FY 2024 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: 05/10/2023)	
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.	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 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 clients living with HIV, 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/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. Within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30-day time limit. If multiple waivers are required, they do not need to be submitted consecutively. 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 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
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: **RWGA Only**	**Primary Medical Care:** • 100% of clients served under the *Targeted to Women at Public 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. Within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30-day time limit. If multiple waivers are required, they do not need to be submitted consecutively. 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 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2024 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: 5/10/2023)	
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)
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 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. **Outreach:** 1 unit of service = 15 minutes of direct client service providing outreach services by a Outreach Worker for eligible clients living with HIV, 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/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/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; • 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. Within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30-day time limit. If multiple waivers are required, they do not need to be submitted consecutively. 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. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWHA 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 living 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 acquiring 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/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 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

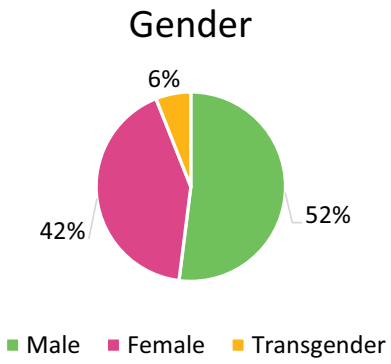
Harris County
Public Health
Building a Healthy Community

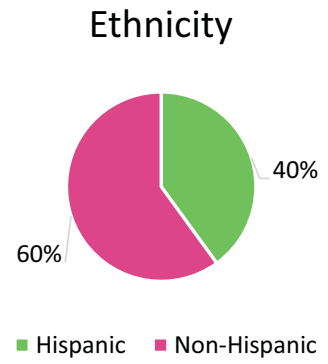
Ryan White Part A, Houston EMA FY20-21 Clinical Care Chart Review Summary of Findings

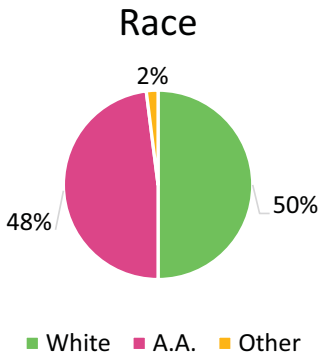
Review period was March 1, 2020 - February 28, 2021

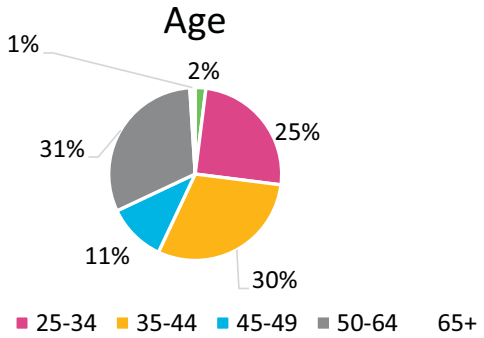
Primary Care Chart Review

- 635 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, and age demographics of each site's overall primary care population
- Female and Transgender clients were oversampled to adequately capture performance data for these populations









Primary Care Measures

Performance Measures	FY19 Rate	FY20 Rate	Change	Goal
Viral Load Suppression	89.4%	90.1%	–	90%
ART Prescription	98.7%	100%	–	95%
PCP Prophylaxis	89.5%	100%	↑	100%
Viral Load Monitoring	97.5%	97.3%	–	90%
HIV Drug Resistance Testing	71.4%	100%	↑	85%
Influenza Vaccination	68.2%	49.7%	↓	65%
Lipid Screening	88.4%	93.5%	↑	90%
Tuberculosis Screening	74.7%	80.1%	↑	75%
Cervical Cancer	82.3%	80.3%	–	75%
STI Testing	79.7%	79.2%	–	65%
Hepatitis B Screening	89.9%	92.6%	↑	95%

Primary Care Measures

Performance Measures	FY19 Rate	FY20 Rate	Change	Goal
Hepatitis B Vaccination	51.8%	52%	–	55%
Hepatitis C Screening	96.4%	96.2%	–	95%
HIV Risk Counseling	81.9%	88%	↑	85%
Pneumococcal	85.5%	85.2%	–	90%
Mental Health Screening	95.1%	96.7%	–	95%
Tobacco Screening	99.8%	99.8%	–	100%
Smoking Cessation Counseling	68%	72%	–	100%
Substance Use Screening	99.5%	98.9%	–	95%
Syphilis Screening	94.5%	95.1%	–	85%

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

Clinical Case Management
All Providers

For FY 2020 (3/1/2020 to 2/28/2021), 1,046 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2019	FY 2020	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	732 (56.4%)	580 (55.5%)	**-0.9%**
35% of clinical case management clients will utilize mental health services	413 (31.8%)	485 (46.4%)	**14.6%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	548 (80.2%)	381 (73.3%)	**-6.9%**
Less than 5% of clients will be homeless or unstably housed	142 (10.9%)	98 (9.4%)	**-1.5%**

According to CPCDMS, 13 (1.2%) clients utilized primary care for the first time and 84 (8.0%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2019
85% of clinical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	7%
Percentage of clients identified with an active substance abuse condition referred to substance abuse treatment	*100%

*Of the 26 clinical case management clients with active substance use disorder, all 26 (100%) received a referral for further treatment.

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%**

KFF

What Do We Know About People with HIV Who Are Not Engaged In Regular HIV Care?

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Key Findings

An ongoing challenge to ending the HIV epidemic in the U.S. is reaching people with HIV who are not receiving regular HIV care and are not virally suppressed. Being engaged in HIV care, including being on antiretroviral therapy, promotes optimal (https://clinicalinfo.hiv.gov/en/guidelines) individual health outcomes and viral suppression, which in turn prevents (https://clinicalinfo.hiv.gov/en/guidelines) transmission of HIV to others. To date, however, robust and representative data on people with HIV who are not receiving regular HIV care have been limited, making it difficult to understand who they are and what barriers they face. This analysis aims to help fill this gap, using nationally representative data to assess the characteristics and experiences of people with HIV who are out of regular HIV care, defined as those who had less than two CD4[1]. or viral load tests at least 3 months apart within a 12-month period *and* were not virally suppressed.

Overall, we find that one-in-five (21%) adults with diagnosed HIV were out-of-care and, compared to their in-care counterparts, they were more likely to report challenges in their interactions with the health system, multiple and complex barriers to access, and unmet needs for ancillary care; they are also more likely to be members of population groups already facing longstanding health disparities. Specifically, we find that:

- People with HIV who were out-of-care were more likely to be Black, young, and to report poorer health status than those in-care. They were also more likely to be uninsured, experience changes in their usual source of care related to insurance changes, and were less likely to have a regular provider or to receive support from the Ryan White Program. There were no statistically significant differences based on state Medicaid expansion status or census region.
- Those out-of-care were more likely to report barriers to care engagement, including in the areas of finances, mental health, and getting to a doctor's office, as well as more dissatisfaction with care than those in-care. They were also more likely to report unmet needs for ancillary social and support services in three domains: clinical, non-HIV medical/behavioral, and subsistence services, with more than half reporting at least one unmet need.
- Whereas virtually all people with HIV in-care were on antiretroviral therapy, a fifth of those out-of- care were not on ARVs, and among those who were, they were more likely to report missing treatment doses. In addition, smaller shares reported being familiar with the concept of treatment as prevention (https://www.cdc.gov/hiv/risk/art/index.html) (TasP) than those in-care, though there were substantial knowledge gaps for both groups.

