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

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

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

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

Program Guidance: Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

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

DSHS Definition:
Provision of end-of-life care provided by licensed hospice care providers to PLWH in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients.

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

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

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

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

Local Definition:
Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Scope of Services:
Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

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

Services not allowed under this service:
- HIV medications under hospice care unless paid for by the PLWH.
- Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.

- Funeral, burial, cremation, or related expenses.
- Nutritional services,
- Durable medical equipment and medical supplies.
- Case management services
- Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the PLWH's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services per legislation.

Standard	Evidence
Program	
1.1 Physician Certification • The attending physician must certify that a PLWH is terminal, defined under Texas Medicaid hospice regulations as having a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification must specify that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification statement must be based on record review or consultation with the referring physician. • The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse. • Must be reassessed by a physician every six (6) months. • Must first seek care from other facilities and denial must be documented in the resident's chart.	• Physician certification documented in the primary service record. • Reassessment documented in the primary service record.
1.2 Denial of Service The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following: • There are no beds available • Level of patient's acuity and staffing limitations • Patient is aggressive and a danger to the staff • Patient is a "no show" Agency must develop and maintain s system to inform Administrative Agency regarding issue of long-term care facilities denying admission for PLWH based on	• Denial of Services documented in the primary service record. • Notification of the Administrative Agency regarding issue of denying admission for PLWH based on inability to provide appropriate level of skilled nursing care documented.

inability to provide appropriate level of skilled nursing care	
1.3 Intake Information Information will be obtained at intake (from the referral source, PLWH or other source) and will include, but is not limited to: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (PLWH self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information	• Intake information documented in the primary service record.
1.4 Comprehensive Health Assessment A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Completed comprehensive health assessment document in the primary service record and dated within 48 hours of admission. • Required elements are included in the comprehensive health assessment.

Hospice provider documents each PLWH's scheduled medications, including dosage and frequency. • HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects. • Hospice provider documents as needed medications for PLWH and includes PLWH's name, dose, route, reason, and outcome.	
1.5 Care Plan Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. These priorities should include culturally and linguistically appropriate goals. A written Plan of Care is completed for each patient within seven (7) calendar days of admission and reviewed monthly. Care Plans will be updated once every six (6) months thereafter or more frequently as clinically indicated. Hospice care should be based on the professional guidelines for supportive and palliative care. Hospice providers will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Completed care plan based on physician's orders documented in the primary service record within 7 calendar days of admission. • Monthly care plan reviews documented in the primary service record. • Care Plan updates documented in the primary service record at least every 6 months.
1.6 Palliative Therapy Palliative therapy is designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure. Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider	• Palliative therapy as ordered by the referring provider documented on the care plan in the primary service record. • Provision of palliative therapy documented in the primary service record.
1.7 Counseling Services for Family The need for counseling services for family members must be assessed and a referral made if requested. The need for counseling services for family members must be consistent with definition of mental health counseling.	• Assessment and referrals documented in the primary service record.
1.8 Bereavement Counseling The need for bereavement counseling services for family members must be consistent with the definition of mental health counseling.	• Discussion of bereavement counseling with family members upon admission to Hospice services documented in the primary service record.

Bereavement counseling must be provided. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • Develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery, • Make bereavement services available to a patient's family and other persons in the bereavement plan of care for up to one year following the death of the patient, • Ensure that bereavement services reflect the needs of the bereaved. Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services in a skilled nursing facility or nursing home per legislation.	• Bereavement care plan documented in the primary services record. • Provision of bereavement counseling documented in the primary services record.
<u>1.9 Mental Health Counseling</u> Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's assessment • The patient's acceptance of these services	• Provision of mental health counseling documented in the primary service record. • Qualifications of mental health professional documented in personnel file.
<u>1.10 Dietary Counseling</u> Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a hospice patient's condition progresses. Dietary	• Dietary counseling documented on the care plan in the primary service record. • Provision of dietary counseling documented in primary service record.

