/2020 to 2/28/2021), 8,331 clients utilized Part A non-medical case management.

HIV Performance Measures	**FY 2019**	**FY 2020**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	4,174 (47.9%)	4,048 (48.6%)	**0.7%**
60% of clients will access RW primary medical care for the first time after accessing service linkage for the first time	462 (49.1%)	344 (49.5%)	**0.4%**
Mean of less than 30 days between first ever service linkage visit and first ever primary medical care visit:			
Mean	31	33	**6.5%**
Median	14	9	**-35.7%**
Mode	1	1	**0.0%**
60% of newly enrolled clients will have a medical visit in each of the four-month periods of the measurement year	128 (45.2%)	68 (33.8%)	**-11.4%**

Primary Care Chart Review Report FY 2020

Ryan White Part A Quality Management Program – Houston EMA

December 2021

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2020, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to six organizations. Approximately 13,000 unduplicated individuals living with HIV receive Ryan White-funded services at these organizations.

Harris County Public Health (HCPH) must ensure the quality and cost effectiveness of primary medical care. The medical services chart review is performed to ensure that the medical care provided adheres to current evidence-based guidelines and standards of care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

Introduction

On March 30, 2021, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to people living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/20 and 2/28/21. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

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

Chart Review Process

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

If documentation on a particular element was not found, a "no data" response was entered into the database. For some data elements, the reviewer looked for documentation that the requisite test/assessment/vaccination was performed, e.g., lipid screening or pneumococcal vaccination. Other data elements required that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was a colposcopy performed? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to evaluate quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider?

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

Tale 1. Data Collection Parameters

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

Tale 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	Viral Load Assays are recommended every 3-6 months. Clients on ART should have a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually for clients at risk
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Screening is recommended at least once since HIV diagnosis, either PPD, IGRA or chest X-ray.
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the previous three years
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV Risk Counseling	Clients are screened for behaviors associated with HIV transmission and risk reduction discussed
Pneumocystis jirovecii Pneumonia (PCP) Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis

The Sample Selection Process

The sample population was selected from a pool of 8,096 clients (adults age 18+) who accessed Part A primary care (excluding vision care) and had at least two visits, at least 90 days apart, between 3/1/20 and 2/28/21. The medical charts of 635 clients were used in this review, representing 7.8% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 42.2% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes for each site. The demographic

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/20-2/28/21

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	328	51.7%	6,050	74.7%
Female	268	42.2%	1,860	23%
Transgender Male to Female	39	6.1%	184	2.3%
Transgender Female to Male	0	0%	2	.01%
TOTAL	**635**		**8,096**	
Race				
Asian	8	1.3%	102	1.3%
African-Amer.	303	47.7%	3.926	48.5%
Pacific Islander	0	0%	8	.1%
Multi-Race	4	.6%	66	.8%
Native Amer.	2	.3%	25	.3%
White	318	50.1%	3,969	49%
TOTAL	**635**		**8,096**	
Hispanic				
Non-Hispanic	380	59.8%	4,973	61.4%
Hispanic	255	40.2%	3,123	38.6%
TOTAL	**635**		**8,096**	
Age				
<=24	14	2.2%	381	4.7%
25-34	157	24.7%	2,353	29.1%
35-44	190	29.9%	2,311	28.5%
45-49	69	10.9%	971	12%
50-64	198	31.2%	1,947	24%
65 and older	7	1.1%	133	1.6%
Total	**635**		**8,096**	

Report Structure

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

[1] http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Findings

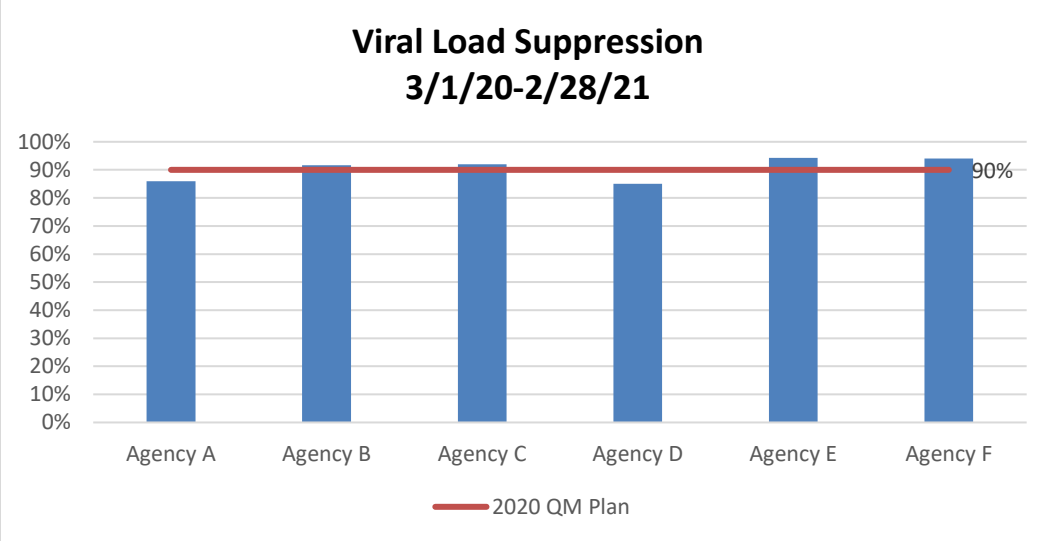
Core Performance Measures

Viral Load Suppression

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

	2018	2019	2020
Number of clients with viral load below limits of quantification at last test during the measurement year	553	559	571
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	630	625	634
Rate	**87.8%**	**89.4%**	**90.1%**
	2.3%	**1.6%**	**.7%**

2020 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	259	235	65
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	294	254	74
Rate	**88.1%**	**92.5%**	**87.8%**

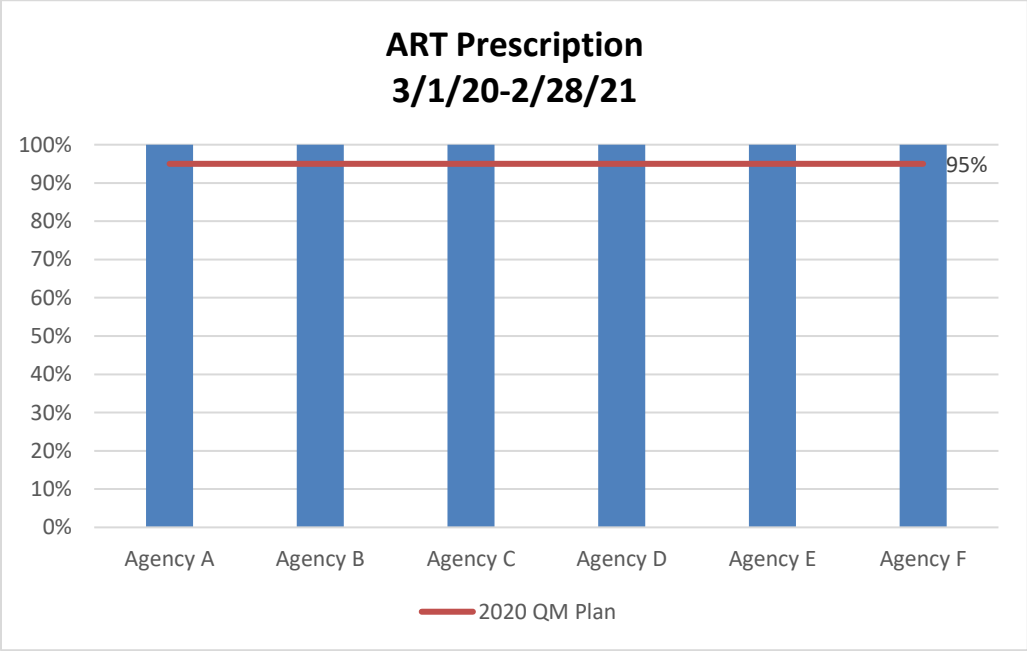


ART Prescription

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

	2018	2019	2020
Number of clients who were prescribed an ART regimen within the measurement year	631	627	635
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**99.4%**	**98.7%**	**100%**
Change from Previous Years Results	**.7%**	**-.7%**	**2.3%**

2020 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	294	255	74
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	294	255	74
Rate	**100%**	**100%**	**100%**

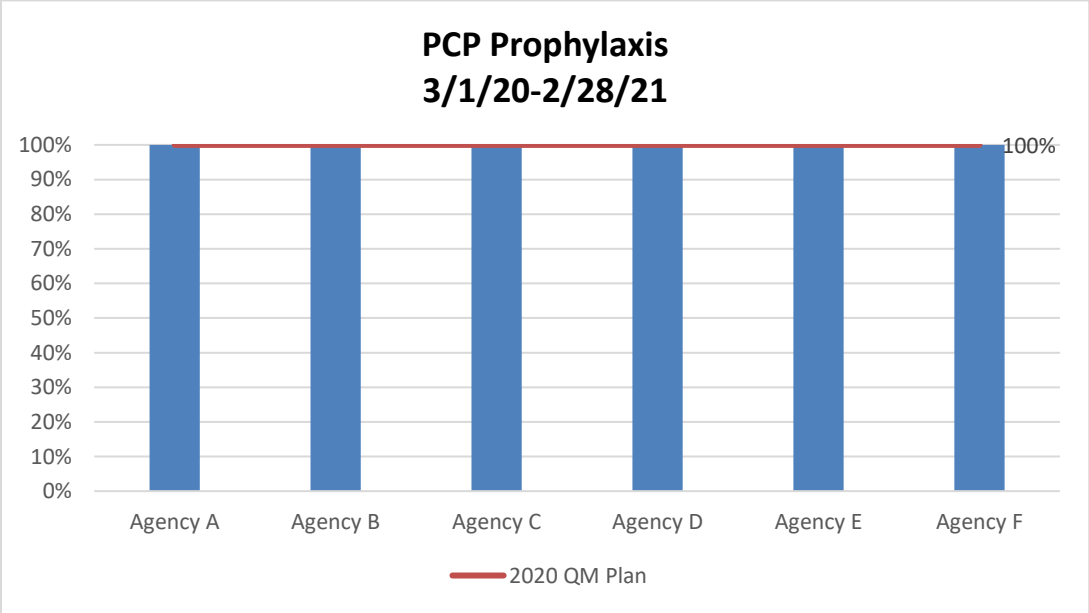


PCP Prophylaxis

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

	2018	2019	2020
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	62	34	41
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	66	38	41
Rate	**93.9%**	**89.5%**	**100%**
Change from Previous Years Results	**.9%**	**-4.4%**	**10.5%**

2020 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	16	22	3
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	16	22	3
Rate	**100%**	**100%**	**100%**



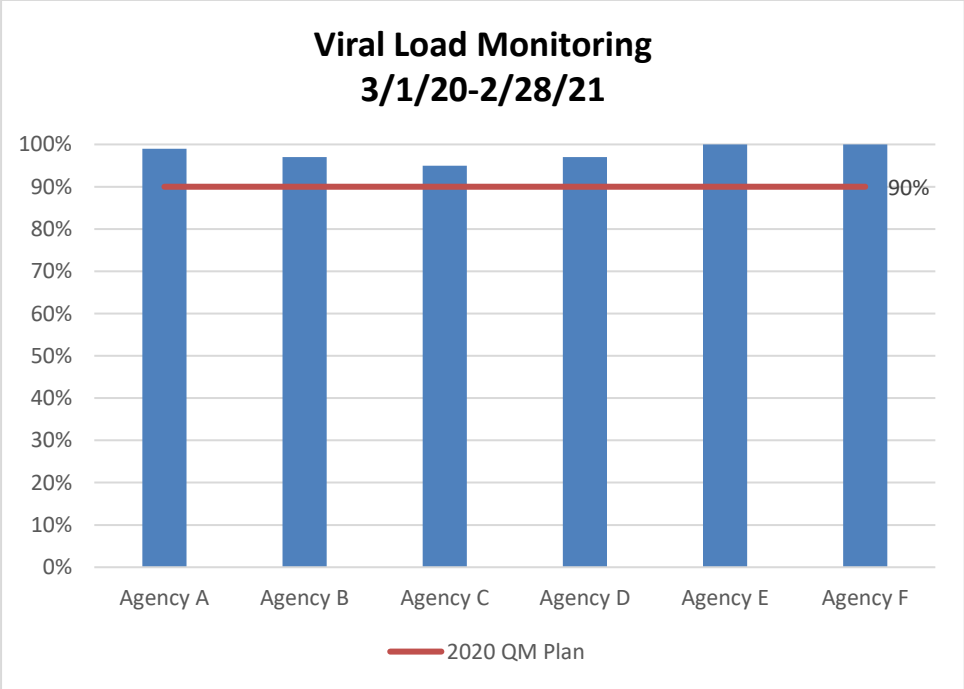
All Ages Performance Measures

Viral Load Monitoring

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

	2018	2019	2020
Number of clients who had a viral load test performed at least every six months during the measurement year	624	619	618
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**98.3%**	**97.5%**	**97.3%**
Change from Previous Years Results	**.3%**	**-.8%**	**-.2%**

2020 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	290	248	68
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	294	255	74
Rate	**98.6%**	**97.3%**	**91.9%**



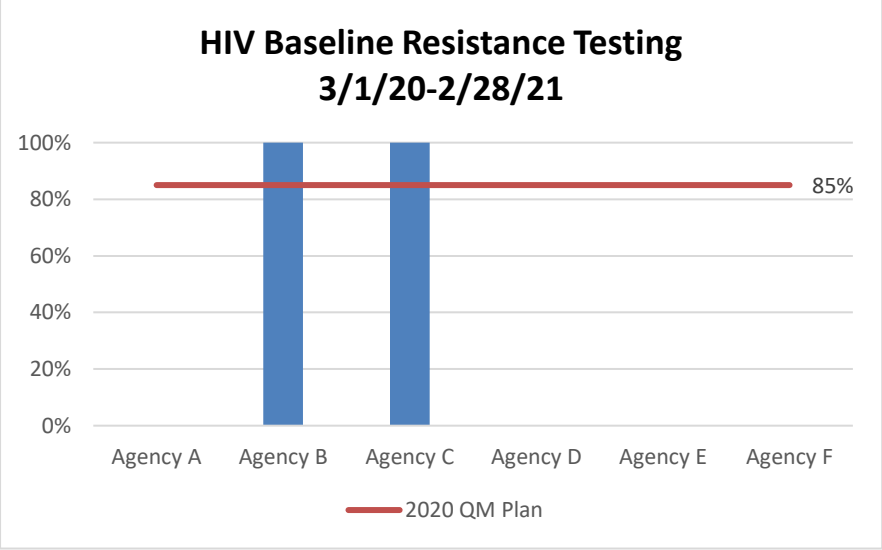
HIV Drug Resistance Testing Before Initiation of Therapy

