Harris County
Public Health
Building a Healthy Community

2025-2026

HOUSTON ELIGIBLE METROPOLITAN AREA
RYAN WHITE CARE ACT PART A
STANDARDS OF CARE
FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

Introduction

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

Purpose

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

Scope

The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2025-2026:

Core Services

- *Clinical Case Management*
- ***Health Insurance Premium and Cost Sharing Assistance***
- Hospice Care
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Medical Case Management*
- *Medical Nutrition Therapy Supplements*
- Mental Health Services
- ***Oral Health***
- *Primary Medical Care (Ambulatory/ Outpatient Primary Care)*
- *Substance Use Outpatient Services*

Support Services

- *Emergency Financial Assistance (Other)*
- *Emergency Financial Assistance (Prescriptions)*
- Food Bank / Home Delivered Meals
- Legal Services
- Linguistic Services
- *Medical Transportation*
- Mental Health Services
- ***Non-Medical Case Management (Service Linkage)***
- *Outreach Services*
- Referral for Healthcare & Support Services
- *Vision Care*

Services are funded as follows:

Part A funded services

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

Standards Development

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

Organization of the SOCs

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

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application • Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Review of personnel and/or volunteer files indicates compliance.
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours of: HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers (e.g., job description), agency-specific information (e.g., Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://www.dshs.texas.gov/hivstd/contractor/casemanage	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure. • Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file. • Signed and dated by employee and supervisor (includes electronic signature).

1.4	<u>Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers</u> All staff tenured 0 – 5 years with their current employer must receive four (4) hours of cultural competency training to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	• Documentation of training is maintained by the agency in the personnel file.
1.5	<u>Staff education on eligibility determination and fee schedule</u> Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record.
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Staff interviews indicate compliance.

2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and	• Documentation of subcontractor monitoring. • Review of Agency's Policies and Procedures Manual indicates compliance.
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually.	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed, and that the employee understands agency policies and procedures.
2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment, and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply. Staff interviews indicate compliance.
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance. • Review of Agency's Policies and Procedures Manual indicates compliance.

2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior. • Review of Agency's Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance. • Review of agency's complaint and grievance files.
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of regular staff meetings. • Staff interviews indicate compliance.
2.8	Accountability There is a system in place to document staff time and effort commensurate to appropriate funding source.	• Staff time sheets or other documentation indicate compliance.
2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours. • Staff time sheets or other documentation indicate compliance.

3.0	**Clients Rights and Responsibilities**	
3.1	Clients Rights and Responsibilities Agency reviews Client Rights and Responsibilities Statement with each client in a language and format the client understands. Agency provides client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors. • Scope of service • Criteria for end of services	• Documentation in client's record.
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Client's interview indicates compliance. • Agency's structural layout and information management indicates compliance. • Signed confidentiality statement in each employee's personnel file.
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record.

3.4	<u>Up to date Release of Information</u> Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain: • Name of the person or entity permitted to make the disclosure. • Name of the client • The purpose of the disclosure • The types of information to be disclosed. • Entities to disclose to • Date on which the consent is signed. • The expiration date of client authorization (or expiration event) no longer than two years. • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the Release of Information, its components, and ways the client can nullify it. Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	• Current Release of Information form with all the required elements signed by client or authorized person in client's record.

3.5	Grievance Procedure Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • To whom complaints can be made. • Steps necessary to complain. • Form of grievance if any. • Timelines and steps taken by the agency to resolve the grievance. • Documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client. • All complaints or grievances initiated by clients are documented on the Agency's standardized form. • Resolution of each grievance/complaint is documented on the standardized form and shared with client. • Confidentiality of grievance. • Addresses and phone numbers of licensing authorities and funding sources. • Language outlining that clients cannot be retaliated against for filing grievances.	• Signed receipt of agency Grievance Procedure, filed in client chart. • Review of Agency's Policies and Procedures Manual indicates compliance. • Review of Agency's Grievance file indicates compliance. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

3.6	<u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the client's or legal guardian request • Changes in client's need which indicates services from another agency. • Fraudulent claims or documentation about HIV diagnosis by the client. • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail, or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g., phone, mail, email, text message, in person via home visit). • Client service plan is completed, and no additional needs are identified. Client must be provided a written notice prior to involuntary termination of services (e.g., due to dangerous behavior, fraudulent claims, or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System. • A copy of written notice and a certified mail receipt for involuntary termination.
3.7	<u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure. • Summary of all services received by the client and the client's response to services. • Referrals made and/or • Instructions given to the individual at discharge (when applicable).	• Documentation in client record and in the Centralized Patient Care Data Management System.

