RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

Effective Date: April 1, 2024/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Allowable Use of Funds:

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

Restricted Use of Funds:

1. HIA excludes plans that do not cover HIV-treatment drugs; specifically, insurance plans must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services to be eligible for premium payments under HIA.
2. HIA excludes any cost associated with liability risk pools.
3. Tax reconciliation due, if the PLWH failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period.
4. HIA funds may not be used to support Out of Pocket payments for inpatient hospitalization, emergency department care or catastrophic coverage.
5. HIA funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.
6. Funds may not be used for payment of services delivered by providers out of network. Exception: When an in-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions.
7. HIA cannot be in the form of direct cash payments to PLWH.
8. HIA funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA.
9. HIA funds may not be used to pay fines or tax obligations incurred by PLWH for not maintaining health insurance coverage required by the Affordable Care Act (ACA).
10. HIA must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage
11. HIA funds may not be used for COBRA coverage if a PLWH is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.
12. HIA funds cannot be used to cover costs associated with Social Security.
13. Life insurance and other elective policies are not covered.
14. HIA funds may not be used if a PLWH is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.

Scope of Services:
The Health Insurance Assistance (HIA) service category is intended to help PLWH maintain a continuity of medical benefits without gaps in health insurance coverage or discretion of treatment. This financial assistance program enables eligible individuals who are HIV positive to utilize their existing third party or public assistance (e.g. Medicare) medical insurance, not to exceed the cost of care delivery. Under this provision an agency can provide assistance with health insurance premiums, standalone dental insurance, co-payments, co-insurance, deductibles, Medicare Part D premiums, and tax reconciliation.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement is that requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Tax Reconciliation: A refundable credit will be given on an individual's federal income tax return if the amount of advance-credit payments is *less* than the tax credit they should have received. Conversely, individuals will have to repay any excess advance payments with their tax returns if the advance payments for the year are *more* than the credit amount. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.

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

Exception: PLWH who were enrolled (and have maintained their plans without a break in coverage), prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.

Program	
1.1 Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine eligibility for this program to ensure that these funds are used as a last resort in order for the PLWH to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Comprehensive Intake/Assessment documented in the primary services record.
1.2 Cost Effectiveness Assessment The cost of insurance plans must be lower than the cost of providing health services through DSHS-funded delivery of care including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Agency must	• Cost effectiveness Assessment and results documented in the primary service record.

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

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

2. PLWH must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline	
1.7 Prescription Eyewear Documentation from physician must be obtained stating that the eye condition is related to the PLWH's HIV infection when HIA funds are used to cover co-pays for prescription eyewear	• Physician statement that the eye condition is related to HIV documented in primary service record.
1.8 Medical Visits PLWH accessing health insurance premium and cost sharing assistance services should demonstrate adherence with their HIV medical or dental care and have documented evidence of attendance of HIV medical or dental appointments in the primary service record. Note: For PLWH who use HIA to enable their use of medical or dental care outside of the RW system: HIA providers are required to maintain documentation of PLWH's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months	• At least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits documented for PLWH with applicable data in TCT or other data system used at the provider location. • Adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months documented for PLWH who use HIA to enable their use of medical care outside of the RWHAP system.
1.9 Viral Suppression PLWH receiving Health Insurance Premium and Cost Sharing Assistance services have evidence of viral suppression as documented in viral load testing. *NOTE: Achieving viral suppression is not required to access HIA.*	• Viral Suppression via HIV viral load test during the measurement year documented for PLWH with applicable data in TCT or other data system used at the provider location, percentage of PLWH, regardless of age.
1.10 Referrals and Tracking Program receives referrals from a broad range of HIV service providers, community stakeholders and clinical providers. Program makes appropriate referrals out when necessary.	• Referral source documented in the primary service record. • Referrals made documented in the primary service record
1.11 Waiver Process Waivers from the AA is required for the following circumstances: 1. HIA payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers, 3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary,	• Approved waiver documented in the primary service record.