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

	2018	2019	2020
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	6	5	4
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	8	7	4
Rate	**75%**	**71.4%**	**100%**
Change from Previous Years Results	**3.6%**	**-3.6%**	**28.6%**

2020 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	0	1	3
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	0	1	3
Rate		**100%**	**100%**

*Agencies A, D, E, & F did not have any clients that met the denominator



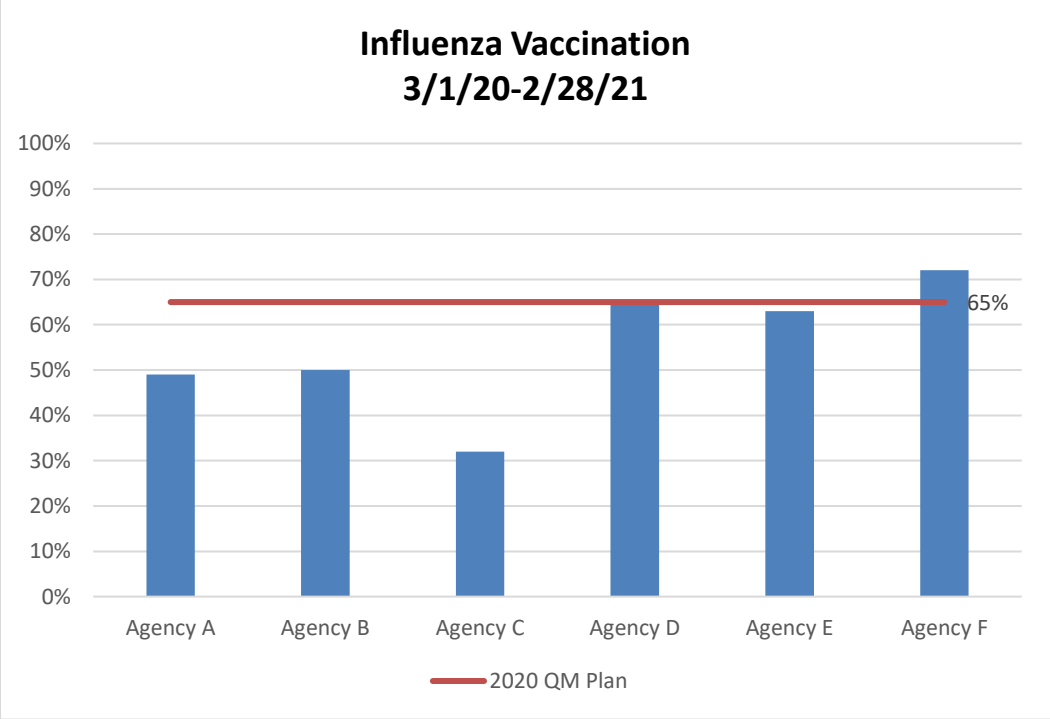
Influenza Vaccination

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

	2018	2019	2020
Number of clients who received influenza vaccination within the measurement year	336	362	281
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	534	531	565
Rate	**62.9%**	**68.2%**	**49.7%**
Change from Previous Years Results	**9.4%**	**5.3%**	**-18.5%**

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

2020 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	122	124	29
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	250	237	67
Rate	**48.8%**	**52.3%**	**43.3%**

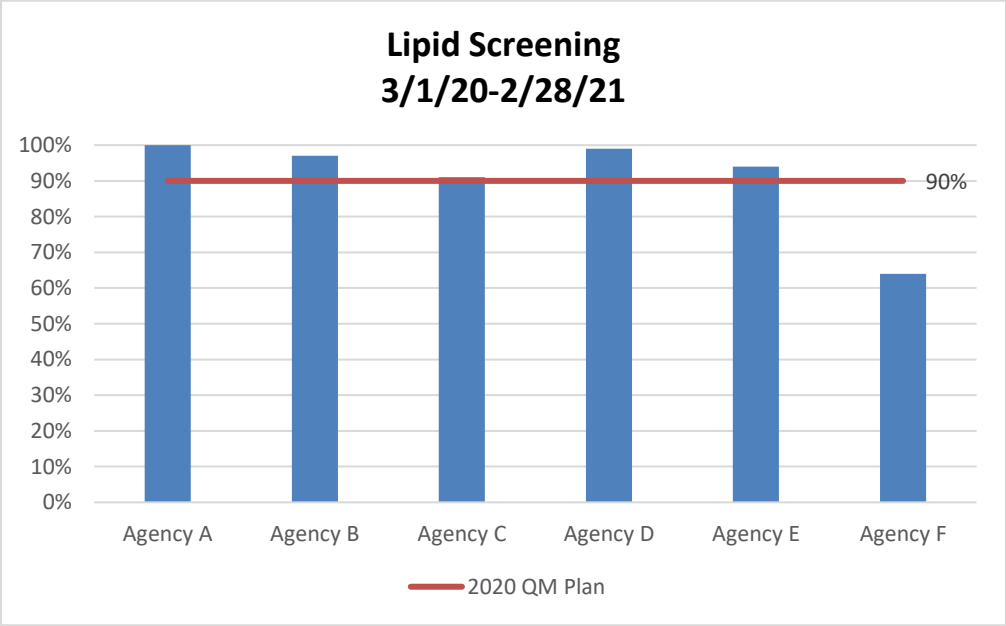


Lipid Screening

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

	2018	2019	2020
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	567	554	594
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	631	627	635
Rate	**89.9%**	**88.4%**	**93.5%**
Change from Previous Years Results	**1.1%**	**-1.5%**	**5.1%**

2020 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	275	237	71
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**93.5%**	**92.9%**	**95.9%**

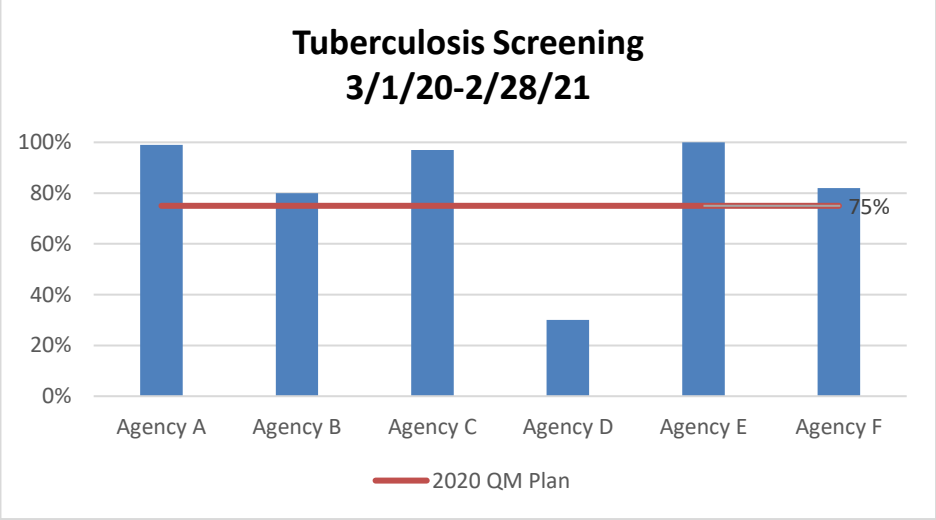


Tuberculosis Screening

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

	2018	2019	2020
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	401	426	454
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	565	570	567
Rate	**71%**	**74.7%**	**80.1%**
Change from Previous Years Results	**3.8%**	**3.7%**	**5.4%**

2020 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	204	187	56
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	263	224	71
Rate	**77.6%**	**83.5%**	**78.9%**



Adolescent/Adult Performance Measures

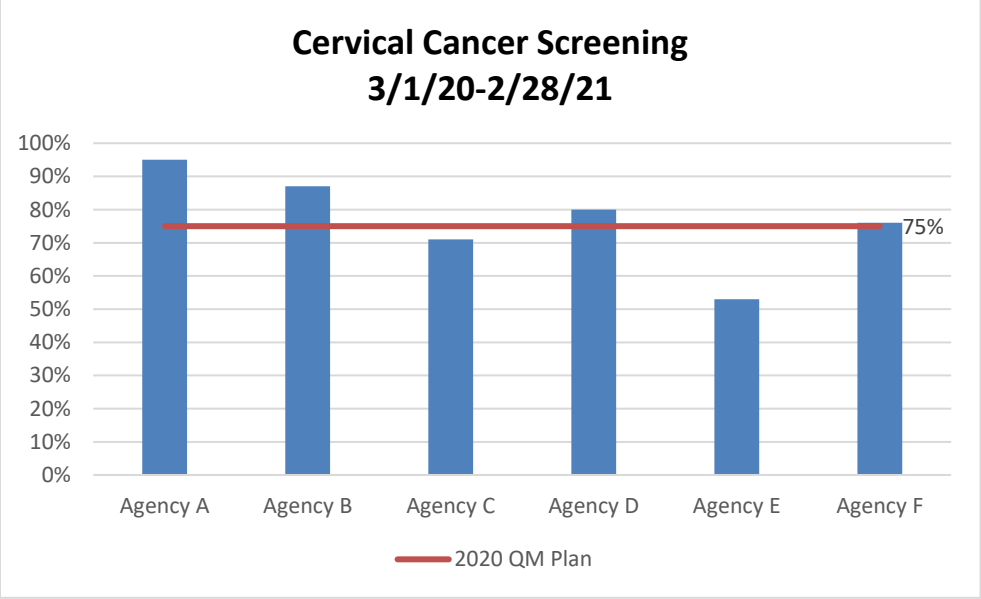
Cervical Cancer Screening

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

	2018	2019	2020
Number of female clients who had Pap screen results documented in the previous three years	199	214	208
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	244	260	259
Rate	**81.6%**	**82.3%**	**80.3%**
Change from Previous Years Results	**-.9%**	**.7%**	**-2%**

- 13.9% (29/208) of pap smears were abnormal

2020 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	122	76	8
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	155	92	9
Rate	**78.7%**	**82.6%**	**88.9%**



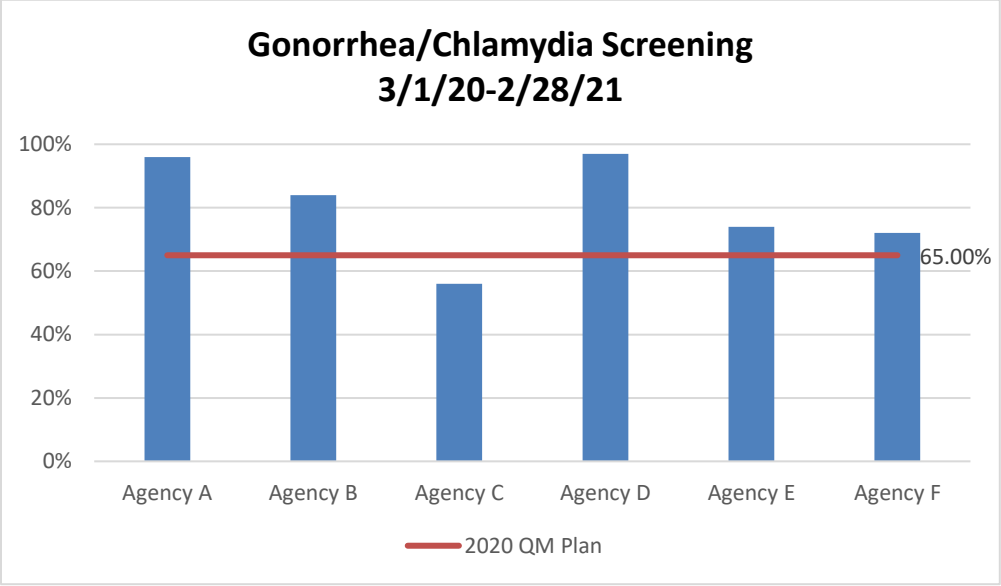
Gonorrhea/Chlamydia Screening

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

	2018	2019	2020
Number of clients who had a test for Gonorrhea/Chlamydia	501	506	503
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**78.9%**	**79.7%**	**79.2%**
Change from Previous Years Results	**1.3%**	**.8%**	**-.5%**

- 20 cases of chlamydia and 22 cases of gonorrhea were identified

2020 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	237	201	57
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**80.6%**	**78.8%**	**77%**



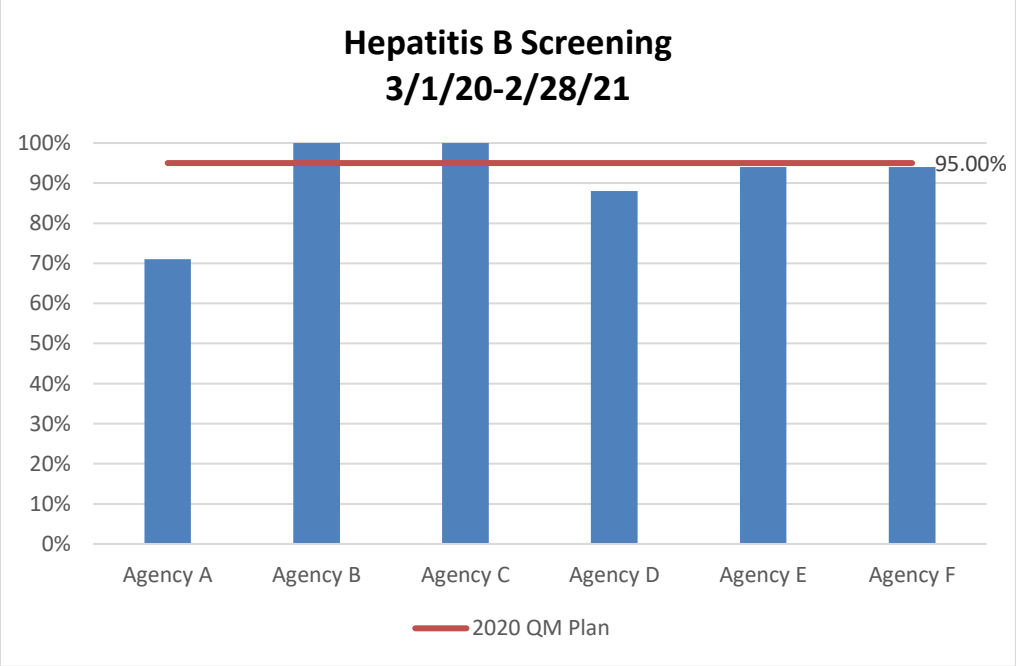
Hepatitis B Screening

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

	2018	2019	2020
Number of clients who have documented Hepatitis B infection status in the health record	577	571	588
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**90.9%**	**89.9%**	**92.6%**
Change from Previous Years Results	**3.8%**	**-1%**	**2.7%**