- Identifying people with HIV who are out-of-care, and better understanding the barriers they face, are first steps towards engaging or reengaging them in-care, addressing their unmet needs, and improving their health status. Doing so could play a role in advancing the goals in the national HIV/AIDS Strategy (https://www.whitehouse.gov/wp-content/uploads/2021/11/National-HIV-AIDS-Strategy.pdf) and the federal Ending the HIV initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/).

Introduction

An ongoing challenge to ending the HIV epidemic in the U.S. is reaching people living with HIV who are out of regular HIV care and not virally suppressed. Being engaged in HIV care, including being on antiretroviral therapy, promotes optimal individual health outcomes (https://clinicalinfo.hiv.gov/en/guidelines) and viral suppression, which also prevents (https://clinicalinfo.hiv.gov/en/guidelines) transmission of HIV. Indeed, an estimated 43% (https://www.cdc.gov/mmwr/volumes/68/wr/mm6811e1.htm) of HIV transmissions are estimated to result from people who were aware of their HIV status but not engaged in care. To date, however, robust and representative data on people with HIV who are not engaged in regular HIV care and the barriers they face have been limited. One exception is a nationally representative analysis (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8628483/) that assessed barriers to care faced by people with HIV who felt they had not received enough care. The current analysis aims to add to this knowledge base, using nationally representative data from the Centers for Disease Control and Prevention's Medical Monitoring Project (MMP). The MMP is a cross-sectional, nationally representative survey of adults with diagnosed HIV in the United States and includes data drawn from both in-depth interviews and medical record abstraction.

For this analysis, we defined people with HIV as not being in care if they (1) had less than two CD4 or viral load tests at least 3 months apart within a 12-month period *and* (2) did not have sustained viral suppression (see box). This definition differs from the one used by the Centers for Disease Control and Prevention which only focuses on lab testing frequency regardless of viral suppression status.[2] By taking this approach, we aimed to identify the most vulnerable individuals within this group, including those who may have the greatest need for targeted engagement efforts. The analysis is limited to adults and is based on data collected between 2018 and 2020 (see Methodology for details).

Table 1: Key Terms

Term	Definition
Out-of-care	Received fewer than two CD4 or viral load tests at least 3 months apart within a 12-month period *AND* had any viral load test where they were virally unsuppressed in the preceding 12 months.
In-care	Received two or more CD4 or viral load tests at least 3 months apart within a 12-month period *OR* was virally suppressed at all tests in the preceding 12 months (regardless of lab test frequency).
Sustained viral suppression	No unsuppressed viral load test results in the preceding 12 months

Findings

Population

Based on the definition described above, 21% of adults with diagnosed HIV were out-of-care during the 2018 to 2020 period. This group was not virally suppressed and had a suboptimal number of recommended lab tests. The remaining 79%, who serve as our comparison group (i.e. those "in-care"), include all those virally suppressed, regardless of the number of lab tests they have received, and others with regular CD4 or viral load labs.

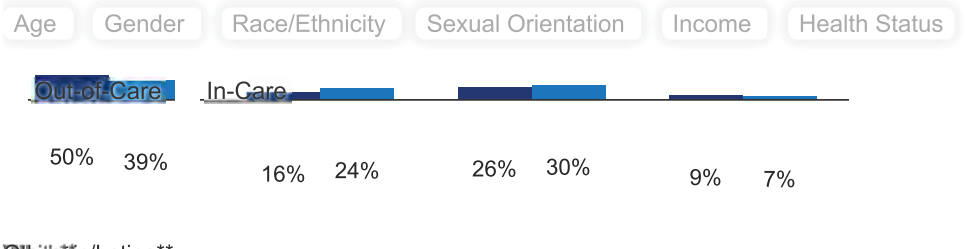
Demographics

People with HIV who were out-of-care differed demographically from those in-care. They were more likely to be Black, younger, and to report poorer self-rated physical health, among other differences (see Figure 1).

- People with HIV who were out-of-care were more likely to be Black (50% of those out of care v. 39% of those in care) and less likely to be Hispanic/Latino (16% v. 24%) or White (26% v. 30%) than those in-care.
- They were also younger than their in-care counterparts, with greater shares between the ages of 18-29 (12% v. 8%) and 30-39 (20% v. 16%). This finding echoes other data (https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-26-no-2/content/national-profile.html) demonstrating lower levels of care engagement among younger people in across certain measures.
- In addition, they were more likely to report "fair or poor" health (35% v. 27%) and less likely to report "excellent or very good" health (28% v. 37%) than those in-care.
- Finally, compared to those in-care, they were somewhat less likely to identify as gay or lesbian (37% v. 42%), have incomes above 400% FPL (9% v. 12%), or be male (72% v. 75%), but there were no other differences in other sexual orientation, poverty, or gender categories.
- There were no statistically significant differences based on state Medicaid expansion status or census region.

Figure 1

Adults with HIV Out-of-Care and In-Care, by Race/Ethnicity



NOTE: ** Age distribution in the in-care v. out of care group significantly different (p<.001). *Age distribution in the in-care v. out of care group significantly different (p<.05)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

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Health Coverage and Ryan White Support

People with HIV who were out-of-care were more likely to be uninsured and less likely to have private insurance than those in-care, but also less likely to receive Ryan White support (see Figure 2).

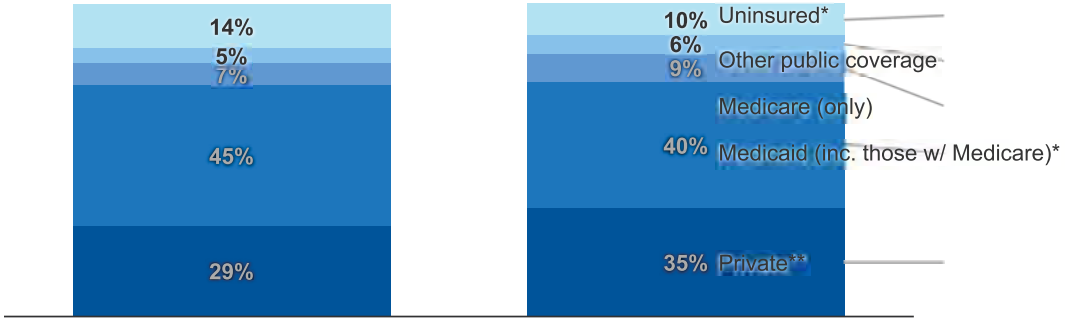
- People with HIV who were out-of-care were more likely to be uninsured (14% v. 10%) or have Medicaid (45% v. 40%) than those in-care, and less likely to have private coverage (29% v. 35%).
- While both groups were similarly likely to report changes to their insurance coverage over the past 12-month period (14% v. 13%), those out-of-care were twice as likely to say this led to a change in their usual source of HIV care (40% v. 19%).
- Finally, compared to their in-care counterparts, those who were out-of-care had significantly lower levels of support from the Ryan White HIV/AIDS Program (39% v. 50%), the nation's HIV safety-net program that provides outpatient HIV care, treatment, and support services to people with HIV who were underinsured and uninsured.