3.8	Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually). Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of clients' evaluation of services is maintained. • Documentation of CAB and public meeting minutes. • Documentation of existence and appropriateness of a suggestion box or other client input mechanism. • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1

3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification. • Improve the safety of using medications. • Reduce the risk of healthcare-associated infections. • Accurately and completely reconcile medications across the continuum of care. • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance.

4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations.	• Agency has procedures for obtaining translation services. • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients. • Availability of interpretive services, bilingual staff, and staff trained in cultural competence. • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record. • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources.	• Availability of the blue book and other educational materials. • Documentation of educational needs assessment and client education in clients' records.

4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs.	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance. • Environmental Review shows a facility that is handicapped accessible.
4.4	Provision of Services for Low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low-income individuals.	• Facility is accessible by public transportation. • Review of Agency's Policies and Procedures Manual indicates compliance. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3

4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that clients living with HIV are not denied services due to current or pre-existing health condition or non- HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance. • A file containing information on clients who have been refused services and the reasons for refusal. • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification, and income in the client record. • Documentation of ineligibility for third party reimbursement. • Documentation of screening for Third Party Payers in accordance with RWGA site visit guidelines. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1

4.8	<u>Re-certification of Client Eligibility</u> Appropriate documentation is required for changes in status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. At a minimum, agency confirms an individual's income, residency and re- screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement. • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent).	• Client record contains documentation of re-certification of client residence, income, and rescreening for third party payers at least every twelve (12) months. • Review of Policies and Procedures indicates compliance. • Information in client's files that includes proof of screening for insurance coverage (i.e., hard/scanned copy of results). • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13- 02

4.9	<u>Charges for Services</u> Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e., the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance. • Review of system for tracking patient charges and payments indicate compliance. • Review of charges and payments in client records indicate compliance with annual cap. • Sliding fee application forms on client record is consistent with Federal guidelines.
4.9b	<u>Provision of services regardless of an individual's ability to pay for the service.</u> Subgrantee billing and collection policies and procedures do not: • Deny services for non-payment. • Deny payment for inability to produce income documentation. • Require full payment prior to service. • Include any other procedure that denies services for non-payment.	

4.10	<u>Information on Program and Eligibility/Sliding Fee Schedule</u> Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update. Agency should maintain a file documenting promotion activity including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency has a written substantiated annual plan to targeted populations. • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record. Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5

4.11	Linkage Into Core Services Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record. • Review of agency's policies & procedures' manual
4.12	Wait Lists It is the expectation that clients will not be put on a Wait List, nor will services be postponed or denied. Agency must notify the administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method. The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and a plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted.

4.13	Intake The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record. • Review of Agency's Policies and Procedures Manual indicates compliance.
5.0	**Quality Management**	
5.1	Continuous Quality Improvement (CQI) Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis • Work products • QM program evaluation • Materials necessary for QM activities	• Review of Agency's Policies and Procedures Manual indicates compliance. • Up-to-date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Up to date QM Manual • Supervisors log on record reviews signed and dated. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of formal agreements with appropriate Points of Entry. • Documentation of referrals and their follow-up.

7.0	**Emergency Management**	
7.1	<u>Emergency Preparedness</u> Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance.

7.2	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: -IS-100.C: Introduction to the Incident Command System, ICS 100 -IS-200.C: ICS for Single Resources and Initial Action Incidents -IS-700.B: National Incident Management System, An Introduction -IS-800.D: National Response Framework, An Introduction The above courses may be accessed at: training.fema.gov/nims/ Agencies providing support services only may complete alternate courses listed for the above areas. All applicable new employees are required to complete the courses within 90 days of hire.	• Agency criteria used to determine appropriate staff for training requirement. • Documentation of all training including certificate of completion in personnel file.
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including: • Communication pathways (for both clients and staff) • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity. Patient clinical and support activities during emergency situations. (http://www.jointcommission.org/)	Emergency Preparedness Plan

7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance.
8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file.