counseling, when identified in the plan of care, must be performed by a qualified person. A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a PLWH are met.	
<u>1.11 Spiritual Counseling</u> A hospice must provide spiritual counseling that meets the PLWH's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the PLWH's and family's spiritual needs, • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a PLWH's spiritual needs, and • Advise the PLWH and family of the availability of spiritual counseling services.	• Discussion of spiritual counseling with PLWH and family members upon admission to Hospice services documented in the primary service record. • Provision of spiritual counseling documented in the primary service record. • Referral to spiritual counseling documented.
<u>1.12 Medical Social Services</u> Medical social services must be provided by a qualified social worker. and is based on: • The PLWH's and family's needs as identified in the patient's assessment • The PLWH's and family's acceptance of these services	• Medical social services documented on the care plan in the primary service record. • Provision of medical social services documented in the primary service record.
<u>1.13 Multidisciplinary Team Approach</u> Programs must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical, and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.	• Multidisciplinary team documented in the primary service record. • Provision of multidisciplinary coordination documented in the primary service record.
<u>1.14 Medication Administration Record</u> Staff documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and	• Medication administration documented in the primary service record.

signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	
1.15 PRN Medication Record Staff documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, outcome, and signature and title of staff.	• PRN medication administration documented in the primary service record.
1.16 Referrals and Tracking Program receives referrals from a broad range of HIV service providers, community stakeholders and clinical providers. Program makes appropriate referrals out when necessary.	• Referral source documented in the primary service record. • Referrals made documented in the primary service record
1.17 Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves, and hospice care is no longer necessary, based on attending physician's plan of care and a referral to Medical Case Management or OAHS must be documented Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility	• Discharge documented in primary service record. • One or more discharge criteria met.
Administrative	
Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments • Standards of Care • Collection of Performance Measures
2.1 Facility Licensure Agency is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation	• License and/or certification available at the site(s) where services are provided. • License and/or certification posted in a highly visible place at site(s) where services are provided.
2.2 Services Requiring Licensed Personnel	• License documented in the personnel file.

All services requiring licensed personnel shall be provided by appropriate licensed personnel in accordance with State of Texas regulations. Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• Staff interviews document compliance.
2.3 Staff Education Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of PLWH. Agency provides access to training activities, including but not limited to: • Updated HIV information, including current treatment methodologies and promising practices • In-service education • DSHS-sponsored trainings	• Agency documents the dissemination of HIV information and training activities relevant to the needs of PLWH to paid staff and volunteers. • Agency documents attendance at training activities. • Materials for training activities (agendas, handouts, etc.) are on file.
2.4 Ongoing Staff Training • Eight (8) hours of training in HIV 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.
2.5 Staff Experience A minimum of one-year documented hospice and/or HIV work experience is preferred	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 Staff Supervision Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years' experience in hospice care of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas licensure requirements. Supervisory, provider or advanced practice registered nurses will document supervision over other staff members	• Work experience for professional supervisory providers documented in personnel file. • Supervision consistent with licensure documented. • Supervision of other staff members by supervisory provider or advanced practice registered nurse documented.
2.7 Volunteer Assistance Volunteers cannot be used to substitute for required personnel. They may however provide	• Policy and/or procedure documents duties and activities conducted by volunteers and oversight.

companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures	• Signed job descriptions documented in volunteer file. • Service provision by volunteers are documented in the primary service record.
2.8 Volunteer Training Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV. For volunteers who are licensed practitioners, training addresses documentation practices	• Trainings and education documented in volunteer file.
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. 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.
2.10 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.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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.	

References

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

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

- 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
HOSPICE SERVICES

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

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

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

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

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

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

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

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

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

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

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

Scope of Services:
The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual PLWH. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.

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

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

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

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

Certification for Medical Interpreters (NBCMI). Where CCHI and NBCMI certification for a specific language do not exist, an equivalent certification (MasterWord, etc.) may be substituted for the CCHI and NBCMI certification. • Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), the National Interpreter Certification (NIC), or the State of Texas at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting.	Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act • Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency scheduling documents appropriate levels of interpreters are requested.
2.6 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.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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.	

References

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

- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- National Culturally and Linguistically Appropriate Services (CLAS) Standards: https://thinkculturalhealth.hhs.gov/clas/standards
- 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
LINGUISTIC INTERPRETIVE SERVICES

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

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
REFERRAL FOR HEALTH CARE TARGETING
THE INCARCERATED AND RECENTLY RELEASED

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

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

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

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

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

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

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

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

Local Definition:
Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible PLWH incarcerated in Harris County Jail to prequalify for public and private programs for which they may be eligible and provide transitional social services to establish or re-establish linkages to the community. RFHC targeting IRR will not exceed 180 days without an approved waiver from TRG.