Figure 2

Health Insurance Coverage Among Adults with HIV, Those Out-of-Care and In-Care

Click on the buttons below to see data for the different variables:

Insurance Status | Ryan White Status



NOTE: ** Health status significantly different for the in-care v. out of care group (p<.001) * Health status significantly different for the in-care v. out of care group (p<.05)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

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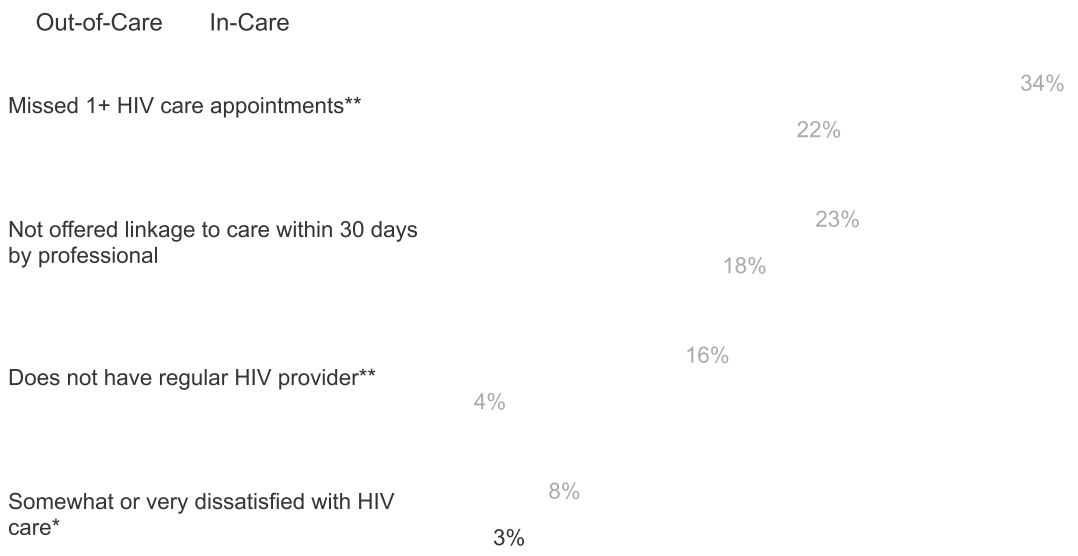
Accessing care

People with HIV who were out-of-care care were less likely to have a regular provider, more likely to be dissatisfied with recent care that they had received, and more likely to have missed appointments, than those in-care.

- While similar shares reported they were not offered assistance in finding HIV care within 30 days of diagnosis by a professional (23% v. 18%), those who were out-of-care were about four times as likely to report not having a regular HIV provider (16% v. 4%).
- In addition, about one-third (34%) of those out-of-care reported missing one or more HIV care appointments in the 12 months prior to the interview compared to one-in-five of those in care (22%).
- They were also more likely to report being “very or somewhat” dissatisfied with the HIV care they received over the preceding 12 months (8% v. 3%).

Figure 3

Linkage to and Experiences with HIV Care Among People with HIV who are Out-of-Care and In-Care



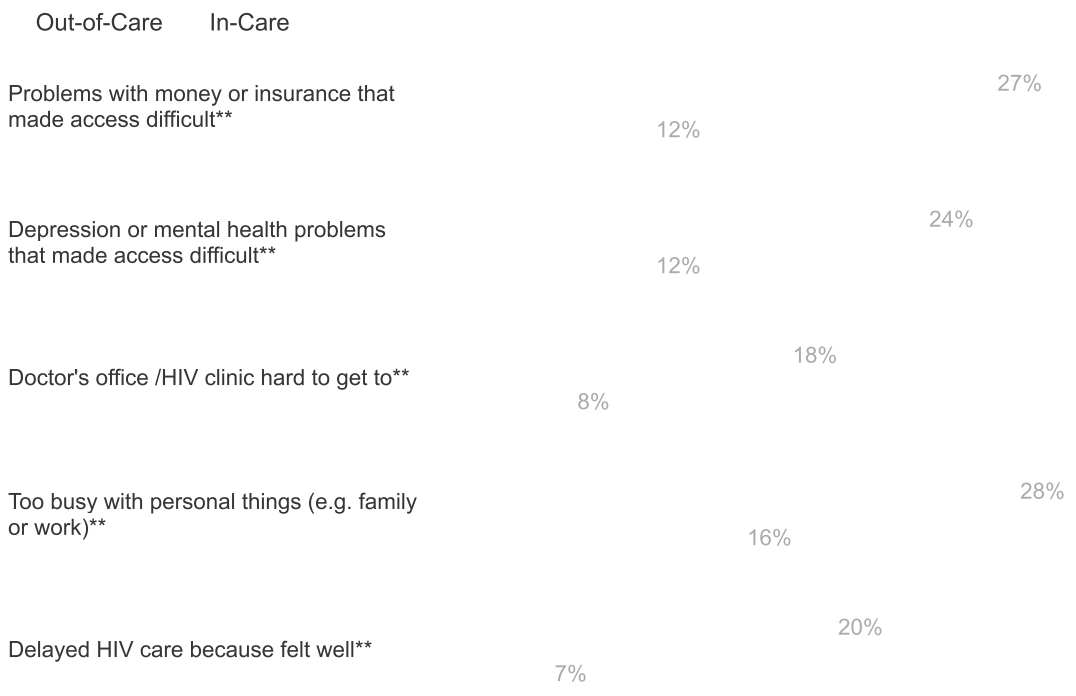
NOTE: ** Variable for the in-care v. out of care group significantly different (p<.001) * Variable for the in-care v. out of care group significantly different (p<.05)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

People with HIV who were out-of-care were also more likely to report certain barriers to care engagement, including in the areas of finances, mental health, and getting to a doctor's office than those in-care.

- Over one-quarter of those reported that problems with money or insurance were barriers to HIV care, compared to just over one-in-ten of those in-care (27% v. 12%). Those out-of-care were also more likely to report facing problems paying medical bills (data not shown).
- In addition, they were twice as likely to report that depression or other mental health problems made it difficult to get HIV care (24% v. 12%), and were more likely to say that personal issues, such as family or work, were barriers to care (28% v 16%).
- About one-in-five (18%) reported that difficulty getting to a doctor's office was a barrier to HIV care, more than double the share of those in care (8%).
- While those out-of-care generally reported more barriers to access, they were also more likely to say they delayed care because they felt well, compared to their in-care counterparts (20% v. 7%).