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Care Coordination Training Curriculum, through the State of Texas TRAIN website https://www.dshs.texas.gov/hivstd/contractor/cm.shtm with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. Mandatory Intimate Partner Violence Training is Required annually and during orientation for all Ryan White Part A funded, primary care co- located, case management staff (SLW, MCM, CCM). RWGA will host two (2) IPV training opportunities annually. Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment.	• Certificates of completion for applicable trainings in the case manager's file. • Sign-in sheets for agency-based trainings maintained by Agency. • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum.
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, applicable case managers will successfully complete CAC training. Applicable case management staff must maintain CAC certification by their Certificated Application Counselor Designated Organization employer annually. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file.
1.4	Case Management Supervisor/Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and non-medical (SLW) Case Managers must fully participate in at least four (4) of the five (5) Case Management Supervisor/Peer-Led two -hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance.

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

[3] National Association of Social Workers (2013). NASW standards for social work case management. Retrieved 12/28/2018 from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3d&portalid=0

1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	• Documentation of staff training.
1.6	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system, and external service providers. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population(s) for conducting a warm handoff. • Documentation of handoff in client record.
2.0	**Timeliness of Services**	
2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record.
2.2	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in

2.3	Case Management Brief Intervention Case Management staff (Medical, Clinical and Service Linkage) will, on occasion, be called to assist a client with a low/intermittent need, (i.e., CPCDMS eligibility renewal, ADAP application renewal, bus pass renewal, or information about a service, etc.) and have no other needs. In this situation the staff may provide a brief intervention with the client. However, if during the visit the staff assesses the client may have further needs than originally presented, the appropriate staff will engage using an assessment (brief / comprehensive) appropriate to their service to better address the client's needs.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes.
2.4	Client Referral and Tracking Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g., legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager. • Work with the Client to determine barriers to referrals and facilitate access to referrals. • Utilize a tracking mechanism to monitor completion of all case management referrals.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of follow-up tracking activities in clients' records. • A current list of agencies that provide services including availability of the Blue Book.
2.5	Client Notification of Service Case Management Provider Turnover Client must be provided notice of assigned case manager service provider's cessation of employment within 30 days 2 weeks of the employee's departure.	• Documentation in client record.

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

Clinical Case Management Services

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

1.0	**Staff Requirements**	
1.1	Minimum Qualifications All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LMFT). LMSW, LPC-I, and LMFT-A may provide Clinical Case Management services with clinical supervision under a waiver agreement. Staff providing Clinical Case Management services with LBSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification. Other training experiences may be considered under a waiver agreement.	• A file will be maintained on each clinical case manager. • Supportive documentation of credentials and job description is maintained by the agency in each clinical case manager file. Documentation should include transcripts and/or diplomas and proof of licensure
1.2	Scope of Services The clinical case management services will include at a minimum, comprehensive assessment including mental health and substance abuse/use; development, implementation, and evaluation of care plans; follow-up; advocacy; direction of clients through the entire spectrum of health and support services and peer support. Other functions include facilitation and coordination of services from one service provider to another including mental health, substance abuse and primary medical care providers.	• Review of client records indicates compliance. • Agency Policy and Procedures indicates compliance.

1.3	Ongoing Education/Training for Clinical Case Managers After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA.	• Certificates of completion are maintained by the agency. • Current License on case manager's file.
2.0	**Timeliness of Services/Documentation**	
2.1	Client Eligibility In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: ● Individual living with HIV in mental health treatment/counseling and/or substance abuse treatment services or whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. ● Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM diagnosis (most current, American Psychiatric Association approved), especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM diagnosis (most current, American Psychiatric Association approved) personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with their ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. Client is in mental health counseling or chemical dependency treatment.	Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record.

2.2	<u>Discharge/Closure from Clinical Case Management Services</u> In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence. ➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	• Documentation in client record.
2. 3	<u>Coordination with Primary Medical Care and Medical Case Management Provider</u> Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs. Clinical Case Management services provided to clients accessing primary medical care from a Ryan White Part A funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every six (6) months or more often if clinically indicated for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi- disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Case conferences are documented in the client record.

2.4	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, their support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns, and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, past or present adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.5	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g., needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated.