- 1.4% (9/635) were Hepatitis B positive

2020 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	275	231	70
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**93.5%**	**90.6%**	**94.6%**

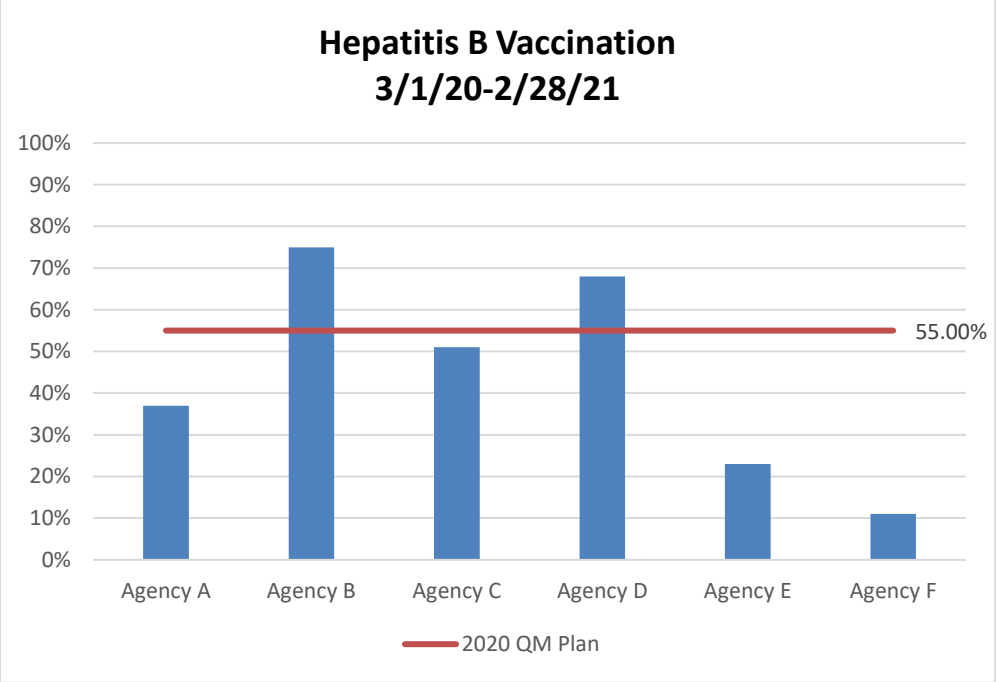


Hepatitis B Vaccination

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

	2018	2019	2020
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	171	177	179
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	347	342	344
Rate	**49.3%**	**51.8%**	**52%**
Change from Previous Years Results	**-2.1%**	**2.5%**	**.2%**

2020 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	65	94	18
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	132	170	39
Rate	**49.2%**	**55.3%**	**46.2%**



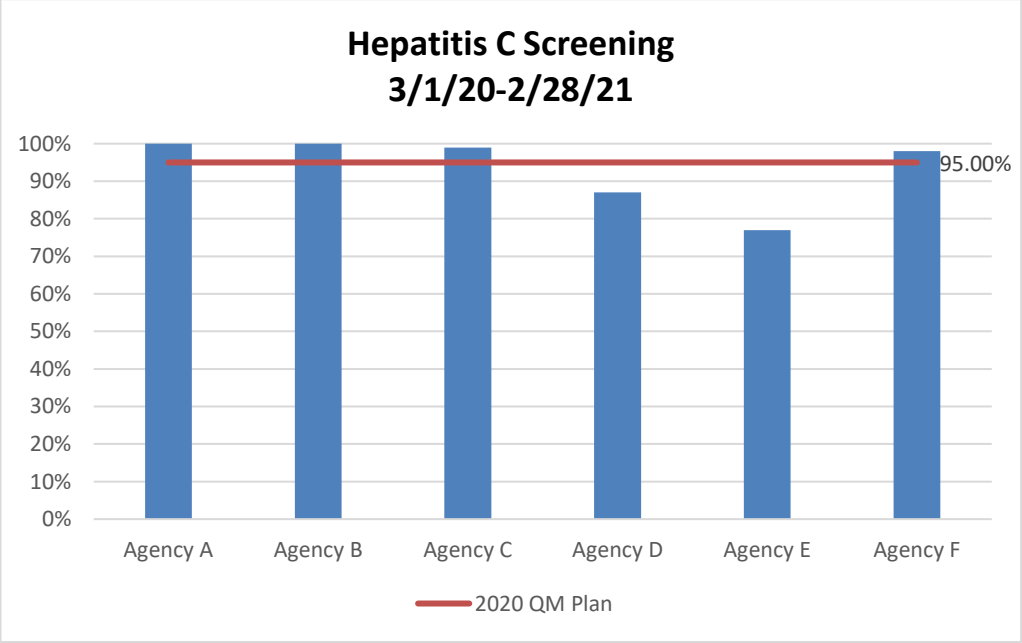
Hepatitis C Screening

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

	2018	2019	2020
Number of clients who have documented HCV status in chart	604	612	611
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**95.1%**	**96.4%**	**96.2%**
Change from Previous Years Results	**2.3%**	**1.3%**	**-.2%**

- 9.1% (58/635) were Hepatitis C positive, including 15 acute infections only and 34 cures (79%)

2020 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	280	246	73
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**95.2%**	**96.5%**	**98.6%**

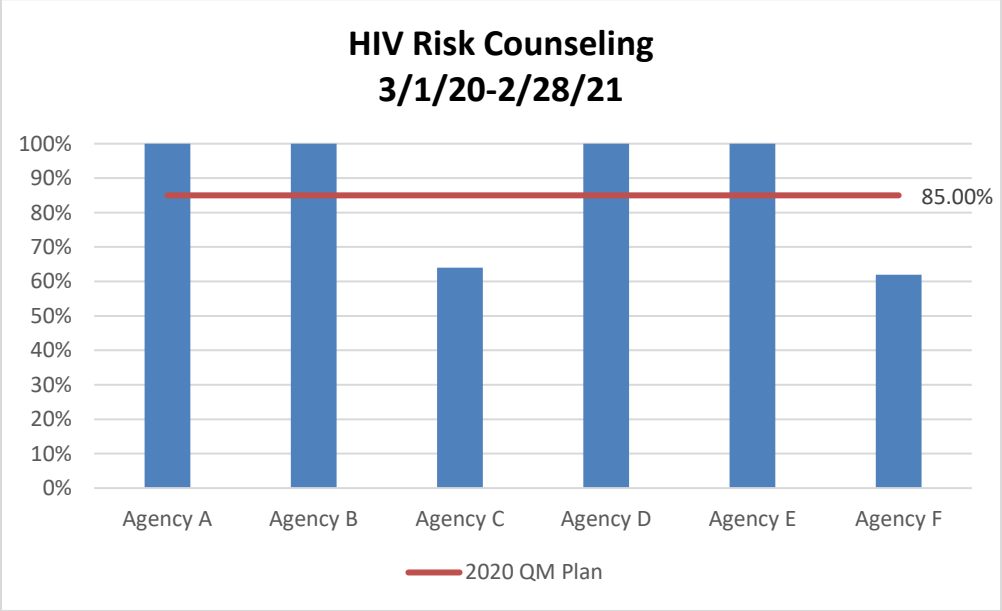


HIV Risk Counseling

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

	2018	2019	2020
Number of clients, as part of their primary care, who received HIV risk counseling	533	520	559
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**83.9%**	**81.9%**	**88%**
Change from Previous Years Results	**-6.8%**	**-2%**	**6.1%**

2020 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	260	222	66
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**88.4%**	**87.1%**	**89.2%**



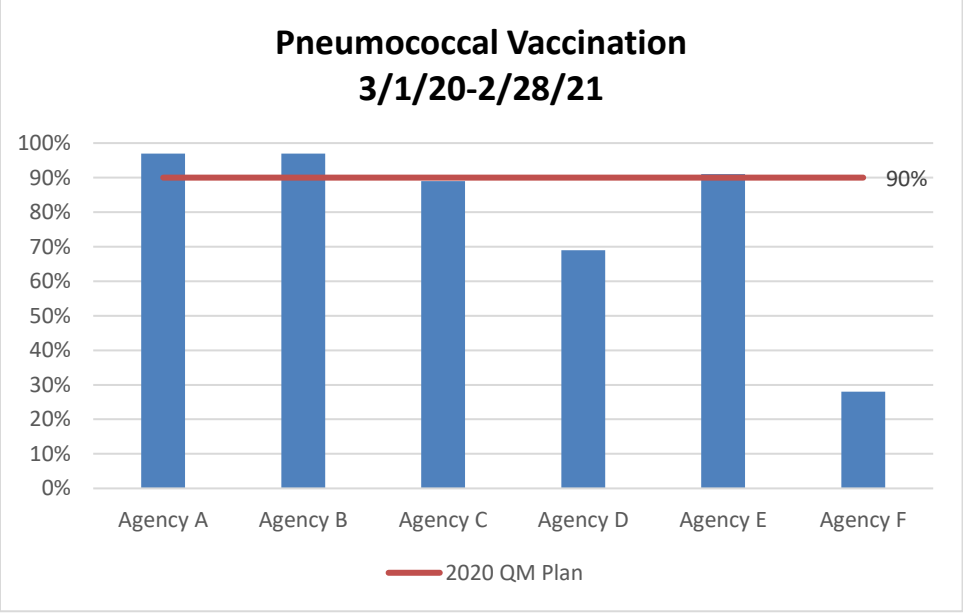
Pneumococcal Vaccination

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

	2018	2019	2020
Number of clients who received pneumococcal vaccination	507	523	518
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	610	612	608
Rate	**83.1%**	**85.5%**	**85.2%**
Change from Previous Years Results	**-.3%**	**2.4%**	**-.3%**

- 381 clients (62.7%) received both PPV13 and PPV23 (FY19- 59.3%, FY18- 65.1%)

2020 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	231	223	55
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	280	242	74
Rate	**82.5%**	**92.1%**	**74.3%**

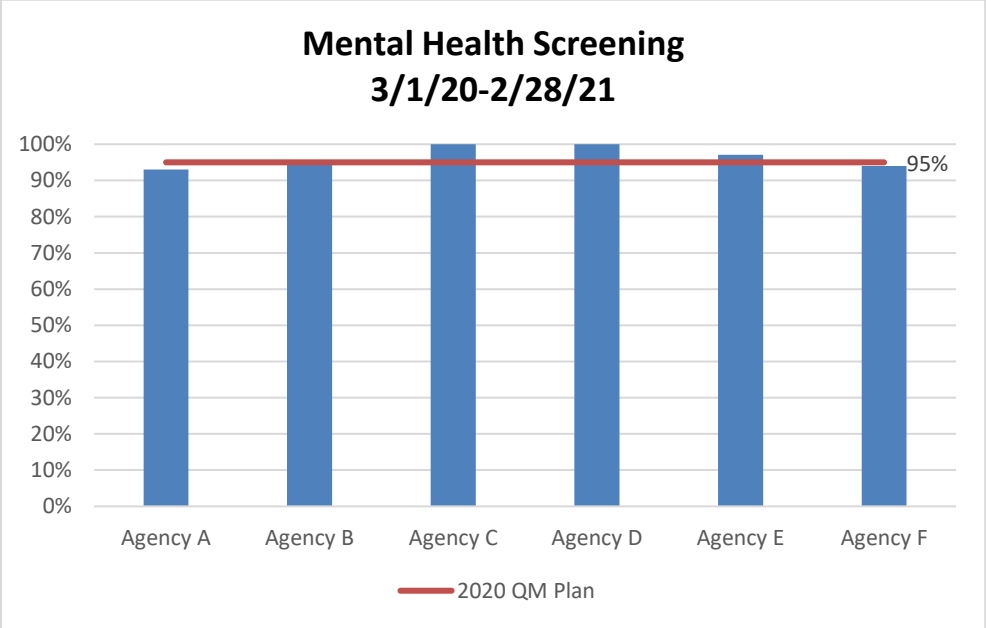


Preventative Care and Screening: Mental Health Screening

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

	2018	2019	2020
Number of clients who received a mental health screening	623	604	614
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.1%**	**95.1%**	**96.7%**
Change from Previous Years Results	**1.7%**	**-3%**	**1.6%**

- 27.6% (175/635) had mental health issues. Of the 64 who needed additional care, 58 (90.6%) were either managed by the primary care provider or referred; 6 clients refused a referral.