Figure 4

Barriers to HIV Care in the Preceding 12 Months Among Adults with HIV, Those Out-of-Care and In-Care



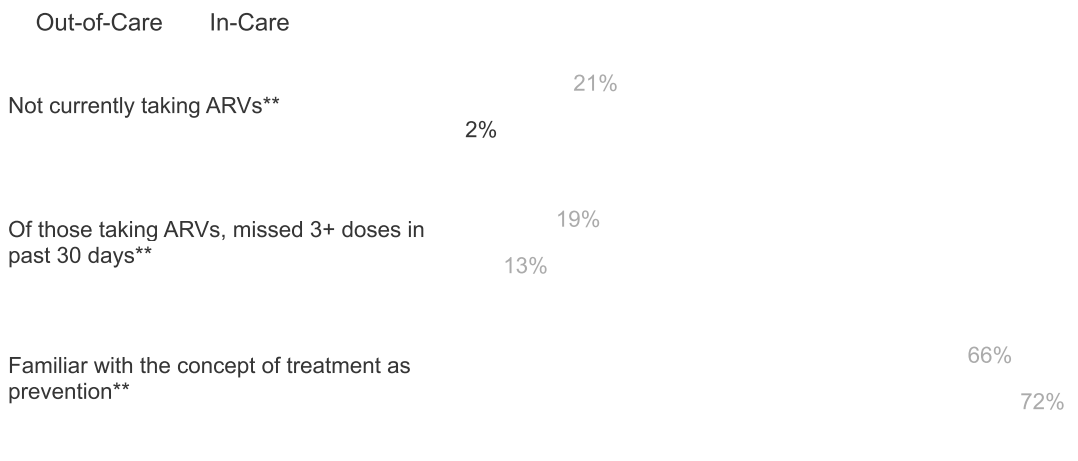
NOTE: ** Variable significantly different for the in-care v. out of care group (p<.001)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019. • PNG

People with HIV who were out-of-care were less likely to report being on antiretroviral therapy, despite the recommendation that such treatment be started as soon as possible (https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines) after diagnosis, and were more likely to report missing ARV treatment doses.

- One-in-five (21%) of those out-of-care reported they were not currently taking ARVs compared to just 2% of those in-care.
- In addition, of those who did report taking ARVs, 19% reported missing three or more doses in the past 30 days, compared to 13% of those in-care.
- While 66% of those who were out-of-care were familiar with the concept of treatment as prevention (i.e. that when someone is virally suppressed due to consistent ARV use, they cannot transmit HIV), one-third were not. In contrast, nearly three-quarters (72%) of those in-care were familiar with the concept.

Figure 5

Experiences with Antiretrovirals (ARVs) Among Adults with HIV, Those Out-of-Care and In-care



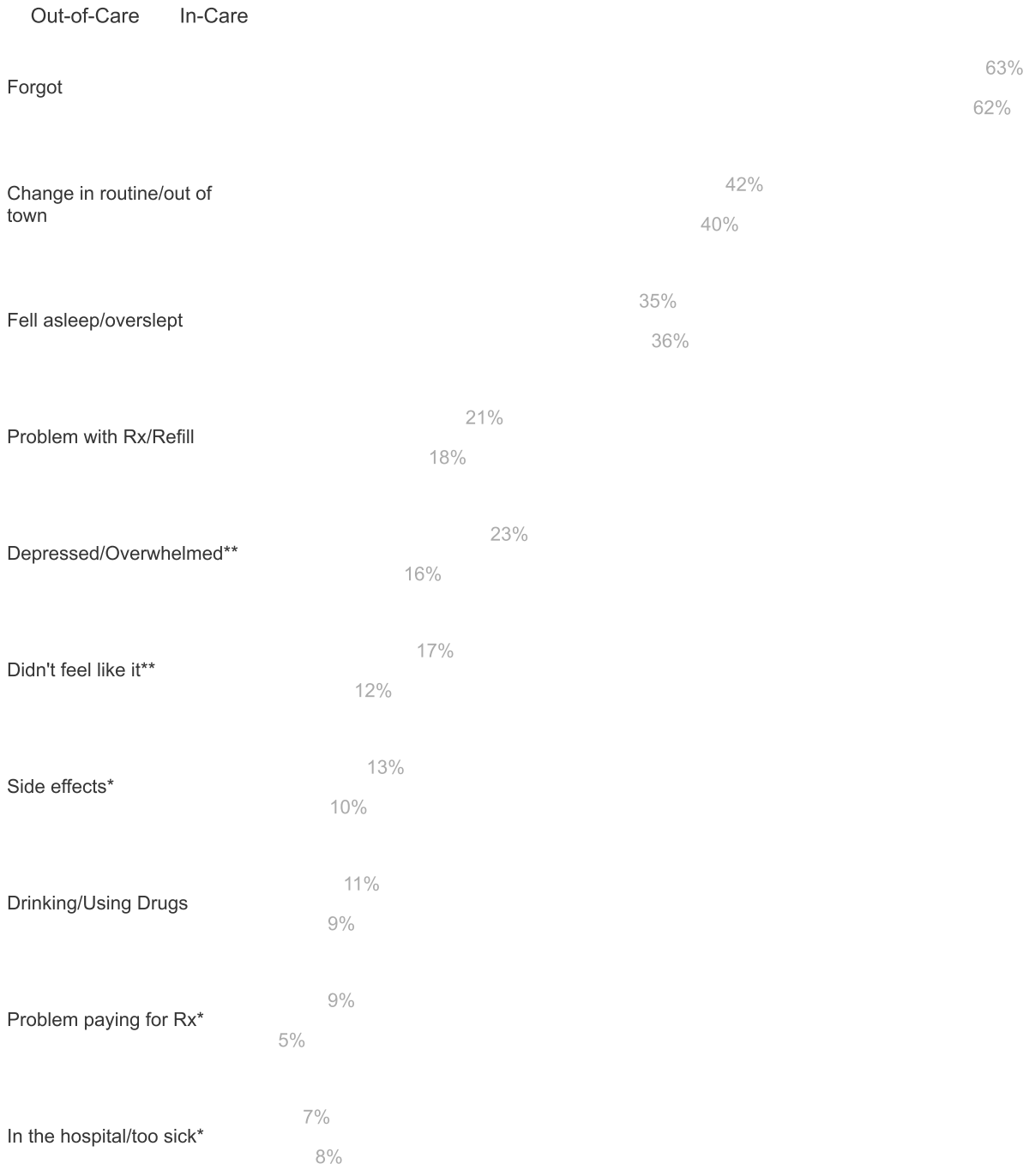
NOTE: ** Variable for the in-care v. out of care group significantly different (p<.001)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

Reasons for missing ARV doses were generally similar between those in and out of care, although there were some exceptions, particularly with respect to mental health challenges.

- For those who were out-of-care, the most common reported reason for missing an ARV dose was forgetting it (63%), followed by a change in daily routine or being out of town (42%), and being asleep (35%). Additionally, about one-in-five reported they had a problem getting a prescription or a refill (21%). Others reported that use of alcohol or drugs (11%) or being too sick or in the hospital (7%) got in the way of taking ARVs. In each case, these were similar to reports from those in-care.
- However, those who were out-of-care were more likely to report the following reasons for not taking ARVs than those in-care: feeling depressed or overwhelmed (23% v. 16%), not feeling like taking the medications (17% v. 12%), , experiencing side effects (13% v. 10%), and having problems paying for the medication (9% v. 5%).