Scope of Services:
Referral For Health Care (RFHC) Targeting the Incarcerated and Recently Released (IRR) provides linkage to core medical and care enabling services. Core Components (include but are not limited to): 1) Benefits Counseling/Assessment (including screening for eligibility for healthcare coverage and other community programs to resolve social determinants of health), 2) Submission of expedited THMP applications through TCT, 3) Referral to community partners and programs, 4) Referral Education to ensure successful completion of referrals, 5) Referral follow-up with community partners and programs to determine outcome of referral, and 6) Coordination of access to HCJ for community partners

Service Intervention Goals of RFHC Targeting the IRR:
1. To bring people living with HIV (PLWH) into Outpatient/Ambulatory Health Services (OAHS).
2. To decrease the number of underserved PLWH by increasing access to care, educating and motivating PLWHs on the importance and benefits of getting into care, through expanding key points of entry.
3. To improve referral services for HIV care and treatment services at key points of entry.

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

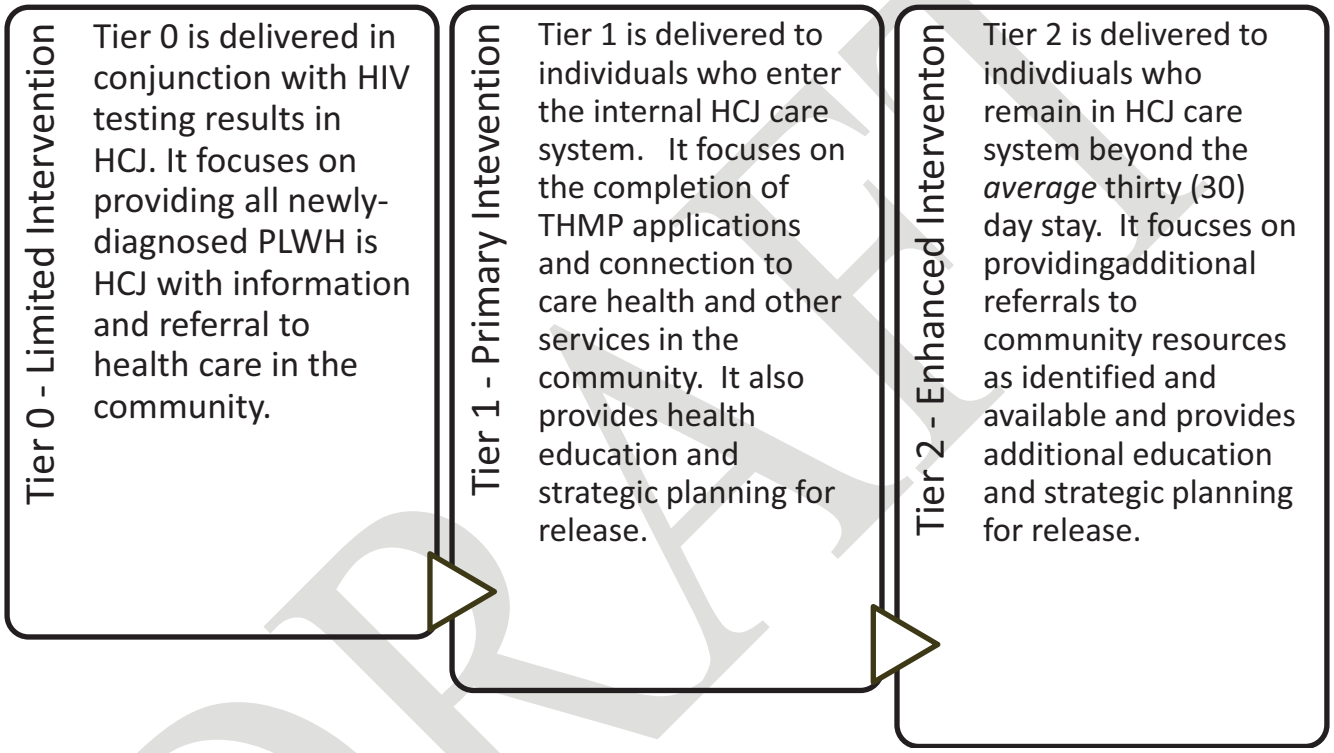
Therefore, RFHC Targeting the IRR has been designed to consider the uncertain nature of length of stay in the service delivery. Three tiers of service provision haven been designated. They are:

- **Tier 0:** The individuals in this tier do **not** stay in HCJ long enough to receive a clinical appointment while incarcerated. The use of zero for this tier's designation reinforces the understanding that the interaction with funded staff will be minimal. The length of stay in this tier is traditionally less than 14 days.
- **Tier 1:** The individuals in this tier stay in HCJ long enough to receive a clinical appointment while incarcerated. This clinical appointment triggers the ability of staff to conduct sufficient

interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days.

- **Tier 2:** The individuals in this tier remain in HCJ long enough to get additional interactions and potentially multiple clinical appointments. The length of stay in this tier is traditionally 30 or more days. **If service will extend past 180 days, a waiver must be obtained from TRG.**

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



Guiding Principles for Intervention:

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

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

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

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

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

Medication Program (THMP). For newly diagnosed PLWH, the Staff will complete the THMP application as part of the first medication appointment and have the provider complete the medical certification form. When PLWH return to HCJ, the Staff will verify the THMP application is still current in TCT (using birth month and half-birth month criteria). If not, an updated THMP application/attestation will be completed	• Screening for current THMP applications for returning PLWH documented in primary service record. • THMP application/attestation upload for returning PLWH based on birth month and half-birth month criteria documented in ARIES.
<u>1.9 THMP Intake Process</u> Staff are expected to meet with eligible PLWH to complete a comprehensive THMP intake including explanation of program benefits and requirements. The intake will also include the determination of PLWH eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI). Staff should identify and screen PLWH for third party payer and potential abuse Staff should obtain, maintain, and submit the required documentation for PLWH application (when available) including the THMP Medical Certification Form (MCF). Due to the incarceration status of the PLWH, the Initial Applications should be submitted as "Expedited."	• THMP education to new/potential PLWH documented in the primary service record. • Completed THMP application and supporting documentation (including the MCF) documented in the primary service record.
<u>1.10 Benefits Continuation Process (ADAP)</u> Staff are expected to meet with new/potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist PLWH and or staff with the submission of complete, accurate ADAP applications. Birth Month/Recertification • Staff should conduct annual recertifications for enrolled PLWH in accordance with THMP policies. Recertification should include completion of the ADAP application, obtaining and verifying all eligibility documentation and timely submission to THMP for approval. • Recertification process should include screening PLWH for third party payer to avoid potential abuse. • Complete ADAP application including the THMP Medical Certification Form (MCF). • Staff must ensure Birth Month/Recertifications are	• Attempts to contact PLWH for attestations and recertifications per established timeframe documented in the primary service record. • Completed attestations and recertifications documented in the primary service record. • Lapse benefits due to non-completion of timely recertification/attestation documented in the primary service record. • Exceptions documented in the primary service record.

submitted by the last day of PLWH's birth month to ensure no lapse in program benefits. Half-Birth Month/6-month Self Attestation • Staff should conduct a 6-month half-birth month/self-attestation for all enrolled PLWH in accordance with THMP policies. Staff will obtain and submit the PLWH's self-attestation with any applicable updated eligibility documentation. Half-birth/6-month self-attestations must be submitted by the last day of the PLWH's half-birth month to ensure no lapse in program benefits. Due to the incarceration status of the PLWH, the Recertifications and/or Self Attestations should be submitted as "Expedited."	
1.11 TCT Application Process The TakeChargeTexas (TCT) Application Process is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • ADAP Applications (with supportive documentation) must be completed through the TCT Application Process for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be completed according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be completed in TCT within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed application in TCT. Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction.	• Policies are in place at all locations that are funded in the state of Texas with RWHAP Part B and State Services funds that ensure TCT information is protected and maintained to ensure confidentiality. • Local policies and procedures are in place relating to TCT and the data collected through TCT. • Uploaded THMP application per established timeframe documented in TCT. • Notification of THMP application per established timeframe documented in primary service record.
1.12 Education/Counseling – Newly Diagnosed The Staff will reinforce prevention messaging/intervention received as part of HIV testing program. Additionally, the Staff will target the following topics:	• Education/counseling consistent with the PLWH's identified need documented in primary service record.