2.6	Service Plan Service planning begins at admission to clinical case management services and is based upon assessment. The clinical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short-term needs met before full-service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	• Documentation in client record on the clinical case management service plan or agency's equivalent form. • Service plan signed by client and the case manager.
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The clinical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the clinical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Non-Medical Case Management Services (Service Linkage Worker)

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

1.0	**Staff Requirements**	
1.1	Minimum Qualifications Service Linkage Worker – unlicensed community case manager: Service linkage workers must have a minimum of 1-year work experience with PLWH, or a community health worker/patient navigator. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish. Agency will provide Service Linkage Worker a written job description upon hire.	• A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker's file.
2.0	**Timeliness of Services/Documentation**	
2.1a	Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (HHD Only) In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services: • Clients not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS.	• Documentation of HIV+ status, residence, identification, and income in the client record. • Documentation of "not in care" status through the CPCDMS.

2.2	<u>Service Linkage Worker Assessment</u> Assessment begins at intake. The service linkage worker will provide client and, if appropriate, their personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager.	• Documentation in client record on the brief assessment form, signed and dated. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	<u>Service Linkage Worker Reassessment</u> Clients on receiving services will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated.
2.4a	<u>Transfer of Not-in-Care and Newly Diagnosed Clients</u> (HHD Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services. Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	• Documentation in client record and in the CPCDMS.

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2.5	Primary Care Newly Diagnosed and Lost to Care Clients Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals. • Description of service linkage worker job duties conducted in the field. • Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.0	**Supervision and Caseload**	
3.1	Service Linkage Worker Supervision A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ Date ➢ Name(s) of case manager(s) present. ➢ Topic(s) covered and/or client(s) reviewed. Plan(s) of action ➢ Supervisor's signature Supervision notes are never maintained in the client record.

3.2	Caseload Coverage – Service Linkage Workers Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System.
3.3	Case Reviews – Service Linkage Workers. Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW.

Medical Case Management

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

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

1.3	Ongoing Education/Training for Medical Case Managers After the first year of employment in the case management system each medical case manager will obtain the minimum n umber of hours of continuing education to maintain his or her licensure.	• Attendance sign-in sheets and/or certificates of completion are maintained by the agency.
2.0	**Timeliness of Service/Documentation**	
2.1	Screening Criteria for Medical Case Management In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following: i. Newly diagnosed ii. New to ART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment ix. Housing issues x. Opportunistic infections xi. Unmanaged chronic health problems/injury/Pain xii. Lack of viral suppression xiii. Positive screening for intimate partner violence xiv. Clinician's referral	• Review of agency's screening criteria for medical case management.

2.1 cont.	Clients with one or more of these criteria would indicate need for medical case management services. The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services. • Client is actively symptomatic with an axis I DSM diagnosis (most current, American Psychiatric Association approved) especially including substance-related disorders (abuse/dependence), mood disorders (major depression, bipolar disorder), anxiety disorders, and other psychotic disorders; or axis II DSM diagnosis (most current, American Psychiatric Association approved) personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with their ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services; • Client is in mental health counseling or chemical dependency treatment.	• Review of agency's screening criteria for medical case management.

2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, their support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g., needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated. • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only).

2.4	Service Plan Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short-term needs met before full-service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	• Documentation in client's record on the medical case management service plan or agency's equivalent form. • Service Plan signed by the client and the case manager.
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision.

4.0	**Geriatric Medical Case Management**	
4.1	**Criteria for Geriatric Medical Case Management** Clients living with HIV/AIDS, ages 60 and older.	• Review of clients' records indicates compliance.
4.2	Service Provisions Oriented to Geriatric Clients • Provide support, education, and established goal-directed medical interventions to achieve optimal treatment outcomes and improve quality of life. • Conduct comprehensive assessments to determine each client's level of need for medical case management and health literacy. • Develop and implement a service plan for each client and provide an ongoing assessment of its efficacy. • Monitor the service plan to ensure its implementation. • Maintain regular contact with each client to monitor response to treatment and identify new needs. • Coordinate access to medically appropriate levels of health and support services, including facilitating and coordinating services from one service provider to another. • Coordinate and track referrals to internal and external services and programs. • Provide or refer to a licensed medical provider assessment involving ADL abilities, cognitive functioning, vision, hearing, nutrition, fall prevention, incontinence, Osteoporosis, and medication contraindications. • Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues. • Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues. • Provide benefits counseling by assisting clients in obtaining access to other public and private programs for which they may be eligible. • Provide advocacy on behalf of clients. • Provide emotional support on behalf of clients. • Provide liaison services with medical providers on behalf of the client.	• Review of clients' records indicates compliance. • Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated. • Documentation in client's record on the medical case management service plan or agency's equivalent form. • Service Plan signed by the client and the case manager.