Figure 6

Reasons Adults with HIV Reporting Missing an ARV Dose in the Past 30 Days, Among Those Out-of-Care and In-Care



NOTE: .** Variable significantly different for the in-care v. out of care group (p<.001) * Variable significantly different for the in-care v. out of care group (p<.05)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

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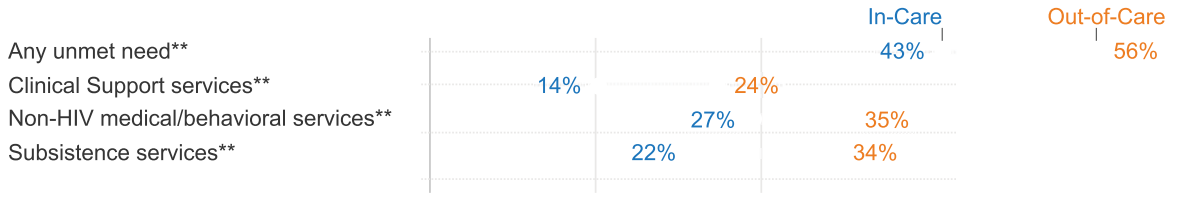
Unmet needs for HIV ancillary services

More than half (56%) of people with HIV who were out-of- care had at least one unmet ancillary care need, across three domains, compared to 43% of the in-care population. Unmet need was higher overall as well as in each domain:

- *Clinical support services*, including case management, adherence counseling, medication through ADAP, peer group, patient navigation services (24% v. 14%)
- *Non-HIV medical/behavioral services*, including dental care, mental health services, drug/alcohol counseling/treatment, and domestic violence services (35% v. 27%)
- *Subsistence services*, including SNAP, WIC, meal or food services, transportation assistance, or shelter/housing services (34% v. 22%).

Figure 7

Unmet Ancillary Care Service Needs Among Adults with HIV, Those In-Care and Out-of-Care



NOTE: ** Variable significantly different for the in-care v. out of care group (p<.001)
Out-of-care defined as receiving < 2 CD4 or viral load tests at least 3 months apart within 12-month period AND having any virally unsuppressed test result in preceding 12 months. In-care defined as receiving 2+ CD4 or viral load tests at least 3 months apart within 12-month period OR being virally suppressed at all tests in the preceding 12 months.
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

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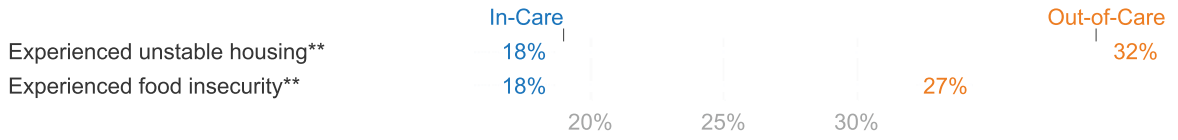
- Specifically, people with HIV who were out-of-care had higher levels of unstable housing or homelessness (32% v. 18%) and hunger/food insecurity (27% v. 18%) over the preceding 12 months.[3]

Figure 8

Experiences of Unstable Housing and Food Insecurity in Prior 12 months Among Adults with HIV, Those In-Care and Out-of-Care



NOTE: ** Variable significantly different for the in-care v. out of care group (p<.001)
SOURCE: KFF/CDC Analysis of the Medical Monitoring Report, 2018 & 2019 • PNG

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Discussion

Identifying people with HIV who are not in HIV care is a first step towards engaging or reengaging them and addressing their unmet needs. While relevant demographic details may help to better design programs for and reach these individuals, there has been limited data available on this population. This analysis provides nationally representative data on people with HIV who are out-of-care, defined as those who were not virally suppressed and did not receive a minimum number of laboratory tests within the prior year, to better

understand their demographics and experiences. We find that in the 2018 to 2020 period, this population was disproportionally younger, uninsured, lower income, and Black. They were also much less likely to be on antiretroviral therapy and many faced overlapping and intersectional structural barriers that can further challenge HIV care engagement and prioritization, including unmet needs for basic, subsistence services such as food, housing, and financial security. That fact that those who were out-of-care were also less likely to be receiving services from the Ryan White Program is notable because the program is a potential resource for reaching this very population with engagement and retention services and in addressing at least some unmet ancillary care needs, though the program is constrained by financial limitations. Additionally, there were substantial knowledge gaps with respect to treatment as prevention, information that may help encourage care engagement when individuals learn they are able to prevent transmission of HIV to sexual partners.

Unless large shares of people with HIV are engaged in care and treatment, it will not be possible to meet most of the goals in the national HIV/AIDS Strategy (https://www.whitehouse.gov/wp-content/uploads/2021/11/National-HIV-AIDS-Strategy.pdf) and the Ending the HIV initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/) (e.g. preventing new infections, reducing disparities, etc.). Progress on these efforts has been somewhat stalled in the U.S., which lags behind (https://www.kff.org/hivaids/slide/hiv-viral-suppression-rate-in-u-s-lowest-among-comparable-high-income-countries-2020-or-latest-year/) peer countries in terms of the national viral suppression level. Reaching and engaging people with HIV who are not engaged in care and not yet virally suppressed, will involve addressing the complex, systemic barriers they face, and which have impeded not only their health and wellbeing but the HIV response in the U.S. more broadly.

Methodology

Data on people with HIV are based on 2018 and 2019 data cycles (which cover data through part of 2020) from the Medical Monitoring Project (MMP), a Centers for Disease Control and Prevention (CDC) surveillance system which produces national and state-level representative estimates of behavioral and clinical characteristics of adults with diagnosed HIV in the United States.

MMP employs a two-stage, complex sampling design. First, jurisdictions are selected from all U.S. states, the District of Columbia, and Puerto Rico using a probability proportional to size sampling strategy based on AIDS prevalence at the end of 2002, such that areas with higher prevalence had a higher probability of selection. Next, adults (aged 18 years and older) with diagnosed HIV were sampled from selected jurisdictions from the National HIV Surveillance System (NHSS), a census of U.S. persons with diagnosed HIV. During the 2018 and 2019 MMP data cycles, data came from: California (including the separately funded jurisdictions of Los Angeles County and San Francisco), Delaware, Florida, Georgia, Illinois (including the separately funded jurisdiction of Chicago), Indiana, Michigan, Mississippi, New Jersey, New York (including the separately funded jurisdiction of New York City), North Carolina, Oregon, Pennsylvania (including the separately funded jurisdiction of Philadelphia), Puerto Rico, Texas (including the separately funded jurisdiction of Houston), Virginia, and Washington.

Data used in this analysis were collected via telephone or face-to-face interviews and medical record abstractions during the following periods:

- 2018 data was collected between June 1, 2018–May 31, 2019
- 2019 data was collected between June 1, 2019–May 31, 2020

The response rate was 100% at the first stage, and was 45% for each of the 2 cycles included in this analysis. Data were weighted based on known probabilities of selection at state or territory and patient levels. In addition, data were weighted to adjust for non-response using predictors of person-level response, and post-stratified to NHSS population totals by age, race/ethnicity, and sex at birth. This analysis includes information on 7,642 adults with HIV.

Of the 7,642 adults sampled, 1,215 were identified as being out-of-care (having fewer than two CD4 or viral load tests at least 3 months apart within a 12-month period) *and* also being virally unsuppressed (having a viral load of equal to or more than 200 copies of HIV per milliliter of blood).