4. Discontinuing HIA payment assistance due to PLWH conduct or fraud, 5. Refusing HIA assistance for a PLWH who is eligible and whom HIA provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted, and 7. Assisting an eligible PLWH with the entire cost of a group policy that includes coverage for persons not eligible for HIA payment assistance	
1.12 Vigorous Pursuit Program must vigorously pursue any excess premium tax credit received by the PLWH from the IRS upon submission of the PLWH's tax return. To meet the standard of "*vigorously pursue*", PLWH receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must: 1. Designate premium tax credit be taken in advance during enrollment. 2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal. 3. Submit prior year tax information no later than May 31st. 4. Reconciliation of advance premium tax credits or liabilities	• Efforts to conduct vigorous pursuit documented in the primary service record.
Administrative	
2.1 Program Policies and/or Procedures Program will develop and maintain policies and/or procedures that outline the delivery of HIA service including, but not limited to, the marketing of service to applicable community stakeholders, cost-effectiveness and expenditure policy, and PLWH contributions. Program must maintain policies on the assistance that can be offered for PLWH who are covered under a group policy. Program must have P&P in place detailing the required process for reconciliation and documentation requirements. Program must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual PLWH, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace. Program will disseminate policies and/or procedures to providers seeking to utilize the service.	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Regional Health Insurance Assistance Policy ▪ Standards of Care ▪ Collection of Performance Measures

Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards	
2.2 Regional Health Insurance Assistance Policy Program will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Program policies and/or procedures document compliance with Regional HIA Policy. • Program Review documents compliance with Regional HIA Policy.
2.3 Ongoing Staff Training Eight (8) hours annually of continuing education in HIV related or other specific topics including a minimum of two (2) hours training in Affordable Care Act is required, as needed.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.4 Staff Experience A minimum of (1) year documented HIV/AIDS work experience is preferred.	• Work experience documented in personnel file with exceptions to work experience noted.
2.5 Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Supervision of staff members by coordinator or manager documented.
2.6 Decreasing Barriers to Care Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable PLWH of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for PLWH to physically present to Health Insurance provider.)	• Policies and/or procedure document compliance. • Review of primary service records document compliance. • Staff interviews
2.7 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

3.8 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 31-35. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses

of Funds Policy Clarification Notice (PCN) 16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance Policy Clarification Notice (PCN) #18-01 (revised 08/30/2018). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/18-01-use-of-rwhap-funds-for-premium-and-cost-sharing-assistance.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Change Notice 14-01. Available at: https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- HRSA/HAB, Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance. Available at: https://hab.hrsa.gov/sites/default/files/hab/program- grants-management/HAB_FAQs_on_Dental_Insurance.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- TDSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001. Available at: http://www.dshs.texas.gov/hivstd/policy/policies.shtm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
HEALTH INSURANCE ASSISTANCE

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

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Effective Date: April 1, 2024/September 1, 2024

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

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

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

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

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

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

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

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

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

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

Scope of Services:
Mental health services include mental health assessment; treatment planning; treatment provision; individual psychotherapy; family psychotherapy; conjoint psychotherapy; group psychotherapy; drop-in psychotherapy groups; and emergency/crisis intervention. also included are psychiatric medication assessment, prescription and monitoring and psychotropic medication management.

General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for affected family members or significant others.

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

Program	
1.1 Orientation Orientation is provided to PLWH who access services to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will include written or verbal information on the following: • Services available	• Orientation documented in the primary service record • Annual PLWH feedback documents compliance.

• Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • PLWH responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	
<u>1.2 Comprehensive Assessment</u> A comprehensive assessment including a psychosocial history will be completed at intake (unless PLWH is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self-Assessment /Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation. The assessment must document DSM-IV diagnosis or diagnoses, utilizing at least Axis I. The initial and comprehensive PLWH assessment (or agency's equivalent) forms must be signed and dated. Updates to the information included in the initial assessment will be recorded in the comprehensive PLWH assessment.	• Documentation of mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the primary service record • If pressing mental health needs emerge during the mental health assessment requiring immediate attention results in the assessment not being finalized by the third session, the exception must be documented in the primary services record.
<u>1.3 Treatment Plan</u> Treatment plans are developed jointly with the counselor and PLWH and must contain all the elements for mental health including: • Description of the diagnosed mental health issue • Statement of the goal(s) and objectives of counseling • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date	• Treatment plan that meets the established criteria documented in the primary service record. • Treatment plans signed by the licensed mental health professional rendering services documented in the primary service record. • Exceptions noted in the primary service record.