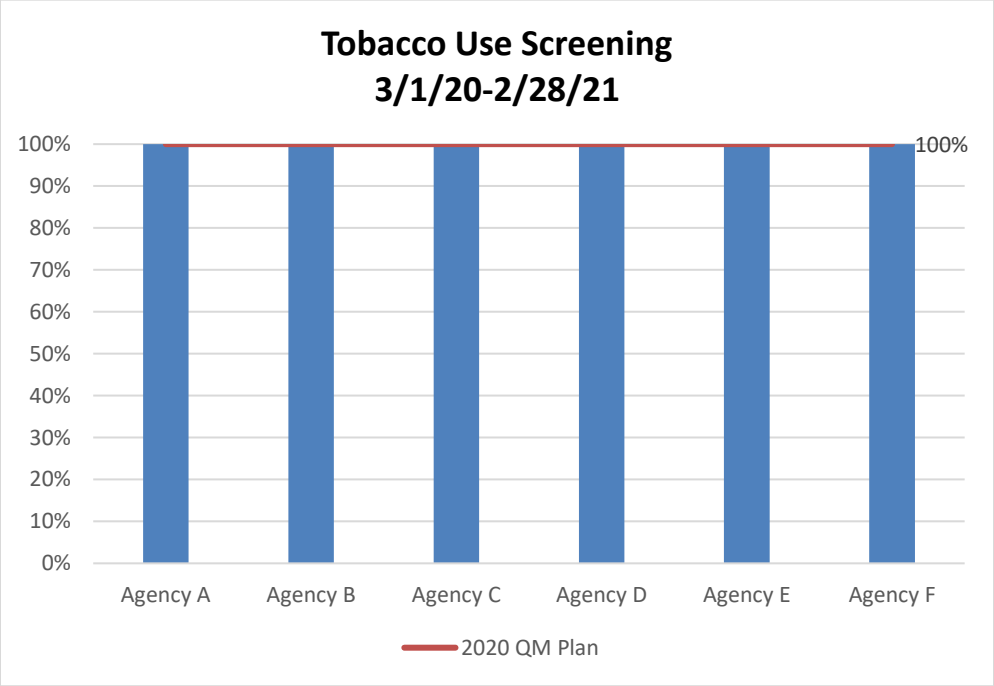


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

	2018	2019	2020
Number of clients who were screened for tobacco use in the measurement period	627	634	634
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.7%**	**99.8%**	**99.8%**
Change from Previous Years Results	**-1.3%**	**1.1%**	**0%**

- Of the 634 clients screened, 159 (25.1%) were current smokers.
- Of the 159 current smokers, 114 (71.7%) received smoking cessation counseling, and 5 (3.1%) refused smoking cessation counseling



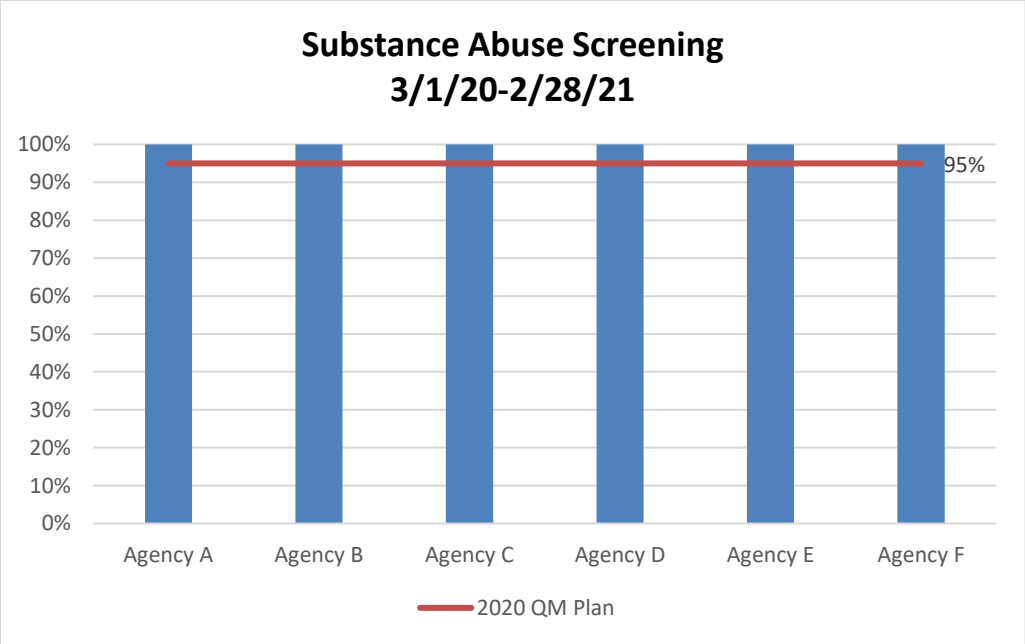
Substance Use Screening

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

	2018	2019	2020
Number of new clients who were screened for substance use within the measurement year	631	632	628
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.4%**	**99.5%**	**98.9%**
Change from Previous Years Results	**.3%**	**.1%**	**-.6%**

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

- 4.9% (31/635) had a substance use disorder. Of the 31 clients who needed referral, 24 (77.4%) received one, and 4 (12.9%) refused.

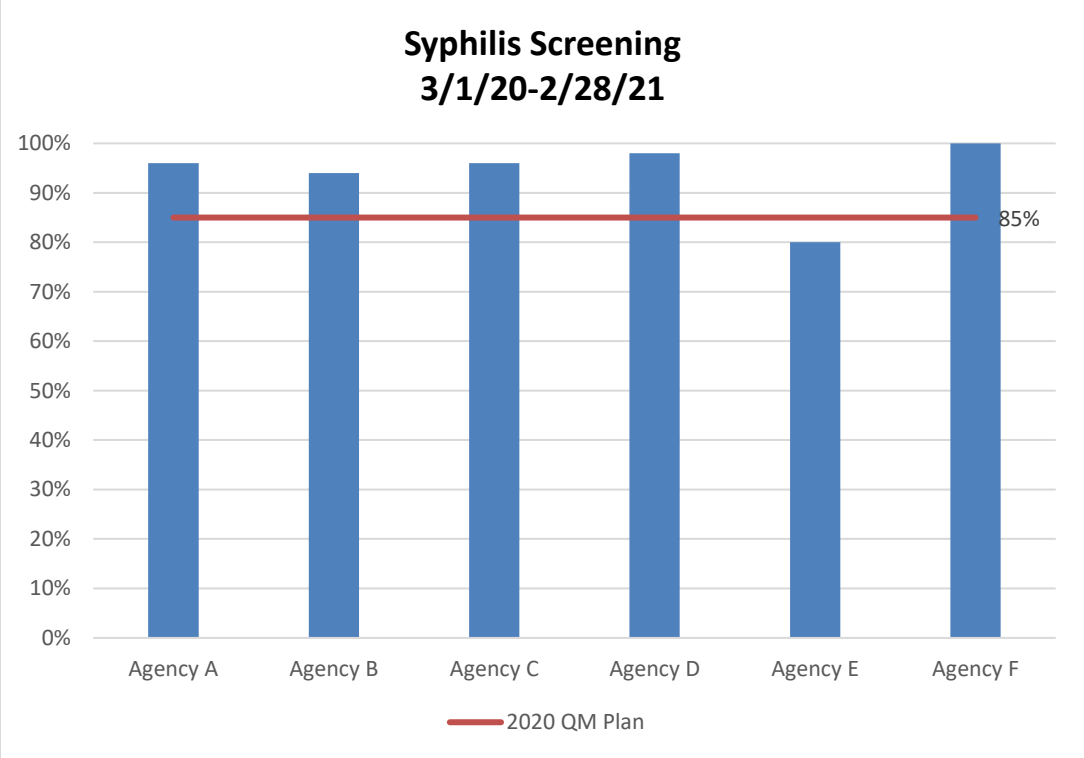


Syphilis Screening

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

	2018	2019	2020
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	602	600	604
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**94.8%**	**94.5%**	**95.1%**
Change from Previous Years Results	**2.4%**	**-.3%**	**.6%**

- 8.8% (56/635) new cases of syphilis diagnosed

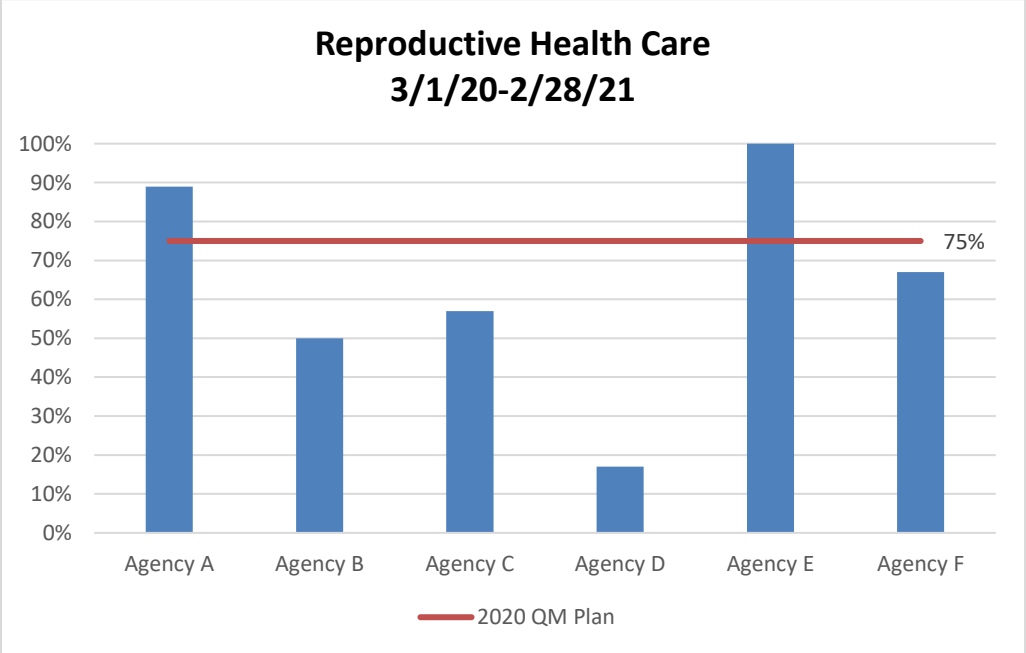


Other Measures

Reproductive Health Care

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

	2018	2019	2020
Number of reproductive-age women who received reproductive health assessment and care	29	37	40
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	54	66	67
Rate	**53.7%**	**56.1%**	**59.7%**
Change from Previous Years Results	**18.8%**	**2.4%**	**3.6%**

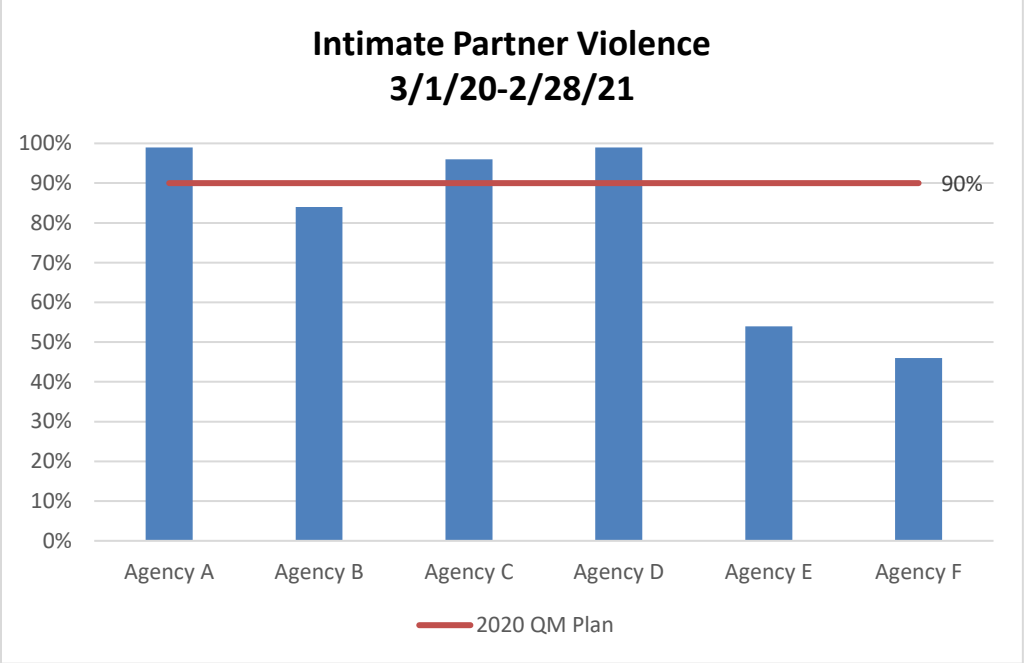


Intimate Partner Violence Screening

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

	2018	2019	2020
Number of clients who received screening for current intimate partner violence	592	577	553
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**93.2%**	**90.9%**	**87.1%**
	14.6%	**-2.3%**	**-3.8%**

* 1/635 screened positive



Adherence Assessment & Counseling

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

	Adherence Assessment		
	2018	2019	2020
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	631	627	635
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	631	627	635
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

ART for Pregnant Women

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

	2018	2019	2020
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	3	2	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	3	2	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

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

	2018	2019	2020
Number of diabetic clients whose last HbA1c in the measurement year was <8%	35	38	55
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	67	65	82
Rate	**52.2%**	**58.5%**	**67.1%**
Change from Previous Years Results	**-12.7%**	**6.3%**	**8.6%**

- 635/635 (100%) of clients were screened for diabetes and 82/635 (12.9%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2018	2019	2020
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	145	147	157
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	181	179
Rate	**80.6%**	**81.2%**	**87.7%**
Change from Previous Years Results	**0%**	**.6%**	**6.5%**

- 179/635 (28.2%) of clients were diagnosed with hypertension

Primary Care: Breast Cancer Screening

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

	2018	2019	2020
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	141	142	145
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	164	167	166
Rate	**86%**	**85%**	**87.3%**
Change from Previous Years Results	**-1.7%**	**-1%**	**2.3%**

Primary Care: Colon Cancer Screening

- Percentage of clients living with HIV, over the age of 50, who received colon cancer screening (colonoscopy, sigmoidoscopy, or fecal occult blood test) or a referral for colon cancer screening

	2018	2019	2020
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	127	123	161
Number of clients over age 50 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	160	173	192
Rate	**79.4%**	**71.1%**	**83.9%**
Change from Previous Years Results	**17.8%**	**-8.3%**	**12.8%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year, which is particularly reassuring in light of the COVID-19 pandemic that occurred in FY20. The decreases seen in Influenza Vaccination and IPV screening were likely related to the increase in telehealth services during the measurement year. The increased telehealth services did not appear to impact other performance measures, and in fact, primary care measures such as diabetes and hypertension control improved. Racial and ethnic disparities continue to be seen, particularly for viral load suppression rates. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 2020-21
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

Table of Contents

Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 624 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2020- February 28, 2021. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation as a, “range of client-centered services that link clients with health care, psychosocial, and other services,” including coordination and follow-up of medical treatment and “adherence counseling to ensure readiness for and adherence to HIV complex treatments.” Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments, lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. It is expected that any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

The Sample

In order to conduct a thorough and comprehensive review, a total of 624 client records were reviewed across seven agencies for the 2020-2021 grant year. This included sixty-one (61) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator based on the total eligible population that received case management services at each site.

Agency	A	B	C	D	E	F	G
# of Charts Reviewed	79	85	91	105	105	98	61

TOTAL 624 (563 excluding non-Primary Care site)

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2020- February 28, 2021 grant year was queried from the Centralized Patient Care Data Management System database. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.

Cumulative Data Summaries

APPOINTMENTS & ENCOUNTERS

The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters and virtual telehealth visits for an HIV-related primary care appointment with a medical provider was counted. Each encounter was assessed for a minimum of 3 medical appointments. Any Viral Load that accompanied the appointment was also recorded.

HIV MEDICAL # appt	A	B	C	D	E	F	TOTAL	PERCENT
0	1	4	11	31	8	4	59	**10%**
1	5	23	9	40	42	10	129	**23%**
2	18	27	10	26	38	15	134	**24%**
3	55	31	61	8	17	69	241	**43%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

The overall sample trends towards a higher number of primary care appointment in the year, with most of the case management review clients having at least 3 appointments in the year (43%), followed by (24%) of the clients having 2 appointments in the year.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The number and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, or Non-Medical Case Manager) were also recorded.