Because respondents in MMP may indicate more than one type of coverage, we relied on a hierarchy to group people into mutually exclusive coverage categories as follows:

- Private coverage overall (with breakouts for employer coverage and marketplace coverage)
- Medicaid coverage, including those dually eligible for Medicare
- Medicare coverage only
- Other public coverage, including Tricare/CHAMPUS, Veteran's Administration, or city/county coverage
- Uninsured

Differences between groups were assessed using prevalence ratios with predicted marginal means.

It is important to note that insurance coverage data were self-reported by respondents and not verified, as was receipt of Ryan White support. In addition, by relying on a hierarchy to group individuals into coverage categories, it is possible individuals were grouped into a coverage category that was not their dominant payer over the course of a year.

Acknowledgments

The authors wish to thank Dr. Sharoda Dasgupta, Stacy Crim, Tamara Carree, and Dr. Linda Beer of the Centers for Disease Control and Prevention (CDC), who were instrumental in this work in providing access to data, guidance, and conducting statistical analysis.

Endnotes

1. A CD4 test is a laboratory test that measures the number of CD4 cells (also known as T cells) in a blood sample. CD4 count is a key laboratory indicator of immune function and indicates HIV stage progression as well as response to HIV treatment.
   ← Return to text (https://www.kff.org/hivaids/issue-brief/what-do-we-know-about-people-with-hiv-who-are-not-engaged-in-regular-hiv-care/#endnote_link_591165-1)

2. For example, see: Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2020. HIV Surveillance Supplemental Report 2022;27(No. 3). https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-27-no-3/index.html (https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-27-no-3/index.html)
   ← Return to text (https://www.kff.org/hivaids/issue-brief/what-do-we-know-about-people-with-hiv-who-are-not-engaged-in-regular-hiv-care/#endnote_link_591165-2)

3. People were considered to have experienced unstable housing if they reported any of the following during the preceding 12 months: moving in with others due to financial issues, moving 2 or more times, or being evicted. People were considered to have experienced homelessness if they experienced any of the following during the preceding 12 months: living on the street, in a shelter, in a single-room–occupancy hotel, or in a car. People were considered to be food insecure if they reported being hungry and not eating because they did not have enough money for food during the past 12 months Centers for Disease Control and Prevention. Data Tables: Quality of Life and HIV Stigma— Indicators for the National HIV/AIDS Strategy, 2022–2025, CDC Medical Monitoring Project, 2017–2020 Cycles. HIV Surveillance Special Report 30. Published September 2022. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-30.pdf (https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-30.pdf).
← Return to text (https://www.kff.org/hivaids/issue-brief/what-do-we-know-about-people-with-hiv-who-are-not-engaged-in-regular-hiv-care/#endnote_link_591165-3)

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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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Committee: Medical Care Criteria Committee
Date of original publication: July 31, 2020

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.

Demographics: At the end of 2020, according to the Centers for Disease Control and Prevention, more than 52% of people with HIV in the United States were ≥50 years old [CDC 2023]. 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.

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, the application of the principles of geriatrics can enhance the quality of care.

Definition of terms:

- **"Older":** Published studies differ in their definitions of older patients with HIV (e.g., ≥50 years old, ≥55 years old, ≥60 years old), 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 2023]. Nonetheless, clinical programs may wish to distinguish different strata within this population, as their needs may differ; a local needs assessment is key to determining how best to care for this population as its age distribution continues to change.
- **"Long-term survivor":** The term long-term survivor has different meanings. Some have defined it as having been diagnosed with HIV before the era of effective antiretroviral therapy; others have defined it in terms of the length of time an individual has lived with HIV, e.g., for at least 1 or 2 decades. Long-term survivors can be any age. For example, older teens and adults who were perinatally infected are long-term survivors. It is useful to ask patients if they self-identify as long-term survivors and what that term means to them.

Effects of Aging

Long-term survivors appear to have physiologic changes consistent with advanced or accentuated aging [Akusjarvi and Neogi 2023], even at the level of gene expression and modification [Esteban-Cantos, et al. 2021; De Francesco, et al. 2019]. When compared with age-matched controls who do not have HIV, older patients with HIV have more comorbidities [Verheij, et al. 2023] 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, low CD4 cell counts, and AIDS at the time of diagnosis [Tavoschi, et al. 2017]. Late initiation of antiretroviral therapy increases the 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 [Pellegrino, et al. 2023; Wandeler, et al. 2016; Samji, et al. 2013]. A Canadian study showed shorter life expectancy among women with HIV than men with HIV [Hogg, et al. 2017]. Women with HIV in resource-rich countries appear to have a heightened risk of comorbidities [Palella, et al. 2019], including cardiovascular disease [Kovacs, et al. 2022; 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

→ GOOD PRACTICES

Approach to Aging in HIV Care

- Discussing the effects of aging with patients who have HIV and are ≥50 years old can help identify medical priorities and evaluate physical function. Such conversations may also prompt consideration of advance directives and help patients recognize the effects of age-associated stigma.
- Taking a proactive approach to aging to help prevent or slow functional and social decline.
- Becoming familiar with the many available screening tools and local and national services will help meet the needs of older patients with HIV.

→ GOOD PRACTICES

- Screening for frailty or functional decline can enable early identification of at-risk patients.
- Including nonpharmacologic measures, such as exercise, nutrition, and socialization is essential to a patient's physical and emotional health.
- Using a framework such as the geriatric 5Ms—mind, mobility, medications, multimorbidity, and matters most—can help inform the choice of screening tests or communicate geriatric concepts, but it is important that screening and assessment be performed with established tools that assess specific domains.
- Prioritizing treatment plans may help reduce the potential for polypharmacy in older patients with HIV who are being treated for multiple comorbidities.
- Evaluating medication lists at every clinical visit to eliminate unnecessary or toxic medications and to identify and mitigate potentially harmful drug-drug interactions will help minimize the effects of polypharmacy in older patients with HIV.
- Facilitating and simplifying access to care (e.g., arranging for a cardiologist to see a patient in the HIV primary care setting) and services as patients' care needs increase can improve overall adherence to and satisfaction with treatment.
- Having 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.
- Referring 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.

Discuss aging-related concerns: 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 unnecessary or inappropriate to discuss aging.

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 the quality of care. Older people with HIV may range from 50 to 80 years old and beyond and are a heterogeneous group. Providing care for older patients requires balance to avoid ageism and neglect of essential care *while at the same* prevent excessive, dangerous, or unnecessary treatments. Determining what is appropriate for patients begins with an assessment of their health and their priorities.

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 issues [Del Carmen, et al. 2019]. This is an opportunity to discuss healthy aging through lifestyle modifications that include exercise, diet, and socialization.

Sexual health: Older age does not preclude discussions of topics that are essential to health. For example, sexuality should be considered 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 postmenopausal 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 the Centers for Disease Control and Prevention Sexually Transmitted Infections Treatment Guidelines, 2021 > Screening Recommendations.

Cancer 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 a patient's priorities or when a patient's prognosis is poor.