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

professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	
1.7 Provision of Service/Progress Notes Services will be provided according to the individual's treatment plan and documented in the primary service record. Progress notes are completed according to the agency's standardized format, completed for each counseling session, and must include: • PLWH name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence	• Service provision in accordance with the individual's treatment plan documented in the primary service record. • Signed progress notes documented in primary service record.
1.8 Coordination of Care Care will be coordinated across the mental health care coordination team members. The PLWH is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the PLWH, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for PLWH who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Coordination of care with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
1.9 Referrals As needed, mental health providers will refer PLWH to full range of medical/mental health services including: • Psychiatric evaluation	• Referrals made documented in the primary service record.

• Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the PLWH's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the PLWH to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s)	
1.10 Discharge Services may be discontinued when the PLWH has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death Discharge planning will be done with each PLWH when treatment goals are met or when PLWH has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable.	• Discharge reason meeting the established criteria documented in primary service record. • Exceptions documented in the primary service record.
1.11 Discharge Summary Discharge summary is completed for each PLWH after 30 days without PLWH contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	•
Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments

applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards. The agency must develop and implement Policies and Procedures that include but are not limited to the following: • PLWH neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self-discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, timeline for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active PLWH at least once every 6 months.	• Standards of Care • Collection of Performance Measures
<u>2.2 Crisis Situations and Behavioral Emergencies</u> Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the PLWH during the orientation process.	• Agency Policy and/or procedure meets established criteria. • Staff Training on the policy is documented. • Crisis situations and behavioral emergencies documented in primary service record.

In urgent, non-life-threatening circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the PLWH to another organization that can provide the requested services.	
2.3 Services Requiring Licensed Personnel Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking PLWH.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Clinical supervision qualifications documented in personnel file.
2.5 Family Counseling Experience Professional counselors must have two years' experience in family counseling if providing services to families.	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	• Completion of orientation documented in personnel file. • Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.

2.7 Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Assessment documented in personnel file. • Training per assessment documented in personnel file.
2.8 Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Professional Liability Insurance documented. • Annual Reviews documents compliance.
2.9 Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.10 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.
2.7 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	

References

- American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS, Washington, DC, 2001. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids.pdf
- American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids-watch.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm

- New York State Department of Health, Mental Health Standards of Care, Delivery of Care. Available at: https://www.health.ny.gov/diseases/aids/providers/standards/mental_health/delivery_of_care.htm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
MENTAL HEALTH SERVICES

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

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES TARGETING SPECIAL POPULATIONS

Effective Date: April 1, 2024/September 1, 2024

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

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

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

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

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

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

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

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

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

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

These targeted mental health services should be delivered to people living with HIV and affected family/partners living within the Houston HIV Service Delivery Area (HSDA). PLWH should also be a member of the following special populations: Transgender persons (emphasizing those who are LatinX/Black and/or under the age of 25), individuals who exchange sex for money, and individuals born outside the US.

Scope of Services:
Mental health services include mental health assessment; treatment planning; treatment provision; individual psychotherapy; family psychotherapy; conjoint psychotherapy; group psychotherapy; drop-in psychotherapy groups; and emergency/crisis intervention. Also included are psychiatric medication assessment, prescription and monitoring and psychotropic medication management.

General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for affected family members or significant others.

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

Program	
1.1 Orientation	• Orientation documented in the primary service record

Orientation is provided to PLWH who access services to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • PLWH responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	• Annual PLWH feedback documents compliance.
<u>1.2 Comprehensive Assessment</u> A comprehensive assessment including a psychosocial history will be completed at intake (unless PLWH is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self-Assessment /Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation. The assessment must document DSM-IV diagnosis or diagnoses, utilizing at least Axis I. The initial and comprehensive PLWH assessment (or agency's equivalent) forms must be signed and dated. Updates to the information included in the initial assessment will be recorded in the comprehensive PLWH assessment.	• Documentation of mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the primary service record • If pressing mental health needs emerge during the mental health assessment requiring immediate attention results in the assessment not being finalized by the third session, the exception must be documented in the primary services record.
<u>1.3 Treatment Plan</u> Treatment plans are developed jointly with the counselor and PLWH and must contain all the elements for mental health including: • Description of the diagnosed mental health issue • Statement of the goal(s) and objectives of counseling	• Treatment plan that meets the established criteria documented in the primary service record. • Treatment plans signed by the licensed mental health professional rendering services documented in the primary service record.