Emergency Financial Assistance (Prescriptions)

Emergency Financial Assistance (EFA) is co-located in ambulatory medical care centers to provide short term (up to 30 days of medication) access to HIV pharmaceutical services to clients who have not yet completed eligibility determination for medications through Pharmaceutical Assistance Programs, State ADAP, State SPAP or other sources. EFA provides short-term (up to 30 days of medication) payments to assist clients with an emergent need for medication. HRSA requirements for EFA include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1a	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for EFA services: • Income no greater than 500% of the Federal poverty level for HIV medications	• Documentation of income in the client record.
1.2a	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days. • Pharmacy will fill prescription within one (1) business day of approval.	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance.

1.3	Medication Formulary RW funded prescriptions for program eligible clients shall be based on current medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications that are available over the counter (OTC) without a prescription, or drugs not on the approved formulary. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. If multiple waivers are required, they do not need to be submitted consecutively. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of billing history indicates compliance. • Documentation in client's record.
2.0	**Staff HIV knowledge is based on documented training.**	
2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance. • Documentation of all training in personnel file. • Specific training requirements are specified in the staff guidelines.

2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
2.3	Pharmacy Staff Experience A minimum of one-year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance. • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present.

Local Pharmacy Assistance Program

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

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 500% of the Federal poverty level for HIV-related medications Move above	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days. • Pharmacy will fill prescription within one (1) business day of approval.	• Documentation in the client record and review of pharmacy summary sheets. • Review of agency's Policies & Procedures Manual indicates compliance.
1.3	LPAP Medication Formulary RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications, or drugs not on the approved formulary, that are available over the counter (OTC) without a prescription. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of billing history indicates compliance. • Documentation in client's record.

2.0	**Staff HIV knowledge is based on documented training.**	
2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance. • Documentation of all training in personnel file. Specific training requirements are specified in the staff guidelines.
2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist (in accordance with the period of their licensure) and pharmacy tech staff.	• Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
2.3	Pharmacy Staff Experience A minimum of one-year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance. and skill development.	• Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance. • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present.

Outreach Services

Providing allowable Ryan White Program outreach and service linkage activities to 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 will be contacted, 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 review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services.

1.0	**Staff Training**	
1.1	**Minimum/Qualifications** Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.	• Documentation of credentials and job description in outreach worker's file. • Documentation includes, but is not limited to high school diploma, GED, and experience.
1.2	Scope of Services (cross reference with service def to ensure this is accurate) The OW will generate EMR reports to determine eligibility for services. Monthly, during OW-RWGA meetings OW will provide client status updates on engagement activities. Outreach workers are expected to document client's immediate needs and barriers to service in order to relink and reengage them back in to care. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a service linkage worker or medical case manager for additional assistance of the client's needs as necessary.	• Review of reporting records indicates compliance. • Monthly review of spreadsheet engagement activities. • Documentation of assessment will be maintained in the client file.

1.3	Ongoing Education/Training for Outreach Workers Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. The Outreach Workers are required to attend a minimum of five (5) of the six (6) Outreach Worker meetings and four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & HHD.	• Documentation of attendance will be maintained by the agency. RWGA will also maintain sign-in logs. • Review of reporting records indicates compliance. • Certificates of completion for applicable trainings in the outreach worker's file.
1.4	Outreach Brief Intervention Outreach staff will, on occasion, be called to assist a client with a low/intermittent need, (such as, CPCDMS eligibility renewal, ADAP application renewal, bus pass renewal, or information about a service, etc.) and have no other needs. In this situation the staff may provide a *brief intervention* with the client. However, if during the visit the staff assesses the client may have further needs than originally presented, the Outreach Worker will refer the client to the appropriate staff who will engage using an assessment (brief / comprehensive) to better address the client's needs.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes.
1.5	Documentation and Reporting Outreach Workers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with DSHS Child Abuse Screening, Documenting and Reporting Policy prior to interaction.	• Documentation of staff training in employee record.