Aging-related syndromes and comorbidities: Some health concerns take on greater relevance as individuals with HIV age. Geriatric or aging-related syndromes, such as frailty, have received special attention. Frailty, which can be measured as a physical construct or as an "accumulation of deficits," is a measure of vulnerability [Kehler, et al. 2022]. Frailty has been

associated with increases in falls [Erlandson, et al. 2019] and mortality [Piggott, et al. 2020; Kelly, et al. 2019], and multiple comorbidities [Masters, et al. 2021; Kelly, et al. 2019] have been linked to its development. However, it is possible to reverse frailty. Early identification may enable increased resources for those at highest risk and may also draw attention to associated comorbidities.

Comorbidities in older individuals with HIV are highly prevalent and require added vigilance (see the NYSDOH AI guideline Comprehensive Primary Care for Adults With HIV). In particular, cardiovascular risk is increased in people with HIV, as is osteoporosis. Guidelines for bone mineral density testing, in particular, are often not followed [Birabaharan, et al. 2021], despite the higher rates of osteoporosis and fractures in people with HIV compared with age-matched controls [Starup-Linde, et al. 2020].

Insurance and long-term care needs: Addressing aging-related concerns directly can help older patients with HIV discuss financial worries and prepare for the future when more personal assistance may be needed. Discussing insurance coverage with patients with HIV when they are in their 60s provides an opportunity to help them prepare for the transition from commercial insurance or SNPs to Medicare-based plans. Planning is essential because commercial insurance plans or SNPs often offer more comprehensive care coordination, medication coverage, and health-maintenance services than Medicare-based plans. People with HIV may need long-term care at an earlier age than those without HIV [Justice and Akgun 2019]. Open discussion about support systems can help patients begin to plan for their long-term care needs.

The 5Ms-an effective communication tool: The geriatric approach can be described as attention to the 5Ms: mind, mobility, multimorbidity, medications, and matters most [Tinetti, et al. 2017]. The 5Ms are a useful way to communicate geriatric principles or choose an area for screening. However, some aging-related syndromes (e.g., dizziness, incontinence) or activities of daily living may not easily fit into one of these categories. Nor do the 5Ms offer a structure for a comprehensive geriatric assessment. The following discussion addresses how the 5Ms can be used to understand and explain geriatric priorities and broaden the focus beyond specific comorbidities. The 5Ms are best viewed as an explanatory framework; it is important that screening and assessment be performed with formally recognized instruments (see Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources).

1. **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]. Even as the prevalence of HIV-associated neurocognitive disorder has decreased among individuals with HIV, having multiple comorbidities can increase the risk of cognitive impairment [Heaton, et al. 2023]. Identifying factors that can be addressed to prevent or slow cognitive deterioration is a fundamental part of assessment in this category.
2. **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.
3. **Multimorbidity and multicomplexity:** Care for older patients with HIV usually involves the 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 multimorbidity, strict adherence to multiple disease-based treatment guidelines may not be possible or may jeopardize a patient's health. 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].
4. **Medications:** While older individuals with HIV are taking antiretroviral medications to suppress the virus, they may also be taking other medications to treat comorbidities, which can make medication management especially challenging. Polypharmacy is common, and women appear to be at higher risk than men, likely because of a higher prevalence of comorbidities [Livio, et al. 2021]. Medication evaluation should include a review of all medications, potential drug-drug interactions [Livio and Marzolini 2019], and short- and long-term toxic effects. 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

antiretroviral regimens if changes involve either initiating or discontinuing a medication with pharmacologic inhibitive or induction actions; these changes may affect levels of coadministered medications.

Consultation with a pharmacist can reduce drug-drug interactions and polypharmacy and help clinicians navigate the complexities of medication management in older patients [Ahmed, et al. 2023]. The University of Liverpool HIV Drug Interactions Checker is a useful tool for checking drug-drug interactions; also see NYSDOH AI ART Drug-Drug Interactions.

5. **Matters most:** This is the broadest category and includes medical and social priorities, sexual health, and advance directives. This category 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. 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. The MOLST can now also be documented electronically in the eMOLST registry.

Geriatric Screening and Assessment

General Screening Tools

Screening identifies individuals who are at risk for medical problems. Although care providers may order screening tests for specific diseases such as cancer, they may not be as familiar with screening tools designed to identify functional impairment or geriatric syndromes. In all cases, the same principles apply: brief, sensitive geriatric screening instruments such as those included in Box 1, below, can be used to identify patients who may need more intensive evaluation.

For those programs that are just starting to identify the needs of their older patients, a general screening questionnaire is an excellent place to start. General screening questionnaires are usually appropriate for all older patients and long-term survivors and often are performed annually around a patient's birthday. Such screenings can be completed before a clinic visit; some questionnaires are completed by the patient and others are administered by a staff member. The modified World Health Organization integrated care for older people (ICOPE) screening tool has been tested for people with HIV in a New York State-wide pilot and can be administered by staff in person or over the phone; sites can also use other surveys based on workflows.

Why perform general geriatric screening? Not every patient requires a formal geriatric assessment. Tools for general geriatric screening are simple and cover a wide variety of domains; if the results indicate that more extensive assessment is warranted, then a more formal and comprehensive evaluation can be performed. Use of general screening tools can improve case-finding and, when coupled with referral, can enable targeted interventions but has not yet been shown to reduce hospitalizations or improve function [Rubenstein, et al. 2007].

Box 1: General Geriatric Screening Tools for Older Adults With HIV

- World Health Organization (WHO): Integrated care for older people (ICOPE): guidance on person-centered assessment and pathways in primary care
- NYSDOH HIV Quality of Care Program: Modified WHO ICOPE screening tool
- Vulnerable Elders Survey-13 (VES 13) [Saliba, et al. 2001]
- Medicare annual wellness visit:
  - Centers for Disease Control and Prevention: A Framework for Patient-Centered Health Risk Assessments
  - American College of Physicians: A Checklist for Your Medicare Wellness Annual Visit

Comprehensive Geriatric Assessment

When a patient has a positive result on a general geriatric screening test, the clinician may consider a more comprehensive assessment using validated tools. Formal assessment is more effective than clinical judgment at uncovering problems [Elam, et al. 1991; Pinholt, et al. 1987].

The Comprehensive 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. In the general geriatric outpatient setting, the CGA has not been shown to reduce mortality or nursing home placement, although it may reduce hospital admissions [Briggs, et al. 2022]. The CGA is a complicated process, requiring both expert assessors and clear care plans to manage areas of deficit, and its mixed success in the community likely stems at least in part from the complexity of creating a system that effectively responds to the assessment and includes patient buy-in.

Consulting experts in geriatric care: Some academic centers have tested models of collaboration with geriatricians [Davis, et al. 2022], including referral to geriatric consultants outside the practice, multidisciplinary geriatric care within the practice, and dual training of clinicians in geriatrics and HIV medicine. More models are being studied.

Choosing domains for focused assessment: Given the limitations in both the HIV care and geriatrics workforces [Armstrong 2021; AGS 2017], access to geriatricians may not be feasible. Community-based programs wishing to assess specific domains in the absence of available expert clinicians may choose from among many options.