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

Mental health professional will discuss the PLWH's concerns with the PLWH about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the PLWH to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	documented in the primary service record. • Changes to medications shared with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
<u>1.7 Provision of Service/Progress Notes</u> Services will be provided according to the individual's treatment plan and documented in the primary service record. Progress notes are completed according to the agency's standardized format, completed for each counseling session, and must include: • PLWH name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence	• Service provision in accordance with the individual's treatment plan documented in the primary service record. • Signed progress notes documented in primary service record.
<u>1.8 Coordination of Care</u> Care will be coordinated across the mental health care coordination team members. The PLWH is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the PLWH, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for PLWH who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding	• Coordination of care with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.

medication management, interactions, and treatment adherence.	
1.9 Referrals As needed, mental health providers will refer PLWH to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the PLWH's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the PLWH to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s)	• Referrals made documented in the primary service record.
1.10 Discharge Services may be discontinued when the PLWH has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death Discharge planning will be done with each PLWH when treatment goals are met or when PLWH has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable.	• Discharge reason meeting the established criteria documented in primary service record. • Exceptions documented in the primary service record.
1.11 Discharge Summary Discharge summary is completed for each PLWH after 30 days without PLWH contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	•

• Date	
Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards. The agency must develop and implement Policies and Procedures that include but are not limited to the following: • PLWH neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self-discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, timeline for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active PLWH at least once every 6 months.	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments • Standards of Care • Collection of Performance Measures
2.2 Crisis Situations and Behavioral Emergencies Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts	• Agency Policy and/or procedure meets established criteria. • Staff Training on the policy is documented. • Crisis situations and behavioral emergencies documented in primary service record.

Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the PLWH during the orientation process. In urgent, non-life-threatening circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the PLWH to another organization that can provide the requested services.	
2.3 Services Requiring Licensed Personnel Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking PLWH.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Clinical supervision qualifications documented in personnel file.
2.5 Family Counseling Experience Professional counselors must have two years' experience in family counseling if providing services to families.	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures	• Completion of orientation documented in personnel file. • Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.

• Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	
2.7 Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Assessment documented in personnel file. • Training per assessment documented in personnel file.
2.8 Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Professional Liability Insurance documented. • Annual Reviews documents compliance.
2.9 Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.10 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.
2.11 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	
<u>2.12 Collaborative Relationships</u> The agency must develop collaborative relationships with community partners that serve each of the identified special populations. These relationships should be documented via Memoranda of Understanding. MOUs will be submitted to TRG for review each year. Referrals should be tracked to evidence the success of these MOUs. Referrals will be reviewed by TRG on an annual basis.	• Executed MOUs are submitted for review to TRG. • Referrals are documented and tracked by the agency. Referral tracking is available for review by TRG and meets expectations.
<u>2.13 Specialized Training</u> Staff should be adequately trained and/or experienced with each of the identified special populations. Training and/or experience should be documented. This documentation will be reviewed by TRG on an annual basis.	• Staff training is documented, available for review by TRG and meets expectations.
<u>2.14 Community Based Approach</u> Services are strongly encouraged to be community based where counseling can be provided in a safe and secure location. Services should be provided on days and at	• Policies and procedures support a community-based approach.

times that are conducive for participation of the identified special populations.	• Primary service records document when services are provided in the community.

References

- American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS, Washington, DC, 2001. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids.pdf
- American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids-watch.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- New York State Department of Health, Mental Health Standards of Care, Delivery of Care. Available at: https://www.health.ny.gov/diseases/aids/providers/standards/mental_health/delivery_of_care.htm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
MENTAL HEALTH SERVICES

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

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
ORAL HEALTH CARE

Effective Date: April 1, 2024/September 1, 2024

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

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

Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance.

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

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

Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.