1.6	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., Outreach worker to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff. • Documentation of warm handoff in the client record.
2.0	**Timeliness of Service/Documentation**	
2.1	Progress Notes All Outreach Worker activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of the occurrence.	• Documentation of client's needs and progress notes will be maintained in client's files. • Legible signed and dated in documentation in the client record.
2.2	Eligibility Criteria for Outreach Eligibility for outreach will vary and is specific to each agency. Criteria m u s t include: Cusp of Falling Out of Care Clients: • Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks. • Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks. • Clients who have not been seen in 4 months by their primary care provider; and/or • Three missed appointments in past 12 months (do not have to be consecutive). Lost-to-Care Clients: • (HRSA) Lost to care definition. Newly Diagnosed Clients: • Applies to clients with a diagnosis within the last 12 months but have not engaged in care.	• Documentation of eligibility criteria will be maintained in client's files. • Legible signed and dated in documentation in the client record.

3.0	**Supervision**	
3.1	<u>Outreach Worker Supervision</u> Four (4) hours of supervision per month must be provided to each outreach worker. At least one (1) hour of supervision must be individual supervision. The remaining three (3) hours may be individual or group. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the outreach worker relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ Date & duration of time ➢ name(s) of outreach worker(s) present ➢ Topic(s) covered and/or client(s) reviewed. ➢ Plan(s) of action ➢ Supervisor's signature Supervision notes are never maintained in the client record.
3.2	<u>Case Reviews – Outreach Worker</u> Supervisor reviews a random sample equal to 10% of unduplicated clients served by each Outreach Worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible and that services provided appropriately.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and Outreach Worker.

Primary Medical Care

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

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

1.0	**Medical Care for persons with HIV should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published HHS treatment guidelines**	
1.1	<u>Minimum Qualifications</u> Medical care for persons living with HIV shall be provided by MD, NP, DO, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV care including fellowship.	• Credentials on file.

1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure. • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 people living with HIV patients within the last year. Maintain a minimum of 30 hours of HIV-specific CME (including a minimum of 10 hours related to antiretroviral therapy) every two years in accordance with State licensure renewal dates. Agencies using contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates. • Physician extenders must obtain this experience within six months of hire. • All staff receive professional supervision. • Staff show training and/or experience with the medical care of adults living with HIV.	• Documentation in personnel record.

1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed /credentialed providers (i.e., MD, DO, CNS, NP, PA).	• Provider will document peer review has occurred annually.
1.4	Standing Delegation Orders (SDO) Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (https://clinicalinfo.hiv.gov/en/guidelines) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines.	• Documentation in client's record. • Exceptions noted in client's record.

1.6 a	Medical Evaluation/Assessment All people living with HIV receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include: • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results. • Resistance testing and co receptor tropism assays as clinically indicated. • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care • Sexual history • Substance abuse history • Review of Systems	• Completed assessment in client's record.

1.7	Medical Records Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered. • The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies).	• Documentation in client's record.
1.8	Plan of Care A plan of care shall be developed for each identified problem and should address diagnostic, therapeutic and educational issues in accordance with the current U.S. HHS treatment guidelines.	• Plan of Care documented in client's record.

1.9	Follow- Up Visits All patients shall have follow–up visits every three to six months or as clinically indicated for treatment monitoring and to detect any changes in the client's HIV status. At each clinic visit the provider will at a minimum: • Measure vital signs including height and weight. • Perform physical examination and update client history. • Measure CBC, CD4 and VL levels every 3-6 months or in accordance with current treatment guidelines. • Evaluate need for ART. • Resistance Testing if clinical indicated. • Evaluate need for prophylaxis of opportunistic infections. • Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan. • Update problem list • Refer client for ophthalmic examination by an ophthalmologist every six months when CD4 count falls below 50CU/MM. • Refer Client for dental evaluation or care every 12 months. • Incorporate HIV prevention strategies into medical care for of persons living with HIV. • Screen for risk behaviors and provide education on risk reduction, including pre-exposure prophylaxis (PrEP) and non-occupational post- exposure prophylaxis (nPEP) for negative partners, and Undetectable Untransmutable. • Assess client comprehension of treatment plan and provide education/referral as indicated. • Refer for other clinical and social services where indicated.	• Content of Follow-up documented in client's record. • Documentation of specialist referral including dental in client's records.