• Living healthy with HIV • Treatment As Prevention • Role of medications in healthy living • Maintenance of immune system • Disclosure to partners and support systems The Staff should coordinate with clinical staff to ensure that health messaging is provided by appropriate clinicians.	
1.13 Education/Counseling – All Based on the comprehensive assessment, the Staff will target the following topics for all PLWH served by the intervention: • Living healthy with HIV • Role of medications in healthy living • Maintenance of immune system • Medication Adherence • THMP Process • Provision of the Mini Blue Book • Disclosure to partners and support systems The Staff should coordinate with clinical staff to ensure that health messaging is provided by appropriate clinicians.	• Education/counseling consistent with the PLWH's identified need documented in primary service record.
1.14 Health Literacy The Staff will provide the PLWH with health literacy messaging that is tailored to "where the PLWH is at" as determined by the comprehensive assessment. Examples of health literacy messaging include: • For newly diagnosed (i.e. treatment naïve), discussion about the importance of medical care, access third party payor options, and Ryan White care services. • Discussion of navigating care system • Discussion of medical home concept • Mapping out best option for community care based on future residence/work • Discussion of community support (EXCLAIM i.e. MAI Project) • Discussion about relationships (including U=U, viral suppression, and self-care) • Discussion about Hope (decreasing stigma and misinformation about living with HIV)	• Provision of health literacy education/messaging documented in the primary service record.
1.15 Coordination of Community Care The Staff will make a referral to community care based on the PLWH's selection of a medical home. This referral will include the arrange appointment for PLWH prior to release to community partners. The referral process with	• Scheduling of community medical appointment documented in primary service record. • When scheduling is not possible, referral to community agency (MAI,

comply with the preferred method of scheduling appointments established with the community partner.	case management, etc.) for follow-up with PLWH upon release documented in the primary service record.
1.16 Transitional Multidisciplinary Team The Staff will be part for the multidisciplinary care team (MDT) within HCJ. The Staff meet and review each PLWH's information with the medical team to improve the quality of care provided while in HCJ. Additionally, the Staff will act as the conduit to deliver the information from the internal MDT to community partners, as appropriate.	• MDT reviews documented in the primary service record. • Communication and/or coordination with community partners documented in primary service record.
1.17 Discharge Planning Staff conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a strategy plan. Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. Staff, MAI, MHMR, DSHS Prevention). Discharge plans should have culturally and linguistically appropriate goals.	• Discharge planning activities documented in the primary service record.
1.18 PLWH Strategy Planning The Staff and the PLWH should discuss honestly the challenges with obtaining resources in the freeworld/ community and develop strategies to minimizing those challenges. The Staff should focus the PLWH on strengths that they have that con contribute to successes in the freeworld/community.	• Strategies developed for obtaining services in the freeworld documented in the primary service record.
1.19 Consent to Release/Exchange Information The Staff will obtain signed consent to release and exchange information from the PLWH to assist in the process of making referrals to community resources	• Signed consent documented in the primary service record.
1.20 Internal Referrals Internal referrals: HIV care; substance use; mental health; referral to other clinic for comorbidities Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • Mental Health, as applicable • Substance Use Treatment, as applicable	• Connection to internal care services documented in the primary service record, as applicable

1.21 External Referrals Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help maintain PLWH in medical care in the freeworld. The Staff will schedule an appointment for PLWH who will be returning to the community with a medical provider of the PLWH's choosing. For PLWH who will be transferring to TDCJ, no appointments will be scheduled. If PLWH is awaiting transfer to TDCJ, Staff will ensure a note is placed in primary service record and external referrals will not occur.	• Referral to community medical care documented in primary service record. • Referral to support services documented in primary service record. • Additional referrals made on behalf of the PLWH documented in primary service record. • Exceptions (when PLWH is awaiting transfer to TCDJ, etc.) documented in primary service record.
1.22 Referral Packet Staff makes referrals to agencies for all PLWHs to be released from Harris County Jail. The referral packet will include: a. A copy of the Harris County Jail Intake/Assessment Form, b. Copy of Medication Certification Form (whenever possible) or otherwise i. Proof of HIV diagnosis, ii. A list of current medications, and c. Copy of ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV services in the community.	• Provision of a referral packet to support external referrals documented in primary service record.
1.23 Referral Tracking/Follow-Up All referrals made will have documentation of follow-up to the referral in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the Staff offered to the PLWH. Successful linkage to care is measured as attendance to the actual medical appointment with a provider with prescribing privileges.	• Referral follow-up activities conducted to ensure that the external referrals were completed, and the outcome of the referral documented in primary service record.
1.24 Disengaged from Care/ DIS Referral After three unsuccessful attempts are made to contact and	• Attempts to reengaged PLWH documented in the primary service