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

Scope of Services:
Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, routine dental examinations, diagnosis and treatment of HIV-related oral pathology, restorative dental services, root canal therapy, prophylaxis, x-rays, fillings, and basic oral surgery (simple extractions), endodontics and oral medication (including pain control) for HIV PLWH 15 years old or older based on a comprehensive individual treatment plan. Referral for specialized care should be completed if clinically indicated.

Additionally, the category includes prosthodontics services including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance. If a provider cannot provide adequate services for emergency care, the PLWH should be referred to a hospital emergency room.

Limitations:
Cosmetic dentistry for cosmetic purposes only is prohibited.

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

Standard	Evidence
Program	
1.1 Dental and Medical History To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the PLWH's health and medication status. Provider obtains and documents HIV primary care provider contact information for each PLWH. Provider obtains from the primary care provider or obtains from the health history information with updates as medically appropriate prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within in last 12 months) CBC laboratory test • Current (within the last 12 months) CD4 and Viral Load laboratory test results or more frequent when clinically indicated • Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level (e.g., Factor VIII activity) and inhibitor titer (e.g., BIA) • Tuberculosis screening result • PLWH's chief complaint, where applicable • Current Medications (including any osteoporotic medications) • Pregnancy status, where applicable • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis A, B, C status • Usual oral hygiene	• Dental and medical health history per established criteria documented in primary service record. • Health history update per established timeframe documented in primary service record.

• Date of last dental examination • Involuntary weight loss or weight gain • Review of systems • Any predisposing conditions that may affect the prognosis, progression and management of oral health condition. An update to the health history should be completed as medically indicated or at least annually.	
1.2 Limited Physical Exam Initial limited physical examination should include, but shall not necessarily be limited to, blood pressure, and pulse/heart rate as may be indicated for each PLWH according to the Texas Board of Dental Examiners. Dental provider will obtain an initial baseline blood pressure/pulse reading during the initial limited physical examination of a PLWH. Dental practitioner should also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a PLWH's vital signs, the dental practitioner must document in the primary service record an acceptable reason why the attempt to obtain vital signs was unsuccessful.	• Limited physical examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.3 Oral Examination PLWH must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established PLWH • D0120-Periodic Oral Evaluation to include bitewing x-rays, established PLWH, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established PLWH; not post-operative visit) • Comprehensive Periodontal Evaluation, new or established PLWH. Source: http://ada.org	• Oral examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.4 Comprehensive Periodontal Examination Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines. PLWH must have a periodontal screening once per year. A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants.	• Agency policies and/or procedures document when a comprehensive periodontal examination should occur. • Comprehensive periodontal examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.

Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the PLWH's dental and medical history and general health assessment. • It may include the evaluation and recording or dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. (Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. PLWH may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with PLWH).	
<u>1.5 Treatment Plan</u> A dental treatment plan should be developed appropriate for the PLWH's health status, financial status, and individual preference should be chosen. A comprehensive, multi-disciplinary treatment plan will be developed and updated in conjunction with the PLWH. PLWH's primary reason for dental visit should be addressed in treatment plan. Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. A comprehensive dental treatment plan that includes preventive care, maintenance and elimination of oral pathology will be developed and updated annually. Various treatment options should be discussed and developed in collaboration with the PLWH. The plan should include culturally and linguistically appropriate goals. Treatment plan should include as clinically indicated: • Provision for the relief of pain • Elimination of infection • Preventive plan component • Periodontal treatment plan if necessary • Elimination of caries • Replacement or maintenance of tooth space or function • Consultation or referral for conditions where treatment is beyond the scope of services offered • Determination of adequate recall interval. • Invasive Procedure Risk Assessment (prior to oral surgery, extraction, or other invasive procedure) • Dental treatment plan will be signed by the oral care health professional providing the services. (*Electronic signatures are acceptable*) Dental treatment plan will be updated annually.	• Treatment plan per established criteria documented in primary service record. • Updated dental treatment plan per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.