The distribution of frequency of case management encounters could be described as evenly distributed across encounters.

CASE MGMNT # appointments	A	B	C	D	E	F	G	TOTAL	PERCENT
1	19	23	17	35	19	32	8	153	**25%**
2	21	17	13	12	30	23	6	122	**20%**
3	9	10	12	12	22	24	15	104	**17%**
4	17	19	16	22	10	10	13	107	**18%**
5	13	16	33	24	24	9	19	138	**22%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*61*	*624*	

VIRAL SUPPRESSION

Any results of HIV Viral Load laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as "Suppressed." Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as "Unsuppressed." Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as "Mixed Status," and clients who had no laboratory tests done within the entire year were coded as "Unknown."

SUPPRESSION STATUS	A	B	C	D	E	F	TOTAL	PERCENT
Suppressed for all labs	32	31	43	72	72	33	283	**50%**
Mixed status	0	0	0	3	10	0	13	**2%**
Unknown (no recent labs on file)	44	51	37	21	10	55	218	**39%**
Unsuppressed for all labs	3	3	11	9	13	10	49	**9%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate of 50%. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to several factors, mainly the Covid-19 pandemic and reduction of in-person labs due to telehealth visits. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, "fluctuating viral load" is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered "New to Care," if they were receiving services for the first time at that particular agency (not necessarily new to HIV treatment or the Houston Ryan White system of care). "Lost to Care" was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. "Re-engaged in Care" was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

CARE STATUS	A	B	C	D	E	F	TOTAL	PERCENT
New to Care	11	5	11	1	2	5	35	**6%**
Lost to Care	11	2	1	15	11	2	42	**7%**
Re-engaged in Care	0	0	0	1	0	0	1	**1%**
Both New and later Lost to Care in the same review year	8	2	20	3	17	15	65	**12%**
Re-engaged and later lost again	0	0	0	1	1	0	2	**<1%**
N/A	49	76	59	84	74	76	418	**74%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Overall, 6% of the sample was considered New to Care, 7% was Lost to Care, and <1%was Re-engaged in Care.

When a client's attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as "Coordination of Care" were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance, or introduction at the first appointment, or home visits.

COMORBIDITIES

To understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

MENTAL HEALTH & SUBSTANCE USE DISORDER (history or active)

Any diagnosis of a mental health disorder (MH) or substance use disorder issue (SUD) was recorded in the chart review tool, including a history of mental illness or substance use. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SUD diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or SUD, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SUD issues. Any conditions other than alcohol misuse, other SUD, depression, bipolar disorder, anxiety, or schizophrenia were recorded as "Other." The most common types of condition coded as "Other" was Post-Traumatic Stress Disorder.

Diagnosis or Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Alcohol abuse/dependence	3	2	5	1	13	6	20	50	**9%**
Other Substance dependence	14	1	5	0	15	7	19	61	**10%**
Depression	16	11	32	14	42	33	37	185	**32%**
Bipolar disorder	6	5	7	1	5	10	14	48	**8%**
Anxiety	9	12	14	51	28	22	32	168	**29%**
Schizophrenia	1	1	0	14	1	2	7	26	**4%**
Other	2	0	11	2	12	9	10	46	**8%**

Overall, 93% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SUD issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE USE DISORDER REFERRALS

For clients with an *active* diagnosis of a mental health or SUD issue, the chart abstractor recorded if they were referred or already engaged in MH/SUD services.

MH referral	A	B	C	D	E	F	TOTAL	PERCENT
N/A	75	82	55	100	97	88	497	**88%**
Yes	3	3	13	5	8	10	42	**7%**
No	1	0	23	0	0	0	24	**4%**
Total	82	85	91	105	105	98	563	

Overall, 88% of the sample would not have been appropriate for a MH or SUD referral based on the information available in their medical record. An additional 7% either did receive a referral or were already engaged in treatment and 4% did not receive a referral.

MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 33% and 25% prevalence within the sample, respectively. The site visit tool does not list obesity as a medical condition however, obesity was the most common co-occurring condition that was coded in the "Other" category.

Medical Condition	A	B	C	D	E	F	TOTAL	PERCENT
Smoking (hx or current)	10	7	12	11	33	10	83	**16%**
Opportunistic Infection	0	0	3	6	0	0	9	**2%**
STIs	38	16	48	3	39	31	175	**33%**
Diabetes	5	11	8	4	20	22	70	**13%**
Cancer	0	3	1	6	0	1	11	**2%**
Hepatitis	7	5	1	7	9	9	38	**7%**
Hypertension	12	37	21	11	22	28	131	**25%**
Other	2	3	5	0	8	1	19	**4%**

SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified "Social Condition" within the sample.

Social Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Homelessness or housing-related issues	5	0	3	4	15	1	10	38	**6%**
Pregnancy or pregnancy-related issues	6	2	0	0	0	0	0	8	**1%**
Recently released	0	0	1	0	2	0	0	3	**<1%**
Intimate Partner Violence	3	0	0	0	5	0	10	18	**2%**

COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp assessments	A	B	C	D	E	F	G	TOTAL	PERCENT
0	62	85	78	100	89	83	0	497	**79%**
1	17	0	13	3	16	15	15	79	**13%**
2	0	0	0	2	0	0	9	11	**2%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	95	105	105	98	61	624	

The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined above, 6% of the sample did not work with a Medical Case Manager within the year. 79% of the sample received zero comprehensive assessments, 13% received one, and 2% received two.

SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action(s) will be taken to address the needs identified on the comprehensive assessment. A service plan can be thought of as an informal, working, contract between client and social worker for accountability of needed actions, and in what order, to meet a client's determined treatment goals. As with the comprehensive assessment, each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of service plans	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**TOTAL**	**PERCENT**
0	65	82	91	102	95	98	7	540	**87%**
1	14	3	0	2	10	0	10	39	**6%**
2	0	0	0	1	0	0	7	8	**1%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	91	105	105	98	61	624	

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. RWGA experienced a transition in CM chart review auditors midway through the chart review process. As a result, it is unclear what the criteria for determining a client was "N/A" at agency "G".

BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six-month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief assessments	**A**	**B**	**C**	**D**	**E**	**F**	**TOTAL**	**PERCENT**
0	52	73	55	56	30	80	346	**61%**
1	24	12	34	38	54	18	180	**33%**
2	3	0	2	7	1	0	13	**2%**
N/A	0	0	0	4	20	0	24	**4%**
Total	79	85	91	105	105	98	563	

Completion of brief assessments were recorded. 4% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 61% of the sample received zero brief assessments, 33% received one, and 2% received two.

ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 624 Comprehensive Assessments and 563 Brief Assessments were reviewed and recorded to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Medication Adherence Counseling, 5) Mental Health, and (6) Insurance. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" and "Medication Adherence Counseling" as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	A	B	C	D	E	F	G	TOTAL	PERCENT
Medical/Medication	42	12	41	37	24	35	8	199	8%
Vaccinations	10	7	0	44	22	0	6	89	4%
Nutrition/Food Pantry	10	8	16	0	18	1	4	57	3%
Dental	31	11	18	16	29	14	8	127	5%
Vision	19	11	31	12	14	13	5	105	4%
Hearing Care	15	9	26	1	0	12	1	64	3%
Home Health Care	10	3	8	0	1	2	0	24	1%
Basic Necessities/Life Skills	41	9	28	4	5	32	5	124	5%
Mental Health	33	9	45	16	24	44	14	185	7%
Substance Use Disorder	43	12	37	4	5	35	6	142	6%
Abuse	27	11	17	1	12	15	2	85	4%
Housing/Living Situation	41	12	35	9	10	34	8	149	6%
Support Systems	47	12	42	3	3	33	1	141	6%
Child Care	14	6	4	0	0	4	0	28	1%
Insurance	52	11	31	3	9	46	4	156	6%
Transportation	36	12	55	11	6	35	6	161	6%
HIV-Related Legal Assistance	25	8	21	0	1	27	0	82	3%
Cultural/Linguistic	28	1	12	0	0	20	0	61	3%
Self-Efficacy	40	1	12	0	0	40	4	97	4%
HIV Education/Prevention	21	12	40	3	4	36	0	116	5%
Family Planning/ Safer Sex	9	11	7	0	4	2	1	34	2%
Employment	39	7	39	0	4	33	4	126	5%
Education/Vocation	35	10	30	0	0	10	0	85	4%
Financial Assistance	8	10	12	21	15	8	13	87	4%
Medication Adherence Counseling	44	9	43	19	27	43	17	182	7%
Client Strengths	1	0	0	1	0	0	3	5	1%

Conclusion

The 2020-2021 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement. This report also gives consideration to challenges and barriers related to Covid-19 pandemic.

The most common co-occurring conditions were: Sexually Transmitted Infections (33%), Depression (32%), and Hypertension (25%). Diabetes and Obesity were also relatively common and providing overview information on nutrition counseling may be a useful topic in frontline case management trainings. The prevalence of complex co-morbidities emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also areas of high performance displayed in this chart review. Most (43 %) of the clients in the sample had at least three HIV-related primary care appointments within the review year. Case Management staff demonstrated a high level of coordination of care in areas. For example, 90% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management to retain them in care.

Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL
Chart Review Date _____/_____/_____
Agency: ☐ AHF ☐ AH ☐ Ave360 ☐ HHS ☐ Legacy ☐ SHF

Review Period:
3/1/20__ - 2/28/20__

CLIENT INFORMATION

Pt. ID # _____ Race: _____

Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk. Gender: _____

Last OAMC Appts:	Virally Suppressed?	← If No, linked to CM?
1.	☐ Y ☐ N ☐ Unk.	
2.	☐ Y ☐ N ☐ Unk.	
3.	☐ Y ☐ N ☐ Unk.	
☐ No appts. during review period		

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description)	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client: ☐ New to care ☐ Lost to care ☐ Re-engaged in care ☐ NA
If yes…. was there documentation of coordination of care or contact attempts? ☐ Y ☐ N ☐ NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)
☐ Alcohol abuse/dependence
☐ Other substance abuse/dependence: _____
☐ Depression
☐ Bipolar disorders
☐ Anxiety disorders
☐ Schizophrenia
☐ Other: _____

Was the client referred or already engaged with MH/SA services?
☐ N/A ☐ Yes ☐ No

Does the client have any co-morbidity?
☐ Opportunistic Infection
☐ Sexually Transmitted Infections (STIs) : _____
☐ Diabetes
☐ Cancer
☐ Hepatitis
☐ Hypertension
☐ Other: _____

Was the client reported to have any of the following conditions?
☐ Homelessness
☐ Pregnancy (or other pregnancy-related conditions)
☐ Recently released
☐ IPV

INSURANCE, BENEFITS, AND INCOME INFORMATION

Health Insurance: ☐ Uninsured ☐ Medicaid _____ ☐ Medicare_____ ☐ Commercial _____
☐ VA ☐ Other? _____

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income $:	Spouse Income $:	Other Income $:	TOTAL HOUSEHOLD INCOME $:

Did the client lose insurance or coverage during the review period? ☐ Y N ☐ Unk. ☐
If so, were they provided with information/education or assistance? ☐ Y N ☐ NA ☐

CASE MANAGEMENT SERVICES

What types of services were provided by a **Medical Case Manager** (MCM?)	What types of services were provided by a **Service Linkage Worker** (SLW?)	Was the client referred for **Clinical Case Management** services in the review period?
☐ **NA (Client not assisted by MCM)** ☐ Comprehensive assessment ☐ Service Plan ☐ Medication adherence counseling ☐ Coordination of medical care ☐ Transportation ☐ ADAP/medication assistance ☐ Eligibility ☐ Community resource/benefits brokerage ☐ Other _____ Did client meet criteria for MCM? Y ☐ N ☐ Unk. ☐	☐ **NA (Client not assisted by SLW)** ☐ Brief assessment ☐ SLW referred client to OAMC ☐ OAMC visit scheduled by SLW ☐ SLW accompanied client to OAMC ☐ SLW called client to remind about OAMC visit ☐ Client did not keep OAMC appt. and SLW contacted them ☐ ADAP/medication assistance ☐ Transportation voucher ☐ Eligibility Were any of the above services provided by an Outreach Worker? Y ☐ N ☐ Unk. ☐	☐ **No- not applicable** ☐ No- applicable, but no referral documented ☐ Yes- and there is evidence of coordination of services ☐ Yes- and there is no evidence of coordination of services ☐ Yes- but client refused services or is already engaged in treatment

Was the case discharged/closed for CM during the review period?		Y ☐	N ☐	NA ☐	Unk. ☐
If yes.....	Client met agency criteria for closure?	Y ☐	N ☐	NA ☐	Unk. ☐
	Client completed treatment program (CCM)	Y ☐	N ☐	NA ☐	Unk. ☐
	Date and reason noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Summary of services received?	Y ☐	N ☐	NA ☐	Unk. ☐
	Referrals noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Instructions given to client at discharge?	Y ☐	N ☐	NA ☐	Unk. ☐

ASSESSMENTS & SERVICE PLANS

		If no assessment or plan:		
Brief Assess. Date 1:	Brief Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Comp. Assess. Date 1:	Comp. Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Service Plan Date 1:	Service Plan Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete

COMPLETED ASSESSMENTS

	MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief					NEXT MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief				
Domain	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)
Medical/Clinical										
Vaccination										
Nutrition/Food Pantry										
Dental Care										
Vision Care										
Hearing Care										
Home Care Needs										
Basic Necessities/Life Skills										
Mental Health										
Substance/Alcohol Use										
Abuse History										
Housing/Living Situation										
Support System										
Child Care/Guardianship										
Insurance Benefits										
Transportation										
HIV-Related Legal										
Cultural/Linguistic										
Self-Efficacy										
HIV Education/Prevention										
Family Planning/Safer Sex										
Employment/Income										
General Education/Vocation										
Financial Assistance										
Medication Adherence										
Client Strengths										
Other										

Public Comment

Re: Emergency Financial Assistance – Pharmacy Assistance

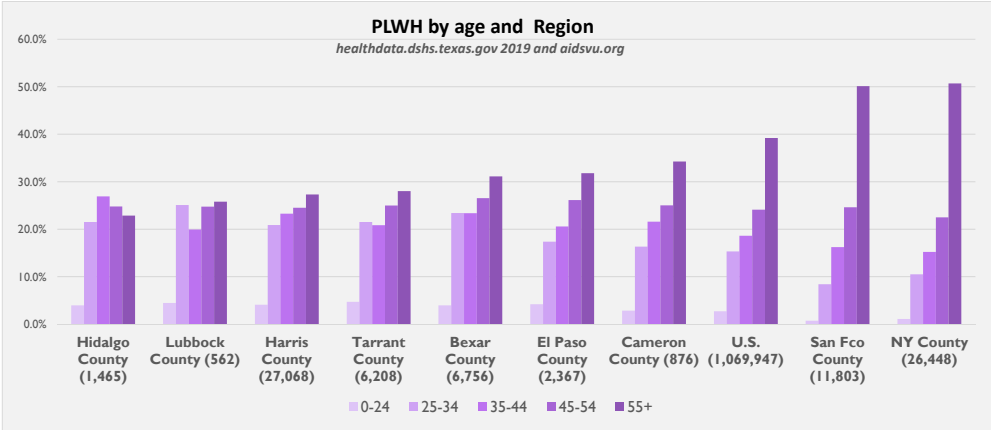
In regard to How to Best Meet the Need, Kevin Aloysius submitted the following comment:

Emergency Financial Assistance – Pharmacy Assistance currently provides limited one-time 30-day supply of medication to patients who do not have private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. He would like to see this increased to 90 days.