re-engage the PLWH, Staff will notify their local Disease Intervention Specialist (DIS) workers so that public health follow-up can occur.	record. • Referral to DIS documented in the primary service record.
1.25 Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of RFHC Targeting the IRR completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Closure summary documented in the primary service record. • Supervisor signature/approval on closure summary documented in the primary service record (electronic review is acceptable).
1.26 Progress Notes The Staff will maintain progress notes in each primary service record with thorough and accurate documentation of the assistance the Staff provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH documented in primary service record.
Tier 2 – (More Than 30 days) – Enhanced Intervention	
Standard	**Evidence**
2.1 Inclusion Criteria Identified PLWH who remain in HCJ beyond 30 days (i.e. potentially seeing a provider with prescribing authority multiple times).	• Primary service record documents that PLWH should be included in this tier
2.2 Benchmarks • Additional Touches as Length of Stay Permits to reinforce Messaging • Coordination of Additional Medical Appointments • Coordination of Referrals to Community Care and Resources. • Increased provision of health literacy, treatment adherence, and other education	• Each benchmark obtained documented in primary service record.
2.3 Reassessment Staff will conduct reassessments at six (6) months and annually thereafter if individuals remain in HCJ long-term. These assessments can be conducted at the time of clinic appointments. If minimal changes are identified, the results should be documented in the progress notes. If significant changes are identified, the assessment form should be updated.	• Completed reassessments per established criteria documented in the primary service record.
2.4 Continued Education/Counseling Based on the comprehensive assessment, the Staff will target the following topics for all PLWH served by the intervention: • Living healthy with HIV • Role of medications in healthy living	• Education/counseling consistent with the PLWH's identified need documented in primary service record.

• Maintenance of immune system • THMP Process (revisit the need for updated application/attestation) • Provision of the Mini Blue Book • Disclosure to partners and support systems The Staff should coordinate with clinical staff to ensure that health messaging is provided by appropriate clinicians.	
2.5 Health Literacy The Staff will provide the PLWH with health literacy messaging that is tailored to "where the PLWH is at" as determined by the comprehensive assessment. Examples of health literacy messaging include: • Enhanced knowledge- accessing care; navigating care system • Discussion about the Patient/Provider relationship and the importance of developing self-efficacy for quality care • Continued discussion of medical home concept • Continued discussion about relationships (including U=U, viral suppression, and self-care) • Continued discussion about Hope (decreasing stigma and misinformation about living with HIV)	• Provision of health literacy education/messaging documented in the primary service record.
2.6 Transitional Multidisciplinary Team The Staff will be part for the multidisciplinary care team (MDT) within HCJ. The Staff meet and review each PLWH's information with the medical team to improve the quality of care provided while in HCJ. Additionally, the Staff will act as the conduit to deliver the information from the internal MDT to community partners, as appropriate	• MDT reviews documented in the primary service record. • Communication and/or coordination with community partners documented in primary service record.
2.7 Discharge Planning Staff conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a strategy plan. Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. Staff, MAI, MHMR, DSHS Prevention). Discharge plans should have culturally and linguistically appropriate goals.	• Discharge planning activities documented in the primary service record.