1.6 Phase 1 Treatment Plan In accordance with the National Monitoring Standards a Phase 1 treatment plan includes prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. Phase 1 treatment plan will be established and updated annually to include what diagnostic, preventative, and therapeutic services will be provided. Phase 1 treatment plan will be established within 12 months of initial assessment. The plan should include culturally and linguistically appropriate goals. Treatment plan should include as clinically indicated: • Restorative treatment • Basic periodontal therapy (non-surgical) • Basic oral surgery (simple extractions and biopsy) • Non-surgical endodontic therapy • Maintenance of tooth space • Tooth eruption guidance for transitional dentition The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	• Phase 1 treatment plan per stablished criteria documented in the primary service record. • Phase 1 treatment plan per established timeframe documented in the primary service record. • Completion of Phase 1 treatment plan per established timeframe documented in the primary service record. • Updated Phase 1 treatment plan per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.
1.7 ~~Annual~~ Hard/Soft Tissue Examination The following elements are part of each PLWH's annual hard/soft tissue examination and are documented in the primary service record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of PLWH needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all PLWH may not exceed two (2) years.	• Hard/soft tissue examination per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.
1.8 Oral Health Education Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager. Provider must provide oral health education once each year which includes but is not limited to the following: • D1330 Oral hygiene instructions • Daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the	• Oral health education per established criteria documented in the primary service record. • Oral health education per established timeframe documented in the primary services record. • Exceptions documented in the primary service record.

PLWH. If deemed appropriate, the reason is stated in the primary service record • D1320 Smoking/tobacco cessation counseling as indicated • Additional areas for instruction may include Nutrition (D1310). • For pediatric PLWH, oral health education should be provided to parents and caregivers and be age appropriate for pediatric PLWH. The content of the oral health education will be documented in the primary service record.	
<u>1.9 Referrals and Tracking</u> Referrals for other services must be documented in the primary service record. Outcome of the referral will be documented in the primary service record.	• Referrals made documented in the primary service record. • Outcome of referrals documented in primary service record.
<u>1.10 Coordination of Care</u> The provider will consult with PLWH's medical care providers when indicated. Consultations will be documented in the primary service record.	• Consultations documented in the primary service record.
<u>1.12 Annual Cap of Charges</u> Maximum amount that may be funded by Ryan White/State Services per PLWH is $3,000/year. • In cases of emergency, the maximum amount may exceed the above cap • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap. • Dental providers must document ***via approved waiver*** the reason for exceeding the yearly maximum amount.	• Approved waiver for charges exceeding annual cap documented in the primary service record.
<u>1.10 Explanation of Charges</u> As part of the delivery of services, any charges that need to be paid by the PLWH should be explained. It is preferred that the PLWH is given the explanation of charges in writing as well as providing it verbally. All explanations of charges should include the explanation that services may not be denied due to an inability to pay.	• Documentation of the explanation of charges present in primary service records reviewed. • PLWH interviews indicate compliance. • Staff interviews indicate compliance.
Administrative	

<u>2.1 Program Policies and/or Procedures</u>
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
 	
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG Contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

<u>2.2 Services Requiring Licensed Personnel</u>	• License documented in the personnel file.

All oral health care professionals, such as general dental practitioners, dental specialists, and dental hygienists shall be properly licensed by the State of Texas Board of Dental Examiners while performing tasks that are legal within the provisions of the Texas Dental Practice including satisfactory arrangements for malpractice insurance. Dental Assistants who make x-rays in Texas must register with the State Board of Dental Examiners. Dental hygienists and assistants will be supervised by a licensed dentist. Students enrolled in a College of Dentistry may perform tasks under the supervision.	• Staff interviews document compliance.
2.3 Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically related issues is required annually for licensed staff. • One (1) hour of training in HIV/AIDS is required annually for all other staff.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.4 Staff Experience Service provider should employ individuals experienced in dental care and knowledgeable in the area of HIV/AIDS dental practice. A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Work experience documented in personnel file with exceptions to work experience noted.
2.5 Supervisor Qualifications Supervision of clinical staff shall be provided by a practitioner with at least two years' experience in dental health assessment and treatment of persons living with HIV.	• Clinical supervision qualifications documented in personnel file.
2.6 Staff Supervision All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.7 Confidentiality Each dental employee will sign a confidentiality statement.	• Signed Confidentiality Statement documented in personnel file.
2.8 Universal Precautions All health care workers should adhere to protective practices as defined by Texas Administrative Code, Title 22, Part 5, Chapter 108, Subchapter B, Rule §108.25, and OSHA Standards for Bloodborne Pathogens (29 CFR 1910.1030), and OSHA Personal Protective Equipment (29 CFR 1910 Sub Part 1.	• Staff training documented in personnel file. • Staff interviews document compliance.
2.9 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	
2.10 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