Institutional capacity to address the health & social needs of older Texan Hispanics/Latinxs living with HIV

Daniel Castellanos, DrPH
VP of Research & Innovation
Latino Commission on AIDS
2/28/23

PLWH BY AGE GROUP

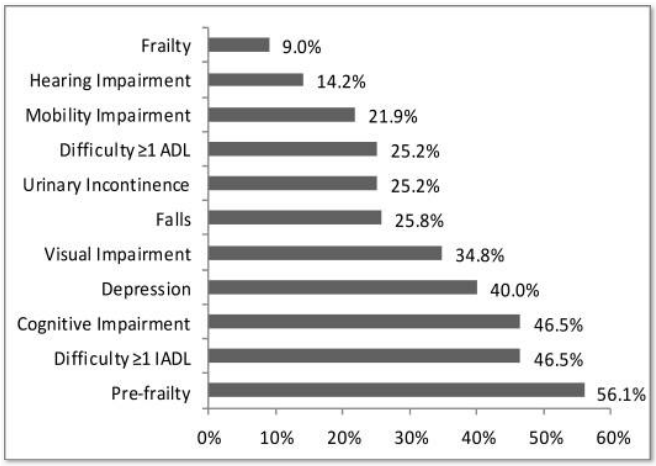


KEY CONCERNS

- Early onset of aging
- Multi-morbidity and polypharmacy
- Mobility impairment and frailty
- Multiple sources of stigmatization
- Long-term trauma
- Isolation

3

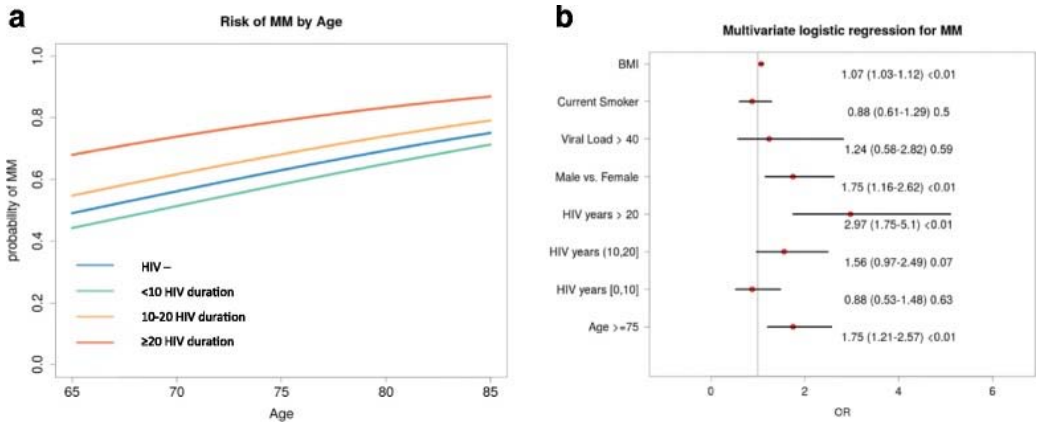
EARLY GERIATRIC SYNDROMES IN PLWH > 50 AND OLDER



Greene, M., Covinsky, K. E., Valcour, V., et al. (2015). Geriatric syndromes in older HIV-infected adults. *Journal of acquired immune deficiency syndromes* (1999), 69(2), 161.

4

MULTI-MORBIDITY (MM)



Guaraldi G, Malagoli A, Calcagno A, et al. The increasing burden and complexity of multi-morbidity and polypharmacy in geriatric HIV patients: a cross sectional study of people aged 65 – 74 years and more than 75 years. *BMC Geriatrics*. 2018/04/20 2018;18(1):99.

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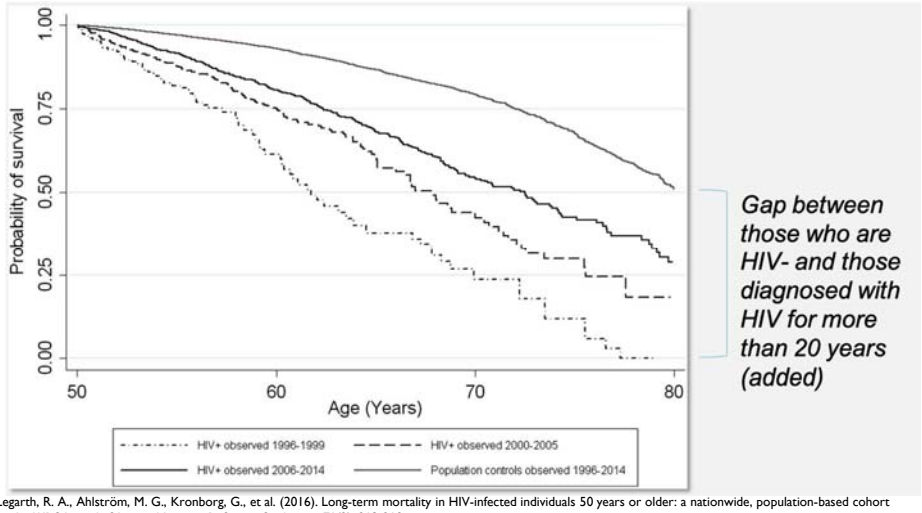
LIFE EXPECTANCY



Legarth, R. A., Ahlström, M. G., Kronborg, G., et al. (2016). Long-term mortality in HIV-infected individuals 50 years or older: a nationwide, population-based cohort study. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 71(2), 213-218.

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KEY CHALLENGES

- Diverse sociocultural and medical views about what constitutes old age
- OPLWH and staff unclear about the impact of HIV versus the aging process
- OPLWH and staff feeling overwhelmed with multiple conditions and treatments
- Early onset of aging requiring prevention, screening, and treatment
- Balancing primary care versus ID medicine versus geriatric care
- Additional resources, workload, and training among non-clinical and clinical staff
- Insurance coverage limitations for specialized services and resource

PROJECT DESCRIPTION

GOAL: To assess the health and social needs of older Texan Hispanics/Latinxs living with HIV and the institutional capacity needs

POTENTIAL QUESTIONS:

- Core health and social service needs related to aging with HIV among Hispanics/Latinxs
- Sociocultural views on aging and aging care among older Hispanics/Latinxs and HIV service providers
- Effective strategies for addressing the aging-related needs of clients
- Programmatic strategies and resources needed for integrating HIV case management and aging services

PROJECT DESCRIPTION

METHODS:

- Interviews with 5 older Texan Hispanic/Latinx individuals living with HIV at each of the 6 organizations
- Interviews with 5 case managers/social workers at each of the 6 organizations
- 300 surveys with older Texan Hispanics/Latinx individuals living with HIV (50 surveys at 6 organizations)

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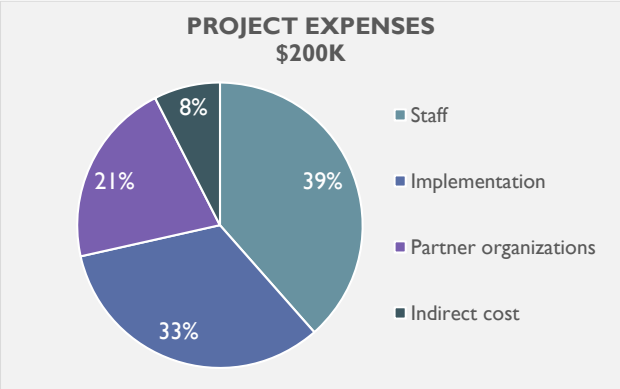
PROJECT EXPENSES (DRAFT)



PROJECT FUNDED BY GILEAD

- Staff ($77K)
- Implementation ($66K)
- Contribution to institutional partners ($42,000)
- Indirect cost ($15K)

ADDITIONAL LCOA SUPPORT

- Staff ($35K)

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WE WANT TO BUILD AREAS OF CONSENSUS BEFORE WE START THIS PROJECT

- Any reactions? What are your thoughts?
- What do you like?
- What do you dislike?

HOW CAN WE ENHANCE THE COLLABORATION EXPERIENCE?

- What could we do to enhance the project?
- How can we support the implementation process at the local level?

TEXAS BEHAVIORAL HEALTH ASSESSMENT

- Conducted 13 focus groups in Texas
- 120 surveys completed
- Submission of invoice
- 2023 National Latinx Conference:

  Community-Led Strategies to Increase Health Equity: Assessing Mental Health and Substance Use Stigmatization and Literacy
  Saturday, May 13th, 11:00am – 11:45am

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Q & A

Daniel Castellanos, DrPH
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Visit https://ilhe.org/

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HRSA Ryan White HIV/AIDS Program

HRSA's Ryan White HIV/AIDS Program

Optimizing HIV Care for People Aging with HIV: Incorporating New Elements of Care

Reference Guide for Aging with HIV

PURPOSE

The purpose of this reference guide is to identify commonly occurring health care and social needs of people aging with HIV and to highlight the screenings and assessments for these needs. This reference guide serves as a starting point for the health care team as it builds and expands its knowledge and practice of serving people aging with HIV.

INTRODUCTION

Because of the successes of HIV treatment over the past three decades, people diagnosed with HIV now have a nearly normal life expectancy. Of the estimated 991,447 people with diagnosed HIV infection in the United States as of 2016, 169,424 (17%) were age 60 years or older; this number represents an absolute increase of 5.5 percent since 2012.[1] The Health Resources and Services Administration's (HRSA's) Ryan White HIV/AIDS Program estimates that of the 533,640 clients served in 2018, 46 percent were age 50 years or older—an increase from 32 percent in 2010.[2] Given these data, it is incumbent upon the clinical and public health communities to ensure the health care system is equipped to address adequately the unique medical conditions and psychosocial needs of people aging with HIV.

People aging with HIV share many of the same health concerns as the general population age 50 years and older. However, people aging with HIV also may experience unique health needs as a result of chronic HIV-related infections that require medical treatment.[3,4] The HIV providers caring for people aging with HIV may lack specialized training in health issues specific to aging patients, similar to general primary care providers in the United States who are grappling with an aging population, as well.[5] In addition, people aging with HIV—many of whom identify as lesbian, gay, bisexual, transgender, or queer—have unique social needs compared with the general aging population. People aging with HIV would benefit from having access to a multidisciplinary health care team that is knowledgeable about community resources available to the aging population and the nuances of health care financing and coverage.

What Is a Geriatric Multidisciplinary Approach to Health Care?

It is a health care approach involving physicians, nurses, medical case managers, occupational therapists, social workers, and others to manage the care of people aging with HIV. Together, the health care team establishes patient-centered goals by addressing the domains of medical problems, cognitive and functional abilities, psychiatric disorders, and social circumstances and maximizes the use of community resources and referrals.

The geriatric multidisciplinary approach to health care, when applied to people aging with HIV, can be highly beneficial.[6] This approach involves all members of the health care team having an understanding of the geriatric conditions and adequately screening, assessing, treating, and referring patients for geriatric clinical and psychosocial conditions. A multidisciplinary team can build the capacity to conduct screenings and assessments for geriatric conditions and make referrals to aging-related resources, even if there is limited or no access to the geriatrician.

HEALTH CARE CHALLENGES OF PEOPLE AGING WITH HIV

Geriatric syndromes are different from other medical syndromes in that there may be multiple etiologies for a common symptom complex.[7] People aging with HIV often have additional geriatric challenges. Typical symptoms, syndromes, and risk factors of people aging with HIV may include the following:

- Hearing decline or loss
- Impaired oral health[8]
  - An elevated prevalence of caries and periodontal disease is likely to affect older adults. Periodontitis is a risk factor for several systemic diseases, and impaired oral health is associated with nutritional problems. Those with cognitive deficiencies are especially at risk.
- Premature aging of the immune system[9]
  - Chronic viral infections, such as HIV infection, often cause immune activation and inflammation and are linked to premature age-associated conditions, including cardiovascular disease, frailty, and bone loss, even in patients using antiretroviral therapy (ART).
  - People aging with HIV may have a reduced immunological response to ART, rendering this therapy less effective.
- Cognitive impairment, which may have multiple etiologies
  - Cognitive impairment due to HIV-associated neurocognitive disorder (HAND) is a known complication of HIV.[10] It is prevalent among those chronically infected with HIV, affecting 20 to 50 percent of people with HIV.[11]
  - Cardiovascular risk factors, the presence of hepatitis C virus, substance use—including alcohol and methamphetamine[12]—female gender, and the presence of depression all have been shown to negatively affect cognitive function and frailty in people aging with HIV.[13]

HIV-Associated Neurocognitive Disorder (HAND) Classification

ANI: asymptomatic neurocognitive impairment—very mild neurocognitive disorder
MND: mild neurocognitive disorder
HAD: HIV-associated dementia

- Functional impairment, the inability to carry out tasks that are needed for day-to-day living, is another critical condition that greatly affects daily life and is a core geriatric assessment. Its onset may be gradual, and the unsuspecting HIV provider may screen only after significant impairment is apparent. The health care team needs to assess functional impairment to determine the degree of HAND the person with HIV is experiencing.
- Falls, which may result from multiple underlying causes (such as functional impairment, frailty, gait instability, cognitive impairment, and adverse reactions to medications), are especially important to monitor and address because of the increased risk of osteoporosis and fractures among people with HIV.
- Polypharmacy among older adults is common,[14] is associated with a higher risk of falls,[15] and is especially challenging in people aging with HIV because they must take ART, in addition to other medications for comorbidities, as well as over-the-counter medications, vitamins, and supplements. Polypharmacy may contribute to cognitive impairment.[16]

COMMON GAPS IN MEDICAL MANAGEMENT FOR PEOPLE AGING WITH HIV

Health care for people aging with HIV is an evolving field with new models of care, and recommendations are beginning to emerge. However, some common gaps in medical management that have already been identified include the following:

- Lack of knowledge about access to affordable hearing aids, glasses, and dental care

- Failure to assess functional or cognitive status and depression
- Limited awareness of decreased vaccine responses due to aging
- Failure to address sexual health, which may be less likely to be discussed because of competing comorbidities or the perception that older people are not sexually active. Providers should continue to ask about sexual activity—including asking about intimate partner violence—and provide appropriate guidance and treatment.