Recommendations from community advisory boards and patient surveys can advise sites about patient priorities, and results from general screenings can prompt more broad assessments to identify high-prevalence problems. 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 lists domains of geriatric assessment and selected resources for older patients with HIV.

Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources

Area for Assessment	Tools and Resources
Functional Deficits and Geriatric Syndromes	
Basic activities of daily living (general)	Katz Index of Independence in Activities of Daily Living: bathing, dressing, toileting, grooming, transferring, locomotion
Instrumental activities of daily living	The Lawton Instrumental Activities of Daily Living (IADL) Scale: telephone, transportation, housekeeping, medication management, financial management, meal preparation
Continence	• National Association for Continence • Urinary incontinence in women: evaluation and management [Hu and Pierre 2019] (provides links to 3 different brief screening tools)
Exercise prescription	• ACSM Exercise is Medicine® Health Care Providers' Action Guide • Evidence-informed practical recommendations for increasing physical activity among persons living with HIV [Montoya, et al. 2019]
Frailty	CGA Toolkit Plus: Frailty
Mental Health	
Cognition	• MoCA Test (Registration and training are required) • Alzheimer's Association Alzheimer's Disease Pocketcard app (available for download through the Apple App Store or Google Play) • Mini-Cog© Quick Screening for Early Dementia Detection
Social isolation, loneliness	Multiple screening tools and interventions are available through: • Campaign to End Loneliness • UCSF Stress Measurement Network
Other areas (e.g., depression, anxiety, stigma)	• 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 Stigma and Discrimination

Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources	
Area for Assessment	**Tools and Resources**
Comorbidities and Medications	
Managing multiple chronic conditions	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 [Boyd, et al. 2019]
Primary care of specific comorbidities	NYSDOH AI guideline Comprehensive Primary Care for Adults With HIV
ART choices and drug-drug interactions	• University of Liverpool HIV Drug Interactions Checker • NYSDOH AI guidelines: - ART Drug-Drug Interactions - Selecting an Initial ART Regimen > ARV Dose Adjustments for Hepatic or Renal Impairment
Medication choices and polypharmacy	• STOPP/START criteria for potentially inappropriate prescribing in older people: version 2 [O'Mahony, et al. 2015] • American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults [AGS 2019]
Bone health	Management algorithms: • Recommendations for evaluation and management of bone disease in HIV [Brown, et al. 2015] • Diagnosis, prevention, and treatment of bone fragility in people living with HIV: a position statement from the Swiss Association against Osteoporosis [Biver, et al. 2019] • Management of osteoporosis in patients living with HIV: a systematic review and meta-analysis [Starup-Linde, et al. 2020]
Nutrition (food insecurity, obesity, undernutrition)	• USDA Food Security in the U.S. > Survey Tools • HIV and antiretroviral therapy-related fat alterations [Koethe, et al. 2020]
Quality of Life	
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) and eMOLST
Caregiving (requiring and providing)	Next Step in Care Toolkits, Guides, and More for Health Care Providers
Elder mistreatment	• New York State Coalition on Elder Abuse • National Center on Elder Abuse > Elder Abuse Screening Tools for Healthcare Professionals
Overall health, pain management	• CDC HRQOL-14 "Healthy Days Measure" • 2017 HIVMA of IDSA Clinical practice guideline for the management of chronic pain in patients living with HIV [Bruce, et al. 2017]
Palliative care, prognosis, and end-of-life plans	• Palliative care as an essential component of the HIV care continuum [Harding 2018] • Prognostic tools: - VACS Index Calculator - UCSF ePrognosis Calculators - Prognostic indices for older adults: a systematic review [Yourman, et al. 2012]

Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources	
Area for Assessment	**Tools and Resources**
Sexual health and menopause	• NYSDOH AI GOALS Framework for Sexual History Taking • NYSDOH AI Guidance: Adopting a Patient-Centered Approach to Sexual Health • Clinical considerations for menopause and associated symptoms in women with HIV [Looby 2023] • Sexual health history: techniques and tips [Savoy, et al. 2020]
Abbreviations: ACSM, American College of Sports Medicine; AGS, American Geriatrics Society; ART, antiretroviral therapy; ARV, antiretroviral medication; CDC, Centers for Disease Control and Prevention; CGA, Comprehensive Geriatric Assessment; GOALS, Give Offer Ask Listen Suggest; HIVMA, HIV Medicine Association; HRQOL, Health-Related Quality of Life; IDSA, Infectious Diseases Society of America; MoCA, Montreal Cognitive Assessment; NIH, National Institutes of Health; NYSDOH AI, New York State Department of Health AIDS Institute; SAMHSA, Substance Abuse and Mental Health Services Administration; UCSF, University of California San Francisco; VACS, Veterans Aging Cohort Study.	

Integrating the Needs of Older Patients Into Medical Care

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 in Box 2, below.

Box 2: Six Steps to Integrating Needs of Older Patients Into HIV Medical Care

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 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: At base, a clinic can implement a policy that all patients with HIV who are ≥50 years old should undergo general screening; the clinic might also create a protocol that would add more focused and detailed screening (e.g., for memory or gait) to be initiated at an older age.
- 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

Box 2: Six Steps to Integrating Needs of Older Patients Into HIV Medical Care

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 simple 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].
  - **Comprehensive assessment:** Some clinics may collaborate with aging specialists, such as geriatricians or nurse practitioners who specialize in gerontology and can perform a more detailed geriatric assessment as a consultation.
  - **Specific screening tools:** If a clinic has decided to focus on specific assessments, these can be built into the workflow. For example, a clinic may determine that all patients ≥55 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: Assessment Domains for Older People With HIV and Selected Tools and Resources would be appropriate for inclusion in a program to enhance the 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; home safety assessment; and/or an exercise program.
- Identify local specialty care providers to whom patients can be referred.

6. Link to the Aging Network for services:

- Connect individuals with HIV who are ≥60 years old to the Aging Network, an interconnected group of agencies that assists older adults in living independently. The Aging Network was initiated through the Older Americans Act of 1965 [National Health Policy Forum 2012].
- Become familiar with locally offered services and assist clients in preparing for the transition to Medicare when medication benefits and care coordination change.

◊ ONLINE RESOURCES FOR AGING AND GERIATRIC CARE

Clinical Resources:

- Care of People Aging with HIV: Northeast/Caribbean AETC Toolkit
- American Geriatrics Society Publications and Tools
- American Geriatrics Society Geriatrics Workforce Enhancement Program (GWEP):
  - GWEP Coordinating Center
  - Finger Lakes Geriatric Education Center (Rochester, Ithaca)
  - Johns Hopkins Medicine GWEP
- Hartford Institute for Geriatric Nursing

Services and Entitlements:

- New York State Office for Aging (provides links to local agencies on aging and other resources like the state *Aging and Disability Resource Center*)
- USAging (from the Association of Area Agencies on Aging)
- Eldercare Locator
- EngAGED: The National Resource Center for Engaging Older Adults
- National Council on Aging *BenefitsCheckUp*
- National Aging and Disability Transportation Center
- Administration for Community Living > Aging and Disability Resource Centers
- Medicare Rights Center
- SAGE > Advocacy for LGBTQ+ Elders

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