1.10	Yearly Surveillance Monitoring and Vaccinations
	• All women living with HIV–should have regular pap tests
	  ➢ An initial negative pap test should be followed with another pap test in 6-12 months and if negative, annually thereafter.
	  ➢ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years.
	  ➢ Women 30 years old and older may have pap test and HPV co- testing, and if normal, repeated every 3 years.
	  ➢ A pap test showing abnormal results should be managed per guidelines.
	• Screening for anal cancer, if indicated.
	• Resistance Testing, if clinical indicated.
	• Chem. panel with LFT and renal function test
	• Influenza vaccination
	• Annual Mental Health Screening with standardized tool
	• TST or IGRA (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Service, Infectious Diseases Society of America. *Guidelines for preventing opportunistic infections among people living with HIV*) (Available at https://clinicalinfo.hiv.gov/en/guidelines)
	  ➢ Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated.
		• Documentation in client's record.

1.11	Preconception Care for Women Living with HIV of Childbearing Age In accordance with the US Department of Health and Human Services recommendations (https://clinicalinfo.hiv.gov/en), preconception care shall be a component of routine primary care for women of childbearing age living with HIV and should include preconception counseling. In addition to the general components of preconception counseling, health care providers should, at a minimum: • Assess women's pregnancy intentions on an ongoing basis and discuss reproductive options. • Offer effective and appropriate contraceptive methods to women who wish to prevent unintended pregnancy. • Counsel on safe sexual practices • Counsel on eliminating of alcohol, illicit drugs and smoking. • Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, and prevention and potential effects of HIV and treatment on pregnancy course and outcomes • Inform women of interventions to prevent sexual transmission of HIV when attempting conception with a partner who does not have HIV. Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur. • Maximum suppression of viral load prior to conception.	• Documentation of preconception counseling and care at initial visit and annual updates in Client's record as applicable.

1.12	Obstetrical Care for Pregnant Women Living with HIV Obstetrical care for pregnant women living with HIV shall be provided by board certified obstetricians experienced in the management of high-risk pregnancy and has at least two years of experience in caring for pregnant women living with HIV. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines https://clinicalinfo.hiv.gov/en	• Documentation in client's record.
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of and Infants, Children and Pre-pubertal Adolescents Care and monitoring of children exposed to HIV must be done in accordance with the HHS guidelines. Treatment of infants and children living with HIV should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Care (https://clinicalinfo.hiv.gov/en) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	• Documentation in client's record.

1.15	<u>Patient Medication Education</u> All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: • the names, actions and purposes of all medications in the patient's regimen • the dosage schedule • food requirements, if any • side effects • drug interactions • and adherence. Patients must be informed of the following: • how to pick up medications • how to get refills • and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year of paid experience in HIV care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include: • the clinic name • the session date and length • the patient's name, patient's ID number, or patient representative's name • the Educator's signature with license and title • the reason for the education (i.e., initial regimen, change in regimen, etc.) • and documentation of all discussed education topics.

1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD, DO, CNS licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record. • Documentation of counseling in client records.
1.17	Documented Non-Adherence with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-adherence with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-adherence with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care Coordinator with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	• Review of Policies and Procedures Manual indicates compliance.

1.19	Intimate Partner Violence Screening Policy The agency must have in place a written policy and procedure regarding client. Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: • Process for ensuring clients are screened for IPV no less than annually (by a health care provider, e.g. MA, RN, NP, PA, MD, DO, CNS, etc.). • Intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management. • State reporting requirements associated with IPV. • Description of required medical record documentation. • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel. Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Procedures Manual indicates compliance. • Documentation in patient record.
1.20	Patient Retention in Care The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include: • Process for client appointment reminders (e.g., timing, frequency, position responsible) • Process for contacting clients after missed appointments (e.g., timing, frequency, position responsible) • Measures to promote retention in care. Process for re-engaging those lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance.
2.0	**Psychiatric care for persons with HIV should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines.**	

2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry guidelines.	• Documentation in patient record

3.0	**In addition to demonstrating competency in the provision of HIV specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	
3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on- call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services ➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	• Agency Policy and Procedure regarding continuity of care.
3.2	Continuity with Referring Providers Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance.

3.3	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g., Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out. • Staff interviews indicate compliance. • Established tracking systems
3.4	Client Notification of Service Provider Turnover Client must be provided notice of assigned service primary care provider's cessation of employment within 14 days of the employee's departure.	• Documentation in patient record
3.5	Recommended Format for Operational Standards Detailed standards and routines for program assessment are found in most recent Joint Commission performance standards.	• Ambulatory HIV cl inical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission.
3.6	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider cancellations, and a protocol for how patients will be accommodated when they do not receive notification in advance of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medication.	• Review of Agency's Policies and Procedures Manual indicates compliance.

Vision Services

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

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

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