Care of People Aging with HIV Toolkit

The Northeast/Caribbean AIDS Education and Training Center has developed a Care of People Aging with HIV Toolkit. The toolkit provides links to screening and assessment instruments, along with programs and papers that offer clinically useful materials.

SCREENING TOOLS FOR GERIATRIC CONDITIONS AMONG PEOPLE AGING WITH HIV

Functional Assessment

A patient's functional status is his or her ability to carry out tasks needed for day-to-day living. These tasks are grouped mostly into activities of daily living—which includes dressing, transferring, eating, grooming, and bathing—and instrumental activities of daily living, such as taking medications accurately, managing funds, using a telephone, grocery shopping, and preparing meals. Different tools are available for assessing a patient's functional status. The majority of these tools are self-reported questionnaires and may be applicable in a primary care setting. Linkage to resources on home health, nursing homes, day programs, and wellness centers can be initiated from the outcome of these assessments.

Frailty, Gait, and Falls Assessment

Frailty, gait, and falls are interrelated. Frailty is a clinically recognizable state of increased vulnerability resulting from an aging-associated decline in reserve and function across multiple physiologic systems, such that the ability to cope with everyday or acute stressors is compromised.[17,18] Gait is one component used to determine a person's frailty. Increased frailty and poor gait result in more falls. According to the frailty criteria developed in the Cardiovascular Health Study, the overall prevalence of frailty in community-dwelling adults age 65 years or older in the United States ranged from 7 to 12 percent and increased with age.[17] Gustafson and colleagues found that women with HIV were more likely to have frailty compared with women without HIV.[19] Various screening tools are available for frailty and gait. See the Care of People Aging with HIV Toolkit for links to some of these tools.

Cognition Assessment: General and HIV-Specific

The U.S. Prevention Task Force has concluded that overall evidence is insufficient to make a single recommendation on screening for mild cognitive impairment; however, Medicare began covering the cost of diagnosing cognitive impairment as part of the annual wellness visit benefit in 2011.[20] Although no robust treatment options exist for cognitive impairment and little evidence supports that early detection will improve the patient's outcome,[21] early detection of cognitive impairment can allow both patients and family members to start planning while the patient is still capable of making informed decisions. The health care team should conduct cognitive assessment screening if individuals complain of memory impairment or other symptoms or if family members identify lapses in memory. Furthermore, the health care team should assess the medications provided to people with HIV to identify and remediate any drug interactions that may cause cognitive impairment.

Although ART is effective at repressing circulating HIV, the central nervous system (CNS) may serve as a reservoir for HIV. Several ART medications are unable to cross the blood-brain barrier to target CNS-specific HIV, allowing the virus to continue to replicate. This replication may lead to neurocognitive disorders in people with HIV as they age. Screening and testing tools specific to HAND detection include the Montreal Cognitive Assessment (MoCA),[22] Frascati criteria,[23] and the HIV dementia scale.[24] In a recent study, prevalence estimates for HAND diagnoses were 33 percent for asymptomatic neurocognitive impairment (ANI), 12 percent for mild neurocognitive disorder (MND), and

2 percent for HIV-associated dementia (HAD).[25] Although the incidence of HAD has been decreasing in recent years, the overall prevalence of all
HAND diagnoses has remained high or has increased over the same period, despite widespread use of ART.[10,11]

MoCA is a 10-minute cognitive screening tool that is widely used in detecting mild cognitive impairment, especially early HAND. Detection of impairment may warrant further evaluation or referral to a geriatrician, neurologist, or neuropsychologist. It may be beneficial to interview the patient's family or persons who are close enough to identify changes in cognitive function.

National HIV Curriculum

The National HIV Curriculum, funded by the Health Resources and Services Administration AIDS Education and Training Center Program, provides ongoing, up-to-date information needed to meet the core competency knowledge for health care providers in the United States. A special topic section on "HIV in Older Adults" is available that covers many of the issues raised in this short report.

Free Continuing Medical Education contact hours and Continuing Medical Education credits are offered throughout the website. Pharmacology Continuing Education for advanced practice nurses is also available for many activities.

Depression Assessment

The National Institute of Mental Health considers depression in older adults to be a significant public health problem.[26] Although widespread, depression in older adults often is undiagnosed and untreated, and the system of care for the treatment of depression lacks a unified approach. A thorough clinical evaluation is essential. Insomnia, which is very common in the older adults, is both a symptom of and a risk factor for depression. Left untreated, depression may contribute to physical, social, and cognitive impairment. Depression may delay recovery from medical treatments and may, in some cases, lead to suicide.

SOCIAL CHALLENGES OF PEOPLE AGING WITH HIV

- **Social isolation** may become more acute among people aging with HIV, particularly those who have experienced the loss of close friends to HIV throughout the past four decades or those who have limited family support.
- **Disclosure of medical information** is a relevant issue for people aging with HIV, who may wrestle with decisions about which components of their medical history they want to disclose to family or friends who may be supporting them.
- **Food and housing insecurity** are often areas of concern for people aging with HIV.
- **Financial management and management of health care benefits**, such as Medicare and Social Security, become more challenging as Americans age and can be especially complex for people aging with HIV because of the high cost of ART and treatment for comorbidities.
- **Traumatic life events** may affect the mental health of people aging with HIV, specifically those who have experienced trauma earlier in life, adding importance to intimate partner violence screening.

CONCLUSIONS

Providing optimal care for people aging with HIV requires a specific focus but can be incorporated into existing HIV care systems. A multidisciplinary approach that balances quality of life with medical necessity, as well as addressing the unique needs of people aging with HIV, is likely to result in improved health outcomes for this population.

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Guidance: Addressing the Needs of Older Patients in HIV Care

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Contents

Purpose of This Guidance

Purpose: Because published evidence to support clinical recommendations is not currently available, this guidance on addressing the needs of older patients in HIV care was developed by the New York State Department of Health AIDS Institute (NYSDOH AI) to present good practices to help clinicians recognize and address the needs of older patients with HIV.

The goals of this guidance are to:

- Raise clinicians' awareness of the needs and concerns of patients with HIV who are ≥50 years old.
- Inform clinicians about an aging-related approach to older patients with HIV.
- Highlight good practices to help clinicians provide optimal care for this population.
- Provide resources about aging with HIV for healthcare providers and their patients.
- Suggest steps to guide medical settings in implementing geriatric care into HIV clinical practice.

Ensuring appropriate care delivery: Although the effects of HIV on aging have been studied for years, HIV care has been acknowledged only recently as a domain of geriatrics [Guaraldi and Rockwood 2017]. Geriatric assessment provides a complete view of a patient's function, cognition, and health, and improves prognostication and treatment decisions [Singh, et al. 2017]. As the population with HIV grows older, application of the principles of geriatrics can enhance quality of care.

Definition of "older": Published studies differ in their definitions of older patients with HIV (e.g., ≥50 years, ≥55 years, ≥60 years), and the needs of individuals within different age groups may differ markedly. This guidance defines older patients as those ≥50 years old, which is the same definition used by the U.S. Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV [DHHS 2022].

Demographics: At the end of 2020, according to the Centers for Disease Control and Prevention (CDC), more than 52% of people with HIV in the United States were ≥50 years old [CDC 2022]. As of the end of 2020 in New York State, 60% of people with HIV were ≥50 years old, and nearly 30% were ≥60 years old [NYCDHMH 2021]. That same year, almost 19% of new HIV diagnoses in New York State occurred in people ≥50 years old, and one-third of them had progressed to AIDS at the time of diagnosis [NYCDHMH 2021]. In light of these New York State demographics, the NYSDOH AI has developed this guidance to help care providers expand services for older people with HIV.

◊ COVID-19: RESOURCES AND GUIDANCE

For treatment guidelines on COVID-19 and other information for healthcare providers in New York State, the NYSDOH AI Clinical Guidelines Program advises clinicians to consult the following resources:

- NYSDOH: COVID-19
- DHHS: Guidance for COVID-19 and Persons with HIV
- CDC: Healthcare Workers: Information on COVID-19
- NIH: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines

Recognizing and Addressing Effects of Aging in Older Patients With HIV

→ GOOD PRACTICES

Recognizing and Addressing Effects of Aging

- With patients who have HIV and are ≥50 years old, discussing the effects of aging can help identify medical priorities and evaluate physical function. Such conversations may also prompt consideration of advance directives and help patients recognize effects of ageism stigma.
- Use of a framework such as the "Geriatric 5 Ms: Mind, Mobility, Medications, Multimorbidity, and Matters Most" can help address issues of aging in patients with HIV.
- Becoming familiar with the many available screening tools and local and national services will help meet the needs of older patients with HIV.
- In older patients with HIV who are being treated for multiple comorbidities, prioritization of treatment plans may help reduce the potential for polypharmacy.
- Evaluation of medication lists at every clinical visit to identify and mitigate potentially harmful drug-drug interactions will help minimize the effects of polypharmacy in older patients with HIV.
- Familiarity with the benefits and local sources of palliative care will help clinicians recognize and meet the needs of older patients who have HIV and other serious illnesses.
- Referral to a social worker or care coordinator can help older patients with HIV to transition from commercial insurance or Special Needs Plans (SNPs) to Medicare without experiencing a loss of services or medication coverage.

Effects of Aging

Long-term survivors, defined as those who have had HIV for more than 2 decades, and especially those who were diagnosed with HIV before the era of effective antiretroviral therapy (ART), appear to have physiologic changes consistent with advanced aging, even at the level of gene expression and modification [De Francesco, et al. 2019]. When compared with age-matched controls who do not have HIV, older patients with HIV have more comorbidities and polypharmacy [Kong, et al. 2019; Guaraldi, et al. 2018]; poorer bone health [Erlandson, et al. 2016]; and higher rates of cognitive decline [Goodkin, et al. 2017; Vance, et al. 2016], depression [Do, et al. 2014], and aging-related syndromes, such as gait impairment and frailty [Falutz 2020]. Mental health can also be affected in many ways; in 1 study of individuals with HIV ≥50 years old in San Francisco, the majority of participants reported loneliness, poor social support, and/or depression, and nearly half reported anxiety [John, et al. 2016]. Older individuals may also experience negative effects due to the stigma of ageism, which may be compounded by other kinds of stigma, such as racial, gender, or HIV-related stigma [Johnson Shen, et al. 2019]. In addition, long-term survivors, who may have expected to die at a young age like so many of their peers, may feel survivor's guilt [Machado 2012].

These age-related concerns are not limited to long-term survivors. Although individuals who are ≥50 years old with newly diagnosed HIV are not likely to exhibit the same degree of age advancement as those who have lived a long time with HIV, they may have a delayed diagnosis, lower CD4 counts, and AIDS at the time of diagnosis [Tavoschi, et al. 2017]. Late initiation of ART increases their long-term risk of complications [Molina, et al. 2018].

Sex differences in the effect of HIV on aging remain an area of controversy. Studies in several countries have found that women with HIV have life expectancies closer to their HIV-negative counterparts than do men with HIV, but this finding has not been supported by studies in North America [Wandeler, et al. 2016; Samji, et al. 2013]. A Canadian study showed shortened life expectancy among women with HIV compared to men with HIV [Hogg, et al. 2017]. Women with HIV in resource-rich countries appear to have a heightened risk of cardiovascular disease [Stone, et al. 2017], cognitive loss [Maki, et al. 2018], and more rapid declines in bone mineral density [Erlandson, et al. 2018].

Approach to Aging in HIV Care

It is essential to discuss aging-related concerns with patients with HIV who are ≥50 years old. Some HIV healthcare providers and their patients have enduring relationships. Such longstanding ties promote high levels of trust, but they can also inhibit exploration of new concerns and promote too tight a focus on keeping viral load undetectable and treating common comorbidities. As a consequence, older individuals with HIV may not recognize concerns as aging-related or may feel it is inappropriate to discuss aging; HIV care providers may have never addressed aging-related needs with patients or developed facility with geriatric assessment.

Care of older patients with HIV begins with recognizing that aging-related issues are a fundamental part of primary care. Geriatric concerns do not supplant other medical conditions; they reframe them in light of a multiplicity of problems and a finite lifespan. A geriatric approach, even for people in their 50s, can improve quality of care.

Older people with HIV may range from age 50 to age 80 and beyond and are a heterogeneous group. Providing care for older patients requires balance to avoid ageism and neglect of essential care *and* prevent excessive, dangerous, or unnecessary treatments. Determining what is appropriate for patients begins with an assessment of their health and their priorities. At its most basic, the geriatric approach can be described as attention to the "5Ms": Mind, Mobility, Multimorbidity, Medications, and Matters Most [Tinetti, et al. 2017]. Although certain aging-related syndromes (e.g., dizziness, incontinence) may not easily fit into one of these categories, the 5Ms have been useful as a way to understand how geriatricians help patients reframe and discuss their problems and their needs (see Table 1: The "5M" Assessment Domains for Older People With HIV and Selected Tools and Resources).

Mind: This category includes all domains of behavioral health, including cognition, mood, and other disorders. General assessment questions about instrumental activities of daily living (e.g., using transportation, managing medications, and handling finances) can provide information about practical concerns and offer clues about cognitive or emotional barriers to self-care. Healthcare providers can also use specific tools (see Table 1) to screen patients for disorders such as depression or cognitive impairment, which may be caused by factors both related to and independent of HIV [Winston and Spudich 2020].

Mobility: Healthcare providers can begin to address mobility with a general assessment of activities of daily living to determine whether patients have difficulty dressing or bathing. Discussion of a patient's fall risk can begin with a question such as, "Have you fallen in the past year?" or healthcare providers can use a comprehensive fall-risk screening tool (see Table 1).