References

- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April 2011, page 9-10. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, page 9-10. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Subchapter A, Rule §108.7 Minimal Standards of Care, General located at https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7

- Texas Administrative Code. Title 22, Part 5, State Board of Dental Examiners, Chapter 108, Subchapter A, Rule §108.8, Records of the Dentist located at: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=8
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at https://statutes.capitol.texas.gov/Docs/HS/htm/HS.85.htm
- HRSA/HAB Clinical Care & Quality Management. HAB Oral Health Performance Measures located at https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio Accessed January 11, 2018.
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- New York State Department of Health AIDS Institute, Management of Periodontal Disease located at: https://www.hivguidelines.org/hiv-care/hiv-related-periodontal-disease/ Accessed October 14, 2020
- New York State Department of Health AIDS Institute, Oral Health Complications located at: https://www.hivguidelines.org/hiv-care/oral-health/. Accessed October 14, 2020
- HB2056: https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB2056
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
ORAL HEALTH CARE

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

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING
SUBSTANCE USE DISORDERS

Effective Date: April 1, 2024/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

Key activities include:

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

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

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

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

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

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

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

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

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

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

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

office and/or medical clinic. Agencies should have systems in place to ensure the security of staff and the protections of PLWH information.	• Community-based service provision documented in primary service record.
Administrative	
2.1 Program Policies and Procedures Program will have a policy that: • Defines and describes N-MCM targeting SUD services (funded through Ryan White or other sources) that complies with the standards of care outlined in this document. • Specifies that services shall be provided in the office and in the field (i.e. community based). • Specifies required referral to and coordination with HIV medical services providers. • Requires referral to and coordination with providers of substance use treatment/counseling, as appropriate. • Requires monitoring of referrals into services Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards.	• Program's Policies and Procedures address systems to comply with ▪ Scope of Services ▪ TRG Contract and Attachments ▪ Performance Measures ▪ Standards of Care
2.2 Agency Licensure The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of substance use treatment/counseling	• Copy of Agency Licensure and/or Certification provided as part of Contract Submissions Process
2.3 Staff Qualifications Non-Medical Case Managers must have at a minimum a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented work experience in providing services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Agency will provide Non-Medical Case Manager a written job description upon hiring.	• Degree documented in personnel file. • Work experience documented in personnel file. • Signed job description documented in personnel file.
2.4 Staff Training Staff must complete the following trainings: • Within thirty (30) days of hire, complete HHS-mandated Cybersecurity training and DSHS Data Security and Confidentiality training (or approved equivalent) • Within sixty (60) days of hire, complete TRG Standards of Care orientation.	• Certificates of completion and/or attendance documented in the staff personnel file. • Any special circumstances for not meeting the timeframes are noted in the staff personnel file.

• Within six (6) months of hire, complete the DSHS HIV Care Coordination Training Curriculum (https://www.dshs.texas.gov/hivstd/contractor/cm.shtm) • After first year, a minimum of 12 hours of continuing education in relevant topics annually.	
2.5 Supervision A minimum of four (4) hours of supervision per month must be provided to each N-MCM by a master's level health professional. At least one (1) hour of supervision must be individual supervision. Supervision activities includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments	• Supervision activities documented and provided for review during the Quality Compliance Review
2.6 Caseload Coverage – N-MCMs Supervisor ensures that there is coverage of the caseload in the absence of the N-MCM or when the position is vacant. N-MCM may assist PLWHs who are routinely seen by other CM team members in the absence of the PLWH's "assigned" case manager.	• • Assignment of case coverage documented in supervisory records. • Activities conducted by staff providing case coverage documented in primary service record.
2.7 Case Reviews – N-MCMs Supervisor reviews a random sample equal to 10% of unduplicated PLWHs served by each N-MCM at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Case reviews documented in primary service record, signed and dated by supervisor and/or quality assurance personnel and N-MCM
2.8 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

organizations' planning and operations.	
2.9 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

References:

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. P. 25-26. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. P. 24-26. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18),

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

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

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