2.8 PLWH Strategy Planning The Staff and the PLWH should discuss honestly the challenges with obtaining resources in the freeworld/ community and develop strategies to minimizing those challenges. The Staff should focus the PLWH on strengths that they have that con contribute to successes in the freeworld/community.	• Strategies developed for obtaining services in the freeworld documented in the primary service record.
2.9 Internal Referrals Internal referrals: HIV care; substance use; mental health; referral to other clinic for comorbidities Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • Mental Health, as applicable • Substance Use Treatment, as applicable	• Connection to internal care services documented in the primary service record, as applicable.
2.10 External Referrals Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: • THMP Application (See Standards 1.8-1.11) • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help maintain PLWH in medical care in the freeworld. The Staff will schedule an appointment for PLWH who will be returning to the community with a medical provider of the PLWH's choosing. For PLWH who will be transferring to TDCJ, no appointments will be scheduled. If PLWH is awaiting transfer to TDCJ, Staff will ensure a note is placed in primary service record and external referrals will not occur.	• Referral to community medical care documented in primary service record. • Referral to support services documented in primary service record. • Additional referrals made on behalf of the PLWH documented in primary service record. • Exceptions (when PLWH is awaiting transfer to TCDJ, etc.) documented in primary service record.
2.12 Referral Packet Staff makes referrals to agencies for all PLWHs to be released from Harris County Jail. The referral packet will include: a. A copy of the Harris County Jail Intake/Assessment Form, b. Copy of Medication Certification Form (whenever possible) or otherwise	• Provision of a referral packet to support external referrals documented in primary service record.

i. Proof of HIV diagnosis, ii. A list of current medications, and c. Copy of ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV services in the community	
2.13 Referral Tracking/Follow-Up All referrals made will have documentation of follow-up to the referral in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the Staff offered to the PLWH. Successful linkage to care is measured as attendance to the actual medical appointment with a provider with prescribing privileges.	• Referral follow-up activities conducted to ensure that the external referrals were completed, and the outcome of the referral documented in primary service record
2.14 Disengaged from Care/DIS Referral After three unsuccessful attempts are made to contact and re-engage the PLWH, Staff will notify their local Disease Intervention Specialist (DIS) workers so that public health follow-up can occur.	• Attempts to reengaged PLWH documented in the primary service record. • Referral to DIS documented in the primary service record.
2.15 Case Closure PLWH who are released from HCJ must have their cases closed with a case closure summary narrative documenting the components of RFHC Targeting the IRR completed with the PLWH and the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM), referral to DIS (if applicable), and referral outcome summary (if applicable).	• Closure summary documented in the primary service record. • Supervisor signature/approval on closure summary documented in the primary service record (electronic review is acceptable).
2.16 Progress Notes The Staff will maintain progress notes in each primary service record with thorough and accurate documentation of the assistance the Staff provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Thorough and accurate progress notes showing component of the intervention provided to and the benchmarks achieved with the PLWH documented in primary service record.
Administrative	
Standard	**Evidence**
3.1 Agency License The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services	• Copy of Agency Licensure provided as part of Contract Submissions Process.
3.2 Program Policies and/or Procedures Agency will have a policy that: • Defines and describes RFHC Targeting the IRR services (funded through Ryan White or other sources)	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments

that include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for PLWHs to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found • Requires monitoring of referrals into care and treatment Additionally, the Program will have policies and procedures that comply with applicable DSHS Universal Standards.	▪ Standards of Care ▪ Collection of Performance Measures
<u>3.3 Staff Qualifications</u> All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. Supervisors must possess a degree in a health/social service field or equivalent experience.	• Assessment of staff qualifications documented in personnel file. • Training to increase staff qualifications documented in personnel file.
<u>3.4 Continuing Education</u> Each staff will complete a minimum of (12) hours of training annually to remain current on HIV care.	• Evidence of training will be documented in the staff personnel records.
<u>3.5 Case Reviews</u> Agency must have and implement a written plan for supervision of Staff. Supervisors must review a 10 percent sample of each team member's primary service records each ninety (90) days for completeness, compliance with these standards, and quality and timeliness of service delivery. Each supervisor must maintain a file on each staff supervised and hold supervisory sessions on at least a monthly basis. The file must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing	• Case reviews by supervisor documented with signed and dated by supervisor and/or quality assurance personnel and Staff member

at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service	
3.6 MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting PLWHs into ongoing care.	• Signed MOUs verified during annual quality compliance review. • Communication and referrals with agencies covered in MOUs documented in primary service record.
3.7 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	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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:

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

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

Intervention-Specific Performance Measures:

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