Many aging-related syndromes, such as frailty and gait disorders, fall into the mobility category. Frailty, often defined as an increased vulnerability to stressors [Bloch 2018], is more prevalent in individuals with HIV compared with age-matched controls [Levett, et al. 2016]. There are many ways to measure frailty, and some can be easily adapted to the clinical setting [Morley, et al. 2013]. Physical activity is an important way to prevent age-related mobility syndromes and evidence-based guidelines for individuals with HIV are available [Montoya, et al. 2019].

Multimorbidity: Care for older patients with HIV usually involves management of multiple comorbidities, each of which may require treatment with multiple medications. Nonpharmacologic management (e.g., smoking cessation, dietary modification, exercise) can also improve symptoms associated with multiple comorbidities [Fitch 2019].

A geriatric perspective recognizes that, in patients with multimorbidities, strict adherence to multiple disease-based treatment guidelines may not be possible or may jeopardize a patient's health. A recent review promotes a "6th M" to suggest that clinicians and patients should focus on problems that are "modifiable" [Erlandson and Karris 2019]. Simultaneous management of multiple chronic conditions necessitates establishing treatment priorities [Yarnall, et al. 2017], which requires understanding a patient's priorities [Tinetti, et al. 2019].

Medications: Many older individuals with HIV take antiretroviral medications to suppress the virus and take other medications to treat comorbidities, which can make medication management especially challenging. Medication evaluation should include a review of all medications, potential drug-drug interactions [Livio and Marzolini 2019], and

short- and long-term toxicities. It may be beneficial to simplify antiretroviral and other medication regimens to ensure that harms from drug-drug interactions and other adverse effects of treatment are avoided [Del Carmen, et al. 2019]. Caution is required when adjusting or simplifying antiretrovirals if regimen changes involve either initiating or discontinuing a medication with pharmacologic inhibitive or induction actions; these changes may have an effect on levels of co-administered medications.

Consultation with a pharmacist can help clinicians manage the complexities of polypharmacy and medication adjustments in older patients. Online resources to are available as well; see:

- University of Liverpool: HIV Drug Interactions Checker
- NYSDOH AI: ART Drug-Drug Interactions

Matters Most: This is the broadest category and includes medical and social priorities, sexual health, and advance directives. Asking questions such as, "Have you thought about aging?" or "What would you like to know about aging with HIV?" creates opportunities to learn about patient's concerns about the future and to discuss survivorship, guilt, ageism, financial worries, and other concerns [Del Carmen, et al. 2019].

Many consider sexuality an essential part of health at any age. There is no age limit at which clinicians should stop taking a sexual history or discussing HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for partners (see the NYSDOH AI guidelines PrEP to Prevent HIV and Promote Sexual Health and PEP to Prevent HIV Infection). Initiating discussions of sexual health, including topics such as erectile dysfunction and loss of libido in men, menopause and post-menopausal sex in women, and screening for sexually transmitted infections as needed, may also provide insights into relationships and the strength of a patient's social network. For more information, see CDC Sexually Transmitted Infections Treatment Guidelines, 2021 > Screening.

Overall, patient health and priorities, rather than age, direct the frequency of cancer screening in individuals with HIV. The literature on adherence to cancer screening guidelines among individuals with HIV is mixed, with most [Corrigan, et al. 2019], but not all [Barnes, et al. 2018], studies failing to find that older individuals were screened less frequently. In patients with a good prognosis, clinicians should continue to follow screening guidelines (see the NYSDOH AI guideline Comprehensive Primary Care for Adults With HIV > Routine Screening and Primary Prevention). Screening can be re-evaluated when it conflicts with patient priorities, or patient prognosis is poor.

Addressing aging-related concerns directly can help older patients with HIV discuss financial concerns and prepare for the future when more personal assistance may be needed. Discussion of insurance coverage can provide an opportunity to help patients prepare for the transition from commercial insurance or SNPs to Medicare-based plans. Planning is essential because these often offer far more comprehensive care coordination, medication coverage, and health-maintenance services than Medicare-based plans.

"Matters most" topics may also include discussion of palliative care and frank discussion of long-term care needs and end-of-life plans. Advance directives should be addressed and, if an advance directive is in place, revisited. It is preferable for the patient to designate a specific agent or agents who can speak for them when they are incapacitated. Those patients who cannot or will not identify a trusted individual to be their agent can complete the NYSDOH Medical Orders for Life-Sustaining Treatment (MOLST) to describe their wishes regarding medical treatment.

Geriatric Assessment

The gold standard for geriatric evaluation is the Comprehensive Geriatric Assessment (CGA), which assesses multiple domains of health and function [Singh, et al. 2017]. Because it is comprehensive, the CGA is lengthy, and its use may not be feasible in many clinical settings (administration can take longer than 1 hour). Table 1 lists domains of geriatric assessment and relevant available resources for older patients with HIV, organized according to the geriatric 5Ms. Clinicians can perform a global assessment such as the one used in the Medicare Annual Wellness Visit [CMS 2022] or choose 1 or several specific areas for focus.

It may be difficult to implement needed aging-related assessments when access to expertise or funding is limited, but every attempt should be made to assess aging-related issues to the degree possible.

Table 1: The "5M" Assessment Domains for Older People With HIV and Selected Tools and Resources		
Assessment	**Source**	**Tools and Resources**
MIND		
Cognition	Hartford Institute for Geriatric Nursing	Lawton Instrumental Activities of Daily Living (IADL) Scale
	Montreal Cognitive Assessment (MoCA)	MoCA© Test (Note: As of September 2020, registration and training will be required.)
	Alzheimer's Association	Alzheimer's Disease Pocketcard mobile app (Note: Available for download through the Apple App Store or Google Play.)
	Mini-Cog©	Mini-Cog© Quick Screening for Early Dementia Detection
Social isolation, loneliness	Campaign to End Loneliness	• Report: The Psychology of Loneliness • Information on Loneliness • Research on Loneliness • Resources
	UCSF > Stress Measurement Network	Stress Measurement Toolbox
Mental health	Calculate by QxMD	Patient Health Questionnaire-4 (PHQ-4): Ultra-Brief Screening for Anxiety and Depression
	SAMHSA	Growing Older: Providing Integrated Care for an Aging Population
	CDC > HIV Basics	HIV Stigma and Discrimination
MOBILITY		
Gait, balance, activity level, fall risk, exercise	Alzheimer's Association	Katz Index of Independence in Activities of Daily Living
	CDC > STEADI: Stopping Elderly Accidents, Deaths, and Injuries	• Algorithm for Fall Risk Screening, Assessment, and Intervention • Preventing Falls in Older Patients: Provider Pocket Guide • Functional Assessments
	Article [Phelan, et al. 2015]	Assessment and management of fall risk in primary care settings
	American College of Sports Medicine	Exercise is Medicine® Health Care Providers Action Guide
	Article [Montoya, et al. 2019]	Evidence-informed practical recommendations for increasing physical activity among persons living with HIV
Frailty	Comprehensive Geriatric Assessment (CGA)	CGA Toolkit Plus: Frailty
MULTIMORBIDITY		
Management of multiple chronic conditions	Article [Boyd, et al. 2019]	Decision making for older adults with multiple chronic conditions: executive summary for the American Geriatrics Society Guiding Principles on the Care of Older Adults With Multimorbidity
Bone health	Article [Brown, et al. 2015]	Recommendations for evaluation and management of bone disease in HIV
	Article [Biver, et al. 2019]	Diagnosis, prevention, and treatment of bone fragility in people living with HIV: a position statement from the Swiss Association Against Osteoporosis
	Article [Starup-Linde, et al. 2020]	Management of osteoporosis in patients living with HIV—a systematic review and meta-analysis
Continence	National Association for Continence	Resources for Healthcare Providers
Food insecurity	USDA > Food Security in the U.S.	Survey Tools
Obesity and lipohypertrophy	Article [Lake, et al. 2017]	Practical review of recognition and management of obesity and lipohypertrophy in human immunodeficiency virus infection

Table 1: The "5M" Assessment Domains for Older People With HIV and Selected Tools and Resources		
Assessment	**Source**	**Tools and Resources**
MEDICATIONS		
Polypharmacy and drug-drug interactions	Article [O'Mahony, et al. 2015]	STOPP/START criteria for potentially inappropriate prescribing in older people: version 2
	University of Liverpool > HIV Drug Interactions	HIV Drug Interactions Checker
	NYSDOH AI Clinical Guidelines Program	• ART Drug-Drug Interactions • ARV Dose Adjustments for Hepatic or Renal Impairment
	Article [AGS 2019]	American Geriatrics Society 2019 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults
MATTERS MOST		
Sexual health	NYSDOH AI Clinical Guidelines Program	GOALS Framework for Sexual History Taking in Primary Care
Advance directives	NYSDOH	• Health Care Proxy: Appointing Your Health Care Agent in New York State (includes fillable form) • Medical Orders for Life-Sustaining Treatment (MOLST)
Working with family caregivers	United Hospital Fund > Next Step in Care	Toolkits, Guides, and More for Health Care Providers
Elder abuse	New York State Coalition on Elder Abuse	• Understanding Elder Abuse • Research & Education
	National Center on Elder Abuse	• Suspect Abuse > Get Help • Reporting Abuse
Quality of life	CDC > Health-Related Quality of Life (HRQOL)	CDC HRQOL-14 "Healthy Days Measure"
Pain management	Article [Bruce, et al. 2017]	2017 HIVMA of IDSA Clinical Practice Guideline for the management of chronic pain in patients living with HIV
Palliative care	Article [Harding 2018]	Palliative care as an essential component of the HIV care continuum
Prognosis	Yale School of Medicine > Veterans Aging Cohort Study (VACS)	VACS Index Calculator
	UCSF	ePrognosis Calculators
Abbreviations: CDC, Centers for Disease Control and Prevention; SAMHSA, Substance Use and Mental Health Services Administration; UCSF, University of California San Francisco; USDA, U.S. Department of Agriculture.		

Integrating the Needs of Older Patients With HIV Into Medical Settings

This guidance is designed to foster a shift in the practitioner's perspective when caring for older patients with HIV. However, the clinician cannot provide optimal care in the absence of support. Clinical practices can also begin to address HIV-related aging issues by taking the steps outlined below.

1. Assess the clinic's ability to meet the needs of older patients with HIV:

- Review the demographics of the patient population to identify the number of patients in need of aging-related services at present and in the near- and long-term.
- Track patient requests for aging-related services and identify options for responding to those requests.
- Identify resources needed to address any aging-related priorities identified by a community or clinic advisory board.

- Identify clinic care providers who are experienced in geriatrics or the care of older patients.
- If the clinic is not able to provide multidisciplinary, comprehensive services, identify how the clinic can assist patients in accessing needed services.
- Anticipate problems with finances and insurance coverage for those approaching age 65 (earlier, for those on disability) who are transitioning to Medicare.

2. Engage older patients with HIV in program planning:

- Provide ample opportunities for patients and clinical care providers and staff to identify needs to be addressed. This is an essential step for programs of any size. The University of California San Francisco (UCSF) used extensive patient input to develop its Golden Compass program for older individuals with HIV [Greene, et al. 2015].
- Provide opportunities for discussion of ageism and stigma, so patients and clinical care providers and staff can understand and identify its effects and how to address them.
- Develop a wish list of services and be realistic about what is possible. Set goals and a timeline for program development.

3. Consider options and develop protocols for identifying patients in need of aging-related care and services. For example, patients may be identified based on:

- Age, such that all patients with HIV who are ≥50 years old should be assessed
- Prognosis, such that a prognostic threshold for referral is established based on measures such as the Veterans Aging Cohort Study (VACS) Index Calculator
- Clinical criteria, such as a recent history of falls, deteriorating memory, polypharmacy, or frailty
- Patient request

4. Develop an assessment strategy:

- Identify who will perform assessments and how results will be communicated to patients and other care providers involved with the patient.
- Determine the scope of assessment: Will it focus on one particular problem (e.g., gait disorders, cognition), or will assessment address a broad array of problems? Examples of assessment types include the following:
  - **Global geriatric screening tools:** Global geriatric screening tools are available for administration by clinical staff or patient self-administration, at home or in the clinic. Dedicated time for assessment may be scheduled as part of primary care, following a model such as the Medicare Annual Wellness Visit [CMS 2022]. Some clinics may collaborate with aging specialists, such as geriatricians or nurse practitioners who specialize in gerontology and can perform a comprehensive geriatric assessment.
  - **Specific screening tools:** If a clinic has decided to focus on one or several specific assessments, these can be built into the workflow. For example, a clinic could determine that all patients ≥50 years old will be screened for fall risk and cognitive impairment. In this case, patients could be asked to complete a fall-risk evaluation, such as the Centers for Disease Control and Prevention STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention, before the visit, or a nurse could administer a timed walk test while the patient is walking from the waiting room to the exam room.
  - Any of the domains listed in Table 1: The "5M" Assessment Domains for Older People With HIV and Selected Tools and Resources would be appropriate for inclusion in a program to enhance care of older individuals with HIV.

5. Develop protocols for referral:

- Identify aging-related care and services that can be provided on-site and care and services that require referral to an external source. Referral protocols can be problem-specific. For example, if a patient is assessed as being at high risk for falls, the clinic should take a standard approach to address that risk, which could include referral to physical therapy, podiatry, or neurology; medication review by a pharmacist; home safety assessment; and/or an exercise program.
- Identify local specialty care providers to whom patients can be referred.

◊ ONLINE CLINICAL RESOURCES FOR AGING AND GERIATRIC CARE	
AETC National Coordinating Resource Center	Care of People Aging with HIV: Northeast/ Caribbean AETC Toolkit
American Academy of HIV Medicine > HIV & Aging	Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV
American Geriatrics Society > Geriatrics Healthcare Professionals	Geriatrics Workforce Enhancement Program: • National Coordinating Center • Finger Lakes Geriatric Education Center (Rochester, Ithaca) • Johns Hopkins Medicine
WHO > Ageing	Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care

Linking to the aging services network: An essential part of care for individuals with HIV who are ≥60 years old is connecting to the aging services network, which was initiated through the Older Americans Act of 1965 [National Health Policy Forum 2012]. Social work and care coordination staff should become familiar with the services that are offered locally and should assist clients in preparing for the transition to Medicare when medication benefits and care coordination change.

◊ ONLINE RESOURCES FOR AGING SERVICES AND ENTITLEMENT
• Aging and Disability Resource Centers • Eldercare Locator • Medicare Rights Center • USAging: Area Agencies on Aging • National Council on Aging: BenefitsCheckUp • New York State Office for the Aging (provides links to local agencies on aging and other resources like the state Aging and Disability Resource Center) • SAGE: Advocacy and Services for LGBTQ+ Elders

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